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PAPER III

MD and DNB psychiatry, theory revision

Speciality Psychiatry

Psychiatry practised at its edges: the child who is still becoming, the patient the law has an interest in, the treatments given under anaesthesia, the mother and the emergency, and the patient who belongs to another ward. Ten complete sets of notes, in one book.

Dr. Wilfred D'souza · Dr. Niharika Reddy

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WEAVE SPRINT · PAPER III

Speciality Psychiatry

THE WEAVE SPRINT SERIES

TITLE

Weave Sprint, Paper III: Speciality Psychiatry

Part of the Weave Sprint series, MD and DNB psychiatry theory revision.

WRITTEN BY

Dr. Wilfred D'souza and Dr. Niharika Reddy

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EDITION

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

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 and thresholds against the current references and your local protocols before any clinical use.

For every resident who has ever sat up the night before,
afraid it will not be enough.

ACKNOWLEDGEMENT

A word of thanks

I want to begin by thanking something I cannot quite name. Call it whatever you like. I have never been certain what to call it, and I have stopped needing to be. There is a part of this work that does not feel like mine. The line that arrives before I have thought of it, the connection I did not plan, the steadiness on a morning I had no reason to be steady. I only hold the pen. Something moves through the holding, and I have learned to thank it without asking it for a name.

Someone once asked me why I give all of this away. Why hand out the notes I sat up making, to the very people sitting the same exam beside me. It is a fair question. If I had kept them, I would probably have scored a few marks more than the next person, and I might have been thought of as the better student. I have turned that over honestly, and I have decided it is a small thing to want. What I get instead, by putting the work in your hands, is the chance to take a little of the fear out of a great many nights. That trade is not close. Easing that fear is not a detour on the way to becoming a good psychiatrist. It is the thing itself. I did not come here to be the best student in the room. I came here to be a good psychiatrist.

And to Niharika, who reads everything first and knows when to be honest and when to wait; and to the residents who study from these pages and write back with the corrections and the questions: thank you. The book is better for you, and so am I.

Dr. Wilfred D'souza

Foreword

This is the third paper of the written examination, gathered into one book. Where the first paper laid the ground the discipline stands on and the second was the discipline at work on the disorders themselves, this one is psychiatry practised at its edges: the child who is still becoming, the patient the law has an interest in, the treatments given under anaesthesia, the mother and the emergency, and the patient who belongs to another ward, another decade or another explanation of what is wrong. These are the settings where general psychiatry stops being general.

The notes were written to be understood, not just revised. Each chapter is a full account of its subject, from the mechanism up to the point the exam tests, so that you can read to learn the first time and read to recall every time after. Where a fact is worth holding exactly, it is marked. Where a mistake is easy to make, it is named before you make it. The colour code on the next pages tells your eye what kind of fact it is looking at before your mind has to decide, and after a few pages it stops being a key you consult and becomes a sense you carry.

Read it in order if you are meeting the material, or open it anywhere if you are returning to it. The contents at the front and the index at the back both jump to the page you want. However you use it, the hope held in these pages is plain: that one ordered, trustworthy place to study from makes the work a little lighter, and that you walk into the hall steadier than you would have otherwise.

HOW TO USE THIS BOOK

The colour memory code

Every note in this volume speaks one visual language, so once you learn it in the first chapter you read the rest without thinking about it.

Concept and rule	The core idea and the principle that follows from it. When a line is petrol, it is the thing to understand, and the thing worth being able to state.
Key number	A figure to hold exactly: a dose, a threshold, a prevalence, a cut-off. Amber means memorise this number, not just the shape of it.
Trap	The mistake the exam is waiting for. When a line is coral, it is warning you off an error that looks right until it costs you the mark.

Hold this is the single line from a topic you must carry out of it. **Good to remember** gathers, for each named thing, what it is, when it matters, and the one number or formula worth keeping. Both help a tired brain find the centre of a dense page fast.

The contents at the front is clickable, and so is the index at the back: every entry jumps to its page. Read to learn once, and to recall as often as you need.

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PART I

Normal Child Development and Milestones

How a child normally develops: the domains, the milestones and the ages, and what counts as a deviation worth acting on.

01 The developmental frameworks

02 The domains and the milestones

03 Development in context and clinical use

04 Apply and consolidate

05 Previously asked

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PAPER III

Normal child development & milestones

Three bands . one complete notes document

The developmental frameworks

1 . Piaget stages of cognitive development

Jean Piaget described cognitive development as an active construction of knowledge, not the passive accumulation of facts. The child acts on the world, builds organised patterns of understanding, finds that some patterns no longer explain experience, and modifies them. The theory therefore asks a more useful question than "What does the child know?": *what form of reasoning is available to the child, and what kind of problem can that reasoning solve?* Piaget proposed an invariant sequence of four broad organisations of thought: sensorimotor, preoperational, concrete operational and formal operational. The sequence is the examinable backbone. The age bands attached to it are textbook descriptors with source variation, not developmental screening cut-offs and never referral thresholds.

How to use this page. First learn the direction of change: action becomes mental representation; representation becomes logical but remains tied to concrete situations; logic then extends to possibilities, propositions and hypotheses. Next learn the characteristic achievement and characteristic error of each stage. Finally, separate three questions that are often collapsed in examinations and clinics: Piagetian stage theory describes the *organisation of cognition*; milestones describe observable developmental attainments across several domains; developmental surveillance and screening decide whether a child's course needs closer evaluation. A child does not "fail Piaget" because one conservation task is failed, and a Piagetian task is not a developmental screening instrument.

Must memorise: sensorimotor action becomes preoperational representation, concrete operations make representation logical for real and tangible problems, and formal operations extend logic to abstract and hypothetical possibilities.

MNEMONIC

"Sensorimotor - Preoperational - Concrete operational - Formal operational"

Sensorimotor action becomes preoperational representation, concrete operations make representation logical for real and tangible problems, and formal operations extend logic to abstract and hypothetical possibilities.

4	birth to 2 years	2 to 7 years	7 to 11 years
BROAD ORGANISATIONS OF THOUGHT	SENSORIMOTOR (BERK)	PREOPERATIONAL (BERK)	CONCRETE OPERATIONAL (BERK)

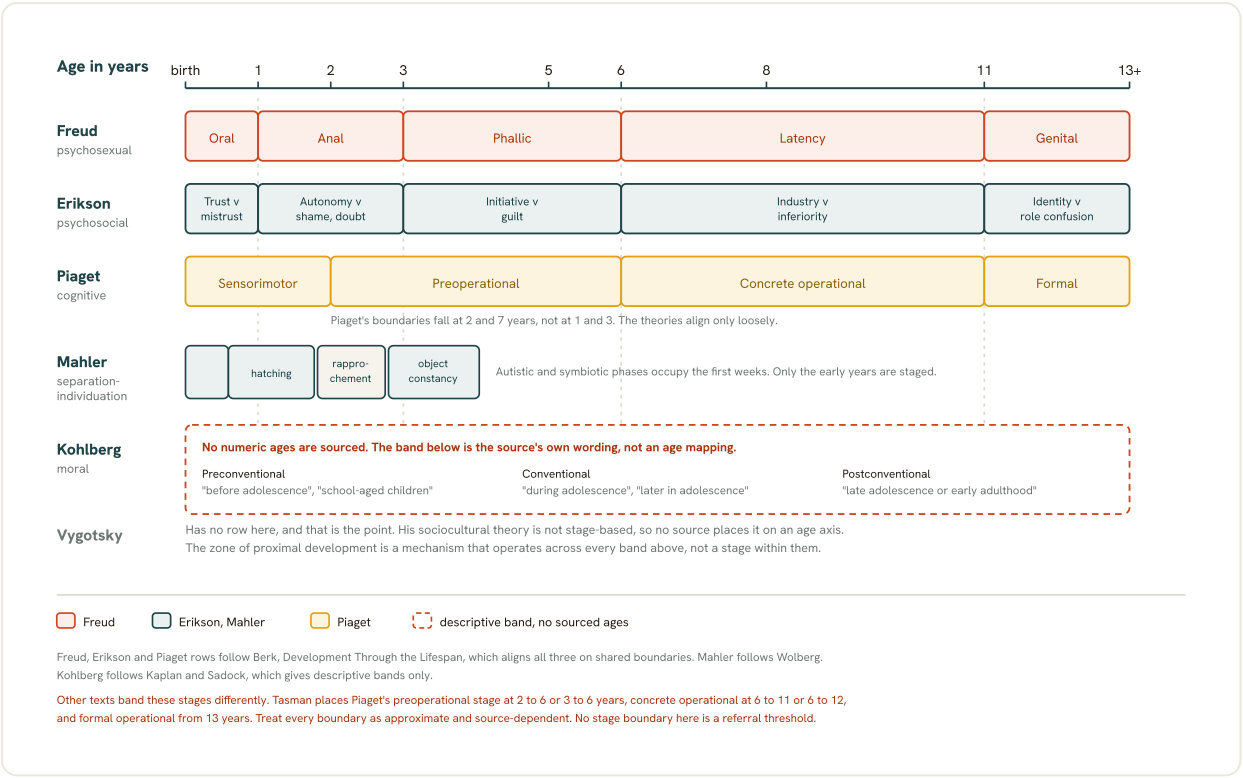


Fig 20.1 The developmental theories aligned on a shared age axis. Freud, Erikson and Piaget after Berk; Mahler after Wolberg; Kohlberg's levels as descriptive bands, since no numeric ages are sourced. Vygotsky carries no row because his theory is not stage-based. Boundaries are approximate and differ between texts.

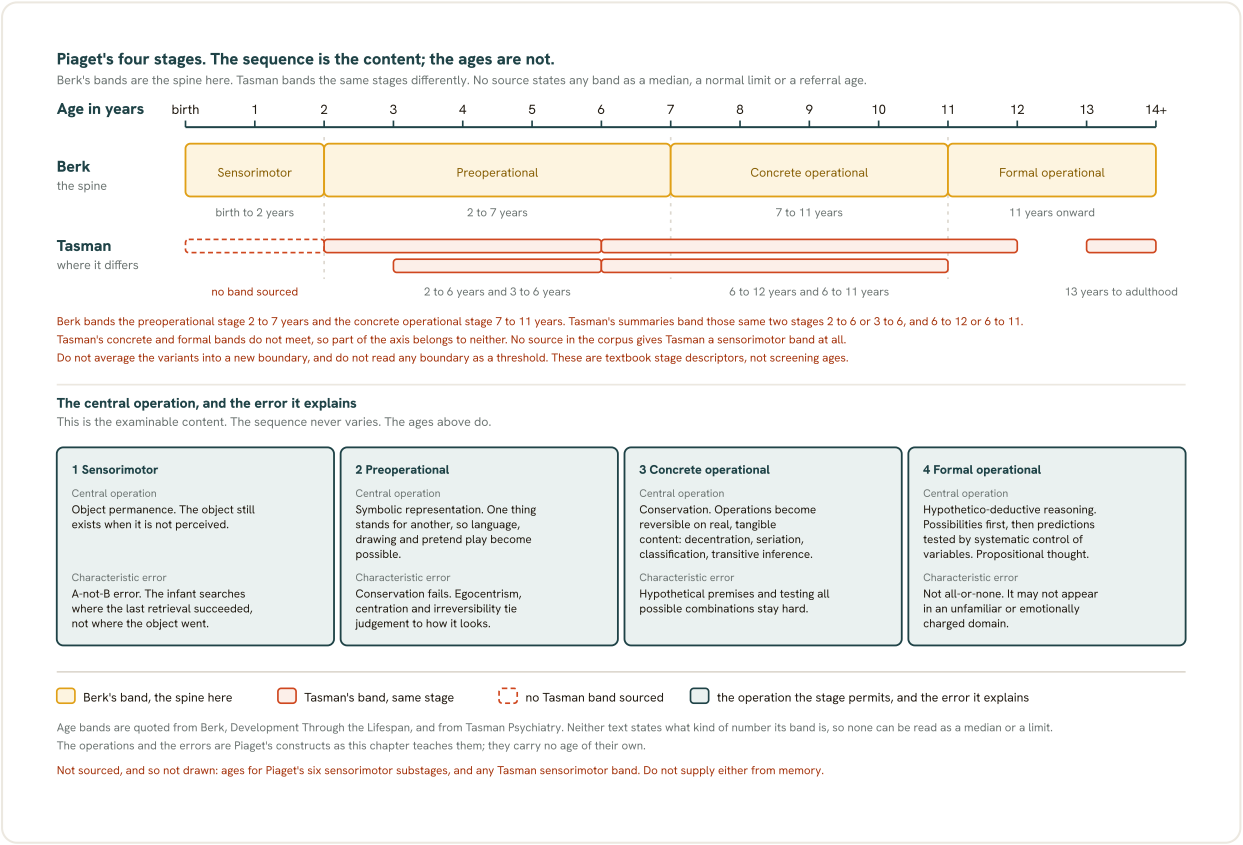


Fig 20.2 Piaget's four stages on an age axis, with the central operation each stage permits and the error it explains. The saffron spine follows Berk, Development Through the Lifespan; the coral bars are Tasman Psychiatry's differing bands for the same stages, shown rather than reconciled. No source states any band as a median, a normal limit or a referral threshold, and no source in the corpus gives Tasman a sensorimotor band.

1.1 The engine of Piaget's theory: schemes, adaptation and equilibration

A **scheme** is an organised pattern for acting on, representing or thinking about experience. An infant may have a grasping scheme; an older child may have a scheme for classifying animals or balancing an equation. Development occurs through **adaptation**, which has two complementary processes. In **assimilation**, the child interprets a new event through an existing scheme, as when every four-legged animal is initially treated as a dog. In **accommodation**, the scheme itself changes because the new event does not fit, so dogs and cows become distinct categories. Assimilation preserves continuity; accommodation permits novelty.

Organisation integrates separate schemes into larger cognitive systems. **Equilibration** is the regulatory process that moves thought from a less adequate balance to a more adequate one: a contradiction produces disequilibrium, and reorganisation restores coherence at a higher level. The theory is therefore *constructivist*. The child is neither a miniature adult nor an empty vessel, but an active reasoner whose errors disclose the structure of thought. In an examination, do not define a stage merely by its age band. Define it by the new operation it permits and the systematic limitation that remains.

RULE **Stage is inferred from the structure of reasoning, not from the answer alone.** Ask the child to explain, compare, predict and justify. A correct answer obtained by guessing or rote learning does not demonstrate an operation; an incorrect answer produced by misunderstanding the language of the task does not prove that the operation is absent.

1.2 Sensorimotor stage: knowledge through action

Berk's *Development Through the Lifespan* lists the **sensorimotor stage** as **birth to 2 years**. This wording is a textbook stage band, not a threshold. Cognition is initially organised through sensory experience and motor action. Repeated actions become circular reactions; schemes are coordinated into intentional means-end behaviour; experimentation becomes increasingly active; and, eventually, action can be represented mentally before it is performed. Piaget divided this progression into six substages, but the clinically useful principle is the movement from reflex-linked activity to deliberate action and internal representation.

The central achievement is **object permanence**, the understanding that an object continues to exist when it is no longer perceived. Before that representation is secure, searching is governed heavily by the immediate perceptual and motor situation. The classic **A-not-B error** occurs when an infant repeatedly retrieves an object from one location and then searches there again after seeing it hidden elsewhere. Later achievements include intentional problem-solving, imitation of an absent model, and the capacity to anticipate an outcome mentally. These are not isolated tricks. Together they mark the beginning of representation, which makes language, pretend play and later symbolic reasoning possible.

Clinical use. Observe how the child explores, searches, imitates and coordinates means with ends rather than relying on a verbal question. Interpretation must remain modest: visual access, motor ability, attention, fatigue, anxiety and familiarity with the task can all alter performance. Object-permanence tasks are demonstrations of a cognitive construct, not stand-alone diagnostic tests.

1.3 Preoperational stage: symbolic thought without reversible operations

Berk lists the **preoperational stage** as **2 to 7 years**. Tasman Psychiatry summaries use 2 to 6 years and 3 to 6 years in separate presentations. These variants should be retained as source conventions, not averaged into a new boundary. The decisive gain is the ability to use one thing to stand for another. Language expands, drawings carry meaning, and pretend play allows a block to become a car or an empty cup to contain imaginary tea. Thought has become representational, but it is not yet governed consistently by logical operations.

The characteristic limitations are linked. **Egocentrism** is difficulty coordinating one's own perspective with another person's perspective; it is not selfishness. The three-mountains task illustrates this failure of perspective-taking. **Centration** is attention to one striking dimension while other relevant dimensions are neglected. **Irreversibility** is difficulty mentally undoing a transformation. Together they explain failure of conservation: after the same quantity is rearranged into a taller or more spread-out appearance, the child judges by the perceptually dominant feature rather than by identity, compensation and reversibility.

Other characteristic forms include animism, in which life or intention is attributed to inanimate objects; artificialism, in which natural events are understood as made for human purposes; and transductive reasoning, in which one particular event is linked directly to another without a valid general principle. In clinical work, such reasoning can make illness, separation or family conflict feel caused by the child's thought or behaviour. The psychiatrist should explore the child's meaning and gently correct self-blame rather than treat developmentally shaped magical explanations as delusions.

1.4 Concrete operational stage: logical operations tied to tangible content

Berk lists the concrete operational stage as **7 to 11 years**; Tasman Psychiatry summaries use 6 to 12 years and 6 to 11 years. Again, these are alternate textbook mappings, not clinical cut-offs. The child can now perform an operation, an internalised mental action that is reversible and coordinated with other actions. Perceptual appearance no longer dominates every judgement, provided the problem concerns familiar or concretely imaginable material.

OPERATION	WHAT IT PERMITS
Conservation	Becomes possible because the child can use identity, compensation and reversibility.
Decentration	Permits simultaneous attention to more than one dimension.
Classification and class inclusion	Permit an item to belong to nested categories.
Seriation and transitive inference	Seriation orders objects along a dimension, and transitive inference coordinates relations to infer an unobserved relation.

Perspective-taking becomes more flexible, rules can be understood as coordinated systems, and explanations become less dependent on a single salient feature.

The limitation is contained in the name: the operations are most reliable when they can be anchored in actual objects, familiar events or imaginable transformations. Purely hypothetical premises, propositions contrary to fact, and systematic testing of all possible combinations remain difficult. For interviewing, use concrete language, timelines, drawings, demonstrations and examples from the child's experience. Abstract labels such as "mood," "risk" or "consequences" may need to be unpacked into observable situations.

1.5 Formal operational stage: reasoning about possibilities

Berk lists the formal operational stage as **11 years onward**, whereas a Tasman Psychiatry summary lists 13 years to adulthood. The two descriptions must not be collapsed into a falsely precise onset. The qualitative advance is that reasoning can operate on propositions and possibilities, not only on directly represented objects. The person can accept a hypothetical premise, derive its implications, and judge whether the conclusion follows even when the premise is not factually true.

- Hypothetico-deductive reasoning begins with possible explanations, derives predictions and tests variables systematically.
- Combinatorial reasoning considers the possible combinations within a problem rather than changing factors haphazardly.
- Propositional thought evaluates the logical relation between statements.
- Metacognition permits reflection on one's own thinking.

These abilities support scientific reasoning, long-range planning, moral debate, identity exploration and consideration of alternative futures.

Formal reasoning is not an all-or-none possession applied uniformly across every subject. Education, cultural tools, practice, interest, emotional arousal and domain knowledge shape whether it appears in a particular task. An adolescent or adult may reason formally in a familiar academic domain and concretely in an unfamiliar or emotionally charged one. The stage should therefore guide the form of questioning, not substitute for an assessment of actual comprehension, decision-making or capacity.

TRAP **Do not turn Piaget's age bands into milestone norms.** The cited texts do not label these bands as medians, normal limits or referral ages. They describe theoretical stages. Source variation, uneven performance and task demands make it incorrect to diagnose delay from a stage label or from one failed Piagetian task.

1.6 The classic tasks: what each task actually tests

A Piagetian task is valuable because the pattern of explanation reveals an underlying operation.

TASK	WHAT IT TESTS
Object-permanence task	The issue is whether the hidden object is represented despite absence from perception.
Perspective-taking task	The issue is coordination of viewpoints.
Conservation task	The examiner changes appearance while preserving quantity, then asks for both judgement and justification.
Class-inclusion task	The child must coordinate a subclass with the larger class.
Seriation and transitivity tasks	Relations must be ordered and mentally coordinated.
Formal-reasoning task	The examiner looks for generation of hypotheses and systematic control of variables.

Administration matters. Establish that the child understands the words, can see and manipulate the materials, and has not interpreted repetition of the question as a signal that the first answer was wrong. Ask "How do you know?" and record the reasoning rather than scoring only correct or incorrect. Repeating the same transformation with familiar objects can distinguish a conceptual limitation from confusion about the task. Do not coach the target operation and then claim to have measured spontaneous competence.

The best viva formulation is: *achievement, error, mechanism, task, limitation*. For preoperational thought, for example, the achievement is symbolic representation; the error is failure of conservation; the mechanism includes centration and irreversibility; the task is transformation of equal quantities; and the limitation is reliance on perceptual appearance. This structure prevents a recital of ages without psychology.

1.7 Strengths, limitations and contemporary reading

Piaget's enduring achievement was to show that children's errors are organised rather than random. He supplied testable constructs, linked knowledge to the child's own activity, and shifted developmental psychology from a catalogue of deficits to a study of changing cognitive structures. His tasks remain powerful teaching devices because they make abstract constructs visible in behaviour.

The limitations are equally examinable. Performance can improve when language is simplified, memory load is reduced or the situation is made familiar, suggesting that some classic tasks underestimate competence. Development is often gradual, overlapping and domain-specific rather than a clean step from one global structure to another. Social interaction, instruction, culture and the tools valued by a community receive less weight than in sociocultural theories. Formal reasoning is not consistently demonstrated across every person and every domain. The useful modern reading is therefore neither to discard Piaget nor to literalise him: retain the sequence as a model of increasingly coordinated representation and logic, while assessing the child's actual strategy in context.

1.8 Age alignment with Erikson, Freud, Kohlberg, Mahler and Vygotsky

The chapter's theory-alignment plate should be read horizontally: theories may discuss the same period of life while explaining different developmental work. Piaget explains the structure of knowing. Erikson's psychosocial stages explain successive tensions between the self and the social world. Berk places autonomy versus shame and doubt at 1 to 3 years, initiative versus guilt at 3 to 6 years, and industry versus inferiority at 6 to 11 years. Thus symbolic expansion, initiative and later school-age mastery overlap in time but are not interchangeable constructs.

Freud's psychosexual stages organise development around changing instinctual zones and conflicts. Berk lists the anal stage at 1 to 3 years, the phallic stage at 3 to 6 years, and latency at 6 to 11 years. Piaget's account does not explain libido or defence, and Freud's account does not test conservation or operations. Alignment helps recall; it does not imply that one theory validates another.

Kohlberg extended a structural approach to moral development, classifying the reasoning used to justify moral decisions rather than merely whether an answer was socially approved. Kaplan and Sadock describes preconventional morality before adolescence, conventional response levels during and later in adolescence, and a postconventional response level in late adolescence or early adulthood. Moral-stage reasoning and Piagetian cognition are related conceptually, but moral judgement also depends on social experience, values and context.

Mahler's separation-individuation theory concerns the child's emerging psychological separateness in relation to the caregiver. Kaplan and Sadock and Wolberg place the hatching period from about 4 or 5 months to 10 months; Wolberg places rapprochement onset between 15 and 18 months, describes the rapprochement crisis around 18 to 24 months, and places libidinal object constancy during the third year of life. These are the sources' own stage descriptions, not screening thresholds. Clinically, Mahler supplies relational language; Piaget supplies cognitive-structural language.

Vygotsky places greater weight on language, shared activity and culturally transmitted tools. The zone of proximal development is the gap between what a learner can do independently and what the learner can do with skilled support. Guided participation and scaffolding reveal emerging capacity that unsupported performance may conceal. Piaget asks what structure the child has constructed; Vygotsky asks what becomes possible in collaboration. The practical synthesis is dynamic: assess independent reasoning, then observe how performance changes with graduated help.

1.9 Piaget within the domains of child development

Piaget principally addresses cognition, although cognition is expressed through movement, language, play and social interaction. A child with a motor or language limitation may therefore perform poorly on a cognitive task for reasons other than the cognitive operation being tested.

1.10 Clinical use: developmental history, surveillance, red flags and Indian screening

Piaget calibrates the cognitive level of the interview; surveillance, red flags and screening are taught under the red-flags topic.

2 . Erikson psychosocial stages

Erik Erikson described personality development as a lifespan sequence of eight **psychosocial stages**. Each stage is organised around a **psychosocial crisis**, a tension between two necessary tendencies that arises from the interaction of biological maturation, the developing ego and the social world. A crisis is not a psychiatric emergency and it is not a choice in which one pole must be eliminated. It is a developmental turning point. A predominantly adaptive resolution strengthens the ego and yields a characteristic virtue; an unfavourable or markedly one-sided resolution leaves greater vulnerability when later tasks are encountered.

How to use this page. Learn the sequence as a chain of questions: *Can I rely on care? Can I act for myself? May I initiate? Can I master valued work? Who am I? Can I share myself without losing myself? What do I contribute? Can I accept the life I have lived?* Then attach the conflict, virtue, relational setting and common clinical distortion to each question. The age bands are textbook mappings whose normative construct was not specified by the sources. They are not medians, outer limits, screening cut-offs or referral thresholds. The theory-alignment plate may help compare Erikson with Piaget, Freud, Kohlberg, Mahler and Vygotsky, but temporal overlap never makes their constructs interchangeable.

Must memorise: trust gives hope, autonomy gives will, initiative gives purpose, industry gives competence, identity gives fidelity, intimacy gives love, generativity gives care, and integrity gives wisdom.

MNEMONIC

"Trust, autonomy, initiative, industry, identity, intimacy, generativity, integrity"

Trust gives hope, autonomy gives will, initiative gives purpose, industry gives competence, identity gives fidelity, intimacy gives love, generativity gives care, and integrity gives wisdom.

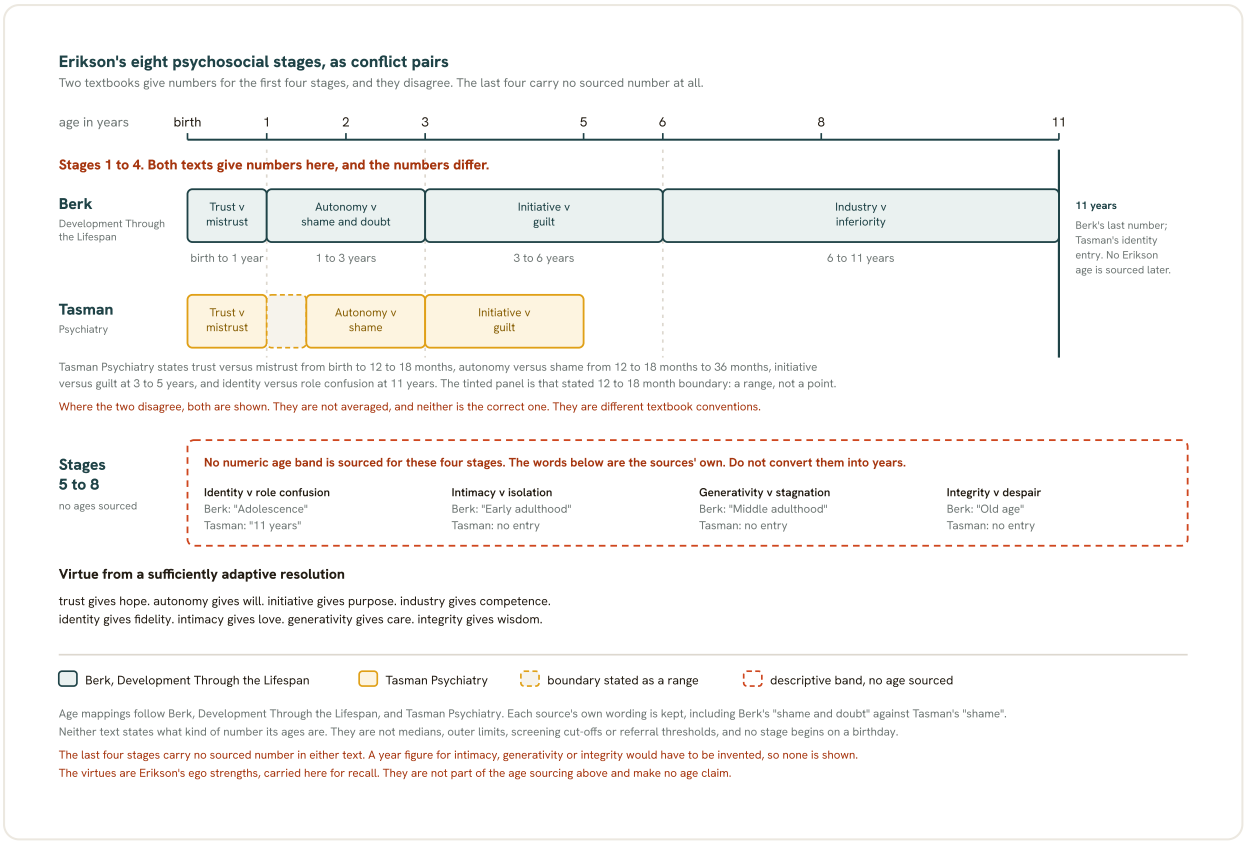


Fig 20.3 Erikson's eight psychosocial stages as conflict pairs. The first four sit on a sourced age axis, Berk's mapping above Tasman Psychiatry's; where the two disagree both are shown rather than averaged. The axis stops at 11 years because neither text gives an Erikson age past it, so the last four stages carry the sources' own life-period words instead of numbers. No boundary here is a referral threshold.

2.1 Architecture of the theory: epigenesis, crisis and ego strength

Erikson extended psychoanalytic development beyond childhood and beyond intrapsychic instinct. His **epigenetic principle** proposes that each psychosocial capacity has a period of relative ascendancy within an ordered sequence, while earlier themes remain active and can be revisited. Trust does not stop when autonomy begins; identity does not become irrelevant after intimacy. Later relationships, illness, migration, parenthood, loss and social change can reactivate earlier tensions and permit partial reworking. The model is therefore stage-like but not mechanically closed.

The two poles are sometimes called syntonic and dystonic tendencies. Healthy development does not mean total trust, autonomy or generativity. Some mistrust protects against exploitation, some shame supports social awareness, and some isolation preserves reflection and boundaries. The task is a workable ratio in which the adaptive tendency predominates without erasing the protective information carried by the other pole. The resulting **ego strength** is not a symptom score. It is a durable capacity, such as hope or fidelity, that supports later developmental work.

Erikson's distinctive contribution is the social location of the crisis.

- Caregiving relationships organise trust.
- Limits and bodily control organise autonomy.
- Family and play organise initiative.

- School and culturally valued work organise industry.
- Peers, ideals and social roles become increasingly important for identity.

Culture determines what counts as competence, legitimate independence, adulthood, contribution and a good life. The theory must therefore be used as a formulation scaffold, not as a culturally neutral measuring instrument.

RULE **Name four elements for every stage:** the conflict, the psychosocial task, the central relational or social field, and the virtue associated with a sufficiently adaptive resolution. Age alone is never an adequate answer.

2.2 Age alignment and how to state it safely

STAGE	BERK, *DEVELOPMENT THROUGH THE LIFESPAN*	TASMAN PSYCHIATRY
basic trust versus mistrust	**birth to 1 year**	trust versus mistrust, birth to 12 to 18 months
autonomy versus shame and doubt	**1 to 3 years**	autonomy versus shame, 12 to 18 months to 36 months
initiative versus guilt	**3 to 6 years**	initiative versus guilt, 3 to 5 years
industry versus inferiority	**6 to 11 years**	
identity versus role confusion	adolescence	11 years
intimacy versus isolation	early adulthood	
generativity versus stagnation	middle adulthood	
integrity versus despair	old age	

These are retained as each source states them. They must not be averaged into a new age boundary, treated as competing referral ages or presented as proof that a person has entered a stage on a birthday.

8 stages	Birth to 1 year	1 to 3 years	3 to 6 years
ONE LIFESPAN SEQUENCE	BERK TRUST MAPPING	BERK AUTONOMY MAPPING	BERK INITIATIVE MAPPING

2.3 Trust and autonomy: hope, will and the beginning of agency

Basic trust versus mistrust asks whether the world is sufficiently reliable for hope. The infant depends on caregivers for regulation, protection and the repeated relief of distress. Sensitive and reasonably predictable care supports a felt expectation that needs can be communicated and that another person may respond. The virtue is hope, the capacity to sustain expectation despite frustration. Mistrust is not produced by every delay or mismatch, and perfect gratification is neither possible nor desirable. The clinically important pattern is whether care is sufficiently coherent for the infant to tolerate absence and uncertainty without the world becoming wholly unsafe.

Trust is relational but not reducible to attachment classification. Attachment theory studies proximity, secure-base behaviour and reunion patterns in particular caregiver relationships; Erikson describes a broader ego expectation about self, others and the social world. Severe inconsistency, neglect or frightening care may compromise both, but a psychiatrist should not infer a specific attachment-pattern from the Eriksonian conflict or diagnose a caregiver from one observed interaction.

Autonomy versus shame and doubt asks whether emerging self-control can coexist with connectedness. Growing motor ability, language, choice, bodily regulation and the repeated use of "no" expand the child's sense of agency. Supportive adults offer bounded choices, tolerate safe attempts, set comprehensible limits and help after failure. The virtue is will, the capacity to choose and persist. Chronic overcontrol, humiliation, ridicule of accidents or demands far beyond capacity can make self-assertion feel dangerous and foster excessive shame or doubt. Permissiveness is not the opposite of shaming control: reliable limits help the child experience autonomy as organised and safe.

In a developmental history, ask how caregivers respond to distress, exploration, refusal, feeding, dressing and bodily-control struggles. Formulate the fit between the child's capacities, temperament and the caregiving environment. Do not attribute current anxiety, dependency or defiance to a single early-stage failure. Erikson supplies a hypothesis about meaning; history, observation and longitudinal evidence must test it.

2.4 Initiative and industry: purpose, competence and the social valuation of action

Initiative versus guilt asks whether the child may imagine, plan and act. Symbolic play, questions, fantasy, imitation of adult roles and self-started activity enlarge the field of action. Initiative is more than independence: it adds direction and purpose. Adults support it by taking ideas seriously, permitting safe experimentation and setting limits without treating curiosity or ambition as badness. The virtue is purpose. Guilt becomes excessive when wishes, questions, rivalry or ordinary attempts at action are repeatedly interpreted as harmful or unacceptable. Some guilt is developmentally useful because it permits concern for the effects of one's actions; incapacitating guilt suppresses initiative itself.

Industry versus inferiority asks whether effort can produce socially valued competence. Schooling, peer comparison, tasks, tools, rules and feedback move the child into a wider field of evaluation. The child learns to sustain attention, practise, cooperate, complete work and take justified pride in mastery. The virtue is competence. Repeated failure, unrecognised learning needs, exclusion, harsh comparison or praise detached from actual effort can undermine industry. Inferiority is not simply low self-esteem. It is the expectation that one's effort will not produce valued mastery.

In Indian clinical practice, marks and rank may dominate the family's account of competence, but industry is wider than examination performance. Practical skill, sport, art, caregiving, language, social contribution and persistence may all organise mastery. A child with ADHD, a specific learning disorder, chronic illness or sensory impairment may be industrious while producing

weak conventional outputs; those conditions themselves are developed in the ADHD and specific learning/communication disorders notes. Formulation should separate ability, opportunity, effort, accommodations and the social meaning attached to performance.

2.5 Identity versus role confusion: the central crisis of adolescence

Identity versus role confusion asks whether the adolescent can experience continuity while exploring possible selves. Identity formation integrates past identifications, bodily change, values, relationships, vocation, culture and imagined futures into a sufficiently coherent answer to "Who am I, and where am I going?" The virtue is fidelity, the capacity to commit to people and ideals while tolerating difference and remaining recognisably oneself. Role confusion may appear as unstable commitments, incompatible self-definitions, chronic diffusion or an identity chosen mainly to meet others' demands.

Erikson's **psychosocial moratorium** is a socially permitted interval for exploration before durable commitments are expected. It is not mere idleness. Marcia operationalised the identity theme along two dimensions, exploration and **commitment**, producing four identity statuses: diffusion, foreclosure, moratorium and achievement. These are statuses rather than an invariant stage sequence.

IDENTITY STATUS	DESCRIPTION
Foreclosure	describes commitment without meaningful exploration.
Moratorium	describes active exploration without settled commitment.
Achievement	combines exploration with commitment.
Diffusion	lacks both.

A person's status may differ across vocation, values and relationships.

Gender identity is a person's experienced sense of gender. It is distinct from gender expression, sexual orientation and sexual behaviour, and none of these should be treated as evidence of role confusion. Identity exploration can be developmentally normal. The clinical task is to assess distress, coercion, stigma, safety, family response, comorbidity and functioning without converting cultural nonconformity into psychopathology. Erikson's language can illuminate coherence and commitment, but it does not determine what a person's identity ought to be.

Psychosexual development is also broader than Freud's sequence of instinctual zones. In adolescence it includes bodily maturation, sexual feelings, relational boundaries, consent, values and the integration of sexuality into identity. The psychiatrist should distinguish normative exploration from exploitation, risky behaviour, compulsivity, trauma-related phenomena, mood-related disinhibition and distress driven by stigma.

The puberty reference plate should be read separately from Erikson's theory-alignment plate. The former describes bodily maturation; the latter aligns theoretical accounts of psychosocial, cognitive, psychosexual, moral and relational development. Physical maturation may alter the

social pressures surrounding identity, but no Tanner stage proves a level of identity formation, moral development or judgement.

2.6 Intimacy, generativity and integrity across adult life

Intimacy versus isolation asks whether identity can enter mutual commitment without dissolution. Berk places it in early adulthood. **Intimacy** includes emotional reciprocity, vulnerability, sexuality, friendship and durable commitment; it is not synonymous with marriage. Erikson's logic is that a sufficiently coherent identity makes it possible to share oneself without either fusion or defensive withdrawal. The virtue is love. Isolation may protect temporarily after loss or threat, but chronic avoidance of mutuality narrows the person's relational world.

Generativity versus stagnation asks what the adult creates, sustains and hands onward. Berk places it in middle adulthood. **Generativity** includes parenting but is not limited to biological parenthood. Teaching, mentoring, clinical service, productive work, institution-building, creativity and care for future generations can all express it. The virtue is care. Stagnation is an excessive narrowing toward self-absorption, repetition or the sense that one's activity does not nourish anything beyond the self.

Integrity versus despair asks whether the life course can be owned as a whole. Berk places it in old age. **Ego integrity** is not the belief that every decision was correct. It is the capacity to accept the singular life one has lived, integrate success with regret and face finitude without repudiating the self. The virtue is wisdom. Despair arises when time feels too short for repair and the life appears wasted, fragmented or intolerably unlike the life that should have been.

Adult developmental crises can organise the meaning of depression, caregiving burden, infertility, retirement, bereavement, migration or occupational disruption, but they do not replace diagnosis. A person without a partner is not necessarily isolated; a person without children is not necessarily stagnant; regret does not by itself mean despair. Ask what the person values, what social opportunities were available and how the present illness has altered the developmental task.

2.7 Alignment with Piaget, Freud, Kohlberg, Mahler and Vygotsky

The chapter's theory-alignment plate should be read horizontally, with one question attached to each theorist. Piaget asks how the structure of cognition changes. His sensorimotor account concerns knowledge through action and the emergence of representation; it does not explain trust. Freud asks how instinctual conflict is organised across the psychosexual stages; temporal overlap with an Eriksonian stage does not make autonomy equivalent to the anal stage or identity equivalent to the genital stage.

Kohlberg asks how reasons for moral decisions are structured. Kaplan and Sadock describe preconventional morality before adolescence, conventional response levels during and later in adolescence, and a postconventional response level in late adolescence or early adulthood. Moral development concerns the justification of right action, whereas Eriksonian identity concerns continuity, values and commitment. A sophisticated moral argument does not prove identity achievement, and social conformity does not by itself establish conventional moral reasoning.

Mahler asks how psychological separateness emerges within the caregiver relationship. Her separation-individuation theory includes a hatching period described by Kaplan and Sadock and Wolberg from about 4 or 5 months to 10 months. Wolberg places rapprochement onset between 15 and 18 months, the rapprochement crisis around 18 to 24 months, and libidinal object constancy during the third year of life. These are source descriptions, not screening thresholds. Mahler's individuation is not the same construct as Erikson's autonomy, although both attend to emerging separateness.

Vygotsky asks what development becomes possible through language, cultural tools and skilled collaboration. The zone of proximal development is the difference between independent performance and performance achieved with appropriate support. Erikson identifies the psychosocial meaning of mastery; Vygotsky helps the clinician observe how guided participation changes actual performance. A child who appears inferior in an unsupported task may reveal strong learning potential when the task is scaffolded.

The safest comparison formula in a viva is *same period, different explanatory target*. The theories can be placed beside one another for recall, but they cannot be added into a single universal clock. Their stage ages are descriptive conventions, their units of analysis differ, and none of the theoretical bands is a developmental referral threshold.

TRAP **Do not diagnose an "unresolved Erikson stage."** The conflicts are formulation constructs, not ICD diagnoses, psychometric scores or developmental-screening results. Avoid retrospective certainty, such as attributing adult symptoms to one caregiving event, and avoid reading age bands as deadlines.

2.8 Clinical formulation: strengths, limitations and cultural use

Erikson is clinically useful because he joins symptom, biography and social context. It prompts the psychiatrist to ask what developmental task the illness interrupts, what virtue remains available as a strength, and what social response is amplifying the conflict. Depression during vocational transition may be experienced through identity and competence; mania may destabilise commitments and intimacy; chronic psychosis may obstruct industry or generativity; caregiving and retirement may transform the meaning of contribution. These formulations enrich management when they remain hypotheses grounded in the person's narrative.

The model also has limits. Its broad concepts are difficult to operationalise, stage boundaries are not sharply defined, and development is more variable and recursive than a strict sequence suggests. The classical account can overprivilege individual autonomy, stable occupational identity and a linear adult life course. Collective identities, caste, class, gendered opportunity, disability, migration, chosen family and economic constraint may shape which resolutions are possible and valued. Indian family interdependence should not be mislabelled dependency merely because it differs from an individualist ideal.

Use **goodness-of-fit** to prevent moralising. **Temperament** refers to constitutionally influenced differences in reactivity and regulation; goodness-of-fit refers to the compatibility between those characteristics and environmental expectations. A cautious child in a patient environment may

develop competence, while the same child under ridicule and forced performance may experience inferiority. The temperament is not the Eriksonian crisis, but the fit can alter how the crisis is negotiated.

A sound formulation states the evidence and its limits: "The current transition appears to reactivate concerns about competence and identity" is defensible; "industry was not resolved, therefore this disorder developed" is not. Erikson should direct questions, identify strengths and organise meaning. It should not be used to blame parents, prescribe a culturally narrow life path or explain away neurodevelopmental, psychiatric and social causes.

2.9 Five worked cases: from recall to application

Worked case 1 - milestone-dating and red-flag reasoning. A child at 24 months of age is described as energetic, insistent on self-feeding and easily frustrated by adult help. The child does not use spontaneous two-word phrases. The Eriksonian reading is autonomy versus shame and doubt: the self-directed behaviour is developmentally meaningful and should be met with bounded choices rather than ridicule. The language finding is a separate red-flag: absence of spontaneous two-word phrases at 24 months of age warrants further developmental evaluation. Do not use "the autonomy stage" to normalise the language concern, and do not infer global delay from a single finding. Assess all developmental domains, hearing, regression and context.

Worked case 2 - attachment-pattern identification. In Ainsworth's Strange Situation, a young child explores while the caregiver is available, becomes distressed on separation, seeks contact on reunion and settles sufficiently to resume exploration. This pattern is most consistent with secure attachment because the caregiver functions as a secure base and haven. The Eriksonian link is supportive, not diagnostic: reliable care may contribute to basic trust, but secure attachment and trust are different constructs. One observation cannot establish the whole caregiving history or prove that an Eriksonian crisis is resolved.

Worked case 3 - temperament and goodness-of-fit. A child within Berk's 6 to 11 years industry-versus-inferiority mapping is slow to approach unfamiliar classroom tasks but works carefully after a demonstration. Repeated public comparison has led the child to say, "I am bad at everything." The theory-application is industry versus inferiority, but the mechanism is not laziness. A cautious temperament is meeting a poor goodness-of-fit. Assess learning, attention, sensory and emotional contributors; provide graduated demonstration, private feedback and tasks that permit observable mastery. The goal is evidence-based competence, not empty reassurance.

Worked case 4 - adolescent identity and risk-taking. An adolescent alternates between career plans, adopts different styles with different peers and takes a hazardous risk in a highly charged group setting, while reasoning thoughtfully about the same risk in clinic. Exploration without settled commitment may fit moratorium rather than pathology. The context shift is compatible with a dual-systems or maturational imbalance account of risk-taking, but it does not excuse harm or prove immaturity. Assess mood elevation, substance use, coercion, self-harm, sleep,

consequences and capacity. Explore identity formation and values without treating gender identity, appearance or nonconformity as role confusion.

Worked case 5 - adult theory-application. An older adult after bereavement reviews a life containing valued work, estrangement and choices now regretted, yet can hold gratitude and sorrow together and remains engaged in mentoring. The dominant Eriksonian formulation is integrity rather than despair, with generativity still active through mentoring. Integrity does not require a flawless or regret-free biography. If pervasive hopelessness, anhedonia, guilt or suicidal thinking is present, assess depressive illness directly; a developmental formulation must never replace risk assessment or diagnosis.

Exam synthesis. In any vignette, first identify the actual phenomenon: a developmental attainment, warning sign, relationship pattern, temperament-environment fit, physical pubertal stage, form of reasoning or psychosocial conflict. Then name the correct framework and state what it can and cannot infer. That separation prevents the commonest error in developmental psychiatry: using an elegant theory as if it were a measurement instrument.

3 . Freud psychosexual stages

Freud's psychosexual theory proposes that personality develops through a sequence in which **libido**, understood as psychic energy associated with the sexual drives, is organised predominantly around a different bodily zone and a different developmental conflict. In examination answers, "sexual" must be used in Freud's broad drive-theory sense rather than reduced to adult genital intercourse. The sequence is **oral, anal, phallic, latency and genital**. Each phase leaves residues in later personality, while excessive frustration or gratification may produce **fixation**; under stress, functioning may move back toward an earlier mode through **regression**. This is a historical psychoanalytic model of personality development, not a contemporary milestone schedule and not a method for diagnosing developmental delay.

How to use this page. First memorise the order, age brackets, principal zone and central conflict. Then add the characteristic mode of gratification, the proposed resolution and the classical fixation themes. Finally, separate three things that candidates commonly collapse: a psychosexual phase is not a developmental milestone, Freud's genital phase is not a Tanner stage, and a psychodynamic formulation is not proof that an early event caused the patient's current disorder.

> **Must memorise:** oral, anal, phallic, latency, genital; the drive focus moves from incorporation, through control and oedipal identification, to relative quiescence and then mature genital organisation.

3.1 The organising model and the five-stage sequence

A changing drive focus, a phase-specific conflict and a possible residue. Freud did not describe five watertight compartments. Earlier modes of pleasure and relating remain available after a later organisation becomes dominant. A stage is therefore best learnt through four linked questions:

1. *Where is gratification centred?*
2. *What conflict must be negotiated?*
3. *How is it resolved?*
4. *What pattern did Freud associate with fixation?*

The theory assumes that constitutional drives interact with caregiving and prohibition. The child's ego gradually develops ways of regulating these pressures, and identification contributes to internal structure, especially during the phallic phase.

Source-reported teaching brackets, not referral thresholds:

STAGE	BERK'S *DEVELOPMENT THROUGH THE LIFESPAN*	*TASMAN PSYCHIATRY*
Oral	Birth to 1 year	birth to 12-18 months
Anal	1-3 years	12-18 to 36 months
Phallic	3-6 years	3-5 years
Latency	6-11 years	
Genital	Adolescence	11 years plus for the adolescent genital phase

Birth to 1 year	1-3 years	3-6 years	6-11 years
ORAL - BERK	ANAL - BERK	PHALLIC - BERK	LATENCY - BERK

The sources state these ages without defining their normative construct. They should therefore be reproduced as the sources' approximate theoretical brackets, never converted into a median, an upper limit of normal or a when to refer threshold. Their overlap also warns against false precision. A child does not become abnormal because a psychodynamic theme appears outside its conventional bracket.

3.2 Oral stage: incorporation, dependence and the first relation to an object

The mouth is the principal zone, and feeding is both gratification and relationship. In the **oral stage**, sucking, swallowing and biting organise pleasure. The breast or feeding caregiver is not merely a source of nutrition in the theory; it is the first major **object**, meaning the person or representation toward whom a drive is directed. Satisfaction involves taking in, while delay and absence introduce frustration. The central developmental themes are receiving, incorporation, dependence and the beginnings of tolerating separation from immediate gratification.

Classical accounts distinguish an earlier *oral receptive* or incorporative mode from a later biting, aggressive mode. Freud and later psychoanalytic writers linked oral fixation with dependency, passivity, demandingness, gullibility or incorporative habits, and linked the biting mode with verbal aggression and hostility. These are theoretical associations, not validated one-to-one predictions. Feeding difficulty, smoking, overeating or dependency in an adult cannot by itself

demonstrate oral fixation, and a resident should never retrofit an infancy narrative merely because an adult symptom looks symbolically oral.

3.3 Anal stage: control, autonomy and the social demand for regulation

Pleasure in retention and expulsion meets the caregiver's demand for bowel control. In the **anal stage**, elimination becomes the principal bodily focus. Toilet training gives the child an arena in which bodily pleasure, autonomy, obedience, defiance, praise and shame can become linked. The theoretically important issue is not simply continence; it is the negotiation between the child's wish to control what is given or withheld and the environment's demand that discharge occur at an acceptable place and time.

Classical descriptions contrast anal-retentive themes, such as excessive orderliness, obstinacy, parsimony and control, with anal-expulsive themes, such as messiness, defiance and poorly regulated discharge. The familiar triad of orderliness, obstinacy and parsimony is a high-yield psychoanalytic association, but it is not a diagnostic triad. Contemporary formulation should ask how control, shame, autonomy and caregiver responses were experienced, while avoiding blame directed at toilet training or at the caregiver.

3.4 Phallic stage: oedipal conflict, identification and superego development

Genital awareness is organised around triangular attachment, rivalry and identification. The **phallic stage** centres on the phallus in Freud's theory and introduces the **Oedipus complex**: desire for the opposite-sex parent, rivalry with the same-sex parent and anxiety about the consequences of that rivalry. In Freud's account of the boy, castration anxiety promotes renunciation of the oedipal wish and identification with the father. This identification contributes to the consolidation of the superego and to the internalisation of prohibitions and ideals.

Freud's account of female development invoked penis envy and a different route through oedipal attachment. It has been criticised as androcentric, anatomically reductionist and based on male development as the norm. The term Electra complex is associated with Jung, not Freud's preferred terminology. In an examination, state the classical proposition accurately, then state the criticism. Resolution is described through relinquishment of the incestuous wish, identification and movement toward relationships outside the original triangle. Fixation has been associated with vanity, exhibitionism, rivalry, sexual inhibition or reckless assertion, but again these are hypotheses within a theory, not diagnostic findings.

TRAP **Phallic is not genital, and genital is not Tanner.** The phallic phase concerns oedipal organisation in early childhood. The later genital phase concerns the mature organisation of drives. Tanner staging describes observable pubertal anatomy and is a different construct altogether. Also remember that Jung, not Freud, popularised "Electra complex" as a label.

3.5 Latency: relative drive quiescence, sublimation and social learning

Latency is a relative reduction in overt psychosexual preoccupation, not the disappearance of libido. During the **latency stage**, oedipal wishes are held by repression and other defences, while energy is increasingly channelled into learning, peer relationships, play, competence and

culturally valued activity. **Sublimation** is the key mechanism: drive energy is redirected toward aims that are socially acceptable and psychologically productive.

Latency is sometimes described as an interval rather than a new erogenous-zone organisation, but it remains part of the five-part examination sequence. Its clinical themes include the capacity to learn, work with peers, follow rules and invest in interests outside the family triangle. It should not be mistaken for a period without sexuality, fantasy or conflict. The word *relative* protects the answer from that overstatement.

3.6 Genital stage: integration, reciprocity and mature object love

Adolescent drive reactivation is reorganised toward reciprocal relationships. In the **genital stage**, earlier partial drives are theoretically integrated under genital primacy. The developmental aim is not mere sexual activity. It is the capacity for reciprocal intimacy, concern for the other person, productive work and a balance between love and responsibility. Mature gratification now depends on recognising the object as a separate person rather than only as a source of need satisfaction.

Unresolved earlier conflicts may reappear when adolescent drives intensify, so the final phase includes both reworking and integration. The phrase *mature genital character* belongs to Freud's normative ideal and should not be treated as a contemporary measure of mental health. Sexual orientation, celibacy, disability, cultural restraint or absence of partnered sexual activity does not indicate failed genital development. This is another reason to keep the historical theory separate from moral judgement and from anatomical puberty.

3.7 Fixation and regression: the mechanisms that connect stages to adult formulation

Fixation is the persistence of a disproportionate libidinal investment in an earlier mode of gratification or conflict. Classical theory attributes it to marked frustration, excessive gratification or difficulty resolving the phase-specific conflict. Regression is a return, especially under stress, to a developmentally earlier organisation of wishes, defences, relationships or behaviour. Fixation describes a relatively enduring vulnerability; regression describes movement toward that point of vulnerability. They are related but not synonyms.

The clinically useful move is thematic and probabilistic. Dependency and taking-in may suggest an oral theme; control, withholding and shame may suggest an anal theme; rivalry, display and triangular relationships may suggest a phallic theme. The clinician then tests the hypothesis against the patient's history, current relationships, transference, defences and culture. The clinically unsafe move is deterministic: inferring a specific childhood event from an adult trait, or explaining a disorder solely by naming a stage.

RULE **A psychosexual formulation generates hypotheses; it does not establish causation.** Use stage language to organise recurring themes in gratification, control, rivalry, identification and intimacy. Do not use it as a developmental test, a diagnosis or proof of what happened in childhood.

3.8 Alignment with other developmental theories: same age axis, different constructs

The companion synthesis map aligns the major theories by age, but alignment means temporal overlap, not conceptual equivalence. Freud maps changing drive organisation through the psychosexual stages. Piaget maps cognitive structure, beginning with the sensorimotor period and moving through preoperational, concrete operational and formal operational thought. Erikson maps relational and social crises through the psychosocial stages. Thus an early-childhood conflict may simultaneously be described as anal in Freud, autonomy versus shame and doubt in Erikson, and sensorimotor or early preoperational in Piaget, without the terms meaning the same thing.

Kohlberg maps moral development from preconventional through conventional to postconventional reasoning. His sourced age relationships are descriptive bands such as before adolescence, during adolescence and later in adolescence, not numeric age ranges; adding numbers would manufacture precision. Mahler maps separation-individuation, including hatching, practising, rapprochement and movement toward object constancy. Vygotsky offers no stage sequence: the zone of proximal development, scaffolding, private speech and socially mediated learning are cross-cutting mechanisms. Vygotsky therefore belongs beside the age plate, not inside it as invented stages.

The clinical use of the alignment is to ask several different questions about the same child: how the child thinks, what social conflict is being negotiated, how drives and relationships are organised, how morality is reasoned, how separation is managed and what learning becomes possible with guidance. The plate prevents tunnel vision; it does not turn six theories into one grand developmental schedule.

3.9 Clinical value, cultural limits and contemporary critique

Freud's model remains important because it introduced developmental continuity, unconscious conflict, infantile sexuality, defence, symbolic meaning and the possibility that early relationship patterns recur in adult life. In psychodynamic assessment it can sharpen attention to how a patient receives care, manages dependency, uses control, enters triangles, responds to prohibition and negotiates intimacy. These themes can be observed in narrative, dreams, symptoms, transference and countertransference, then integrated with attachment, temperament, trauma, learning and the current social environment.

Its limitations are equally examinable. The theory was derived largely from retrospective clinical reconstruction rather than prospective developmental research; several central propositions are difficult to falsify; the account of female development is androcentric; the model can be heteronormative and overly centred on sexuality; and stage-to-trait links are vulnerable to circular explanation. Culture changes the meanings of feeding, sleeping, toilet training, bodily privacy, family hierarchy and adolescent intimacy. For Indian practice, joint-family structures and family-mediated caregiving may alter the relational expression of dependence or autonomy without indicating pathology. Use the theory as one formulation lens, not as a universal cultural ruler.

INDIA

The Freud brackets above come from general developmental and psychiatry texts and are not **Indian norms**. No verified India-specific psychosexual-stage age adaptation is supplied here, so none should be invented. Indian developmental instruments answer a different question: the **Trivandrum Development Screening Chart** screens development from **0 to 6 years** using 51 items, with one item delay constituting a positive screen, while **DASII** yields Motor DQ and Mental DQ, and a DQ below **85** is used as a delay marker in Indian follow-up practice. Neither instrument validates oral, anal or phallic fixation.

3.10 Spotting deviation from normal: developmental surveillance is a separate clinical task

Psychosexual stages do not define developmental red flags. Developmental surveillance is longitudinal observation of developmental progress, caregiver concerns and function, supported by milestone-based screening when indicated. It is the correct framework for spotting deviation, warning signs and deciding when to refer. Calling a child "fixated" does none of these jobs and may delay proper assessment.

High-yield developmental red flags include the following:

REFERRAL SIGNAL	AGE
Absent babbling	at **12 months**.
Absent single words	at **16 months**.
Absent spontaneous two-word phrases	at **24 months**.
Loss of language or social skills	at any age.

These are referral signals from *Developmental Psychopathology*, not Freud-derived ages. For gross motor development, the **WHO norms** are achievement windows bounded by the 1st and 99th centiles and are intended to signal the need for appropriate screening when a child appears late; they are screening signals, not diagnostic thresholds. India was one of the WHO study sites. Use the companion milestone plate for the individual windows rather than recreating it here.

The apparent Western-versus-Indian comparison must also be handled honestly. Freud's source brackets are theoretical ages, not **Western norms**, while the Trivandrum chart and DASII are Indian screening or assessment instruments, not psychosexual-stage adaptations. There is therefore no like-for-like set of **Indian norms** to place beside Freud's ages. Record genuine differences when two sources measure the same construct; when they do not, name the mismatch instead of forcing an alignment.

3.11 Consolidation: mnemonic, active recall and reconstruction

MNEMONIC

"Old Analysts Prefer Long Games"

O-A-P-L-G gives Oral, Anal, Phallic, Latency, Genital. Attach one organising word to each: *incorporation, control, identification, sublimation, reciprocity*. The mnemonic fixes order; the five organising words recover the theory.

Redraw from memory. Reconstruct the companion **synthesis map** with **theories by age** on separate horizontal lanes, place Freud's five stages on its lane, keep Kohlberg's bands descriptive, and draw Vygotsky as a cross-cutting mechanism. Then add the companion **milestone anchors** and developmental red flags on a separate clinical lane. Keeping the theory lanes separate from the surveillance lane is the final examination safeguard.

4 . Moral development (Kohlberg)

Lawrence Kohlberg's theory of moral development describes development in the *reasoning used to justify a moral decision*. It is not chiefly a theory of whether a person gives the examiner the approved answer, behaves well, obeys the law, or possesses a particular religious belief. Kohlberg extended Piaget's interest in the development of moral judgement and proposed an invariant sequence of increasingly differentiated ways of answering a central question: *why is an action right or wrong?* The sequence contains **three** levels, each containing **two** stages. The centre of moral authority shifts from externally imposed consequences, to interpersonal and social expectations, and finally to principles that can be used to evaluate the social order itself.

How to use this page. First fix the architecture: **preconventional**, **conventional**, and **postconventional**; then learn the contrast within each pair of stages. Stage 1 avoids punishment, stage 2 pursues exchange; stage 3 seeks interpersonal approval, stage 4 maintains the social system; stage 5 tests rules against rights and social contract, stage 6 reasons from universal ethical principles. In a dilemma, always identify the justification rather than the chosen act. Timing must remain descriptive: Kaplan and Sadock relates the stages to bands such as "school-aged children" and "during adolescence", but supplies no numeric ages for Kohlberg.

Must remember: Kohlberg stages the *reason for the judgement*, not the judgement itself.

MNEMONIC

"Punishment - Exchange - Approval - Law - Contract - Principle"

The sequence is punishment, exchange, approval, law, social contract, universal principle.

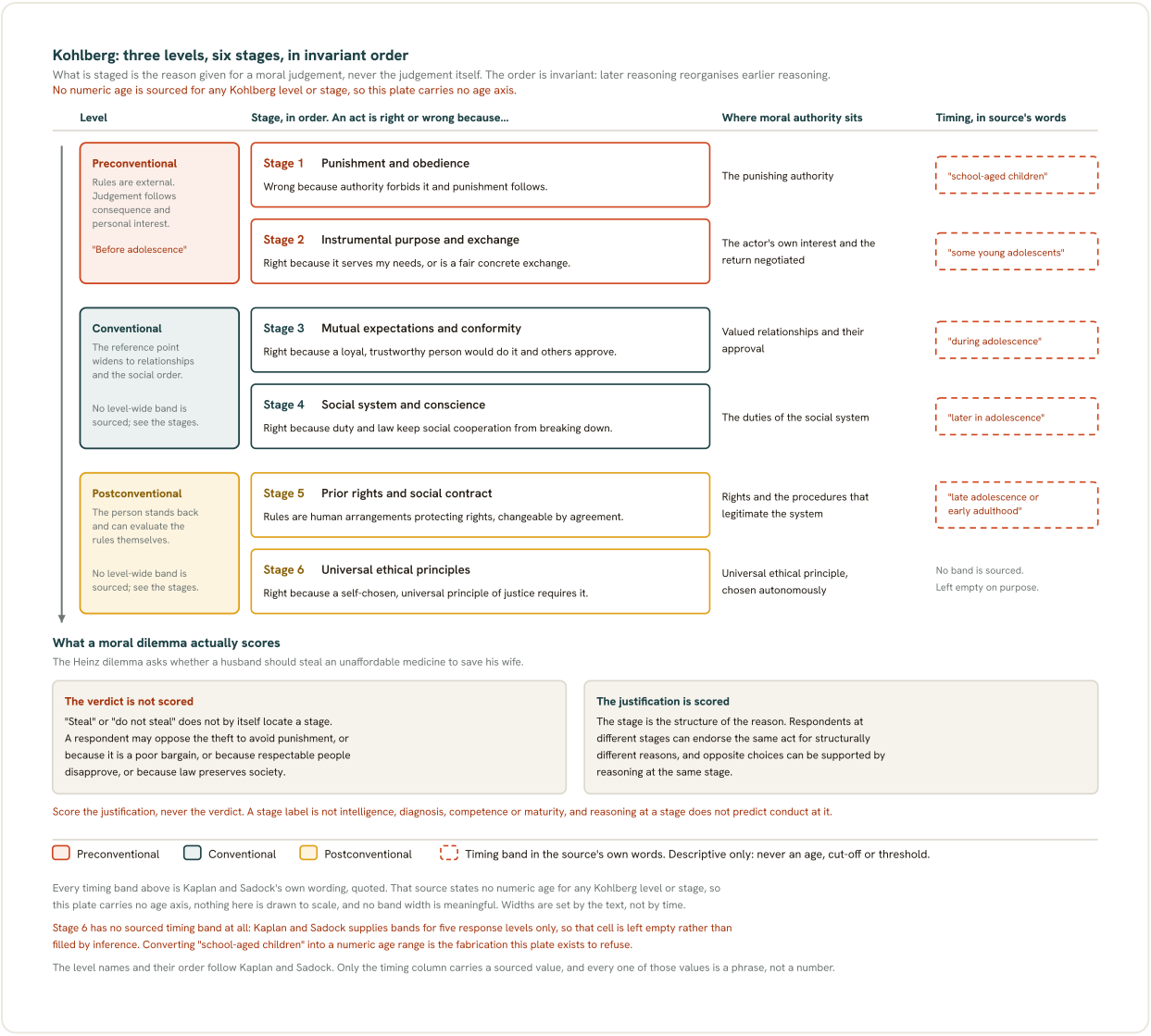


Fig 20.4 Kohlberg's three levels and six ordered stages, with what a moral dilemma scores. The timing column quotes Kaplan and Sadock's descriptive bands verbatim; that source gives no numeric age for any level or stage, so the plate has no age axis and nothing on it is drawn to scale. A level-wide band is sourced for the preconventional level only, and stage 6 has no band at all, so its cell is left empty rather than inferred.

4.1 Method and architecture: three levels, six ordered stages

A stage is a structure of reasoning, not a list of moral opinions. Kohlberg used hypothetical moral dilemmas, classically the Heinz dilemma, and questioned the respondent about the decision and its justification. In that dilemma, a person must consider whether a husband should steal an unaffordable medicine to save his wife. Saying "steal" or "do not steal" does not by itself locate a stage. A respondent might oppose theft because of punishment, because it is a poor bargain, because respectable people disapprove, because law preserves society, or because a law may be overridden by a more fundamental right. Conversely, respondents at different stages can endorse the same action for structurally different reasons.

3	6	2
LEVELS	ORDERED STAGES	STAGES PER LEVEL

The model is cognitive-developmental. Stages are proposed to occur in sequence, with later reasoning reorganising rather than merely adding to earlier reasoning. Movement depends on

cognitive development, perspective-taking and encounters with moral conflict. A person may show a dominant mode with adjacent-stage reasoning rather than perfectly pure performance in every situation. Developmental advance also does not guarantee moral conduct: behaviour is additionally shaped by emotion, impulse control, identification, attachment, reward, coercion, group norms and opportunity.

RULE **Score the justification, not the verdict.** Two people may make the same choice at different stages, and opposite choices may be supported by reasoning at the same stage.

4.2 Preconventional morality: consequences and personal interest

At the preconventional level, rules are experienced as external to the self. The child recognises authority and social rules, but moral judgement is organised around concrete consequences and personal advantage rather than around preserving a shared social system. Kaplan and Sadock describes this level as occurring **before adolescence**. This is a descriptive relationship, not a cutoff, expected range, or referral threshold.

Stage 1: punishment-and-obedience orientation. An act is wrong because authority prohibits it and punishment follows. Consequences are taken as evidence of wrongness, and the more severe the consequence, the worse the act may appear. Obedience is heteronomous: the rule comes from a powerful other, and the perspectives or intentions of those involved are poorly coordinated. Kaplan and Sadock associates this response level with **school-aged children**.

Stage 2: instrumental purpose, individualism and exchange. The person now recognises that different individuals have different interests. What is right serves one's needs and, where useful, the needs of others through a concrete exchange: "I will help you if you help me." Fairness is therefore understood as equal exchange or reciprocity, not yet as loyalty, social duty or impartial principle. Kaplan and Sadock notes this response level in **some young adolescents**. The phrase "some" matters: it must not be converted into a universal age norm.

4.3 Conventional morality: relationship approval and maintenance of society

At the conventional level, the reference point expands from the actor's immediate consequences to membership in relationships and society. The person values expectations, roles, rules and institutions because these sustain interpersonal trust and an ordered social world. "Conventional" here means conformity to a recognised social order, not shallow thinking.

Stage 3: mutual interpersonal expectations, relationships and conformity. The morally good person is kind, loyal, trustworthy and approved by significant others. Intentions become important, and the respondent can take the viewpoint of another person, but judgement remains tied to the expectations of close relationships and the wish to be seen as a "good" person. Kaplan and Sadock places this response level **during adolescence**.

Stage 4: social-system and conscience orientation. The frame widens from close relationships to society as an organised whole. Right conduct means performing one's duty, respecting legitimate authority and maintaining laws and institutions because social cooperation would otherwise break down. This is not simply fear of punishment: stage 1 obeys power to avoid

consequences, whereas stage 4 endorses law as necessary for the system. Kaplan and Sadock relates this response level to **later in adolescence**.

4.4 Postconventional morality: evaluating rules by principles

At the postconventional level, a person can stand back from a particular society's rules and ask whether they are justifiable. Laws remain important, but their legitimacy depends on values and principles that rational persons could endorse. The crucial move is from being governed by the social order to being able to evaluate it. Postconventional reasoning should not be confused with reflexive rebellion, personal preference, or disregard for law.

Stage 5: prior rights and social-contract orientation. Rules are understood as human arrangements designed to protect welfare, liberty and rights. Because arrangements are socially created, they may be changed by agreed procedures when they fail those purposes. Some values and rights retain priority even when a majority prefers otherwise. Kaplan and Sadock associates this response level with **late adolescence or early adulthood**; this wording is descriptive and does not imply that everyone reaches the stage.

Stage 6: universal ethical-principle orientation. Moral judgement is guided by self-chosen, generalisable principles of justice, equality and respect for human dignity. A valid principle applies consistently across persons, including oneself, and conscience follows the principle when ordinary law conflicts with it. Stage 6 differs from stage 5 in its source of obligation: stage 5 emphasises a fair social contract and basic rights, whereas stage 6 emphasises universal principles chosen through autonomous moral reasoning.

4.5 The sequence as a set of contrasts

The fastest way to retrieve the stages in an examination is to ask where moral authority sits. At stage 1 it sits with the punishing authority; at stage 2 with the individual's concrete interest and negotiated return; at stage 3 with valued relationships and approval; at stage 4 with the duties of the social system; at stage 5 with rights and procedures that legitimate the system; and at stage 6 with universal ethical principle. Three contrasts prevent most errors.

CONTRAST	DISTINCTION
Punishment versus law:	both may support obedience, but one avoids a consequence while the other preserves social order.
Approval versus contract:	one asks what a good person in the relationship would do, while the other asks what free and equal persons could justify.
Contract versus principle:	one revises law through shared procedures, while the other tests every law and procedure against a generalisable ethical commitment.

TRAP **Do not turn descriptive bands into numeric ages.** "School-aged children", "some young adolescents", "during adolescence", "later in adolescence", and "late adolescence or early adulthood" are Kaplan and Sadock's formulations. Kohlberg has no sourced numeric age row for the theory-alignment plate.

4.6 What the theory explains, and what it does not

Kohlberg explains the organisation of moral judgement. It does not provide a complete psychology of morality. Knowing what is right does not ensure doing it, and sophisticated reasoning can be used after the fact to rationalise conduct. Empathy, guilt, shame, temperament, attachment, modelling, cultural learning, power, material constraint and the immediate social context can all influence behaviour without being reducible to a reasoning stage. Nor should a stage label be mistaken for intelligence, diagnosis, legal competence, criminal responsibility or overall maturity.

The approach nevertheless made important contributions. It treated children as active constructors of moral meaning rather than passive recipients of rules; separated the structure of a reason from its surface content; and supplied a developmental account of perspective-taking, authority, reciprocity, obligation and justice. Its structured dilemmas also made moral reasoning open to systematic interview and longitudinal study.

4.7 Criticisms and later refinements

Justice is not the whole of morality. Carol Gilligan argued that an emphasis on rights, rules and abstract justice can undervalue an ethic of care centred on relationship, responsibility and response to need. The useful examination answer is not that one sex reasons by justice and another by care as a fixed biological divide. The stronger criticism is that the scoring framework privileged one moral voice and that care and justice may both be available across persons and contexts.

Culture shapes the meaning of mature reasoning. The proposed order has received support across settings, but the claim that abstract individual rights represent the highest endpoint can favour liberal, individualistic assumptions. Community, sacred obligation, family duty and relational responsibility may be morally elaborated rather than merely conventional. **Dilemma performance is also context-sensitive.** Hypothetical answers may not predict action under fear, loyalty, intoxication, peer pressure or personal loss; education and verbal ability influence how reasons are expressed; and the same person may reason differently across dilemmas. Finally, stage boundaries may be less discrete than a strict staircase suggests, with mixed and adjacent-stage responses occurring in practice.

4.8 Clinical use and relation to the other developmental theories

Use the framework to formulate reasoning, never to stamp a child with a stage. In a child or adolescent assessment, a clinician can ask how the patient understood a conflict involving rules, peers, harm or fairness, then explore intentions, consequences, perspective-taking and the perceived source of obligation. A shift from "I will be punished" to "people will be harmed" or "the rule protects everyone" adds clinically useful information about social cognition and judgement. Interpretation must remain contextual and should be integrated with cognitive ability, language, family values, school experience, neurodevelopment, affect regulation and actual behaviour. It is not a diagnostic test and should not be used alone for a forensic conclusion.

CLINICAL USE

After a recurrent rule-breaking episode, ask the patient to explain why the act was acceptable or unacceptable, what each person believed, and whether the rule would remain fair if roles were reversed. The purpose is to sample perspective-taking and the structure of moral reasoning, not to demand a socially approved answer. A rehearsed answer without corresponding conduct is still clinically informative: it shows the gap between moral cognition and moral action.

Use the accompanying theory-alignment plate as a map of different questions, not as proof that the theories describe the same process.

- Piaget, from the sensorimotor period onward, maps changes in cognitive structure.
- Erikson maps psychosocial stages and their central conflicts.
- Freud maps psychosexual stages.
- Mahler describes separation-individuation.
- Kohlberg maps moral reasoning.

Vygotsky should sit beside, not inside, that stage sequence: sociocultural mediation, private speech and the zone of proximal development are cross-cutting mechanisms, not age-bound stages. Kohlberg likewise appears on the plate only in Kaplan and Sadock's descriptive bands, never on an invented numeric age axis.

5 . Mahler separation-individuation theory

Margaret Mahler's separation-individuation theory is a psychoanalytic account of how the infant moves from an experienced psychological unity with the mother toward a stable sense of being a separate person who can remain emotionally connected to her. Its subject is the ***psychological birth*** of the individual, not biological birth and not the attainment of a motor milestone. **Two** developmental lines proceed together but are not identical: **separation** is the emergence from symbiotic fusion and the differentiation of self from object, while **individuation** is the acquisition of a distinctive identity, autonomous ego functions and an enduring inner sense of self.



Fig 20.5 Mahler's account of psychological birth. Separation and individuation proceed together through differentiation, practising and rapprochement toward a stable inner representation of the caregiver and a distinct sense of self.

How to use this page. Fix the distinction between separation and individuation, then learn the sequence: the historical precursor phases of normal autism and normal symbiosis, followed by differentiation or hatching, practising, rapprochement, and consolidation toward libidinal object constancy. For each phase, ask what changes in self-object boundaries, exploration, use of the caregiver and mental representation. Finally, retain the limits: this is an object-relations formulation, not a developmental screening schedule, and its age brackets must not be converted into referral thresholds.

Must memorise: separation means "I am not you"; individuation means "I am me"; their sequence is hatching, practising, rapprochement and consolidation toward object constancy.

MNEMONIC

"Hatching - practising - rapprochement - consolidation"

separation means "I am not you"; individuation means "I am me"; their sequence is hatching, practising, rapprochement and consolidation toward object constancy.

5.1 The organising model: psychological birth through two intertwined lines

The child becomes separate without becoming unrelated. Mahler's model belongs to object-relations theory, where an ***object*** is a significant person as experienced and mentally represented, not an inanimate thing. Development requires a gradual reorganisation of the infant-mother relationship. Perceptual differentiation, locomotion and autonomous ego capacities support separation; the consolidation of identity and internal representations supports individuation. The endpoint is therefore neither fusion nor detachment. It is the capacity to function as a distinct self while maintaining a dependable emotional bond with a whole caregiver.

Mahler developed the theory through observations of young children and their mothers. In the classical vocabulary, *mother* denotes the central maternal object. In contemporary clinical use, *primary caregiver* is often the more accurate functional term, while the original terminology should still be named in an examination answer. The theory focuses on intrapsychic organisation inferred from behaviour within a relationship; it does not claim that visible independence alone proves psychological individuation.

Source-reported theoretical timings, not normative cut-offs:

TIMING	STAGE	SOURCE
The first weeks of the infant's life	normal autistic phase	in Wolberg's *Technique of Psychotherapy*
Three to four weeks	normal symbiotic phase	as reported by Wolberg
About 4 or 5 months to 10 months	hatching phase	in Wolberg
Between 15 and 18 months	onset of rapprochement	in Wolberg
15-24 months	is the rapprochement phase	in *Cognitive Therapy of Personality Disorders*
Around 18 to 24 months of age	rapprochement crisis	in Wolberg
During the third year of life	libidinal object constancy	in Wolberg

The first weeks of the infant's life	About 4 or 5 months to 10 months	15-24 months	During the third year of life
NORMAL AUTISTIC PHASE	HATCHING PHASE	RAPPROCHEMENT PHASE	LIBIDINAL OBJECT CONSTANCY

These sources state theoretical ages without identifying them as medians, expected ranges, upper limits or red-flag thresholds. They must therefore be repeated only as source-reported stage

timings. Overlap or variation between texts is not evidence of abnormal development, and none of these values tells a clinician when to refer a child.

RULE **Mahler's ages locate concepts within a theory; they do not define developmental normality.** Use developmental surveillance and validated screening instruments to detect delay. Do not diagnose a failed phase, fixation or developmental disorder from a child's calendar age.

5.2 Precursor phases: normal autism and normal symbiosis

Mahler begins with states in which self and other are not yet represented as clearly separate. In the historical **normal autistic phase**, the infant was described as predominantly invested in physiological regulation and protected from external stimulation by a relatively closed psychological barrier. The term *autistic* here belongs to Mahler's early psychoanalytic vocabulary. It does not mean autism spectrum disorder, does not predict it and should never be entered into a modern case record as though it were a diagnosis.

In the **normal symbiotic phase**, the infant is increasingly responsive to the mothering environment but is theorised to experience infant and mother as a dual unity within a common boundary. Symbiosis in this model is an intrapsychic state of undifferentiation, not merely closeness, dependence or frequent physical contact. The caregiver regulates tension and supplies gratification, while repeated experiences begin to organise an expectation of relief and relationship. Normal symbiosis is a precursor to differentiation; persistent adult dependency cannot simply be labelled proof that the person is "stuck" in it.

5.3 Differentiation or hatching: the beginning of separation

Attention turns outward and the infant begins to inspect the boundary between familiar self-object unity and the wider world. The **differentiation subphase**, also called hatching, marks the proper beginning of separation-individuation. The metaphor is psychological, not anatomical. The infant becomes more alert to the environment, studies the mother's face and body, compares familiar and unfamiliar people, and begins to move physically away while checking back perceptually. These behaviours are read as signs of emerging differentiation rather than complete selfhood.

The clinical emphasis is on discrimination and boundary formation. Familiarity becomes more organised, the external world acquires greater salience and the mother is increasingly apprehended as a particular object rather than merely part of a need-satisfying unit. Yet separation remains supported by the caregiver's availability. Hatching is therefore not abrupt detachment. It is a gradual opening of a relationship in which difference can be noticed without the bond disappearing.

5.4 Practising: locomotion, exploration and the exhilaration of autonomy

New autonomous capacities widen the child's psychological and physical world. In the **practising subphase**, locomotion and other developing ego functions permit active exploration away from the caregiver. Mahler described an exuberant investment in the wider world, with the child appearing temporarily absorbed in newly acquired competence and relative independence.

The caregiver remains the secure emotional centre. The child returns for brief contact or emotional refuelling, then ventures outward again.

The high-yield paradox is that apparent independence still rests on dependable availability. Exploration does not prove that the object is no longer needed; it shows that connection can support movement away. Clinically, this helps the resident observe how autonomy and dependence coexist rather than forcing behaviour into either "independent" or "dependent". Motor progress may facilitate practising, but Mahler's phase is a relational and intrapsychic construct, not a motor-development category.

5.5 Rapprochement: separateness becomes emotionally costly

The child now recognises separateness more fully and seeks renewed emotional closeness without surrendering autonomy. In the **rapprochement subphase**, the earlier exhilaration of practising gives way to a sharper awareness that the caregiver is a separate person who cannot be controlled by omnipotent wish. The child brings discoveries back to share, follows the caregiver, demands participation and alternates between bids for help and assertions of independence. Mahler described this push-pull as **ambitendency**: a simultaneous wish to move away and to be close.

The rapprochement crisis is the intensification of that conflict. Dependence may feel necessary, while closeness may threaten the new autonomy. Frustration exposes the fact that the loved object also disappoints, so affectionate and angry experiences must increasingly be held together rather than kept apart. A sufficiently available caregiver neither abandons the child nor erases every frustration. She permits approach, tolerates rejection and survives ambivalence, helping the child discover that separateness need not mean loss.

5.6 Consolidation and libidinal object constancy

A stable inner representation permits connection across absence, frustration and mixed feeling. During consolidation, individuation advances and self-other boundaries become more durable. **Libidinal object constancy** means that a predominantly positive, emotionally invested representation of the caregiver can be maintained when she is absent, unavailable or temporarily experienced as frustrating. Love and anger can be directed toward the same whole person without that person having to become entirely good or entirely bad.

Object constancy depends on integrating affectively contrasting representations of self and object. It supports tolerance of delay, separation and ordinary ambivalence, while stabilising identity and relationships. It is an achievement with degrees, not an all-or-none certificate permanently acquired at a single moment. Stress can still strain the capacity to hold a complex view of self and others.

TRAP **Object constancy is not Piagetian object permanence.** Object permanence is the cognitive understanding that an object continues to exist when not perceived. Mahler's object constancy is affective and representational: the relationship to a whole loved person remains internally available across absence and frustration. Also, Mahler's "normal autistic phase" is not autism spectrum disorder.

5.7 Clinical formulation: useful relational questions, not developmental verdicts

Mahler gives the psychiatrist a vocabulary for recurrent tensions between closeness and autonomy. In assessment, ask:

- whether separation evokes abandonment;
- whether intimacy evokes engulfment;
- whether the patient alternates between clinging and withdrawal;
- whether disappointment rapidly converts an admired person into a hated one;
- whether an absent attachment figure can remain emotionally real.

Similar patterns may appear in relationships, the therapeutic frame, transference and countertransference.

The model has been influential in psychodynamic formulations of borderline personality organisation, particularly accounts of unstable self-image, splitting, fear of abandonment and rapprochement-like oscillation. The safe formulation is analogical and probabilistic: a present pattern resembles a conflict described by the theory. The unsafe formulation is causal and retrospective: the patient has a disorder because a named Mahler phase failed. Adult symptoms cannot reconstruct infancy with that certainty, and no single relational pattern is specific to one developmental history.

Its limitations are examinable. The earliest phases rely on inferences about infant subjectivity; later infant research challenges the idea of an originally closed or wholly undifferentiated infant; the word *autistic* is now misleading; and the original mother-infant dyad may understate fathers, grandparents, siblings, multiple caregivers, temperament and the wider social environment. The theory may also invite caregiver blame if used crudely. Its continuing value lies in organising clinical questions about boundaries, ambivalence and internal representations, not in serving as a literal developmental test.

5.8 Alignment with the major developmental theories

The companion theory-alignment map places the models on a shared age axis, but temporal overlap does not make their constructs interchangeable. Mahler explains separation-individuation and self-object differentiation. Piaget explains changing structures of thought from the sensorimotor stage onward. Erikson organises development through psychosocial stages such as trust versus mistrust and autonomy versus shame and doubt. Freud organises drive and conflict through the psychosexual stages. The map supplies the source-reported age bands; the text must not turn lateral alignment into theoretical equivalence.

Kohlberg describes moral development in the ordered levels preconventional, conventional and postconventional. Kaplan and Sadock relate these to descriptive bands such as before adolescence, during adolescence, later in adolescence, and late adolescence or early adulthood; no sourced numeric ages should be invented. Vygotsky is not a stage theorist. His zone of proximal development, scaffolding, private speech and socially mediated learning are mechanisms that

operate across development, so he belongs beside the age-aligned stage theories rather than inside the plate as a fabricated sequence.

Clinically, each theory asks a different question of the same presentation: Piaget asks how the child represents and reasons; Erikson asks what social conflict is being negotiated; Freud asks how drive and defence are organised; Kohlberg asks how a moral judgement is reasoned; Mahler asks how separateness and connection are managed; Vygotsky asks what learning becomes possible with guided participation. A strong examination answer preserves those levels instead of blending them into a single omnibus theory.

5.9 Nearby relational constructs: theory of mind, language and parenting

Theory of mind is the capacity to attribute mental states to oneself and others and to understand that another person's belief may differ from reality and from one's own belief. *Psychotherapy for Borderline Personality Disorders* reports that passing a false-belief task is expected at **four or five years**. This is not Mahler's object constancy: theory of mind concerns representing another mind, whereas object constancy concerns sustaining an affective representation of a whole attachment object.

The major language acquisition theories also answer a different question.

THEORY	EMPHASIS
Chomsky	emphasises an innate biological preparedness for language and rule formation.
Skinner	emphasises operant learning, reinforcement, shaping and imitation.
Vygotsky	emphasises social mediation, shared activity and the transformation of interpersonal speech into private speech and self-regulation.

Contemporary understanding is not served by making any one of these a subphase of separation-individuation. Language can express emerging self-other distinction, but language development and Mahler's relational sequence are not the same construct.

Baumrind parenting styles classify patterns of warmth and behavioural demand. The classic styles are authoritative, authoritarian and permissive; the later two-dimensional extension adds uninvolved or neglectful parenting. They describe caregiving climate rather than the child's intrapsychic phase. In a clinical interview they help characterise limits, responsiveness and autonomy support, but they neither diagnose a Mahlerian disturbance nor prove how the child experiences the caregiver.

5.10 Indian clinical use and examination reconstruction

INDIA

Mahler's source-reported timings are not Indian developmental norms, and no verified India-specific age adaptation of the theory is supplied here. In Indian families, caregiving may be distributed across parents, grandparents, siblings and other relatives; proximity and interdependence may be valued without implying failed individuation. Formulate the child's actual pattern of boundaries, exploration, availability and emotional representation within that family and culture. Do not mistake a Western ideal of early behavioural independence for psychological health, and do not use Mahler in place of Indian developmental screening or formal assessment.

How to write the long answer. Begin with psychological birth and define separation and individuation separately. Name the precursor phases, then describe hatching, practising, rapprochement and consolidation in order. Attach one organising idea to each: *differentiation, exploration, ambivalence, integration*. Distinguish object constancy from object permanence, give one psychodynamic formulation use, and close with the empirical, cultural and caregiver-blame limitations.

6 . Vygotsky sociocultural theory and zone of proximal development

Lev Vygotsky's sociocultural theory explains cognitive development as a socially mediated process. The child does not develop as an isolated thinker who later enters society. Learning begins in shared activity with more knowledgeable people, is organised by culturally supplied tools and signs, especially language, and is gradually transformed into the child's own psychological functioning. The best-known construct is the **zone of proximal development** (ZPD): the region between what a learner can accomplish independently and what the learner can accomplish through effective guidance or collaboration. The theory is developmental, but it is **not stage-based**. It supplies no Vygotskian sequence of age-linked stages.

How to use this page. Build the answer around one movement: **from shared regulation to self-regulation**. First define social mediation and internalisation, then define the ZPD by its **two** boundaries, explain contingent support and its withdrawal, and connect private speech with the development of self-guidance. End with educational and clinical use, followed by the limits of inferring learning potential from a brief interaction. Schunk's *Learning Theories: An Educational Perspective*, Berk's *Development Through the Lifespan* and Ciccarelli's account support the conceptual treatment; none supplies age stages for Vygotsky.

Must memorise: Development moves from the social plane to the psychological plane: what the learner first does with guidance is gradually internalised and done independently.

6.1 The sociocultural proposition: mind develops through mediated participation

Higher mental functions have social origins and are culturally organised. Vygotsky distinguished elementary capacities with a biological basis from **higher mental functions**, such as deliberate attention, strategic memory, planning and conceptual thought. Higher functions do

not simply unfold from maturation. They are reorganised through participation in culturally structured activity. A caregiver labels objects, directs attention, breaks a task into parts, models a strategy and helps the child remember what to do next. In time, the child takes over these regulatory operations.

This account is dialectical: the social world shapes the child, but the child is not passive. The learner acts, responds, selects tools, alters the interaction and gradually becomes a participant with greater responsibility. Development is therefore neither the direct transmission of adult knowledge nor solitary discovery alone. It is the transformation of activity conducted between people into activity organised within the person.

6.2 Cultural tools, signs and internalisation

Human beings change cognition by using culturally inherited means. **Mediation** occurs when action is organised through a tool or sign rather than by a direct stimulus-response link. Material tools change the external environment; psychological tools and signs change how attention, memory and problem-solving are organised. Language, writing, counting systems, diagrams, mnemonics, maps and culturally taught problem-solving routines are examples. Because cultures provide different tools and practices, the form and priorities of cognition cannot be understood apart from the learner's social setting.

Internalisation is not the copying of an external act into an unchanged inner space. It is a transformation. An instruction first spoken by another person may later be spoken by the child to guide action, then become abbreviated as inner speech. The original interaction is reconstructed as a means of self-regulation. The common summary is that a higher function appears first on the *interpsychological* plane, between people, and later on the *intrapsychological* plane, within the person.

RULE **Social origin does not mean passive absorption.** Internalisation is an active reorganisation of shared activity into self-directed psychological functioning.

6.3 The zone of proximal development: actual and potential performance

The ZPD is defined by the difference that appropriate assistance makes. The learner's lower boundary is the level of **independent performance**, often called the actual developmental level. The upper boundary is the level of **assisted performance** that becomes possible with adult guidance or collaboration with a more capable peer. The ZPD is the region between these boundaries. It is not everything a child cannot do, and it is not a fixed store of hidden intelligence. A task lies beyond the useful zone when even well-matched assistance does not make performance possible.

Three

INSTRUCTIONAL LOCATIONS

INSTRUCTIONAL LOCATION	DESCRIPTION
Below the ZPD	already mastered independently, so extensive help adds little developmental value.
Within the ZPD	not yet independent, but achievable with responsive guidance, making it the principal teaching zone.
Beyond the ZPD	not achievable even with suitable support at that point, so prompting alone becomes unproductive.

The ZPD shifts attention from a static question, *What can this learner do now?*, to a developmental question, *What can this learner do with help, and how much help is required?* Two learners with the same unaided score may differ in responsiveness to modelling, prompts, feedback and transfer. Conversely, assisted success must not be counted as independent mastery. The quality of the support, the learner's familiarity with the language and task, motivation, anxiety, fatigue and the relationship with the examiner can all affect the observed zone.

6.4 Scaffolding: contingent support, fading and transfer of responsibility

Scaffolding is the instructional process most commonly used to operationalise the ZPD. The more knowledgeable participant recruits attention, simplifies the task, models a step, asks a leading question, supplies a cue, highlights an error or maintains motivation. Support is *contingent*: it increases when the learner is stuck and decreases when competence appears. The aim is not permanent assistance but a transfer of responsibility to the learner through fading.

The term *scaffolding* was introduced later by Wood, Bruner and Ross rather than coined by Vygotsky. It is compatible with his account, but the **two** terms are not synonyms. The ZPD describes a relation between present independent performance and assisted possibility; scaffolding describes one way of supporting activity within that relation. Good scaffolding is calibrated and temporary. Giving the answer, overprompting every step or withdrawing help abruptly can all obscure what the learner understands.

TRAP **ZPD is not the task itself, and scaffolding is not unlimited help.** The zone is defined by the learner's change in performance under appropriate assistance. Support must be adjusted and then faded until the learner regulates the task independently.

6.5 Language, private speech and the growth of self-regulation

Speech changes from a means of coordinating with others into a means of coordinating oneself. In shared activity, **social speech** allows a caregiver and child to direct attention, label a goal and organise action. The child later uses **private speech**, audible speech addressed to the self, to plan, inhibit an impulsive response, sequence steps and correct errors. With increasing internalisation, this becomes condensed **inner speech**. Inner speech is not merely ordinary conversation moved silently into the head; it becomes abbreviated and shaped for self-guidance.

Private speech is therefore functional rather than simply immature. It is especially likely when a task is difficult, novel or requires control, and overt self-talk may reappear when an older learner is challenged. The classic contrast is with Piaget, who treated egocentric speech mainly as

evidence that the young child had not yet fully accommodated the listener's perspective. Vygotsky instead emphasised its transition from interpersonal communication to intrapersonal regulation. The views address different features of children's self-directed talk and should not be reduced to a slogan that one theorist found it useless and the other useful.

6.6 Learning leads development: teaching within the emerging competence

Vygotsky rejected teaching that merely waits for fully formed capacities. Instruction is most developmentally productive when it engages functions that are emerging and supports performance within the ZPD. In this sense, appropriately organised learning leads development: guided participation creates opportunities for the learner to practise forms of attention, reasoning and self-regulation that later become independent. This does not mean that any teaching can override readiness, neurodevelopmental constraints or prior knowledge. The learner must be able to participate meaningfully in the supported activity.

Applications include modelling with gradual withdrawal, guided questioning, cooperative learning, peer tutoring, reciprocal teaching, cognitive apprenticeship and worked examples that become progressively incomplete. A more capable peer may support learning, but peer status alone does not guarantee effective mediation. The peer must understand the task, communicate accessibly, notice the learner's response and adjust help. Collaboration is valuable when responsibility and explanation are shared, not when one student completes the work for another.

6.7 Dynamic assessment and clinical use

Dynamic assessment extends the ZPD into assessment by embedding teaching within the evaluation. A test-teach-retest format, graduated prompts or mediated learning can show which cues unlock performance, how rapidly a strategy is acquired, whether improvement transfers to a related task and how much assistance remains necessary. This complements a static score by sampling learning processes and modifiability. It does not make standardised assessment redundant, and assisted performance should be reported separately from unaided performance.

> **CLINICAL USE**
>
> When a child cannot organise a multistep task, first observe independent performance. Then offer the least intrusive useful support, such as restating the goal, modelling the first step or giving a visual sequence, and record the response. Improvement with modest, transferable support suggests an accessible learning pathway; persistent difficulty despite well-matched help suggests the need to examine language comprehension, attention, memory, intellectual functioning, anxiety, sensory factors and the suitability of the task. This is formulation evidence, not a diagnosis.

In psychiatry, the same logic can guide cognitive remediation, executive-function support, psychoeducation and rehabilitation. The clinician identifies what the patient can manage alone, co-constructs the next step and withdraws prompts as self-management improves. The goal is agency, not dependence on the therapist. A person's need for scaffolding may vary across tasks and states, so the ZPD should not be treated as a single stable trait or converted into a global intelligence label.

6.8 Alignment with stage theories: a cross-cutting mechanism, not another row

The accompanying theory-alignment plate places different developmental questions beside one another. Piaget describes changes in cognitive structure from the sensorimotor period onward. Erikson organises development through psychosocial stages and their central conflicts. Freud proposes psychosexual stages organised around drive, bodily focus and conflict. Kohlberg describes ordered forms of moral development, but his sourced age relationships are descriptive bands rather than numeric ranges. Mahler describes separation-individuation and the development of psychological separateness in relationship.

Vygotsky differs structurally from all five: sociocultural theory and the zone of proximal development specify mechanisms through which learning and self-regulation can occur across development. There are no Vygotskian stages to align by age. The plate should therefore show Vygotsky beside the stage sequences as a cross-cutting mechanism, never as an invented age row. Temporal overlap between theories also does not make their constructs equivalent: cognitive structure, psychosocial conflict, psychosexual organisation, moral reasoning, separation and supported learning answer different questions.

6.9 Culture, Indian clinical interpretation and limitations

Culture is constitutive in the theory, not decorative context added after cognition develops. Languages, scripts, number systems, schooling practices, work routines, narratives and patterns of adult-child participation influence which skills are practised and how they are organised. This is a major strength of the framework. It also creates a methodological challenge: performance in an unfamiliar testing interaction may underestimate competence acquired through everyday participation, while familiarity with school-like dialogue may advantage another learner.

> **INDIA**
>
> In Indian practice, mediation may be distributed across parents, grandparents, siblings, teachers and peers, and learning may occur through observation, participation, recitation, demonstration or direct questioning. These forms should be described rather than ranked against a single classroom ideal. Language of testing matters in a multilingual child, as does familiarity with the examiner's style. No verified India-specific numeric ZPD norm or Vygotskian age-stage adaptation is supplied here, and none should be invented. The absence of an age table is expected because the ZPD is relational and task-specific, not an age stage.

The principal criticisms are equally examinable.

- The theory gives powerful concepts but less precise specification of how broad cultural processes produce particular individual cognitive changes.
- The boundaries of a ZPD can be difficult to measure reliably because assistance is interactive and examiner-dependent.
- A more capable partner may transmit error, prejudice or conformity as well as skill.
- Social mediation can be overstated at the expense of biological maturation, temperament, spontaneous exploration and individual construction.

- Successful performance with help does not prove durable learning unless support can be faded and the strategy transfers beyond the teaching episode.

6.10 Examination reconstruction

Long-answer sequence. Define sociocultural theory, state the social origin of higher mental functions, explain cultural tools and internalisation, define both boundaries of the ZPD, distinguish the ZPD from scaffolding, trace social speech to private and inner speech, then add dynamic assessment, one clinical use and the principal criticisms. Close by stating that Vygotsky proposed no age-linked stages.

MNEMONIC

Social activity - mediation - internalisation - ZPD - contingent support - fading - self-regulation.

It traces the movement from shared regulation to self-regulation. If that chain is intact, the rest of the answer can be rebuilt rather than recited.

7 . Bowlby and Ainsworth attachment theory and Strange Situation

Attachment is an enduring, selective emotional bond in which a child seeks proximity to a familiar caregiver, especially when frightened, tired, ill or uncertain. John Bowlby supplied the evolutionary and developmental theory; Mary Ainsworth converted that theory into naturalistic observation and a standardised laboratory assessment, the Strange Situation. The central idea is functional rather than sentimental: the caregiver becomes a **safe haven** under threat and a **secure base** from which the child can explore. The examiner usually wants **three** distinctions. Attachment is not simply feeding or dependency, an attachment pattern is not a fixed personality trait, and insecure attachment is not in itself a psychiatric disorder.

How to use this page. First learn Bowlby's attachment behavioural system and internal working model. Then learn why Ainsworth treated exploration, separation and reunion as one organised system. Finally, identify the **four** patterns from reunion behaviour: secure, avoidant, ambivalent or resistant, and disorganised. The final section connects attachment with normal adolescent development, because adolescence reorganises rather than abolishes the secure-base relationship.

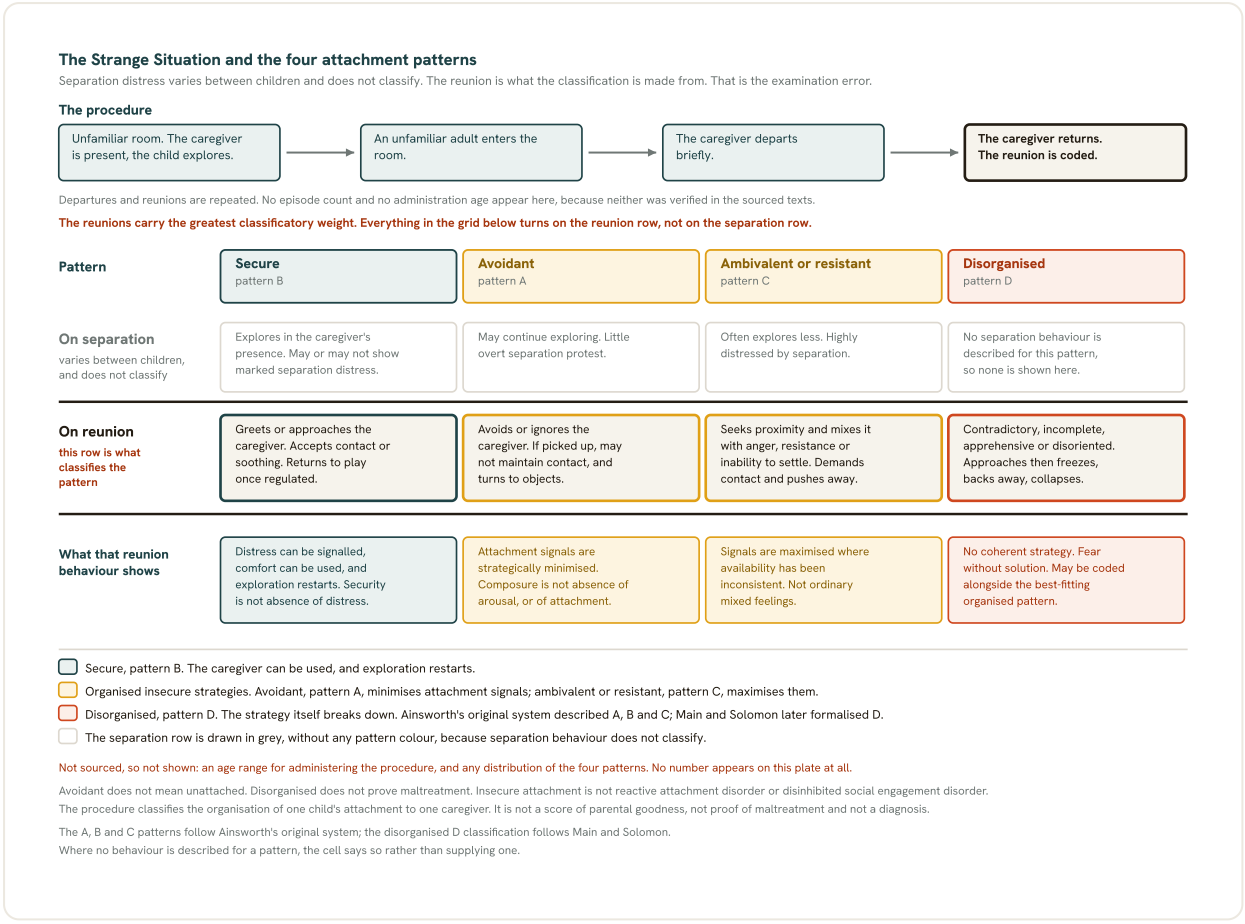


Fig 20.6 The Strange Situation and the four attachment patterns, keyed to behaviour on separation and on reunion. The separation row is drawn grey and undifferentiated because separation distress varies and does not classify; the reunion row carries the classification. The organised A, B and C patterns follow Ainsworth's original system, the disorganised D classification follows Main and Solomon. No age, episode count or pattern distribution appears, because none was verified in the sourced texts.

7.1 Bowlby: attachment as an evolved behavioural system

Proximity to a protective caregiver is the set goal. Bowlby rejected the drive-reduction claim that the infant becomes attached merely because the caregiver supplies food. He drew on psychoanalysis, ethology, control-systems thinking and observations of separation to propose an innate **attachment behavioural system**. Signals such as crying, smiling, calling, clinging and following increase caregiver proximity. The system is activated by threat, pain, fatigue, unfamiliarity or separation; it is relatively quiet when the child feels safe, allowing exploration and play. Attachment and exploration are therefore complementary systems. A securely based child is not continuously close to the caregiver. The child moves away to explore and returns when safety must be restored.

Bowlby's term monotropy described a tendency for one attachment figure to acquire special importance, not a biological rule that a child can form only one bond. Children can develop a hierarchy of attachments to several consistent caregivers. What matters clinically is not whether care matches a narrow family form, but whether available caregivers are familiar, responsive and sufficiently predictable. Bowlby's early writing on maternal deprivation was historically influential, but a modern reading separates the effects of prolonged loss, disrupted continuity,

insensitive care and the wider adversity that often accompanies them. The theory predicts risk, not destiny.

RULE **Attachment is a safety-regulation system, not a measure of how much a child loves a parent.** Read proximity-seeking, exploration and reunion as organised behaviour serving protection.

7.2 Internal working models and developmental organisation

Repeated interactions become expectations about self, others and help. Through recurrent caregiver responses, the child constructs **internal working models**: expectations about whether distress will be noticed, whether another person will be available, and whether the self is worthy and effective in eliciting care. These models guide attention, affect regulation, memory, help-seeking and later relationships. A history of responsive care favours open signalling and confidence in comfort; recurrent rejection may favour suppression of attachment signals; inconsistent response may amplify them. These are adaptive strategies in a particular relationship, not conscious decisions and not immutable templates.

Bowlby's developmental account is commonly organised as a phase sequence, and the qualitative progression runs as follows:

PHASE	QUALITATIVE PROGRESSION
Pre-attachment	broadly directed social signals.
Attachment-in-the-making	preference for familiar caregivers.
Clear-cut attachment	active proximity regulation.
Goal-corrected partnership	an increasing ability to represent the caregiver's goals and negotiate separation.

Working models are carried forward through continuity of expectations and relationships, but they remain open to revision through later caregiving, reflective capacity, psychotherapy and corrective relationships. Stability is therefore probabilistic, with both continuity and change expected.

7.3 Ainsworth: sensitivity, secure base and observational method

Ainsworth made caregiver-child organisation observable. Her naturalistic work in Uganda and later longitudinal observations in Baltimore refined Bowlby's theory. She described the infant's use of the caregiver as a secure base and emphasised **caregiver sensitivity**: noticing the child's signals, interpreting them accurately, and responding promptly and appropriately. Sensitivity is associated with security, but neither one interaction nor one caregiver characteristic mechanically produces a classification. Child temperament, caregiver state, cumulative experience, culture and the immediate context all contribute to observed behaviour.

Ainsworth's major methodological advance was to judge the organisation of behaviour rather than count isolated acts. Crying alone does not define insecurity, and a child who does not cry is not automatically secure. The question is whether the child can use the caregiver to regulate arousal and then resume exploration. This shift from single behaviours to the pattern linking

separation, proximity-seeking, contact, soothing and renewed play is the conceptual bridge to the Strange Situation.

7.4 Strange Situation: procedure, observations and scoring logic

A standardised, progressively stressful observation of attachment and exploration. The **Strange Situation Procedure** places a young child and caregiver in an unfamiliar room, introduces an unfamiliar adult, and includes brief caregiver departures and reunions. These manipulations activate the attachment system while leaving opportunities for play. Observers code exploration, distress on separation, response to the unfamiliar adult, proximity-seeking, contact maintenance, resistance, avoidance and the child's capacity to settle. The reunions carry the greatest classificatory weight because they show what the child does when the attachment figure becomes available after stress.

The procedure does not provide a global score of parental goodness, prove maltreatment, measure the total strength of the bond or diagnose a disorder. It samples behaviour in a structured context and classifies the organisation of one child's attachment to one caregiver. The original Ainsworth system described the organised A, B and C patterns. Mary Main and Judith Solomon later formalised the disorganised or D classification for behaviour that lacks a coherent approach to the attachment dilemma.

Must memorise: In the Strange Situation, reunion behaviour is decisive: secure children seek and use comfort, avoidant children minimise contact, resistant or ambivalent children seek yet resist it, and disorganised children show no coherent strategy.

MNEMONIC

"Seek, minimise, seek yet resist, no coherent strategy"

In the Strange Situation, reunion behaviour is decisive: secure children seek and use comfort, avoidant children minimise contact, resistant or ambivalent children seek yet resist it, and disorganised children show no coherent strategy.

7.5 Secure and avoidant attachment patterns

Secure, pattern B: distress can be signalled, comfort can be used, exploration can restart. A **secure** child generally explores in the caregiver's presence, may or may not show marked separation distress, greets or approaches the caregiver on reunion, accepts contact or soothing, and returns to play once regulated. Security is therefore not absence of distress. It is the flexible and effective use of the caregiver when distressed. The associated caregiving history is commonly sensitive, available and reasonably predictable, but the classification remains descriptive and probabilistic rather than a retrospective proof of caregiving quality.

Avoidant, pattern A: attachment signals are minimised. An **avoidant** child may continue exploring, show little overt separation protest, and avoid or ignore the caregiver on reunion. If picked up, the child may not actively maintain contact and may turn attention toward objects. The crucial interpretation is strategic minimisation of visible attachment behaviour in that

relationship, often associated with expected rejection or discomfort around bids for closeness. Apparent composure must not be equated with absence of arousal, absence of attachment or superior independence.

7.6 Resistant or ambivalent and disorganised attachment patterns

Resistant or ambivalent, pattern C: attachment signals are intensified but do not readily achieve settling. The **ambivalent** or resistant child often explores less, becomes highly distressed by separation, and on reunion combines proximity-seeking with anger, resistance or inability to settle. The child may demand contact and simultaneously push away, arch or remain preoccupied with the caregiver. This pattern is understood as maximising attachment signals when caregiver availability has been experienced as inconsistent. The word ambivalent refers to the observed mixture of approach and resistance, not to ordinary mixed feelings.

Disorganised, pattern D: the attachment strategy breaks down. A **disorganised** child shows contradictory, incomplete, apprehensive or markedly disoriented behaviour in the caregiver's presence, such as approaching and then freezing, backing away, collapsing, or displaying incompatible sequences without a stable strategy. The caregiver may be simultaneously the expected source of safety and a source of alarm, creating fear without solution. Disorganisation is associated with frightening or frightened caregiving, unresolved caregiver trauma, maltreatment and severe family stress, but it is not specific to any one cause. It may be coded alongside the best-fitting organised pattern and must never be treated as proof that abuse occurred.

TRAP **Do not convert attachment classifications into diagnoses.** Avoidant does not mean unattached, disorganised does not prove maltreatment, and insecure attachment is not synonymous with reactive attachment disorder or disinhibited social engagement disorder. RAD and DSED are separate clinical disorders linked to a history of severely insufficient care, and they are developed in the Child behavioural, emotional and other disorders notes.

7.7 Interpretation, cultural caution and clinical use

Classify the relationship in context, not the child's essence. Attachment security may differ across caregivers because each relationship has a different history. Classifications show moderate continuity at group level when care and context remain stable, but individual change is possible. Temperament can affect the intensity and style of distress without by itself determining security. Cultural practices also shape baseline separation experience, proximity, stranger familiarity and the social meaning of independence. Cross-cultural differences in pattern distribution therefore require ecological interpretation rather than a hierarchy of cultures.

Clinically, attachment theory helps formulate emotion regulation, help-seeking, interpersonal expectations and the meaning of separation. It does not justify diagnosing an attachment style from an adult's brief self-report, reading childhood causation directly from a current relationship, or blaming one caregiver. Adult attachment interviews and romantic-attachment questionnaires examine related but non-identical constructs and are not interchangeable with the Strange Situation. In a psychiatric assessment, ask:

- Who actually provided care.

- How the child sought comfort.
- How caregivers responded.
- Whether separations or changes in placement occurred.
- How the relationship functions now.

Use these observations to build a developmental formulation, not a label masquerading as explanation.

7.8 Attachment in adolescence: the secure base at a distance

Adolescence changes the regulation of closeness; it does not end attachment. In normal adolescent development, the secure-base function becomes less dependent on immediate physical proximity and more dependent on the expectation that support is available. Autonomy and attachment are not opposites. Security permits exploration of education, peers, values and intimate relationships, while caregivers remain a refuge under significant stress. Peers and romantic partners acquire attachment functions, but this redistribution is gradual and relationship-specific.

3	4
EXAM DISTINCTIONS	REUNION PATTERNS

8 . Temperament and goodness of fit (Thomas and Chess)

Temperament is the characteristic style with which a child responds to the world: the tempo, intensity, regularity and flexibility of behaviour rather than its particular content. Thomas and Chess captured the distinction neatly by asking *how* a child behaves, not *what* the child does or *why* the child does it. Temperament appears early, has a constitutional contribution and shows some continuity, but it is neither an immutable biological destiny nor a diagnosis. Its expression changes with development, relationships, learning, culture and context.

How to use this page. First learn the **nine dimensions**, then the **three types** derived from recurring combinations of those dimensions. Finally, understand **goodness of fit**, because that is the clinically important part of Thomas and Chess: adaptation depends not on a supposedly good or bad child, but on the match between the child's temperament and the demands, expectations and supports of the environment. In a theory answer, define temperament, list the nine dimensions, describe the three types with their classic proportions, explain goodness of fit and finish with clinical application and limitations.

> **The must-memorise line:** Thomas and Chess described nine dimensions and three temperamental constellations, but outcome depends chiefly on goodness of fit between the child and the environment.

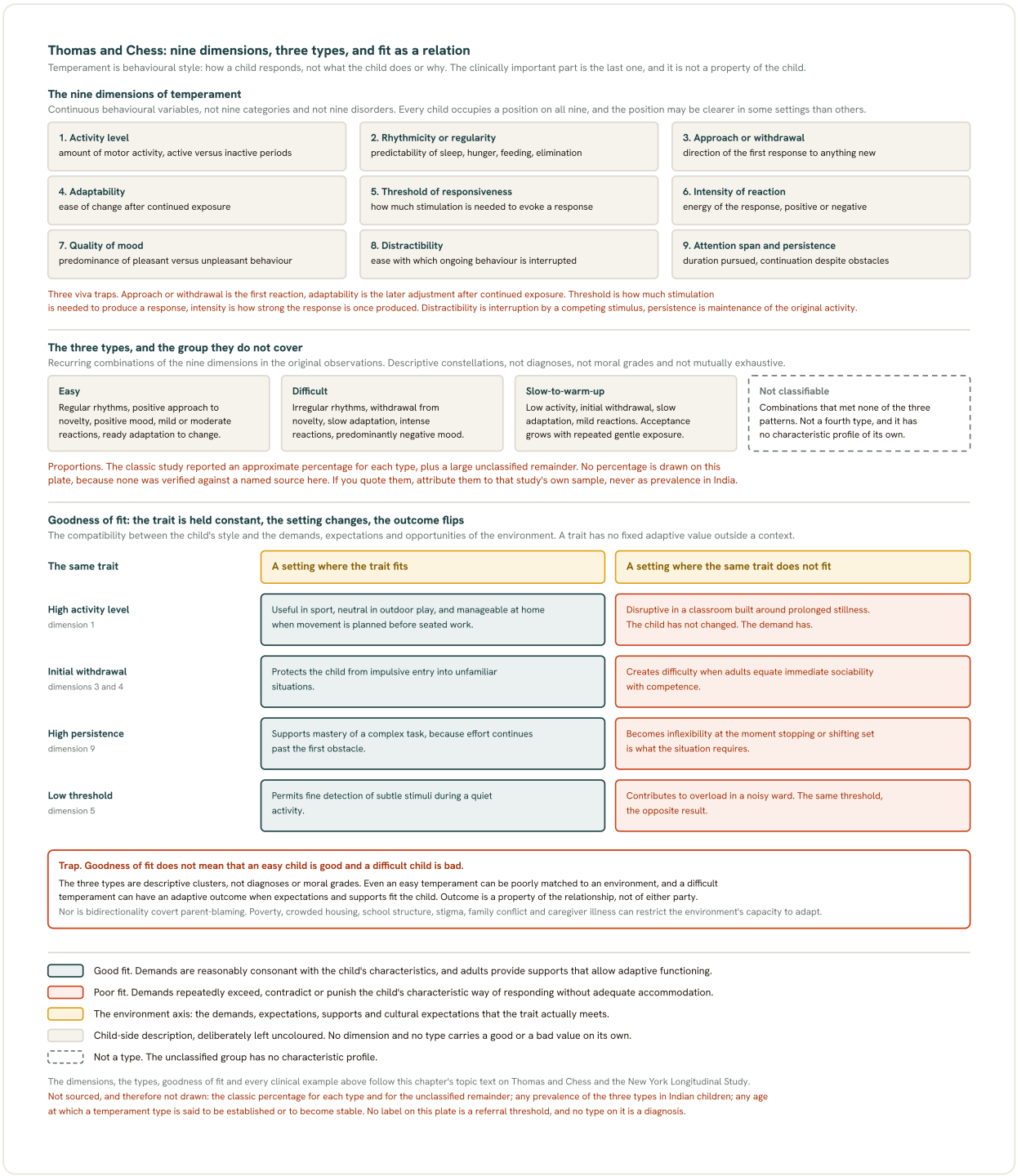


Fig 20.7 Thomas and Chess drawn as an interaction. The nine dimensions and the three types are the child side and are left uncoloured, because no dimension and no type carries a value on its own; a fourth box marks the group the three types did not cover, which is not a fourth type. Colour appears only in the fit table, where one trait is held constant and meets two settings, and the outcome reverses without the child changing. Content follows this chapter's topic text on Thomas and Chess and the New York Longitudinal Study. The classic proportions for each type are named on the plate but not drawn, because no percentage for them was verified against a named source here.

8.1 Thomas and Chess: the interactional view of temperament

Temperament is behavioural style, and development is transactional. In the New York Longitudinal Study, Alexander Thomas, Stella Chess and colleagues followed children and their families to examine early individual differences and later adjustment. Their work challenged explanations that attributed children's behavioural problems either entirely to innate defect or

entirely to parental handling. Children differ from the outset in how readily they become aroused, approach novelty, adapt to change, sustain activity and express mood. These differences alter how caregivers respond; caregiver responses then shape how the child's style is expressed and regulated. Child and environment therefore influence one another over time.

This is a **transactional model**, not a one-way causal model. A highly active child may invite more prohibition from an exhausted caregiver, while the resulting conflict may further amplify restless behaviour. The same child in a setting with safe movement, brief instructions and predictable transitions may function well. Conversely, an initially easy interaction can deteriorate when environmental demands change. Temperament contributes to the probability and form of an interaction; it does not independently dictate psychopathology.

RULE **Describe the child, the environment and the match.** A Thomas-and-Chess formulation is incomplete if it lists traits but does not show how environmental demands, caregiver responses and cultural expectations convert those traits into adaptation or difficulty.

8.2 The nine dimensions of temperament

The nine dimensions are continuous behavioural variables, not nine separate disorders. Each child occupies a position on every dimension, and the position may be more evident in some settings than in others. The examiner usually expects the complete list with a one-line meaning:

DIMENSION	MEANING
Activity level	the amount of motor activity and the relative proportion of active to inactive periods. Ask how much the child moves during play, meals, travel, learning and sleep-related routines.
Rhythmicity or regularity	the predictability of biological functions and routines, including sleep, hunger, feeding and elimination.
Approach or withdrawal	the direction of the initial response to a new person, place, food, activity or other stimulus. Approach means initial acceptance or engagement; withdrawal means initial hesitation, avoidance or distress.
Adaptability	the ease and speed with which behaviour changes after continued exposure to novelty or altered circumstances. It is distinct from the first response: a child may initially withdraw yet adapt well after familiarisation.
Threshold of responsiveness	the intensity of stimulation required to evoke a response. A low threshold means that weak light, sound, texture, temperature or social stimulation is sufficient; a high threshold means that stronger stimulation is needed.
Intensity of reaction	the energy level of the response, whether positive or negative. It concerns how strongly emotion or behaviour is expressed, not which emotion is expressed.
Quality of mood	the relative predominance of pleasant, friendly and joyful behaviour versus unpleasant, distressed or unfriendly behaviour.
Distractibility	the ease with which an ongoing behaviour is interrupted or altered by extraneous stimulation. It is not synonymous with a disorder of attention.
Attention span and persistence	the duration for which an activity is pursued and the tendency to continue despite obstacles. Attention span concerns sustained engagement; persistence concerns continuation when continuation becomes difficult.

Three distinctions prevent common viva errors. **Approach-withdrawal** is the initial reaction, whereas **adaptability** is the later adjustment. **Threshold** is the amount of stimulation needed to produce a response, whereas **intensity** is the strength of the response once produced. **Distractibility** is interruption by competing stimuli, whereas **attention span and persistence** describe maintenance of the original activity.

8.3 The three types: easy, difficult and slow-to-warm-up

The three types are clusters of dimensions found repeatedly in the original observations. They are descriptive constellations, not mutually exhaustive categories. A child's profile may resemble one constellation, contain features of several, or fit none. The labels are historically important and highly examinable, but the word *difficult* must be handled carefully because it describes a pattern of interactional challenge rather than a defective child.

TEMPERAMENTAL CONSTELLATION	CHARACTERISTIC PATTERN	LIKELY INTERACTIONAL ISSUE
Easy temperament	Regular biological rhythms, positive approach to novelty, relatively positive mood, mild or moderate reactions and ready adaptation to change	Usually elicits confident and rewarding caregiving, but genuine distress may be overlooked because the child is usually manageable
Difficult temperament	Irregular rhythms, withdrawal from novelty, slow adaptation, intense reactions and predominantly negative mood	May evoke coercion, criticism or inconsistent responses, producing escalating conflict when expectations are rigid
Slow-to-warm-up temperament	Low activity, initial withdrawal, slow adaptation and relatively mild reactions; acceptance increases gradually with repeated non-threatening exposure	May be misread as stubborn, uninterested or incapable if adults demand rapid participation

9	40%	10%	15%
DIMENSIONS IN THE THOMAS AND CHESS FRAMEWORK	APPROXIMATELY EASY IN THE CLASSIC CLASSIFICATION	APPROXIMATELY DIFFICULT IN THE CLASSIC CLASSIFICATION	APPROXIMATELY SLOW-TO-WARM-UP IN THE CLASSIC CLASSIFICATION

The proportions belong to the classic study classification and should not be presented as universal prevalence estimates for contemporary Indian children. Their examination value lies in showing that the three types never covered the entire population. The unclassified group is not a fourth type. In the classic study classification, **35%** were approximately mixed or not classifiable into the three types; their combinations did not meet one of the three characteristic patterns.

8.4 Goodness of fit: the central clinical proposition

Goodness of fit is the compatibility between the child's temperamental capacities and style, and the demands, expectations and opportunities of the environment. A good fit occurs when environmental demands are reasonably consonant with the child's characteristics and when adults provide supports that allow adaptive functioning. A poor fit occurs when demands repeatedly exceed, contradict or punish the child's characteristic way of responding without adequate accommodation or skill-building. The outcome is a property of the relationship between child and context, not a moral property located inside either one.

Consider high activity. It may be disruptive in a classroom built around prolonged stillness, useful in sport, neutral during outdoor play and manageable at home when movement is planned before seated work. Initial withdrawal may protect a child from impulsive entry into unfamiliar

situations, yet create difficulty when adults equate immediate sociability with competence. High persistence may support mastery of a complex task but become inflexibility when stopping or shifting is required. A low sensory threshold may contribute to overload in a noisy ward yet permit fine detection of subtle stimuli in a quiet activity. The trait has no fixed adaptive value outside a context.

Goodness of fit also includes culture. Families and schools differ in the value placed on quietness, assertiveness, emotional expressiveness, regularity, rapid sociability and obedience. A style praised in one setting may be discouraged in another. Cultural formulation does not mean accepting severe impairment or harmful caregiving. It means identifying whose expectation is being used, what the setting actually requires and whether that requirement can be modified without compromising the child's development or safety.

TRAP **Goodness of fit does not mean that an easy child is good and a difficult child is bad.** The three types are descriptive clusters, not diagnoses or moral grades. Even an easy temperament can be poorly matched to an environment, and a difficult temperament can have an adaptive outcome when expectations and supports fit the child.

8.5 From temperament to outcome: risk, protection and bidirectional effects

Temperament affects outcome through repeated transactions rather than direct determinism. A temperamental feature can influence exposure to situations, the responses elicited from other people, the child's interpretation of those responses and opportunities to practise regulation. When a mismatch is chronic, child and adult may enter a self-reinforcing sequence. Intense protest evokes harsh control; harsh control increases arousal and protest; both participants then anticipate conflict. When fit improves, the sequence can reverse: predictable preparation reduces arousal, calmer participation evokes more supportive responses, and successful experiences expand the child's tolerance.

Temperament can therefore function as a risk factor, a protective factor or a modifier of how other risks are expressed. It may influence the form of a symptom without being its cause. Inhibited approach can resemble anxiety, high activity can resemble hyperactivity, negative mood can resemble depression, irregularity can complicate sleep and feeding, and low persistence can look like defiance or inattention. The resident must establish pervasiveness, developmental change, subjective distress, functional impairment and the full syndrome before moving from style to disorder.

Parent and child effects are bidirectional, but bidirectionality must not become covert parent-blaming. Caregivers bring their own temperament, health, stress, beliefs, resources and expectations. A mismatch may occur between a highly intense child and a highly intense caregiver, or between an active child and a caregiver whose circumstances allow little safe movement. Poverty, crowded housing, school structure, stigma, family conflict and caregiver illness can restrict the environment's capacity to adapt even when the caregiver understands the child well.

8.6 Clinical assessment of temperament and fit

Assess a pattern across time and settings, not a single performance in the clinic. Begin with concrete examples rather than labels. Instead of asking whether the child is difficult, ask what happens with an unfamiliar person, an unexpected change, waiting, loud sound, a missed meal, a challenging task or a transition away from preferred play. Establish the trigger, initial response, intensity, duration, adaptability after continued exposure, recovery and effect on function. Map the answers onto the nine dimensions only after hearing the behaviour.

Take accounts from the child where developmentally appropriate, caregivers and teachers, because temperament is expressed differently across contexts and each observer has a relationship-specific view. Direct observation should sample free activity, structured demands, novelty, transition, frustration and recovery. The clinic itself is an unfamiliar and stimulating environment, so withdrawal, silence or high activity there cannot be assumed to represent the child's usual style. Look for both stable tendencies and situational exceptions; exceptions reveal environments in which fit is already better.

A useful formulation has four parts:

1. **Child profile:** identify the prominent dimensions and strengths using neutral behavioural language.
2. **Environmental profile:** identify family, school and cultural demands, available supports and the temperaments of important caregivers.
3. **Fit and transaction:** specify where mismatch occurs, how each participant responds and what cycle maintains the difficulty.
4. **Clinical boundary:** assess impairment and alternatives, including neurodevelopmental disorder, anxiety, mood disturbance, sleep or medical problems, trauma, attachment disturbance, sensory impairment and adverse environment.

Temperament is not a diagnosis of exclusion, but neither should it be used to explain away a disorder. The key question is whether the nine-dimension profile adequately describes a stable style or whether there is an additional syndrome with distress, impairment, developmental deviation or episodic change. A previously characteristic style that changes markedly should prompt assessment for state-related causes rather than being relabelled as temperament.

8.7 Management: change the fit, support regulation and preserve strengths

The intervention target is usually the transaction, not eradication of the trait. The clinician first reframes the behaviour in non-moral language, helps caregivers anticipate predictable points of mismatch and designs the environment so that the child can succeed while gradually building capacity. This is sometimes called temperamental guidance. It validates the child's style without allowing harmful behaviour and supports the caregiver without implying that every difficulty results from parenting.

Management follows the functional profile. An irregular child benefits from external predictability and consistent cues without punitive battles over perfect regularity. A child who

withdraws from novelty benefits from preparation, observation from a safe distance, gradual entry and repeated low-pressure exposure rather than forced sociability. A highly active child needs planned movement, brief achievable seated tasks and safe outlets. A child with intense reactions needs calm adult responses, simple limits and help labelling early arousal before escalation. A child with a low threshold may need reduction of avoidable sensory load and graded coping with unavoidable stimulation. Low persistence calls for task chunking, visible completion points and reinforcement of effort, whereas very high persistence may require supported transitions and practice shifting set.

The environment must adapt, but accommodation is not capitulation. A good fit both accepts the child's starting style and teaches the skills needed for wider participation. Expectations should be realistic, explicit and gradually increased. School collaboration is often decisive because the child may spend much of the waking routine under group demands. Review whether the change reduces conflict, improves participation and preserves the child's strengths; if impairment persists, reassess the formulation and comorbidity.

8.8 Strengths, limitations and later extensions

The model's enduring strength is that it moved child psychiatry from blame toward person-environment interaction. It offered an observable vocabulary for early behavioural individuality, recognised the child's active contribution to relationships and generated the clinically useful concept of goodness of fit. It also anticipated contemporary developmental psychopathology by treating outcome as the product of transactions over time rather than a simple line from one early trait to one later disorder.

Its limitations are equally examinable. The three types compress continuous traits and leave a substantial group unclassified. Several dimensions overlap conceptually, and ratings can be influenced by the observer's expectations, mood and relationship with the child. Stability is relative rather than absolute because the expression of temperament changes with maturation and context. The classic proportions arose from a particular sample and should not be universalised across socioeconomic and cultural settings. Finally, later temperament models organise traits differently and give greater attention to reactivity, self-regulation and biological mechanisms, so Thomas and Chess should be presented as a foundational framework rather than the final taxonomy of temperament.

The historical labels also require ethical translation. *Difficult* is useful in an examination when explicitly attributed to the Thomas-and-Chess classification, but clinical communication should describe the actual profile: irregular, initially withdrawing, slowly adaptive, intensely reactive or predominantly negative in mood. Precise description reduces shame and leads directly to intervention. A global label does neither.

8.9 Examination synthesis and retrieval

A complete short note can be built in five moves. Define temperament as behavioural style; name Thomas and Chess and the New York Longitudinal Study; list all nine dimensions; describe easy, difficult and slow-to-warm-up temperaments with the classic proportions and the

unclassified remainder; then explain goodness of fit with one clinical example, bidirectionality, management and limitations. If time is short, marks are lost most often by omitting threshold, confusing adaptability with approach, or listing the three types without explaining fit.

MNEMONIC

"move, clock, meet, change, notice, react, feel, shift, stay"

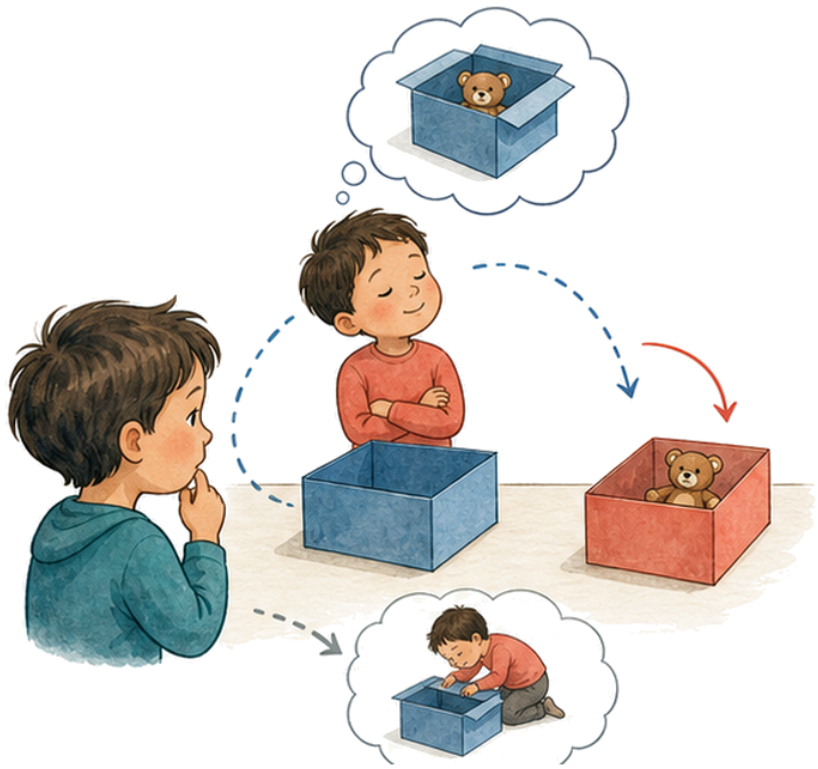
Move recalls activity level; clock, rhythmicity; meet, approach or withdrawal; change, adaptability; notice, threshold; react, intensity; feel, quality of mood; shift, distractibility; and stay, attention span and persistence. The sequence is only a retrieval aid. In the answer, use the formal terms.

Worked viva formulation: A child initially refuses unfamiliar classroom activities, reacts mildly and joins after repeated observation. This is closer to a slow-to-warm-up pattern than a difficult pattern because intensity is low and adaptation occurs gradually. If the teacher permits observation and phased entry, participation improves: that is better goodness of fit. If the child is forced to perform immediately and is repeatedly criticised, withdrawal may increase: that is poorer fit. Neither response alone establishes an anxiety disorder; distress, pervasiveness, persistence and impairment still require assessment.

Final clinical synthesis. Thomas and Chess supplied a vocabulary for the child's characteristic style, but their larger contribution was relational. Temperament describes how the child enters an interaction; goodness of fit explains why the same style can lead to competence in one environment and conflict in another. The mature answer neither blames the child nor idealises accommodation. It identifies the profile, maps the environment, changes the transaction and assesses separately for disorder.

9 . Theory of mind development

Theory of mind is the capacity to attribute mental states to oneself and to other people, and to use those attributions to explain and predict behaviour. The attributed states include intentions, desires, knowledge, beliefs, emotions and pretence. The decisive idea is representational: another person acts on how the world is represented in that person's mind, not necessarily on how the world really is or on what the observer knows. Theory of mind therefore permits the child to understand deception, surprise, misunderstanding, secrecy, irony and the fact that two people can interpret the same event differently. It is often called **mentalizing**, although clinical literature sometimes uses mentalizing more broadly for the imaginative interpretation of self and others in terms of intentional mental states.



- Joint attention
- Pretence
- First-order belief
- Second-order belief
- Mental-state inference

Fig 20.8 Theory of mind develops through interacting social, representational, linguistic and executive capacities. False-belief understanding is the central test: another person acts on what they believe, even when that belief conflicts with reality.

This is not a single switch and not a synonym for sociability. Its development rests on an interacting set of capacities: social attention, joint attention, symbolic representation, language, executive control, autobiographical memory and experience of conversation. A child may be affectionate yet fail a formal false-belief task because the language is too difficult; another may pass a structured task yet misunderstand rapidly changing intentions in ordinary interaction. For an examination answer, define the construct, describe its precursors, explain the false-belief test, compare the major explanatory models, and finish with clinical interpretation rather than treating one task as a diagnostic instrument.

Must remember: False belief is the examination pivot: the child must predict action from another person's belief even when that belief conflicts with reality and with the child's own knowledge.

9.1 What theory of mind includes, and what it does not

A representational account of minds, not merely a response to behaviour. At the simplest level, the child recognises that people are agents whose actions are directed toward goals. Development then involves distinguishing *desire* from *belief*: two people can want different outcomes, and two people can hold different representations of the same reality. Mature social understanding further requires recognising that access to information determines knowledge, that beliefs may be false, and that outward expression can differ from inner emotion. These strands do not have to develop at identical rates, which is why theory of mind is better considered a family of related abilities than a unitary faculty.

Cognitive theory of mind concerns beliefs, intentions and knowledge. **Affective theory of mind** concerns inference about another person's feelings. **Empathy** overlaps with the second but is not identical to it: affective resonance, concern and the motivation to help are separable from the ability to identify what someone feels. **Joint attention** is also distinct. It is the shared coordination of attention between a person and an object or event, and is a developmental foundation for learning what another person is attending to; it does not by itself demonstrate understanding of false belief. Likewise, mirror self-recognition concerns representation of the self, not direct proof that the child represents another person's mind.

RULE **Do not equate precursor, correlate and criterion.** Joint attention, pointing, pretend play, language and executive control support theory of mind. The classic explicit test is false-belief reasoning. None of these observations alone diagnoses or excludes a neurodevelopmental disorder.

9.2 Developmental sequence: from shared attention to represented belief

The sequence is more reliable than a rigid age ladder.

1. Early face-to-face reciprocity and turn-taking make interaction predictable.
2. The infant then coordinates gaze and attention with another person, follows what the other person is attending to, and uses gestures such as pointing to request or share interest.
3. Symbolic and pretend play show that one object or action can stand for another, an essential representational step.
4. The child subsequently reasons about desires, perception and access to knowledge, then understands that belief can diverge from reality.

MNEMONIC

"Share - Symbolise - Believe"

Shared attention follows what another person is attending to; symbolic and pretend play show that one object or action can stand for another; then the child understands that belief can diverge from reality.

Conversation with caregivers and peers supplies repeated evidence that different people know, want, remember and feel different things.

8 to 12 months	Around 12 months	18 months of age	Four or five years
JOINT ATTENTION ACCURACY	JOINT ATTENTION AND POINTING	SYMBOLIC PLAY	EXPLICIT FALSE-BELIEF TASK PERFORMANCE

Berk describes joint attention as becoming more accurate across 8 to 12 months. This is a developmental description, not a referral cutoff. The *New Oxford Textbook of Psychiatry* describes joint attention and pointing as expected in most typically developing children around 12 months. Dulcan describes symbolic play as expected at 18 months of age. *Developmental Psychopathology* places its expected appearance at approximately **20 months of age**. These are source-specific descriptions, not interchangeable thresholds. *Psychotherapy for Borderline Personality* describes explicit false-belief task performance as expected at four or five years. Berk also reports performance after **three and a half years** and describes a span between **four and six years**, but those statements do not establish referral thresholds.

The source language matters clinically. An expected attainment age describes what usually occurs; it is not an upper limit and it is not a red-flag threshold. The range reported by Berk is also not permission to refer every child outside an average-looking point. Development must be interpreted longitudinally and in context, especially when task language, hearing, schooling or cultural familiarity may alter performance.

9.3 False-belief tasks: the classic demonstration

The test asks whether the child can suppress reality and answer from another mind. In the classic change-of-location task, a protagonist puts an object in one location and leaves. In the protagonist's absence, the object is moved. The child is asked where the protagonist will look on returning. The reality-based answer is the new location; the belief-based answer is the original location, because that is where the protagonist falsely believes the object remains. A correct response therefore requires the child to represent the protagonist's informational access separately from the child's own knowledge.

The unexpected-contents task uses a familiar container whose actual contents violate its appearance. After discovering the contents, the child is asked what another, uninformed person will think is inside. Related paradigms test appearance versus reality, knowledge from seeing, hidden emotion, deception, irony and social faux pas. **First-order false belief** has the form, "She thinks X." **Second-order false belief** embeds one mind within another, "He thinks that she thinks X." No verified numeric attainment age for the second-order form is supplied here, so it should not be placed on an age axis.

Good testing includes control questions. The examiner checks whether the child remembers the object's original and current locations, follows the story, identifies who saw the transfer, and understands the question. Failure can arise from receptive-language load, working-memory demand, inattention or difficulty inhibiting the true location. Success can also be achieved through learned verbal rules rather than flexible social understanding. Spontaneous behaviour in natural interaction and performance across several tasks are therefore more informative than a single pass or fail.

TRAP **"The child knows where the object really is" is not the target answer.** False-belief tasks deliberately pit the child's true knowledge against the protagonist's outdated belief. Also avoid converting expected performance at four or five years into a diagnostic or referral cutoff.

9.4 Competing explanations of theory of mind development

No single account explains every finding.

ACCOUNT	EXPLANATION	QUALIFICATION
Theory-theory account	Proposes that children build and revise an informal causal theory of mind, much as they revise explanations in other knowledge domains. Observed action, testimony and conversational correction provide evidence; conceptual change moves the child from desire-based explanations toward representational belief.	Its strength is developmental change, but the metaphor of a child scientist can understate embodied and relational learning.
Simulation account	Proposes that the child predicts another person's action by using their own mind as a model, imaginatively placing themselves in the other's situation and adjusting for differences. It captures perspective-taking and the intimate relation between self-knowledge and understanding others.	It struggles when the other person's beliefs, motives or emotional responses are very unlike the child's own.
Modular or domain-specific accounts	Propose a specialised mechanism for representing propositional attitudes such as belief. They explain the apparently distinctive problem posed by mental representations and the characteristic social-cognitive profile seen in some neurodevelopmental conditions.	However, a strongly encapsulated module can underplay the effects of language, executive function, teaching and social experience.
Executive-function accounts	Emphasise working memory, cognitive flexibility and inhibitory control. The child must hold two representations in mind and inhibit the salient true state of affairs.	
Language and sociocultural accounts	Emphasise mental-state vocabulary, complement syntax, narrative, sibling and peer discourse, and conversation about reasons for behaviour. Complement constructions such as "She thinks that..." permit one proposition to be represented inside another, mirroring the representational structure demanded by false-belief reasoning.	Association does not establish that language alone causes theory of mind: linguistic competence, executive control and social understanding remain partly dissociable. The most defensible synthesis is interactive: representational competence, executive control, language and social experience constrain one another across development.

Applied to theory of mind, the sociocultural frame directs attention to joint activity, conversation about feelings and reasons.

Responsive mental-state conversation supports theory of mind.

9.5 Psychopathology: delayed, reduced and excessive mentalizing

Clinical interpretation. Theory of mind disturbance is clinically important but diagnostically non-specific. In autism spectrum disorder, whose fuller treatment is in the Intellectual disability and autism spectrum disorder notes, difficulties may involve spontaneous joint attention, integrating contextual cues, inferring intentions or applying explicit knowledge rapidly in everyday interaction. Some verbally able individuals pass standard false-belief tasks through language or learned strategies while continuing to find unstructured social inference effortful. A failed task is not sufficient for diagnosis, and a passed task does not exclude autism.

In schizophrenia and other psychotic states, difficulty may involve both under-attribution and distorted attribution of intention, especially under ambiguity. In personality pathology, particularly borderline presentations, the problem may be unstable or excessive inference about mental states, sometimes termed hypermentalizing, rather than a simple absence of theory of mind. Mood, arousal, trauma, attachment insecurity and interpersonal threat can transiently reduce the accuracy of mentalizing. The useful clinical contrast is therefore hypomentalizing, too little or overly concrete inference; hypermentalizing, elaborate inference unsupported by evidence; and reasonably calibrated mentalizing, which remains tentative and revisable.

Performance is also affected by intellectual functioning, language disorder, attention, executive dysfunction, hearing impairment and limited familiarity with the test format. Deficits can be trait-like, state-dependent or secondary to another cognitive limitation. Theory of mind should therefore contribute to formulation, never substitute for the full developmental and mental-state assessment.

9.6 Clinical assessment and examination synthesis

Assess development, task performance and real-world use separately. Begin with caregiver history of early reciprocity, gesture, joint attention, pretend play, language development, peer relationships, understanding of deception and humour, and any loss of language or social skills. Observe gaze coordination, sharing of interest, response to another person's distress, flexibility during misunderstanding and the person's tendency to check uncertain interpretations. In a formal task, simplify the language without changing the logic, establish that the person understood and remembered the story, and include reality, memory and information-access controls.

Interpret the result against receptive and expressive language, attention, working memory, inhibition, general cognitive level, hearing, educational exposure and cultural-linguistic context. Repeating the same task with translated words is not automatically a valid cultural adaptation. In multilingual Indian settings, establish the language in which the child normally discusses intentions and emotions, and use collateral examples from home and school. When developmental concern is broader than theory of mind, use an appropriate validated developmental screening or assessment pathway, developed in the Child psychiatry: assessment, treatment, services and protection notes, rather than inventing a false-belief referral age.

The short-answer synthesis is compact. Theory of mind is the capacity to represent one's own and others' mental states and predict behaviour from them. Joint attention and symbolic play are precursors; explicit false-belief reasoning is the classic test. Development reflects interacting domain-specific, simulation, executive, language and sociocultural processes. Clinically, failure is non-specific, success can be scaffolded, and the valid unit of assessment is the developing person in context rather than a single task score.

10 . Language acquisition theories (Chomsky, Skinner, Vygotsky)

Language acquisition asks how a child moves from hearing speech in social interaction to understanding and producing a rule-governed, productive language. **Three** classic answers emphasise different causal levels. B. F. Skinner treats verbal behaviour as behaviour shaped by its consequences and controlling context. Noam Chomsky argues that the speed, uniformity and generativity of acquisition require an innate, species-typical capacity for grammar. Lev Vygotsky places language within socially mediated development: speech first coordinates activity between people and is then internalised as a tool for thought and self-regulation. The most defensible contemporary answer is not to declare one winner. Biological preparedness, learning mechanisms and communicative participation operate at different levels and answer different parts of the problem.

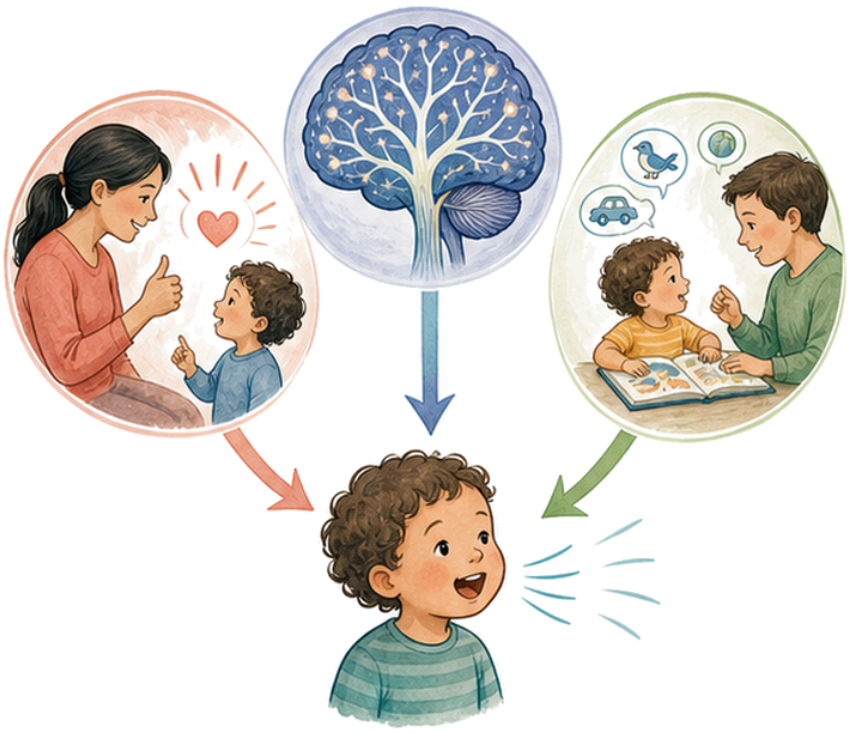


Fig 20.9 Classic accounts of language acquisition work at different causal levels: Skinner emphasises learning contingencies, Chomsky innate grammatical preparedness, and Vygotsky socially mediated speech that becomes internalised.

How to use this page. Learn each theory through **four** questions: *what is acquired, what drives acquisition, what evidence supports it, and what does it fail to explain?* For Skinner, the unit is a functional verbal response and the driver is its learning history. For Chomsky, the central object is grammatical competence and the driver is an innate language faculty constrained by universal principles. For Vygotsky, the unit is mediated social activity and the developmental movement is from shared speech to inner regulation. In a long answer, compare mechanisms rather than writing three disconnected biographies.

Must memorise: Skinner explains language through learning contingencies, Chomsky through innate grammatical preparedness, and Vygotsky through social mediation and internalisation.

10.1 The problem every theory must solve

Children acquire more than a stock of copied words. They learn a sound system, a lexicon, rules for combining words, meanings, conversational intentions and the social conditions under which an utterance is appropriate. They also produce sentences they have never heard, understand that the same form can serve different functions, and make systematic errors that reveal an active rule rather than random failure. Any adequate theory must therefore explain productivity, generativity, comprehension, social use, variation across languages and the transition from assisted participation to increasingly independent communication.

The theories differ partly because they choose different explananda. Skinner asks what environmental variables control a verbal act. Chomsky asks what internal system makes grammatical knowledge possible. Vygotsky asks how culturally organised interaction becomes a psychological tool. A behavioural account can explain why a request occurs in one context without specifying the child's abstract grammar. A grammatical account can explain structural knowledge without explaining why the child chooses a tact, request or reassurance in a particular relationship. A sociocultural account can explain guided participation without, by itself, providing a formal grammar. Apparent contradiction often falls once the level of explanation is named.

3	1	0
CAUSAL EMPHASES	DEVELOPMENTAL PROBLEM	THEORIES SUFFICIENT ALONE

10.2 Skinner: language as learned verbal behaviour

Speech is behaviour whose form and probability are shaped by antecedents and consequences. In Skinner's operant account, the child emits vocal behaviour; caregivers and the wider verbal community selectively respond; useful forms become more likely in relevant contexts. Positive reinforcement, shaping of closer approximations, imitation, prompting, stimulus discrimination and generalisation all contribute. Reinforcement need not mean sweets or praise. Receiving the requested object, attracting attention, continuing a pleasurable exchange or obtaining information can itself strengthen a verbal response.

Skinner classified verbal behaviour by its controlling relation rather than by conventional grammar.

VERBAL OPERANT	CONTROLLING RELATION
A mand	is controlled by a motivating condition and specifies its characteristic consequence, as when a thirsty child requests water.
A tact	is evoked by an object, event or property and maintained by socially generalised consequences, as when the child names a dog.
An echoic response	has point-to-point similarity with heard speech.
An intraverbal	is occasioned by other verbal behaviour without simply reproducing it, as in answering a question or completing a familiar phrase.
Autoclitic behaviour	qualifies or organises other verbal responses, indicating relations such as certainty, negation or attribution.

The same spoken word can therefore belong to different operants depending on what controls it and what consequence follows.

The account is strongest where the learning history is visible: vocabulary taught through joint activity, requests shaped by successful communication, pronunciation altered by feedback, and context-specific use acquired through modelling and consequences. It also gave language research an insistence on observable function. Its central weakness is explanatory reach. Children generate novel utterances, acquire complex structure without explicit reinforcement of every form, and produce rule-based overgeneralisation rather than merely imitating adult speech. Caregivers also respond to meaning, truth and conversational success, not consistently to grammatical form. Conditioning is therefore relevant, but a complete language theory cannot be a catalogue of reinforced sentences.

10.3 Chomsky: an innate capacity for generative grammar

Finite exposure yields knowledge capable of generating indefinitely many sentences.

Chomsky's nativist theory begins from the mismatch between the linguistic input available to the child and the structured grammatical knowledge eventually acquired. The input is variable, incomplete and not organised as a formal lesson, yet children converge on complex rules and recognise relations that cannot be reduced to adjacent word associations. This is the classic **poverty-of-the-stimulus argument**: experience is necessary to select and develop a language, but experience alone appears insufficient to specify every constraint the learner comes to respect.

The traditional examination formulation is an innate **language acquisition device**, a theoretical language-learning capacity that allows the child to extract grammatical structure from speech. In later generative accounts, the more important idea is **universal grammar**: species-typical initial constraints or principles that delimit the kinds of grammar a human learner can acquire. The child is not born knowing English, Hindi, Kannada or any other particular language. The claim is that human biology supplies a structured readiness, while exposure determines which language-specific system develops.

Chomsky also distinguished **competence**, the speaker-hearer's internal knowledge of language, from **performance**, actual language use under limits of attention, memory, motivation and context. A hesitant or incomplete utterance does not necessarily reveal an absent rule. The theory explains productivity, rapid rule extraction and patterned errors more convincingly than simple imitation does. Its limitations are equally important: the proposed innate content is difficult to specify and test independently; formal grammar does not by itself explain vocabulary learning, communicative intention, caregiver-child interaction or cultural variation; and usage-based evidence shows that distributional learning and repeated constructions carry more information than a stark poverty account sometimes assumes.

RULE **Innate capacity is not innate vocabulary.** Chomsky proposes biological preparedness for acquiring grammatical structure. The particular language, its words and its conventional uses still require exposure and participation.

10.4 Vygotsky: language is socially mediated and then internalised

Language develops in joint activity before it becomes a means of organising the self. Vygotsky's sociocultural theory treats language as both a cultural sign system and a psychological tool. A more knowledgeable participant directs attention, labels experience, interprets the child's attempts, models a form, asks questions and structures the activity. Through such mediated participation, the child gains not only words but culturally patterned ways of remembering, planning, categorising and solving problems. Acquisition is therefore inseparable from the purposes for which people communicate.

The **zone of proximal development** (ZPD) is the region between what the learner can perform independently and what becomes possible with responsive guidance or collaboration. Language supports learning within this zone through modelling, prompts, recasts, expansion of the child's utterance, shared attention and dialogue. Scaffolding is the later term commonly used for contingent support that is adjusted and gradually withdrawn. It is compatible with Vygotsky, but was not his own term and is not synonymous with the ZPD.

Development proceeds through the following sequence.

1. Social speech, used to coordinate with another person.
2. Private speech, audible self-directed language used to guide action.
3. Condensed inner speech.

Private speech is therefore a transitional instrument of self-regulation rather than meaningless immaturity. Vygotsky's theory is developmental but **not stage-based**. It provides no sequence of Vygotskian stages and no age row for the accompanying theory-alignment plate. Its major strengths are the integration of language, culture, teaching and self-regulation. Its limitations include imprecise measurement of the ZPD, dependence on the skill of the assisting partner, and less specification of biological constraints and formal linguistic structure.

10.5 Direct comparison: what changes the child's language?

Skinner locates change in contingencies. The child repeats and differentiates verbal acts because their consequences vary across situations. The adult is a source of models, prompts and reinforcement. Error is a response not yet adequately shaped or brought under the relevant stimulus control. **Chomsky locates change in the growth of an internally constrained grammar.** Input triggers and informs a biologically prepared system. The adult provides linguistic data, but need not explicitly teach every rule. Error can reveal a productive rule that has been extended too widely. **Vygotsky locates change in participation and internalisation.** The adult or capable peer co-regulates attention and meaning within activity, then transfers responsibility as the child appropriates language for communication and thought.

Their signature predictions also differ. A Skinnerian analysis asks whether changing antecedents and consequences changes the target utterance. A Chomskyan analysis asks whether the child's output displays rule-governed structure not directly copied from the input. A Vygotskian analysis asks how performance changes under calibrated assistance and whether socially organised speech becomes independent self-guidance. These predictions can coexist in one episode. A caregiver may reinforce a request, supply grammatically structured input, and scaffold the child's participation at the same time.

TRAP **Do not write "Skinner equals nurture, Chomsky equals nature, Vygotsky equals both" and stop.** A scoring answer names the mechanism: operant contingencies, innate grammatical constraints, and socially mediated internalisation.

10.6 What later evidence adds: interaction, statistics and use

Later approaches weaken the idea that acquisition must be assigned to a single mechanism. Social-interactionist accounts emphasise joint attention, turn-taking, communicative intention and responsive caregiver speech. Usage-based accounts propose that children learn recurring constructions from meaningful use and gradually abstract patterns across exemplars. Statistical learning shows that learners can extract distributional regularities from sequences, while connectionist models demonstrate how graded patterns may emerge without an explicitly represented rule for every construction. These approaches challenge a rigid version of both imitation-only behaviourism and richly pre-specified grammar.

They do not erase the classic theories. Reinforcement and modelling demonstrably alter language behaviour; human neurobiology constrains which communication systems can be acquired and how readily; and language develops in relationships structured by culture. The useful synthesis is biopsychosocial and developmental: biologically prepared learning systems detect structure in socially meaningful input, while interaction supplies motives, feedback, shared reference and opportunities for practice. The relative contribution of each process varies across phonology, grammar, vocabulary, pragmatics and inner speech.

10.7 Clinical and Indian interpretation

A theory is not a milestone chart and cannot diagnose delay. Chomsky, Skinner and Vygotsky explain proposed mechanisms of acquisition; developmental surveillance asks whether

communication skills are emerging as expected and whether a sourced referral signal is present. The accompanying language-milestone plate should be read according to the construct attached to each value: expected attainment, expected range, median, upper limit and red flag are not interchangeable. A child outside an expected description is not automatically disordered, while a sourced red flag warrants further evaluation rather than a theory-based label.

INDIA

Assessment in India must establish the child's exposure and competence across all languages used at home, school and the wider community. Code-switching, language mixing and unequal vocabulary across languages can reflect ordinary multilingual use rather than deficient grammar. Ask who speaks which language with the child, for what purpose, with what consistency, and whether the concern appears across languages. Skinner directs attention to opportunities and consequences for communication; Chomsky prevents low exposure from being mistaken for absent human language capacity; Vygotsky directs attention to family dialogue, siblings, teachers, cultural tools and the child's response to support. None justifies judging competence from performance in the examiner's preferred language alone.

Clinically, use the theories to generate questions, not conclusions. Does the child initiate communication when it produces a meaningful consequence? Can a model, prompt or expansion elicit a more advanced form? Does the child produce novel combinations rather than echoes alone? How does performance change with a familiar communication partner? Is language being used for joint attention, requests, comment, play and self-guidance? Hearing, oral-motor function, cognition, social communication, the language environment and regression must be assessed separately. Loss of language or social skill is a red flag at any age and is never explained away as a preferred theoretical pathway.

10.8 Examination reconstruction

Long-answer sequence. Define language acquisition, state the problem of productivity, then write Skinner as operant learning with verbal operants, Chomsky as innate grammatical preparedness with universal grammar and competence-performance, and Vygotsky as social mediation with the ZPD, private speech and internalisation. Compare the role of input, adult, child and error; add one strength and one limitation of each; end with an interactionist synthesis and the statement that Vygotsky has no age-linked stages.

MNEMONIC

"Consequence - grammar - mediation"

Skinner shapes use, Chomsky constrains structure, Vygotsky transforms shared speech into self-regulation.

11 . Parenting styles (Baumrind) and family influences on development

Parenting style is the relatively stable emotional climate in which caregivers exercise authority, express warmth, communicate expectations and respond to the child. It is broader than a single

parenting practice. A practice is a specific act, such as praising effort, supervising internet use or imposing a consequence; a style is the recurring relational pattern within which such acts acquire meaning. Baumrind's work made this pattern examinable by distinguishing authoritative, authoritarian and permissive parenting. Maccoby and Martin later organised the framework along two dimensions, **responsiveness** and **demandingness**, and separated an uninvolved pattern from permissiveness.

How to use this page. Learn the two dimensions before the four labels. Then connect parenting with development through modelling, reinforcement, attachment, language, emotion socialisation and family systems. In a long answer, define style, draw the two-by-two classification, distinguish each pattern, discuss associated outcomes without claiming causation, and finish with bidirectionality, culture, socioeconomic context and clinical assessment. The central correction is simple: families influence development powerfully, but neither parenting style nor family structure mechanically determines a child's outcome.

The must-memorise line: authoritative parenting combines high responsiveness with high demandingness: warmth without structure is permissive, and structure without responsiveness is authoritarian.

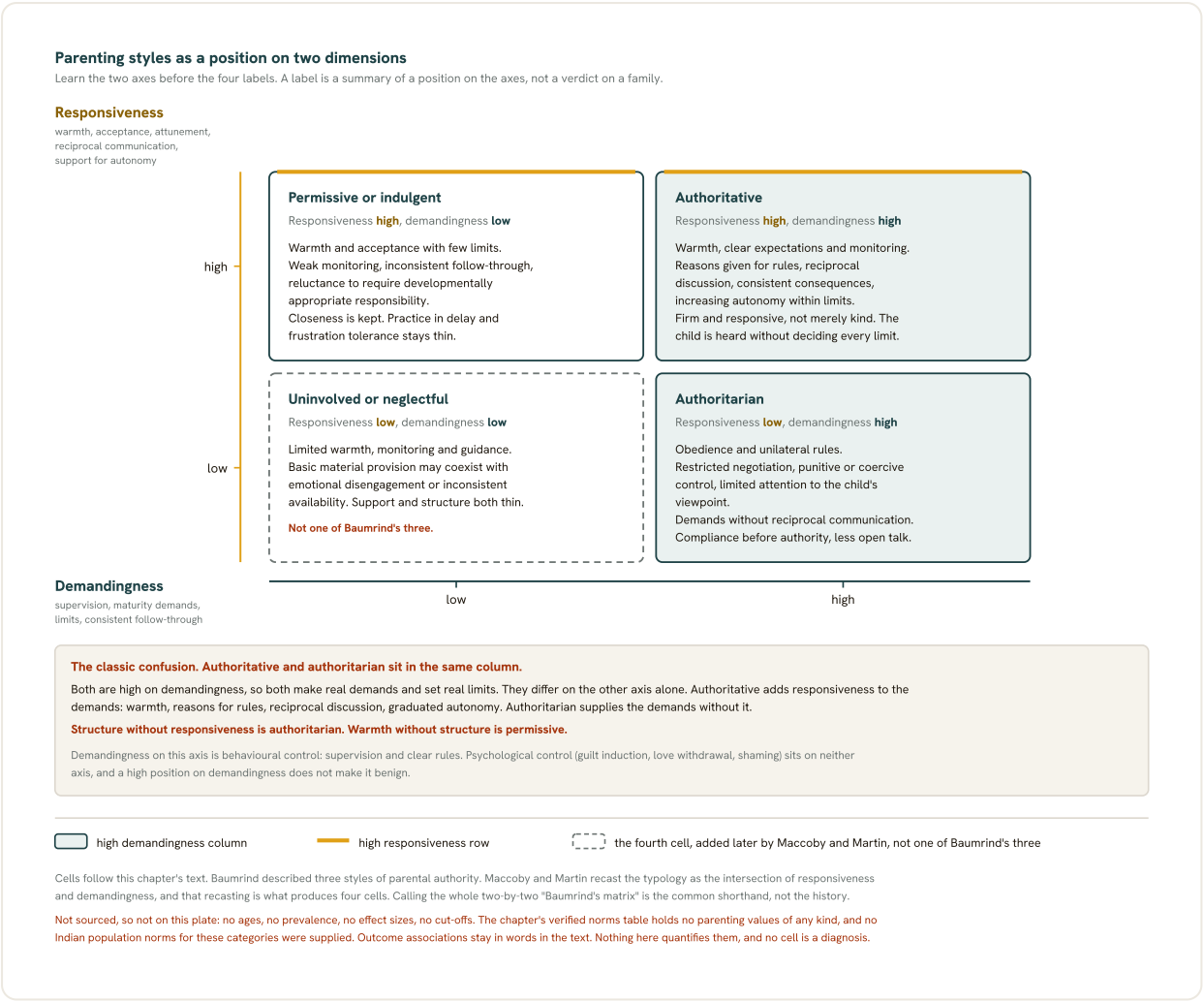


Fig 20.10 The parenting styles placed on responsiveness and demandingness. Fill marks the high-demandingness column and the saffron edge marks the high-responsiveness row, so authoritative and authoritarian are visibly the same column and a different row: they differ on responsiveness alone. The low-low cell is drawn dashed because it is Maccoby and Martin's addition, not one of Baumrind's original three styles. No ages, prevalence figures or effect sizes appear because none were sourced for this chapter.

11.1 From Baumrind's three styles to the two-dimensional model

Baumrind described patterns of parental authority; the familiar four-cell matrix is a later extension. Diana Baumrind distinguished three broad parenting styles from observations of parent-child interaction. **Authoritative parenting** combined firm standards with warmth and communication. **Authoritarian parenting** emphasised obedience and control with relatively little reciprocal discussion. **Permissive parenting** was accepting and non-punitive but placed few consistent demands on the child. Maccoby and Martin subsequently recast the typology as the intersection of responsiveness and demandingness, producing four cells and adding the low-low pattern commonly called **uninvolved** or neglectful parenting.

Responsiveness refers to warmth, acceptance, attunement, reciprocal communication and support for age-appropriate autonomy. It asks whether the caregiver notices and responds to the child's needs while recognising the child as a separate person. Demandingness refers to supervision, maturity demands, behavioural expectations, limit-setting and consistent follow-through. It asks whether the caregiver provides an organised structure and expects the child to participate in it. Neither dimension is intrinsically good at its maximum. Responsiveness without

boundaries can fail to contain behaviour, while demandingness that becomes rigid, humiliating or coercive is not healthy structure.

2	3	4
CLASSIFICATION DIMENSIONS: RESPONSIVENESS AND DEMANDINGNESS	STYLES IN BAUMRIND'S ORIGINAL TYPOLOGY	CELLS IN THE LATER MACCOBY-MARTIN FORMULATION

MNEMONIC

"High responsiveness + high demandingness = authoritative"

Authoritative parenting combines high responsiveness with high demandingness: warmth without structure is permissive, and structure without responsiveness is authoritarian.

11.2 The four parenting styles

Classify the observed pattern on both dimensions, then describe what the caregiver actually does. The labels are useful summaries, but behavioural description prevents them from becoming moral verdicts.

STYLE	RESPONSIVENESS	DEMANDINGNESS	CHARACTERISTIC FAMILY CLIMATE
Authoritative	High	High	Warmth, clear expectations, monitoring, reasons for rules, reciprocal discussion, consistent consequences and increasing autonomy within limits
Authoritarian	Low	High	Obedience, unilateral rules, restricted negotiation, punitive or coercive control, and limited attention to the child's viewpoint
Permissive or indulgent	High	Low	Warmth and acceptance with few limits, weak monitoring, inconsistent follow-through or reluctance to require developmentally appropriate responsibility
Uninvolved	Low	Low	Limited warmth, monitoring and guidance; basic material provision may coexist with emotional disengagement or inconsistent availability

RULE **Authoritative means firm and responsive, not merely kind.** It preserves parental authority while making rules predictable, proportionate and open to explanation. The child may be heard without being allowed to decide every limit.

Three distinctions carry marks:

Authoritative and authoritarian parenting
are not synonyms: both contain demands, but only the former combines them with responsiveness and reciprocal communication.

Permissive and uninvolved parenting
both have low demandingness, but permissive parenting retains warmth and engagement.

behavioural control from psychological control
Behavioural control, such as supervision and clear rules, differs from psychological control, such as guilt induction, love withdrawal, shaming or intrusion into the child's emotional world. The former can be protective; the latter constrains autonomy and can be harmful even when the household appears orderly.

11.3 Developmental correlates and the problem of causal overclaim

Parenting styles are associated with developmental outcomes, but the associations are probabilistic and context-dependent. Across much of the literature, authoritative parenting is associated with stronger self-regulation, social competence, academic engagement and psychological adjustment. Its proposed advantage is not leniency. Predictable limits reduce uncertainty, warmth preserves connection, explanations help the child internalise rules, and graduated autonomy gives repeated practice in decision-making. These processes can support both competence and relatedness.

Authoritarian parenting is commonly associated with compliant behaviour in the immediate presence of authority but less spontaneous autonomy, lower open communication and, in some settings, more internalising or externalising difficulty. Permissive parenting may preserve closeness but provide insufficient practice in delay, frustration tolerance and responsibility. Uninvolved parenting is associated with broad developmental risk because both relational support and behavioural organisation are reduced. None of these statements diagnoses an individual child or proves that a parenting style caused an outcome. Effects vary with temperament, developmental capacity, caregiver consistency, neighbourhood safety, peer context, culture and the meaning the child assigns to control.

TRAP **Do not turn an association into parent-blaming.** Child temperament and behaviour alter parenting, caregiver stress and illness constrain responsiveness, and social adversity can make consistency difficult. A style label describes a pattern in a system; it does not identify a single cause or assign guilt.

11.4 Why parenting has effects: six developmental pathways

Parenting influences development through repeated transactions, not through the label itself. Six pathways organise the answer:

DEVELOPMENTAL PATHWAY	HOW IT INFLUENCES DEVELOPMENT
Attachment and co-regulation:	sensitive, predictable responses help the child use the caregiver as a source of safety and regulation. Repeated co-regulation contributes to later self-regulation, although attachment is relationship-specific and should not be inferred from a global style label alone.
Modelling:	children observe how adults manage anger, disagreement, affection, work, substances, gender roles and help-seeking. What caregivers enact may teach more strongly than what they instruct.
Reinforcement and discipline:	attention, praise, withdrawal of attention and consequences alter the probability of behaviour. Harsh or inconsistent discipline can create a coercive cycle in which escalating child behaviour and escalating adult control reinforce one another.
Emotion socialisation:	caregivers label emotions, validate or dismiss them, model regulation and teach which expressions are acceptable. Emotion coaching can build recognition and modulation; ridicule or punishment of emotion may produce concealment without regulation.
Cognitive and language stimulation:	conversation, shared attention, play, explanation and responsive expansion of the child's communication provide material for language, executive control and social understanding.
Opportunity and monitoring:	families shape exposure to peers, education, sleep routines, media, risk, responsibility and supportive adults. Monitoring is protective when it is informed and proportionate, but becomes intrusive when it denies developmentally appropriate privacy and autonomy.

These pathways interact. A caregiver who calmly labels distress, maintains a clear limit and helps the child recover is simultaneously providing co-regulation, modelling, language, reinforcement and emotion socialisation. Conversely, chronic conflict can occupy attention, disturb sleep, reduce exploration and make even ordinary demands feel threatening. The developmental effect lies in the recurring pattern and its meaning, not in one isolated exchange.

11.5 The family as a system: bidirectionality, relationships and context

A child develops within a network of relationships whose members continually influence one another. A transactional model rejects a one-way arrow from parent to child. The child's temperament, neurodevelopmental profile, health and behaviour evoke responses from caregivers; those responses alter the child's subsequent behaviour; the new behaviour then changes the caregiver again. An irritable child may meet an exhausted caregiver, escalating both distress and control, whereas the same child may settle with predictable routines and a caregiver who has support. This is an interaction, not proof that either participant is intrinsically difficult.

Family systems theory adds that each dyad is affected by the larger system. The quality of the couple or co-parenting relationship can increase consistency or draw the child into conflict. Triangulation occurs when tension between adults is displaced through the child or the child is recruited into an alliance. Boundaries can become excessively diffuse or rigid, roles can reverse through parentification, and one member can be designated as the problem-bearer for a wider family difficulty. These concepts are hypotheses for assessment, not labels to impose after a single interview.

Family influence extends beyond parents. Siblings provide companionship, conflict, imitation, comparison and practice in negotiation; differential parenting may be as important as average parenting. Grandparents and other caregivers can supply continuity and protection, or create conflicting rules when caregiving authority is unclear. The developmental importance of family structure depends largely on relationship quality, stability, resources and conflict. A single-parent, joint, blended, adoptive or same-sex-parent family is not inherently pathogenic. Structure tells the clinician who is present; process tells the clinician what happens between them.

11.6 Language acquisition: what the family supplies and what it cannot explain alone

The family creates the language-learning environment, but no single language acquisition theory is sufficient. Skinner emphasised learning through imitation, shaping and reinforcement. Caregivers do reinforce communicative success, model words and expand incomplete utterances, but children generate novel sentences and acquire grammar too rapidly for direct reinforcement to be the whole account. Chomsky emphasised an innate biological preparedness for language and the child's capacity to infer an underlying grammar from limited input. This explains productive rule learning but does not make social interaction dispensable.

Vygotsky treated higher mental functions as socially mediated and later internalised. In the zone of proximal development, a child performs with guidance beyond what can yet be done independently; scaffolding is the temporary support that is adjusted and withdrawn as competence grows. Dialogue with caregivers becomes increasingly internalised, including through private speech, and supports planning and self-regulation. Vygotsky proposed a cross-cutting developmental mechanism, not a sequence of age-defined stages, so he should not be forced onto a numeric stage axis.

The useful synthesis is interactionist. Biological preparedness makes language possible; exposure supplies a linguistic system; attention and memory extract regularities; reinforcement shapes communicative effectiveness; and responsive interaction gives words shared reference and social purpose. Family practices matter through turn-taking, joint attention, contingent response, elaboration, mental-state talk and opportunities to speak. Parenting style changes the climate of these exchanges. Authoritative dialogue invites explanation within structure, authoritarian exchanges may privilege commands and obedience, permissive interaction may be rich but inconsistently organised, and uninvolved parenting may provide less contingent communication. These are tendencies, not fixed predictions about any family or language community.

11.7 Theory of mind, false belief and family conversation

Social understanding develops through representing minds as well as observing behaviour. Theory of mind is the capacity to attribute beliefs, desires, intentions and emotions to oneself and others, and to understand that another person's mental state may differ from one's own and from reality. A standard false-belief task tests whether the child predicts behaviour from an actor's mistaken belief rather than from the child's own knowledge. The cited developmental source describes success on such a task as expected at **four or five years**. This is an expected attainment statement, not a diagnostic or referral threshold.

Family interaction can support theory of mind through conversation about feelings, motives, mistakes, deception and different viewpoints; shared reading and sibling disputes also provide occasions to explain why people act as they do. Language is both a medium for discussing mental states and a cognitive resource for holding competing representations in mind. Performance also depends on comprehension, attention, memory, inhibition, task wording, familiarity and culture. Failure on one false-belief task therefore does not establish a global absence of theory of mind, identify a parenting style or diagnose a disorder.

11.8 Broader family influences on development

Parenting occurs inside social conditions that can protect or constrain the family. Development is influenced by caregiver mental and physical health, substance use, marital and intergenerational conflict, domestic violence, bereavement, migration, discrimination, poverty, housing, nutrition, educational access, neighbourhood safety and social support. These factors may act directly on the child and indirectly by altering caregiver availability, predictability and emotional reserve. Treating a resource-constrained family as simply inconsistent confuses a social determinant with a character judgement.

Risk is cumulative but not destiny. Stable relationships, a caregiver who can repair after conflict, supportive kin, school connection, safe routines and access to treatment can buffer adversity. Family conflict is particularly harmful when it is intense, chronic, unresolved or draws the child into adult disputes. In contrast, observing disagreement followed by negotiation and repair can teach that relationships survive conflict. The clinically relevant variables are exposure, meaning, persistence, protection and recovery.

Family transmission is also not purely environmental. Parents and children share genetic liabilities, and genetically influenced child characteristics can shape both the environments selected by the family and the responses evoked from others. This does not reduce development to heredity. It explains why an observed association between parenting and child outcome may contain inherited, evocative and environmental pathways at the same time. Developmental formulation should keep all three visible.

11.9 Culture and the Indian family context

The two dimensions travel better across cultures than stereotypes about the four labels. Responsiveness and demandingness can be described behaviourally in any family, but the meaning of obedience, autonomy, proximity, privacy and interdependence varies. Firm control

may be interpreted differently when it is embedded in warmth, shared obligation and credible concern for safety. This cultural moderation does not make humiliation, violence, terror or coercive psychological control benign. Culture explains meaning; it does not excuse harm.

INDIA

Assessment should identify the actual caregiving unit rather than assuming a nuclear household. Grandparents, older siblings and other relatives may share authority, care and financial responsibility. Educational pressure, respect for elders, family interdependence and collective decision-making may be valued, while autonomy may be expressed through negotiated responsibility rather than early separation. Ask who sets rules, who comforts, who supervises, whether caregivers agree, and how the child understands these practices. Do not label joint-family involvement, close parent-child proximity or deference to elders as pathology without evidence of distress, coercion or impairment. Equally, do not hide abuse or severe restriction behind the phrase "Indian culture." No verified Indian population norms for Baumrind-style prevalence or comparative effect sizes are supplied here, so Western associations must not be relabelled as Indian norms.

11.10 Clinical assessment, formulation and intervention

Translate labels into observable sequences and modifiable processes. Ask each caregiver and the child, when developmentally appropriate, for concrete recent examples of praise, rules, refusal, anger, affection, supervision, privacy, conflict and repair. Establish what happened before the interaction, what each person did, what followed immediately and what happened the next time. Observe tone, turn-taking, intrusiveness, warmth, limit-setting and the child's bids for help or autonomy. Obtain information across home, school and other caregiving settings because a family may be structured in one domain and overwhelmed in another.

A useful formulation has **five** layers:

1. The child's temperament and developmental capacities.
2. The caregiver's style, health and history.
3. Specific parenting practices.
4. Relationships and alliances across the family.
5. The wider cultural, socioeconomic and safety context.

Then identify the feedback loop maintaining the difficulty and the protective processes already present. Screen directly for violence, maltreatment, caregiver mental illness, substance problems and risk to the child rather than allowing a benign style label to obscure safeguarding concerns.

Intervention targets the process that can change. Core elements include predictable routines, developmentally appropriate expectations, clear brief instructions, positive attention for desired behaviour, consistent non-violent consequences, emotion coaching, collaborative problem-solving, graduated autonomy and repair after conflict. Parent-management approaches are especially useful for coercive cycles and inconsistent reinforcement; family work is useful when conflict, alliances or contradictory caregiving maintain the problem; treatment of caregiver

illness and practical social support may be prerequisites for change. The aim is not to manufacture an idealised parent. It is to increase safety, responsiveness, effective structure and the family's capacity to adapt as the child develops.

Final synthesis. Baumrind's framework is a map of the caregiving climate, not a verdict on a family. The strongest answer begins with responsiveness and demandingness, distinguishes the original three styles from the later fourth, explains developmental pathways, and then qualifies every outcome claim with bidirectionality, temperament, culture and social context. Family relationships provide the setting in which language, emotion regulation, theory of mind and autonomy are practised. Their influence is profound precisely because it is repeated, relational and modifiable, not because it is deterministic.

The domains and the milestones

12 . Domains of child development (motor, language, cognitive, social, emotional)

Child development is an ordered but variable acquisition of function across five interacting domains: **gross motor**, **fine motor**, **language and speech**, **cognitive development**, and **social and emotional development**. The domains are separated for examination and screening, not because they develop independently. A child who cannot explore because of a motor impairment receives a different stream of cognitive and social experience; a child with impaired hearing may appear delayed in language, play and social reciprocity; a child exposed to chronic adversity may show effects across attention, learning, affect regulation and relationships. The clinically useful question is therefore not merely, "Has the child acquired the milestone?" It is, "What is the pattern across domains, what is the trajectory, and is there loss, asymmetry or a qualitative abnormality?"

How to use this page. First learn the architecture: the five domains, the principles of developmental progression, and the distinction between a typical age, a normal window and a referral threshold. Then use the milestone, stage-alignment and primitive-reflex plates as reference tools rather than as lists of isolated dates. Finally, learn how normal variation becomes a clinical signal: developmental surveillance detects a trajectory, screening estimates risk, assessment characterises the profile, and diagnosis explains it. The central exam skill is to move from a remembered milestone to a domain-specific interpretation without turning a screening cut into a diagnosis.

Development is a trajectory across domains: loss at any age, marked asymmetry, or a milestone outside a construct-explicit window demands explanation, not a reflex label.

MNEMONIC

"G F L C S: five interacting domains"

Gross motor, **F**ine motor, **L**anguage and speech, **C**ognitive development, and **S**ocial and emotional development are the five interacting domains.

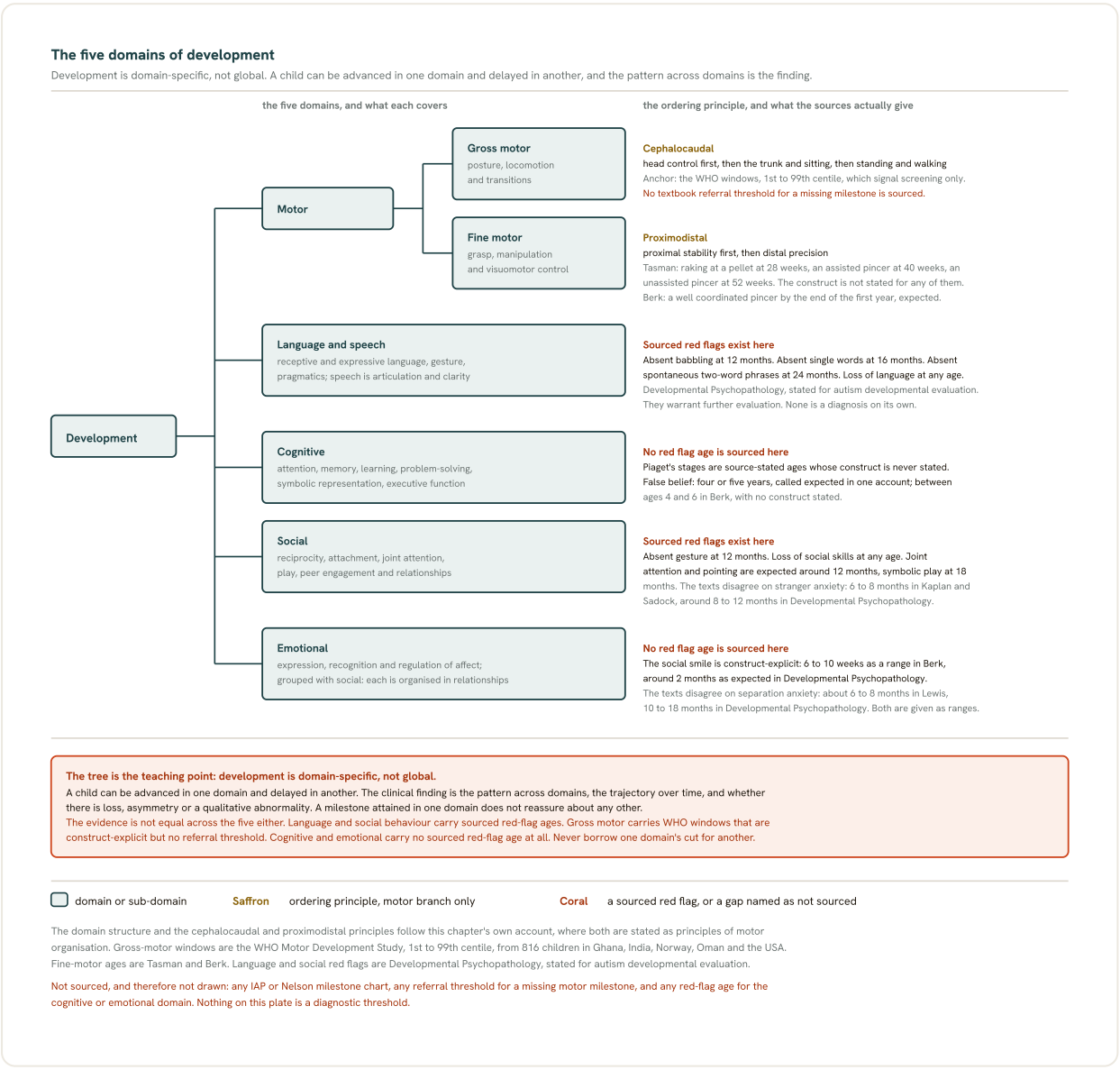


Fig 20.11 The five domains as a classification tree, with the two ordering principles that govern the motor branch only. Gross-motor windows are the WHO Motor Development Study, 1st to 99th centile; fine-motor ages are Tasman and Berk; language and social red flags are Developmental Psychopathology, stated for autism developmental evaluation. Cognitive and emotional development carry no sourced red-flag age, and that absence is drawn rather than filled in.

12.1 Organising development: domains, direction and developmental constructs

Development is orderly, cumulative and uneven. The sequence is usually more stable than the precise timing. Motor control proceeds broadly cephalocaudal, from head control towards control of the trunk and lower limbs, and proximodistal, from central and proximal stability towards distal precision. General movements become differentiated skills; reflex-dominated behaviour gives way to voluntary control; receptive capacities commonly precede expressive performance; and regulation is first shared with a caregiver before it becomes increasingly internal. Earlier

skills constrain later ones, but a child need not advance at the same rate in every domain. A jagged profile may be more informative than a uniformly low profile.

The five-domain formulation prevents two common errors. First, *motor* must be divided into gross motor posture and locomotion, and fine motor grasp, manipulation and visuomotor integration. Second, *language* is not synonymous with speech: language includes receptive and expressive symbolic communication, pragmatics and gesture, whereas speech concerns the motor production and intelligibility of sounds. Cognition includes attention, memory, learning, problem-solving, symbolic representation and executive functions. The social domain concerns reciprocity, attachment, joint attention, play and relationships; the emotional domain concerns expression, recognition and regulation of affect. These last two are often combined as social and emotional development because each is organised within relationships.

RULE **Always attach an age to its construct.** "Half of children by" states a median; "usually by" states an expected attainment; "normally between" states an expected range; "still normal up to" states an upper limit; and "refer if absent by" states a red flag. One cannot be substituted for another.

A milestone is a conveniently observable marker, not the whole developmental process. Milestones by age are useful only when the source and normative meaning are retained. Many textbook milestone ages are presented without saying whether they are averages, typical attainments or outer limits. Such values can be repeated as the source states them, but they cannot honestly be converted into "when to refer" thresholds. The reference plates therefore distinguish construct-explicit ranges from source-stated ages whose statistical role is unclear.

12.2 Motor development: posture, locomotion, grasp and visuomotor control

Gross motor development builds an antigravity platform; fine motor development uses that platform for exploration. Gross motor examination follows head control, rolling, sitting, transitional movements, standing, gait, running, jumping and stairs. Fine motor examination follows visual regard and reach, grasp pattern, transfer, release, pincer control, block construction, scribbling and copying. Quality matters as much as attainment: persistent fisting, early fixed hand preference, asymmetry, abnormal tone, unusual movement strategies or loss of a skill cannot be reassured away by the presence of another milestone.

The most defensible infancy anchor is the WHO Motor Development Study, which followed children in Ghana, India, Norway, Oman and the USA. Its windows run from the 1st to the 99th centile and are explicitly screening signals, not diagnostic thresholds. The gross-motor milestone plate gives all six windows, from sitting without support through walking alone, with the centile construct visible beside each value. Their breadth is a corrective to the false precision of a single milestone date. They signal the need for screening when a child appears late; they do not by themselves diagnose developmental delay.

4.3%	90%	5 sites
OF CHILDREN IN THE WHO STUDY DID NOT EXHIBIT HANDS-AND-KNEES CRAWLING AT ALL	APPROXIMATELY ACHIEVED FIVE GROSS MOTOR MILESTONES IN A COMMON SEQUENCE	INCLUDED INDIA, MAKING THE WHO WINDOWS DIRECTLY RELEVANT TO INDIAN TEACHING

Crawling is the classic trap. It is common but not universal, so absence of crawling alone is not a developmental red flag. Look instead at the child's overall locomotor strategy, tone, symmetry, transitions and progression towards supported and independent mobility. The full gross-motor milestone plate should be read as a set of windows, not a railway timetable.

Fine motor progression illustrates proximodistal organisation. An early palmar or raking approach becomes increasingly radial and then finger-thumb controlled; voluntary release and construction follow. The fine-motor milestone plate preserves Berk's expected ranges alongside the source-stated ages from Indian and international clinical references whose normative construct is unclear. It carries the longer sequence from grasp and transfer through block construction, scribbling and copying forms. At examination, link a failure to vision, tone, coordination, opportunity and comprehension before calling it an isolated fine-motor delay.

12.3 Language and speech: receptive, expressive, pragmatic and phonological development

Communication begins before words and comprehension generally outruns production. The sequence runs through social attention, reciprocal vocalisation, cooing, babbling, gesture, understanding of familiar words and commands, meaningful single words, word combinations, increasingly grammatical sentences, narrative and conversational competence. **Receptive language** is what the child understands; **expressive language** is what the child communicates through gesture, words and sentences; **pragmatics** is the social use of communication; and speech is the articulation, fluency, voice and motor realisation of language. A child may therefore have normal language with a speech-sound problem, or intact speech production with impaired social communication.

Source-stated expectations provide useful anchors without pretending to be universal deadlines. The language milestone plate separates cooing and babbling, receptive language, gesture, meaningful words, word combinations, vocabulary growth, grammar and intelligibility, and labels whether a value is expected, a range, a median or merely source-stated. One especially examinable construct error concerns Tasman's median expressive vocabulary of **50 words at 18 months** in US toddlers: this means half had reached that number, not that every child below it has delay. Expected intelligibility values in Kaplan and Sadock and DSM-5-TR are likewise not automatic referral thresholds.

The Indian Psychiatric Society clinical reference places babbling at 4 to 5 months, picking up familiar objects on request at 1 year, and two- to three-word sentences at **2 years**, but does not state the normative construct for these ages. Berk, in contrast, gives **18 to 24 months** as an expected range for combining two words. These statements should remain side by side rather than being collapsed into one falsely exact Indian or Western cut-off.

Language assessment begins with hearing and the communication environment, then separates comprehension, expression, gesture, reciprocity, speech clarity and oral-motor function. Ask about the languages used with the child and judge competence across the entire linguistic repertoire. Multilingual exposure does not justify loss of language, absent gesture or poor

reciprocity. Conversely, a smaller vocabulary in each individual language can mislead if the child's total conceptual vocabulary and communicative effectiveness are ignored.

12.4 Cognitive development, language acquisition and theory of mind

Cognition develops through action, representation, language and increasingly organised reasoning. Piaget's account remains the standard examination scaffold.

1. The sensorimotor stage emphasises knowledge through perception and action and the emergence of object permanence.
2. The preoperational stage brings symbolic representation but reasoning remains intuitive and vulnerable to centration and egocentrism.
3. Concrete operations bring conservation, reversibility and logical operations on tangible material.
4. Formal operations permit systematic abstraction and hypothetical reasoning.

The stage-alignment plate gives the source-stated age ranges. The clinical use is not to "diagnose a Piaget stage" but to pitch questions, explanations and testing tasks at the child's representational capacity.

Vygotsky offers a complementary, non-stage account. Cognitive development is socially and culturally mediated; skills first occur between people and are then internalised. The zone of proximal development is the distance between what a learner can do independently and what becomes possible with competent assistance. Scaffolding supplies temporary structure and is withdrawn as mastery grows; private speech helps organise behaviour and becomes internal speech. In assessment, compare unsupported performance with the child's response to graded prompts. The amount and kind of help that unlocks performance may reveal learning potential that a static score misses.

Three broad families explain language acquisition. Skinner's learning account emphasises imitation, shaping and reinforcement of communicative behaviour. Chomsky's nativist account argues that the speed and generativity of grammar require an evolved language capacity rather than reinforcement alone. Social-interactionist accounts, including Vygotsky's, emphasise joint activity, caregiver responsiveness, shared attention and language used within the zone of proximal development. Contemporary clinical reasoning is integrative: biological preparedness, auditory and cognitive capacities, social motivation, exposure and contingent interaction all matter. The practical use is causal restraint. Delayed language is not automatically poor parenting, and a rich language environment does not exclude hearing impairment, neurodevelopmental disorder or oral-motor difficulty.

Theory of mind is the capacity to represent mental states as mental states and to understand that another person may hold a belief different from reality and from one's own. Passing a false-belief task is expected at about **4 or 5 years** in the cited account. Failure on one task is not synonymous with autism: performance also depends on language comprehension, working memory, attention and the exact task demands. Clinically, theory of mind is examined through

pretend play, perspective-taking, deception, humour, social inference and the child's explanation of other people's actions, not through one laboratory item alone.

12.5 Social and emotional development: attachment, play, temperament and parenting

Social-emotional development is regulation within relationships. Early reciprocal attention and the social smile are followed by selective attachment behaviour, wariness of unfamiliar people, separation protest, joint attention, imitation, symbolic play, peer engagement and increasingly reflective emotion regulation. The social-emotional milestone plate sets out the source-stated windows and expected attainments for these behaviours. Observe whether they are spontaneous, shared for enjoyment and integrated with eye gaze, affect and gesture, rather than merely present on command.

The literature gives different expected windows for the normal anxieties of attachment. The plate therefore keeps Lewis, Kaplan and Sadock, and Developmental Psychopathology side by side instead of collapsing them into one cut-off. The examinable principle is qualitative: separation and stranger anxiety reflect discrimination of familiar caregivers and attachment, and become concerning when intensity, persistence or developmental context causes marked impairment.

Thomas and Chess describe **temperament** through nine dimensions: activity level, rhythmicity, approach or withdrawal, adaptability, threshold of responsiveness, intensity of reaction, quality of mood, distractibility, and attention span or persistence. Their three types are easy, difficult, and slow-to-warm-up. These are descriptive constellations, not diagnoses, and many children do not fit a pure type. **Goodness of fit** is the match between the child's temperamental characteristics and the demands, expectations and supports of the environment. A highly active child may function well where movement is permitted and poorly where prolonged stillness is demanded. Clinical intervention can therefore alter the fit without pathologising the child.

Baumrind parenting styles organise caregiving by responsiveness and demandingness.

PARENTING STYLE	PATTERN
Authoritative parenting	Combines warmth with clear, developmentally appropriate limits.
Authoritarian parenting	Is controlling with lower responsiveness.
Permissive parenting	Is responsive with few consistent demands.
The later uninvolved category	Describes low responsiveness and low demandingness.

These patterns are associations, not deterministic labels, and must be interpreted in cultural, socioeconomic and safety context. The clinical use is to translate a style label into modifiable behaviour: predictability, contingent warmth, supervision, repair after conflict and limits that match the child's developmental capacity.

12.6 Stage theories on one axis: psychosocial, psychosexual, moral and relational development

Stage theories ask different questions and should be aligned, not blended. The alignment plate places the source-stated numeric stages on a shared axis while leaving genuinely non-

numeric theories non-numeric.

12.7 Primitive reflexes: emergence, integration and neurological meaning

Primitive reflexes are expected early patterns whose interpretation depends on the specific reflex, the method and the neurological context. The primitive-reflex plate shows appearance, how each reflex is elicited, and the source-stated disappearance. At the bedside assess symmetry, vigour, habituation where relevant, and persistence alongside tone, posture and voluntary movement. Absence when expected, marked asymmetry, or persistence that interferes with voluntary control may indicate central or peripheral dysfunction, but gestational age, illness and state of arousal matter.

The sources do not always give one disappearance age. Berk, Hutchison and Tasman differ for Moro and palmar grasp, while Babinski has separate expected, upper-limit and red-flag statements. The primitive-reflex plate displays these source-specific claims without forcing them into one value. Hutchison also gives a general warning about persistence of primitive reflexes, yet its reflex-specific entries show why the honest answer must name the reflex and construct rather than manufacture a universal cut-off.

TRAP **A disappearance age is not automatically a referral age.** Textbooks may report different expected ages for the same reflex. State the source, preserve whether it is expected, an upper limit or a red flag, and interpret the reflex within the neurological examination.

Reflexes should not be recited in isolation from developmental organisation. Their integration permits increasingly selective voluntary movement, but development is not a simple switch from "reflex present" to "reflex absent". The reflex table is a reference for examination; the clinical task is to decide whether the entire motor pattern is coherent.

12.8 Developmental surveillance, red flags and Indian assessment pathways

A concise clinical synthesis. Name the affected and preserved domains; describe onset, sequence, rate, plateau or regression; compare performance with construct-appropriate norms; examine hearing, vision, growth, neurology and dysmorphism; document the relational and learning environment; and choose screening or assessment deliberately. The diagnostic question comes last. Developmental competence is not the accumulation of dates but the organisation of increasingly adaptive function across motor, language, cognitive, social and emotional systems.

13 . Gross motor and fine motor milestones by age

Developmental milestones are landmarks in an unfolding process, not deadlines stamped onto a child. The exam task is therefore twofold: know the age-linked sequence well enough to recognise a delay, and know what kind of age each source is giving you. An **expected range** describes variation in attainment; an **expected age** describes what a typical child usually does; an **upper limit** marks the outer boundary of normal; and a **red-flag threshold** triggers further assessment. Most textbook ages do not identify which of these constructs they represent. Those ages may be repeated in the source's own terms, but they must never be promoted into referral rules.

How to use this page. Begin with the two orienting maps: the **developmental-theory alignment** and the **domains-and-milestones framework**. Then use the accompanying milestone plates to learn sequence and age together. Read gross motor against the construct-explicit WHO windows, read fine motor as source-labelled examination anchors, and finish by asking whether the child is following the expected sequence, whether skills have been lost, and whether screening rather than diagnosis is the next step.

The must-memorise line: an age is not a referral threshold until the source identifies it as an upper limit or a red flag.

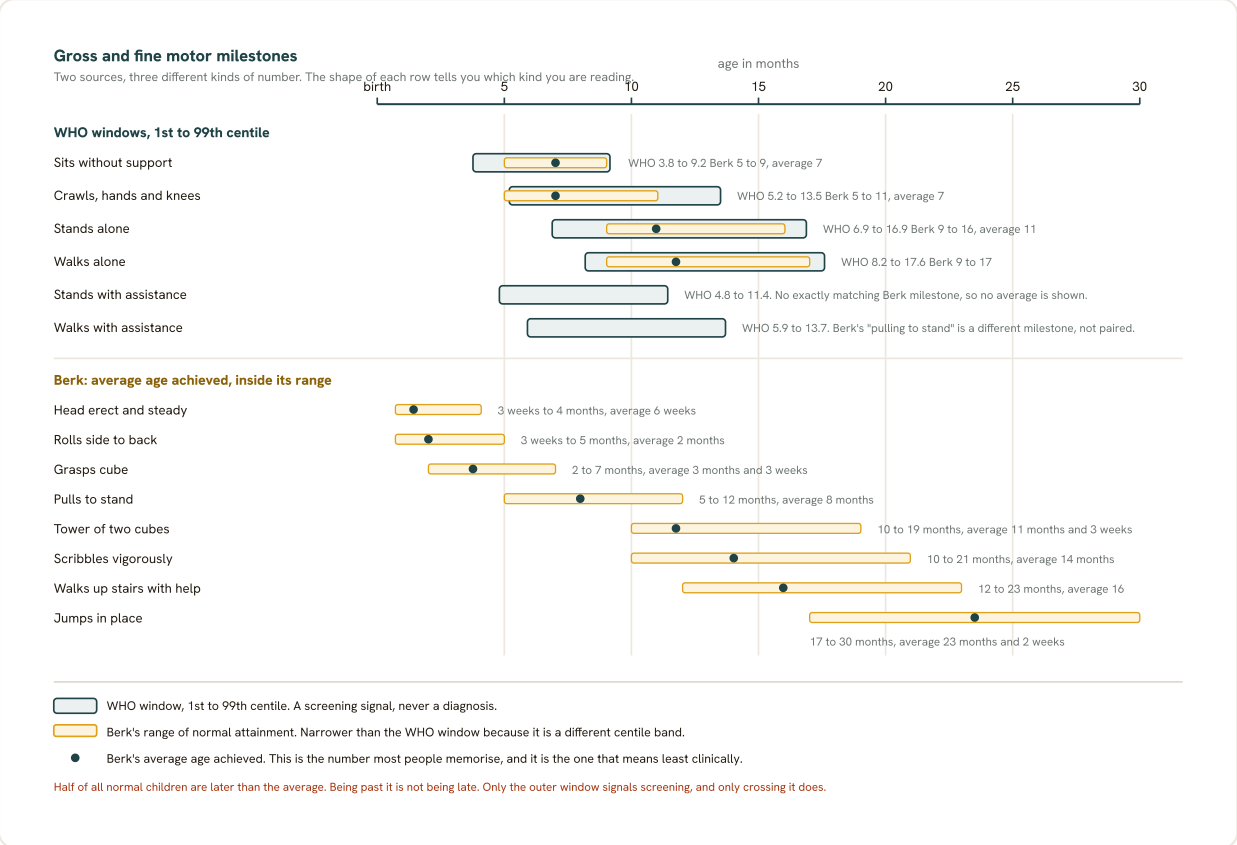


Fig 20.12 Motor milestones from two sources, drawn so the kind of number is visible. Outer bars are the WHO Motor Development Study windows between the 1st and 99th centiles, from 816 children in Ghana, India, Norway, Oman and the USA. Inner bars and dots are Berk's ranges and average ages. Where no Berk milestone matches a WHO one exactly, no average is shown rather than pairing an approximate equivalent.

13.1 The twin orienting maps: theories by age and domains and milestones

One map explains the child; the other describes the child's observable development. The developmental-theory alignment places the stage theories beside one another so that the resident can compare what each theory foregrounds at the same period: cognition in Piaget, psychosocial conflict in Erikson, drive organisation in Freud, separation-individuation in Mahler and moral reasoning in Kohlberg. Vygotsky belongs beside, not inside, this age axis because his sociocultural account is not a stage sequence. The second map is the domains-and-milestones framework: gross motor, fine motor, language and speech, social and emotional development, and cognitive or adaptive functioning. Together they prevent a common error, which is to confuse a theory about development with a milestone used to observe it.

The maps also operate at different levels. A **stage theory** supplies a broad organising idea, while a **milestone** is a directly elicited or observed behaviour. Neither is a diagnosis. A child may attain motor skills within a wide normal window while showing difficulty in another domain, and apparent delay may reflect opportunity, illness, sensory impairment or cultural variation rather than a unitary disorder. The developmental framework is therefore always domain-specific before it becomes global.

RULE **Separate sequence, age and construct.** First ask whether the skill appears in the expected developmental order; then identify the source's age; finally decide whether that age is an expected range, an upper limit, a red flag or an age whose normative role is unclear.

MNEMONIC

"SAC: Sequence, Age, Construct"

First ask whether the skill appears in the expected developmental order (Sequence), then identify the source's age (Age), and finally decide whether that age is an expected range, an upper limit, a red flag or an age whose normative role is unclear (Construct).

13.2 Band A: the stage-theory alignment

The theories by age plate is an alignment device, not a claim that the theories are interchangeable. Read its source-specific age bands horizontally, but keep each theory's question distinct. Piaget's sequence of sensorimotor, preoperational, concrete operational and formal operational stages helps the clinician pitch explanations and tasks to the child's mode of reasoning. Erikson's psychosocial stages, from trust through autonomy, initiative, industry and identity, organise the age-salient relational conflict. Freud's psychosexual stages, oral, anal, phallic, latency and genital, remain historically important for formulation and examination theory. The age bands on the plate are source descriptions whose normative construct is unclear; none defines a clinical threshold.

Mahler's separation-individuation model follows differentiation, practising, rapprochement and object constancy, and is clinically useful when thinking about autonomy in relation to a caregiver. Kohlberg's moral development must not be assigned invented numerical ages: Kaplan and Sadock uses descriptive bands such as before adolescence, during adolescence and late adolescence or early adulthood. Vygotsky proposed no age stages. His zone of proximal development, scaffolding, private speech and socially mediated learning are cross-cutting mechanisms that guide how much support permits the child's next level of performance. The plate therefore shows Kohlberg as descriptive bands and Vygotsky beside the age axis, never as fabricated numeric rows.

13.3 Band B: the five domains and the organisation of motor development

The domains of child development are related but not reducible to one another. **Gross motor** development concerns posture, balance and large antigravity movements; **fine motor** development concerns reach, grasp, release, manipulation and visuomotor construction. The remaining domains are language and speech, social and emotional development, and cognitive or

adaptive functioning. Examination should therefore be domain-specific: delayed independent walking is not equivalent to delayed pincer grasp, and either may occur with preserved language and social reciprocity.

Motor control generally becomes organised in a **cephalocaudal** direction, with control of the head and upper trunk preceding control needed for standing and walking, and in a **proximodistal** direction, with shoulder and arm control preceding refined finger use. These are organising gradients, not clocks. The milestones by age plates convert the gradients into observable behaviours, while the clinician tests quality as well as attainment: symmetry, tone, postural control, movement strategy, persistence of primitive patterns and spontaneous use of both hands.

13.4 Gross motor milestones by age: use WHO windows as screening signals

The WHO Motor Development Study gives the most defensible construct-explicit gross motor framework. It followed 816 children from Ghana, India, Norway, Oman and the USA and derived windows bounded by the 1st and 99th centiles. These are *windows of achievement*, intended to support descriptive population comparisons and to signal the need for screening when a child appears late. They are not diagnostic boundaries. The gross motor plate therefore owns the complete sequence, while the prose here teaches how to interpret it:

1. sitting without support;
2. standing with assistance;
3. hands-and-knees crawling;
4. walking with assistance;
5. standing alone;
6. walking alone.

3.8 to 9.2 months	8.2 to 17.6 months	4.3 percent
WHO 1ST-TO-99TH-CENTILE WINDOW FOR SITTING WITHOUT SUPPORT	WHO 1ST-TO-99TH-CENTILE WINDOW FOR WALKING ALONE	CHILDREN DID NOT SHOW HANDS-AND-KNEES CRAWLING AT ALL

The span between the two anchors matters. Standing alone has the widest WHO window, from 6.9 to 16.9 months, while sitting without support has the narrowest. About **90 percent** of children achieved five of the milestones in a common sequence, but crawling was not universal. India was one of the WHO study sites, so the WHO norms are not simply Western norms imported into Indian practice, although they are still multinational rather than an Indian-only reference.

Source-specific differences must remain visible. For Western norms, Berk reports a U.S. expected range of 5 to 9 months for sitting alone and 9 to 17 months for walking alone. WHO gives **3.8 to 9.2 months** and **8.2 to 17.6 months** respectively. Kaplan and Sadock gives 9 to 15 months as an expected range for independent walking. These figures answer different source questions and should not be averaged into a new norm.

TRAP **Failure to crawl is not, by itself, a red flag.** WHO found that 4.3 percent of children never exhibited hands-and-knees crawling. The examination error is to convert a non-universal milestone into a compulsory gateway to walking.

13.5 Fine motor milestones by age: grasp, transfer, pincer and construction

Fine motor development is a progression from whole-hand contact to precise opposition and planned construction. The fine motor plate should be learned as a sequence:

SEQUENCE	FINE MOTOR MILESTONE
1	early grasp;
2	purposeful transfer between hands;
3	radial hand use;
4	pincer opposition;
5	spontaneous scribbling;
6	block construction;
7	copying forms.

The child's posture and vision matter throughout; a poor reach may arise from proximal instability, and an apparent manipulation problem may reflect visual or asymmetric motor difficulty.

The source labels must be preserved. The IPS child and adolescent psychiatry guideline lists bidextrous grasp at 3 months, monodextrous grasp and object transfer at 6 months, and pincer grasp at 9 months, but does not state whether these are expected ages, averages or limits. Kaplan and Sadock says the pincer grasp is first seen at about 9 months, again without converting the statement into a threshold. Berk makes the stronger construct-explicit claim that a well-coordinated pincer grasp is expected by the end of the first year. For a U.S. reference range, Berk places vigorous scribbling between 10 and 21 months and building a tower of two cubes between 10 and 19 months.

Tasman supplies the familiar examination sequence for block towers and copied forms, but those entries have an unclear normative construct. They belong on the milestone plate as source-listed anchors, not in a referral algorithm. The same caution applies when different books disagree: Tasman lists copying a cross and a square at 48 months, while the IPS guideline lists copying a cross at 3 years. Record both source claims; do not collapse them, choose a hidden average or describe either as an upper limit.

13.6 Primitive reflexes: appearance, disappearance and the meaning of persistence

Primitive reflexes are normal early motor phenomena whose later persistence may indicate impaired cortical maturation or neurological dysfunction. The accompanying reflex table owns the verified appearance and disappearance ages and should be used during revision to pair each reflex with how it is elicited. In prose, the high-yield principle is that a reflex age remains

source-specific: Moro disappearance is expected at 12 weeks in Tasman but at 6 months in Berk and Hutchison, while asymmetric tonic neck reflex disappearance is expected at 4 months in Berk. The disagreement must be shown rather than silently harmonised.

Hutchison treats persistence of primitive reflexes beyond the fourth month of life as a general red flag, but its individual-reflex statements must still be respected. The extensor plantar response may remain within the upper limit up to 18 months, whereas Babinski persistence beyond 2 years is a red flag. Thus, primitive reflexes are interpreted by reflex, context and source, not by applying one disappearance age indiscriminately to all.

13.7 Step 5: developmental history, screening and Indian clinical use

A milestone concern becomes clinically meaningful only after a developmental history and direct observation. The developmental history establishes pregnancy and birth context, illness, opportunity for movement, the sequence and quality of attainment across all five domains, asymmetry or early hand preference, functional impact, family observations and any loss of previously acquired skills. Loss of language or social skills at any age requires assessment. Developmental screening then identifies children who need fuller evaluation; it does not itself provide an aetiological diagnosis.

WHO norms contribute a multinational motor reference that included an Indian site.

14 . Language and speech developmental milestones

Language development is not a list of words tied to birthdays. It is the progressive organisation of attention, comprehension, symbolic representation, vocabulary, grammar, speech-sound production and social communication. The examination task is to recognise the sequence, separate receptive language from expressive language and speech, preserve the normative meaning of every age, and identify the few absences that are genuine developmental red flags. An expected age describes what a typical child usually does; a median means that half of the reference group has attained the skill; an upper limit marks the outer boundary of normal; and a red-flag threshold warrants further assessment. A textbook age whose construct is unclear must never be converted into a referral rule.

How to use this page. Start with the twin orienting maps, the **developmental-theory alignment** and the **domains-and-milestones framework**. Then follow communication from prelinguistic vocalisation to words, combinations, grammar and intelligibility. Read the accompanying milestones by age plate for the full source-labelled sequence, not as a set of deadlines. Finish with worked cases and retrieval prompts. Throughout, ask four questions:

- what domain is being tested;
- whether the skill is understood or produced;
- what construct the stated age carries; and
- whether the finding requires observation, screening or referral.

The must-memorise line: refer for absent babbling or gestures at **12 months**, absent single words at **16 months**, absent spontaneous two-word phrases at **24 months**, or loss of language or social skills at any age.

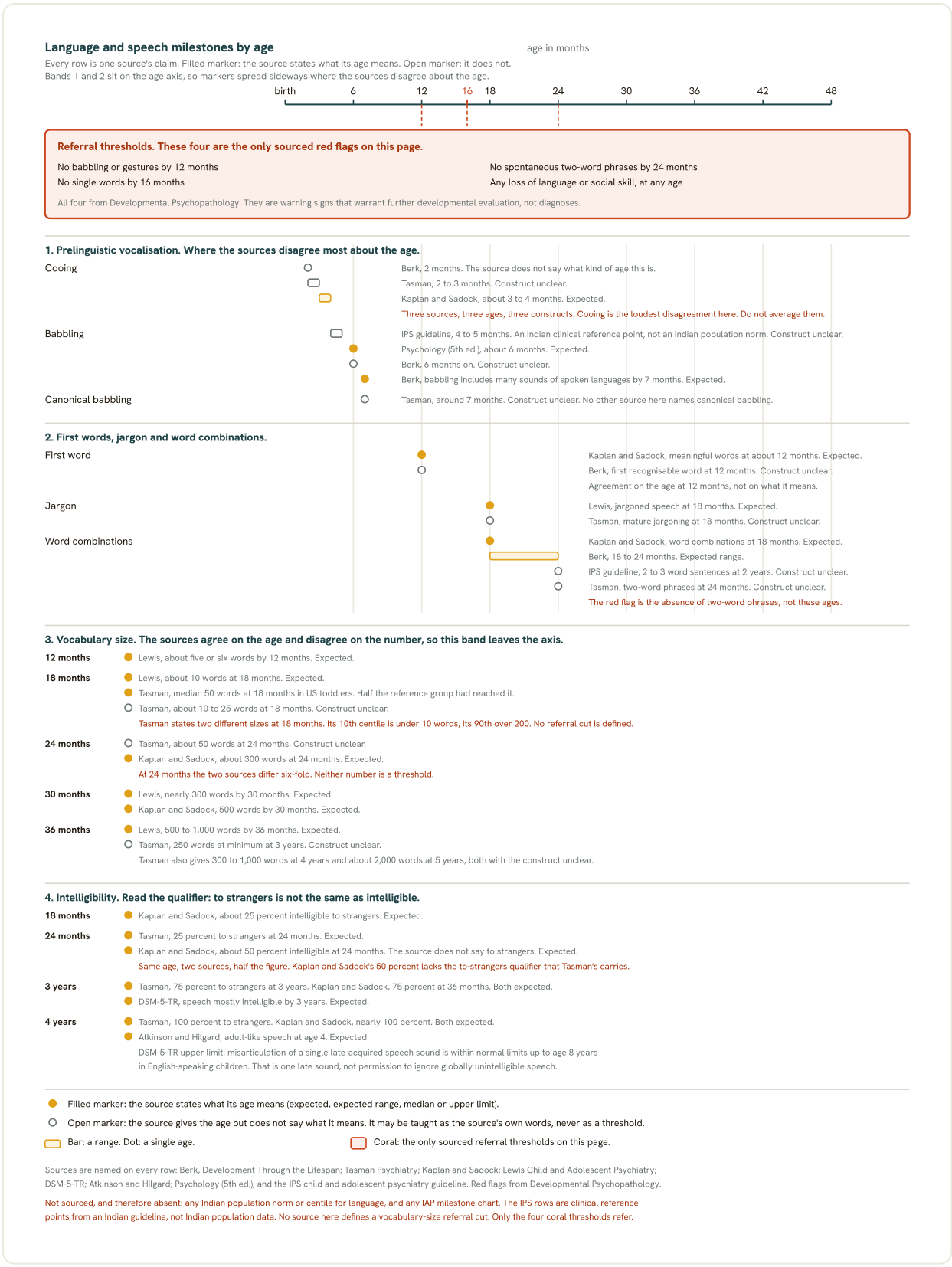


Fig 20.13 Language and speech milestones, drawn so that source and construct stay visible. Each row is one source's stated claim: Berk (Development Through the Lifespan), Tasman, Kaplan and Sadock, Lewis, DSM-5-TR, Atkinson and Hilgard, Psychology (5th ed.) and the IPS child and adolescent psychiatry guideline. Filled markers are ages whose normative construct the source states; open markers are ages it leaves unclear. Cooing, babbling and vocabulary size are shown as disagreements rather than averaged, because no source reports an average. The coral band carries the four red flags from Developmental Psychopathology, which are the only referral thresholds here.

14.1 The twin orienting maps: developmental theories and observable milestones

One map explains development; the other records what the child can do. The developmental-theory alignment places major theories by age on a shared axis without pretending that they describe the same process. Piaget's sensorimotor, preoperational, concrete operational and formal operational stages concern the organisation of thought and help the clinician pitch explanations and tasks. Erikson's psychosocial stages concern trust, autonomy, initiative, industry and identity and help frame the child's age-salient relational task. Freud's psychosexual stages, oral, anal, phallic, latency and genital, remain historically important in examination theory and psychodynamic formulation. The accompanying alignment plate owns the source-specific age bands. Their normative construct is unclear, so none is a clinical threshold.

Mahler's separation-individuation theory follows differentiation, practising, rapprochement and object constancy and is useful when formulating autonomy in relation to the caregiver. Its sourced ages remain on the alignment plate because their normative construct is unclear. Kohlberg's moral development must remain in Kaplan and Sadock's descriptive bands: before adolescence, school-aged children, some young adolescents, during adolescence, later in adolescence, and late adolescence or early adulthood. These bands help the clinician examine the structure of moral reasoning, but no numeric age may be manufactured from them. Vygotsky did not propose age stages. His zone of proximal development, scaffolding, private speech and socially mediated learning sit beside the age axis as mechanisms that explain how supported performance can exceed independent performance.

The second orienting map is the domains-and-milestones framework. It divides observable development into gross motor, fine motor, language and speech, social and emotional, and cognitive or adaptive domains. A theory is an explanatory lens; a milestone is an observed or elicited behaviour. The distinction matters clinically: a child may have age-appropriate gross motor and fine motor skills but delayed language, or may speak little because hearing, opportunity or social reciprocity is impaired. The developmental framework is therefore domain-specific before it becomes a global judgement.

RULE **Name the construct before using the age.** Say "expected" only when the source says typical attainment, "median" only when it identifies the 50th percentile, "upper limit" only for an outer normal boundary, and "red flag" only for a stated referral threshold. Otherwise attribute the age to its source and leave its normative role unclear.

14.2 Band A relational and constitutional frameworks

Attachment, temperament, theory of mind, language-acquisition theory and parenting style influence the communicative environment. In practice, biology, learning and responsive interaction work together.

14.3 Band B: the five domains and the architecture of communication

Language is one developmental domain, but it recruits all the others. The five domains of child development are gross motor, fine motor, language and speech, social and emotional, and cognitive or adaptive functioning. Gross motor development concerns posture and large

movement; fine motor development concerns reach, grasp, manipulation and visuomotor construction. Motor control is commonly organised along cephalocaudal and proximodistal gradients. Language and speech concerns comprehension, symbolic communication, words and grammar, plus the motor production of intelligible sounds. Social and emotional development supplies reciprocity and joint engagement, while cognition supports representation, memory and rule learning.

Within communication, keep four components separate.

COMPONENT	FUNCTION
Receptive language	is what the child understands.
Expressive language	is what the child communicates.
Speech	is the motor and acoustic production of sounds.
Pragmatics	is the socially appropriate use of communication.

Infants understand more than they can produce, so the absence of spoken words does not by itself define the level of comprehension. Assessment must sample response to name, words and commands, gestures and joint attention, spontaneous communication, vocabulary, sentence structure, articulation, voice, fluency and intelligibility. Hearing must be examined because a sensory limitation can mimic or compound language delay.

The milestone framework is sequential rather than rigidly universal. Prelinguistic vocalisation precedes meaningful words; single words precede productive combinations; vocabulary and grammar expand; and speech becomes increasingly intelligible. The accompanying domain-specific plates own the full motor, language and social and emotional milestone reference tables. They should be read horizontally across age and vertically within each domain, without duplicating them into a second prose table.

14.4 From cooing and babbling to words and combinations

Early communication moves from vocal play to symbols shared with another person. Kaplan and Sadock describes cooing as expected at about 3 to 4 months and meaningful words as expected at about 12 months. *Psychology* (5th ed.) describes babbling as expected at about 6 months, while Berk states that babbling includes many sounds of spoken languages by 7 months. These expected claims should be distinguished from source-listed ages whose construct is unclear, such as cooing at 2 months in Berk, canonical babbling around 7 months in Tasman, and first recognisable word at 12 months in Berk.

The Indian clinical reference in the IPS child and adolescent psychiatry guideline lists babbling at 4 to 5 months, understanding "no" at 9 months and picking up familiar objects when asked at 1 year. The source does not say whether these are expected ages, averages or limits. They should therefore be retained as IPS clinical reference points, not labelled Indian population centiles and not converted into referral thresholds. Western and Indian-source statements stay visible side by side because silently averaging them creates a norm that no source reported.

Kaplan and Sadock describes word combinations as expected at 18 months. Berk gives an expected range of 18 to 24 months for combining two words, while the IPS guideline lists 2- to 3-word sentences at 2 years without specifying the normative construct. Lewis describes one-word sentences as expected at 18 months, jargoned speech at 18 months, and three- to four-word sentences by 3 years. The correct examination answer names the behaviour, the source and the construct, then uses the explicit red-flag thresholds for referral rather than treating any one textbook anchor as a deadline.

14.5 Vocabulary, grammar and intelligibility

Vocabulary size varies widely; communicative organisation and intelligibility provide the more useful sequence. Lewis gives expected expressive vocabulary anchors of about five or six words by 12 months, about 10 words at 18 months, nearly 300 words by 30 months, and 500 to 1,000 words by 36 months. Tasman reports a median of 50 words at 18 months among US toddlers, meaning half had attained that vocabulary size by that age. It also reports fewer than 10 words at the 10th percentile and more than 200 at the 90th percentile at 18 months, but does not define a referral cut. These values demonstrate variability and must not be collapsed into a single universal minimum.

about 25 percent	about 50 percent	about 75 percent	nearly 100 percent
SPEECH INTELLIGIBLE TO STRANGERS AT 18 MONTHS	EXPECTED SPEECH INTELLIGIBILITY AT 24 MONTHS	KAPLAN AND SADOCK EXPECTS INTELLIGIBILITY TO STRANGERS AT 36 MONTHS	EXPECTED SPEECH INTELLIGIBILITY AND ADULT-LIKE AT 4 YEARS

DSM-5-TR says speech is mostly intelligible by 3 years.

Grammar changes alongside vocabulary. **Telegraphic speech**, in which content words carry meaning while smaller grammatical elements are sparse, is expected around a year and a half in *Psychology* (5th ed.). Two- and three-word sentences are expected at about 2 years in Atkinson and Hilgard, and sentences become progressively more grammatical. By about 6 years, children are expected to be nearly as fluent as adults. Fluency, grammar and articulation are related but separable, so a child may have age-appropriate ideas and sentence structure yet remain difficult to understand.

Speech-sound expectations must also preserve their construct. DSM-5-TR states that most speech sounds and words become clear with development, while misarticulation of a single late-acquired English speech sound can remain within normal limits up to 8 years. That is an upper-limit statement for a specific late-acquired sound in English-speaking children, not permission to ignore globally unintelligible speech or impairment in another linguistic context.

TRAP **Do not turn a vocabulary count into a universal referral threshold.** At 18 months, Lewis expects about 10 words, while Tasman reports a US median of 50 words and a very wide percentile spread. The four explicit communication red flags, functional impairment, trajectory, comprehension, hearing and social communication decide escalation.

14.6 Primitive reflexes, adolescence and the wider developmental axis

Communication must be interpreted within neurological and maturational development. **Primitive reflexes** are expected early neurological responses. The accompanying reflex table owns their verified appearance, method by which each is elicited, and source-specific disappearance. The high-yield lesson is not to harmonise disagreement: Tasman expects Moro disappearance at 12 weeks, whereas Berk and Hutchison give 6 months; Berk expects asymmetric tonic neck reflex disappearance at 4 months. Hutchison treats persistence of primitive reflexes beyond the fourth month of life as a general red flag, but allows an extensor plantar response up to 18 months as an upper limit and treats Babinski persistence beyond 2 years as a red flag. Each reflex must therefore be interpreted individually.

Adolescent development extends the same developmental method beyond childhood. Its tasks include identity formation, autonomy, peer and intimate relationships, values, gender identity and continuing psychosexual development. Puberty describes biological maturation, while Tanner staging records morphology rather than assigning a fixed age. Girls are staged separately for breast and pubic-hair development; boys for genital and pubic-hair development. Stage I is preadolescent and stage V is mature or adult distribution. The verified puberty plate retains sex-specific ranges without inventing Indian timing data.

The neurodevelopment of adolescence is often framed through a dual-systems or maturational imbalance account, in which reward and socioemotional salience can exert strong influence while cognitive control continues to consolidate. This helps explain peer-sensitive risk-taking without treating normal exploration as pathology. Clinically, the resident asks about persistence, context, impairment, mood, substance use, trauma and coercion rather than applying a moral label.

14.7 Step 5: developmental red flags, surveillance and Indian screening

Screen and refer. The practical question is when to refer, and these explicit thresholds answer it more safely than an unlabelled textbook milestone. Arrange comprehensive developmental, hearing and communication assessment when concern persists or a red flag is present.

14.8 Step 6: five worked cases

Worked case 1, milestone-dating: An 18-month-old uses about 10 words, understands familiar requests and has started combining words. Lewis treats about 10 expressive words as expected at this age, Kaplan and Sadock expects word combinations, and Tasman reports a much higher US median of 50 words. The correct conclusion is that the sources describe different constructs and populations. Assess trajectory, comprehension, hearing and function; do not diagnose delay from the median.

Worked case 2, red-flag: A child has no single words at 16 months. This meets a verified red-flag threshold for further developmental evaluation. Take a full developmental history, test hearing, observe gestures, joint attention and reciprocity, screen development, and refer. Waiting for an unlabelled later textbook anchor would misuse the evidence.

Worked case 3, attachment-pattern: In a Strange Situation vignette, a child explores with the caregiver present, is distressed by separation, seeks comfort on reunion and then returns to play.

The pattern is secure attachment because the caregiver functions as a secure base and reunion restores regulation. The answer describes the observed strategy, not the worth of the parent.

Worked case 4, temperament and goodness-of-fit: A slow-to-warm-up child speaks freely at home but becomes silent when repeatedly pressed to perform before unfamiliar adults. Thomas and Chess directs attention to approach or withdrawal, adaptability and intensity. A slower, predictable introduction improves goodness of fit. The theory explains context-sensitive performance without assuming a fixed language deficit.

Worked case 5, theory-application: A child can complete a verbal classification task with graduated prompts but not independently. Vygotsky locates this performance in the zone of proximal development and supports scaffolding followed by withdrawal of help. Piaget asks what kind of reasoning the task demands, while Erikson asks how the encounter supports initiative or industry. The theories illuminate different aspects of one observation and do not replace direct assessment.

14.9 Step 7: consolidation, retrieval and synthesis

MNEMONIC

"Hear, Share, Say, String, Clear."

Hear stands for receptive language and hearing; *Share* for gesture, joint attention and pragmatics; *Say* for meaningful words and vocabulary; *String* for word combinations and grammar; *Clear* for articulation and intelligibility. Run the mnemonic in that order during a developmental history. Add the red-flag ladder separately: 12 for babbling or gestures, 16 for a single word, 24 for a spontaneous pair, and any age for loss.

Synthesis map: redraw from memory two parallel lines. On the first, place the sourced theories by age, keeping Kohlberg as descriptive bands and Vygotsky as a cross-cutting mechanism. On the second, place milestone anchors from cooing and babbling through words, combinations, grammar and intelligibility. Beneath both, write the five domains and the four red flags. This makes the theory-alignment map explain the child while the milestone map records the child's observable function.

Final clinical synthesis. Language assessment is developmental reasoning in miniature: identify the domain, distinguish understanding from production, describe the sequence and trajectory, preserve the source's normative construct, look for regression and social-communication change, examine hearing and the caregiving environment, and use screening to decide who needs formal assessment. The safest resident is not the one who recites the most ages, but the one who knows exactly what each age is allowed to mean.

15 . Social and emotional developmental milestones

Social and emotional development is the progressive organisation of reciprocal engagement, attachment behaviour, shared attention, play, self-awareness, understanding of other minds and regulation of affect within relationships. It is not a single skill and it cannot be judged from eye

contact alone. A child may produce a behaviour on request yet rarely use it spontaneously to share interest; another may show an age-listed behaviour but with poor reciprocity, little affective integration or loss of previously acquired skills. For the psychiatry resident, the decisive task is therefore to combine milestone timing with quality, context, trajectory and function.

How to use this page. Begin with the five domains of child development, then learn the social and emotional sequence from social reciprocity through joint attention, symbolic play, peer engagement and theory of mind. Use the accompanying social and emotional milestone plate for the domain-specific reference table. This page explains what the entries mean, why normal anxiety windows differ across sources, and how to move from milestones by age to developmental surveillance and referral without converting an expected age into a red-flag threshold.

In social and emotional development, timing starts the assessment; spontaneity, reciprocity, integration, trajectory and loss decide its clinical meaning.

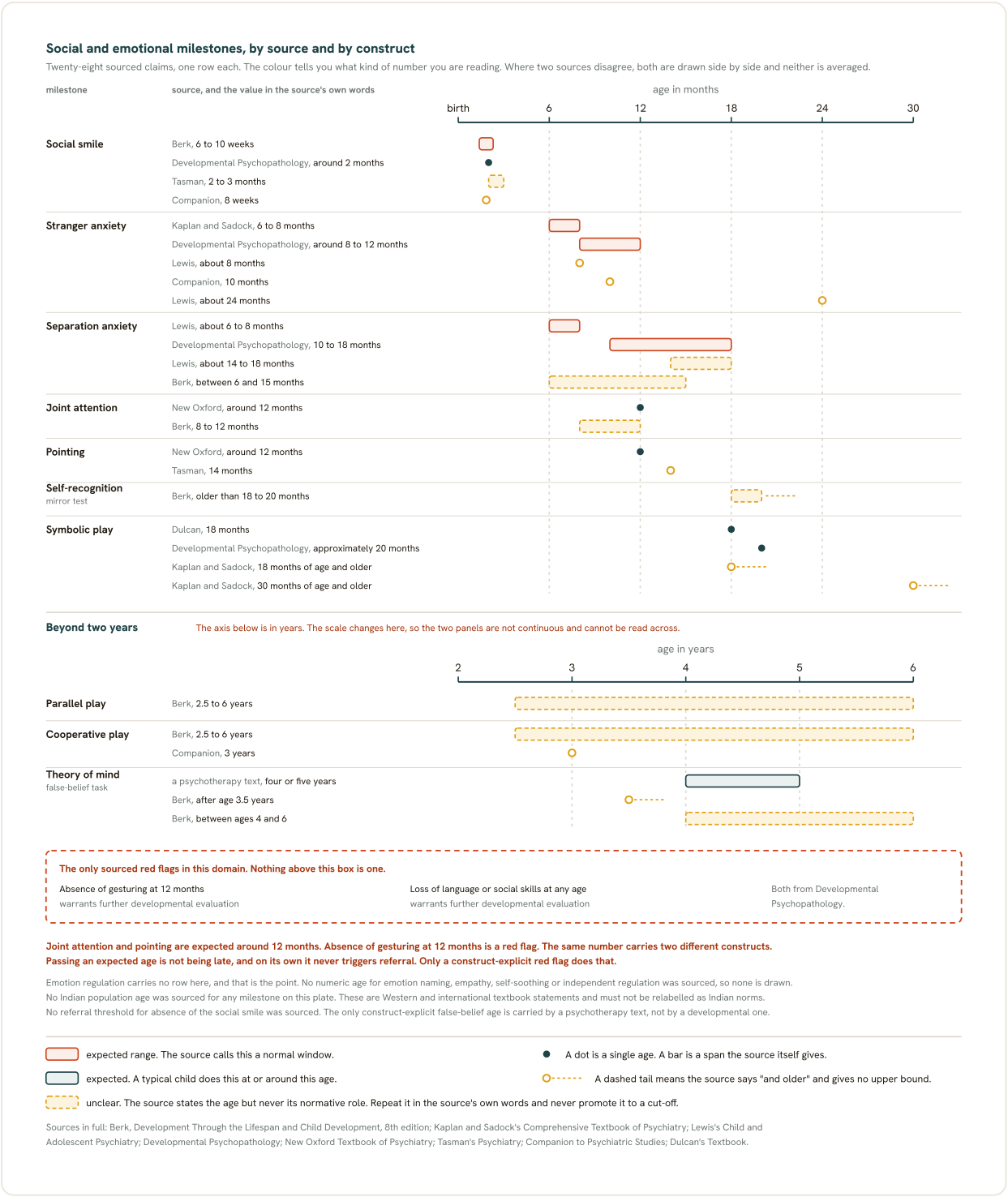


Fig 20.14 Social and emotional milestones, drawn one row per sourced claim so that disagreement between texts stays visible. Colour encodes the normative construct each source states for itself: an expected range, an expected age, or an age whose role the source never states. Stranger anxiety is 6 to 8 months in Kaplan and Sadock and around 8 to 12 months in Developmental Psychopathology; separation anxiety is about 6 to 8 months in Lewis and 10 to 18 months in Developmental Psychopathology. Both windows are kept side by side and neither is averaged. No milestone on this plate is a referral threshold; the only two sourced red flags for this domain are boxed separately. The lower panel is on a years axis, not months.

15.1 The domain within the five-domain developmental map

The domains are examined separately but develop as one system. The five domains are gross motor, fine motor, language and speech, cognitive or adaptive development, and social and emotional development.

DOMAIN	CONTRIBUTION
Gross motor development	supplies posture and mobility.
Fine motor development	supplies reach, grasp and manipulation.
Language and speech	supplies comprehension, expression and verbal communication.
Cognition	supplies representation, learning and problem-solving.
Social and emotional development	supplies reciprocity, relationships, play and regulation.

Social behaviour therefore recruits every other domain. A child must be able to perceive a social cue, orient and act on it, understand its meaning, and regulate the resulting arousal.

The general motor principles of cephalocaudal and proximodistal progression explain why early postural control and proximal stability support later exploration and gesture, but they are not laws for dating social milestones. Social-emotional progression is better understood as widening organisation: regulation is initially supported by a caregiver, dyadic engagement becomes shared engagement around an object or event, symbolic play permits representation, peer interaction becomes more coordinated, and the child increasingly understands mental states. These are linked developmental achievements, not isolated party tricks.

RULE **Name the construct whenever you name an age.** An expected age says what usually occurs; an expected range describes a normal window; a source-stated age with an unclear construct must remain source-stated; and a red flag says when absence warrants further evaluation. None can silently substitute for another.

The accompanying plate owns the full domain-specific social and emotional milestone reference table. Read it horizontally to see the child's profile across functions and vertically to follow one function over time. Where two sources give different windows, retain both. Where a source does not identify its value as expected, median, upper limit or red flag, do not promote that value into a clinical cut-off.

15.2 Early reciprocity and the social smile

The earliest useful observation is not whether the infant smiles, but whether the smile is socially organised. A **social smile** is elicited in reciprocal interaction and is integrated with orientation, facial affect and the other person's behaviour. Berk gives an expected range of **6 to 10 weeks**; *Developmental Psychopathology* describes it as expected at around 2 months in typically developing infants. These are compatible expected statements, not referral thresholds. Tasman lists 2 to 3 months and *Companion to Psychiatric Studies* lists 8 weeks, but neither source states the normative construct, so those values should be repeated only in the source's own descriptive role.

During examination, create an opportunity for mutual engagement rather than commanding a performance. Observe orientation to the caregiver's face and voice, change in affect with

interaction, reciprocal vocal or facial response, ease of soothing and recovery after arousal. A single smile is weak evidence if it is not socially directed; limited eye contact is also nonspecific when considered alone. Vision, hearing, illness, fatigue, temperament, unfamiliar surroundings and the caregiver-child interaction can all change what appears in the room. The correct mental status description is behavioural and present tense, while the developmental history establishes whether the pattern is typical, delayed, inconsistent or lost.

15.3 Selective relationships: stranger anxiety and separation anxiety

Wariness and protest can be normal signs that the infant now discriminates familiar relationships. **Stranger anxiety** refers to wariness or distress in response to an unfamiliar person. Kaplan and Sadock gives an expected range of 6 to 8 months, whereas *Developmental Psychopathology* gives an expected range of 8 to 12 months. Lewis describes about 8 months and about 24 months, and *Companion to Psychiatric Studies* lists 10 months, but those source statements have an unclear normative construct. The expected ranges must remain side by side; averaging them would create a norm reported by neither source.

Separation anxiety is distress associated with separation from a familiar caregiver. Lewis gives an expected range of about 6 to 8 months, while *Developmental Psychopathology* gives an expected range of 10 to 18 months. Lewis also describes about 14 to 18 months and Berk describes 6 to 15 months, but those two statements do not specify their normative role. This source variation is itself examinable: the behaviour is developmentally intelligible, but the literature does not provide one universal date that separates normal from abnormal.

TRAP **Normal anxiety is not defined by one birthday.** Do not diagnose from the mere presence or absence of stranger or separation anxiety at one visit, and do not merge differing source windows. Judge intensity, persistence, context, recovery with the caregiver, functional impairment and the wider developmental profile.

Clinically, observe whether the caregiver functions as a source of regulation and whether distress settles sufficiently for exploration to resume. The form of the response matters more than its theatrical intensity. A tired infant in an unfamiliar clinic may protest strongly; a quiet infant may freeze rather than cry. The resident should document the trigger, proximity-seeking, consolability, recovery, exploration and consistency across settings before inferring a relational pattern.

15.4 Joint attention and pointing: from dyadic to shared engagement

Joint attention turns a two-person exchange into a shared mental focus on something in the world. **Joint attention** requires coordinated attention between child, another person and an object or event. It includes following another person's gaze or point and actively directing another person's attention for sharing, not merely to obtain an object. The *New Oxford Textbook of Psychiatry* states that joint attention is expected around **12 months** in most typically developing children. Berk describes increasing accuracy between 8 and 12 months, but does not specify the normative construct for that age band.

Pointing is likewise expected around 12 months in most typically developing children according to the *New Oxford Textbook of Psychiatry*; Tasman lists 14 months without defining whether that is an expected age, average or limit. The important distinction is functional. Imperative pointing requests something; declarative pointing shares interest for its own social value. Assessment should therefore sample gaze-following, showing, giving, pointing, shifting gaze between object and person, and checking the adult's response. A hand movement without coordinated gaze or shared affect is not equivalent to spontaneous declarative communication.

Because social communication and language develop together, ask how the child communicates wants, enjoyment and surprise before relying on spoken vocabulary. Hearing and vision must be considered. So must opportunity: the meaning of a behaviour depends on whether it appears spontaneously across familiar settings, not merely after repeated prompting in a clinic. Around 12 months is an expected attainment statement for joint attention and pointing, whereas absence of gesturing at 12 months is the separately sourced red-flag statement. The identical number does not make the constructs interchangeable.

15.5 Symbolic play, self-recognition and peer sociability

Play reveals representation, social reciprocity and flexibility in a natural behavioural sample.

Symbolic play, also called pretend play, uses an action or object to stand for something else. Dulcan describes symbolic play as expected at **18 months**; *Developmental Psychopathology* describes it as expected at approximately 20 months in most children. Kaplan and Sadock lists symbolic play at 18 months and older and at 30 months and older in clinical play descriptions, but those statements do not identify a normative construct. The expected values belong on the milestone plate as separate source claims, not as a new averaged deadline.

Examine play for initiation, imitation, shared enjoyment, symbolic substitution, sequencing, flexibility and inclusion of another person. Functional use of an object is not yet symbolic use; repetitive manipulation is not equivalent to pretend play; and reproducing a prompted action once is weaker evidence than spontaneous flexible play. The play sample should be interpreted with fine motor ability, language comprehension, cognitive level, sensory profile, familiarity with the materials and prior opportunity.

Self-recognition in the mirror test is reported by Berk in children older than 18 to 20 months, but the source does not say whether this is an average, range or limit. Keep it as a source-stated observation. For peer sociability, *Companion to Psychiatric Studies* lists cooperative play at 3 years, while Berk describes both parallel play and cooperative play across 2.5 to 6 years. Their normative constructs are unclear. These figures describe patterns in the cited sources and must not be treated as referral deadlines.

Parallel and cooperative play are also not mutually exclusive stages through which every child marches on a fixed timetable. Ask what the child actually does with peers: watches, imitates, plays alongside, exchanges objects, negotiates roles, sustains a shared theme, tolerates frustration and repairs conflict. Context matters. Solitary play in a new clinic cannot establish the child's usual

peer competence, while school reports and direct observation in familiar settings may reveal a very different profile.

15.6 Understanding minds and regulating emotion

Later social competence depends increasingly on representing internal states rather than responding only to visible behaviour. **Theory of mind** is the capacity to understand that another person can have thoughts, intentions, desires and beliefs different from one's own. Success on a standard false-belief task is expected at **4 or 5 years** in the cited source. Berk reports performance after 3.5 years and between 4 and 6 years but does not identify the normative construct of those values. Failure on a single task is not a diagnosis because language comprehension, attention, working memory and task demands contribute to performance.

Emotional development includes recognition and expression of affect, use of another person's signals, tolerance of arousal, recovery after frustration and an increasing capacity to regulate behaviour in context. The clinically useful sequence is qualitative: regulation begins in interaction with a caregiver and becomes progressively internalised, flexible and responsive to social rules. No verified numeric ages for specific emotion-labelling or self-regulation milestones were supplied, so none should be invented. Assessment instead compares behaviour across home, school and clinic, noting triggers, strategies, recovery, caregiver support and impairment.

Social cognition and emotion regulation must be interpreted culturally. Eye gaze, proximity, independence, deference, emotional display and adult-child conversation vary with family and community expectations. Culture does not explain away regression, marked functional impairment or absence of basic communicative gesture, but it changes the form in which competence is expressed. A sound answer describes the observed behaviour first, then considers developmental level, language, sensory capacity, temperament, context and culture before drawing a clinical inference.

15.7 Step 5: spotting deviation from normal and deciding when to refer

Developmental red flags are construct-explicit escalation signals, not retrospective labels. The verified social-communication warning signs are absence of gesturing at **12 months** and loss of language or social skills at any age. Both warrant further developmental evaluation. Because language and social communication are tightly coupled, absence of babbling at 12 months, absence of single words at 16 months and absence of spontaneous two-word phrases at 24 months are additional communication red flags that should be checked in the same assessment. A red flag indicates when to refer; it does not establish aetiology or diagnosis.

Spotting deviation requires more than threshold checking. Look for regression, plateau, marked unevenness across domains, lack of spontaneous reciprocity, poor integration of gaze, gesture and affect, unusual rigidity or repetitive play, weak generalisation across settings, and functional impact on learning or relationships. Only those two social-communication findings above are verified referral thresholds in the supplied evidence. Expected ages for the social smile, joint attention, pointing or symbolic play must not be relabelled as red flags merely because the child has passed them.

A focused developmental history records pregnancy and birth context, health, hearing and vision, opportunities for interaction, caregiver concerns, the sequence of attainment across gross motor, fine motor, language and speech, cognition, and social and emotional development, plus any loss of skills. Observe the child with the caregiver and during free play. Sample response to social bids, shared enjoyment, gesture, joint attention, imitation, symbolic play, flexibility, regulation and recovery. Seek reports across settings because a short clinic encounter can under-sample both strengths and difficulties.

Developmental surveillance is the longitudinal clinical process of eliciting concerns, observing development and following trajectory. **Developmental screening** uses a standardised tool to identify children who need comprehensive assessment. Screening is not diagnosis. Refer promptly for comprehensive developmental assessment when a verified red flag is present, when skills are lost, or when persistent concern and functional impairment remain despite an apparently reassuring single observation. Hearing and vision assessment are integral where communication or social response is in question.

15.8 Indian screening context without invented Indian milestones

Indian practice has validated screening instruments, but the available evidence does not supply an Indian social-emotional milestone table. The Trivandrum Development Screening Chart, developed at the Child Development Centre in Kerala, covers 0 to 6 years and contains 51 items. In the validation study by Nair and colleagues, one item delay was the operational positive result called TDSC delay, with DDST as the reference standard. This is a screening rule for the instrument as a whole, not permission to reconstruct individual item ages or to convert a textbook social milestone into a TDSC cut.

1,183 CHILDREN IN THE TDSC VALIDATION SAMPLE	**84.62%** SENSITIVITY, WITH A 95 PERCENT CONFIDENCE INTERVAL FROM 71.92 TO 93.12	**90.8%** SPECIFICITY, WITH A 95 PERCENT CONFIDENCE INTERVAL FROM 88.97 TO 92.43	**99.23%** NEGATIVE PREDICTIVE VALUE, WITH A 95 PERCENT CONFIDENCE INTERVAL FROM 98.48 TO 99.67

The DASII yields separate Motor DQ and Mental DQ values, and Indian follow-up practice uses a DQ below 85 as a delay marker. That marker is instrument-level evidence, not a milestone age. The Baroda Development Screening Test was India's first developmental screening tool, introduced in 1991. These instruments help organise referral after developmental surveillance raises concern; they do not replace a social history, direct observation, sensory assessment or a fuller developmental evaluation.

No verified Indian population ages for the social smile, stranger anxiety, separation anxiety, joint attention, pointing, symbolic play, peer play or false-belief performance were supplied. The Western and international textbook statements on the milestone plate therefore remain labelled by source and population where known. They must not be relabelled as Indian norms. This is especially important in viva answers: name the source construct, describe the behaviour and use the validated Indian screening pathway without claiming an Indian centile that has not been published in the material available here.

15.9 Clinical application and retrieval

- **Worked vignette 1, expected age versus red flag:** A caregiver reports no communicative gestures, including no pointing, showing or giving, at 12 months. Pointing itself is expected around 12 months in the *New Oxford Textbook of Psychiatry*, while absence of gesturing at 12 months is separately sourced as a warning sign. Clarify gaze shifts and shared enjoyment as part of the wider social-communication profile. Because the red-flag construct is met, arrange further developmental evaluation; do not diagnose from that finding alone.
- **Worked vignette 2, source variation:** An infant becomes wary of an unfamiliar examiner. Kaplan and Sadock gives a stranger-anxiety range of 6 to 8 months, while *Developmental Psychopathology* gives 8 to 12 months. The correct answer preserves both expected ranges and interprets the behaviour through familiarity, intensity, consolability and recovery. It does not average the ranges and does not call ordinary wariness pathological.
- **Worked vignette 3, play quality:** A child reproduces feeding a doll after repeated demonstration but does not initiate pretend actions, share enjoyment or vary the play. The observed imitation is real, but it does not by itself establish spontaneous flexible symbolic play. Sample familiar materials and caregiver interaction, assess language, cognition and fine motor ability, and obtain behaviour across settings before interpreting the finding.

MNEMONIC

"smile, selective relationships, share, symbol, self and minds"

Smile recalls early reciprocity. Selective relationships recalls stranger and separation anxiety. Share recalls joint attention and pointing. Symbol recalls pretend and peer play. Self recalls self-recognition. Minds recalls false-belief understanding.

Then add the clinical spine: five domains, spontaneous quality, trajectory, loss, developmental surveillance, screening and referral.

Final clinical synthesis. Social and emotional milestones are best understood as an expanding capacity to engage, share, represent, relate and regulate. The safe examination answer names the behaviour, gives the source's normative construct, preserves population and source differences, describes quality and context, looks for loss and functional impairment, and uses construct-explicit warning signs to decide when to refer. Recitation earns a mark; disciplined interpretation prevents harm.

16 . Primitive reflexes and their disappearance

Primitive reflexes are stereotyped, involuntary motor responses elicited by a defined sensory or positional stimulus in the immature nervous system. Their orderly appearance in the newborn and subsequent disappearance reflect intact lower neural pathways followed by increasing supraspinal control. They are therefore neither ordinary voluntary milestones nor isolated curiosities. In an examination, each reflex must be judged by four questions:

1. Is it present when it should be?

2. Is it elicited correctly?
3. Is it symmetrical?
4. Has it been inhibited when expected?

The accompanying reflex table is the visual reference for appearance and disappearance ages. Use it as a source-labelled map, because several respected textbooks give different disappearance points for the same reflex. The safe clinical answer is not to average discrepant ages. State the reflex, demonstrate how it is elicited, quote the named source or range, and distinguish an expected disappearance from an upper limit or a red-flag threshold.

Must memorise: A primitive reflex is interpreted by expected presence, adequate elicitation, symmetry and timely disappearance, never by presence or absence alone.

MNEMONIC

"Present, elicit, symmetry, disappear"

Interpret a primitive reflex by whether it is present when it should be, elicited correctly, symmetrical and inhibited when expected.

Primitive reflexes: elicitation, appearance, disappearance

Persistence beyond the disappearance age is the sign, not the reflex itself. Read one reflex across its row. Do not collapse the table into a single disappearance rule.

Reflex	How it is elicited, and the response	Appears	Disappears, by named source
Rooting	Stroke the cheek or corner of the mouth. The neonate turns toward it, opens the mouth.	● neonate Morgan	● Berk: 3 weeks, becomes voluntary turning ● Neuroanatomy atlas: about 1 year of age
Sucking	Contact with the lips or palate produces rhythmic sucking.	● neonate Kaplan and Sadock	● Berk: after 4 months ● Neuroanatomy atlas: about 1 year of age
Moro	Infant fully supported, a brief controlled head-position change. Never an actual drop.	● Neonatal period, first 4 weeks Tasman	● Tasman: 12 weeks ● Berk and Hutchison: 6 months
Asymmetric tonic neck	Turn the supine infant's head to one side. Face side extends, occiput side flexes: fencer.	○ 4 weeks Tasman	● Berk: 4 months
Palmar grasp	A finger laid across the palm, gentle pressure. The fingers flex around it.	● neonate Kaplan and Sadock	● Hutchison: 2 months ● Berk: 3 to 4 months
Plantar grasp	Pressure at the base of the toes produces toe flexion.	Not sourced No age in the cited texts.	● Hutchison: 2 months
Stepping	Held upright, soles on a firm surface, the body inclined forward. Alternating steps.	● Neonatal period, first 4 weeks Tasman	● Hutchison: 2 months ○ Berk: 2 months, in relation to weight gain
Babinski extensor plantar	Stroke the lateral sole, heel to forefoot, then medially. Great toe extends, toes fan.	● newborns New Oxford	● Berk: 8 to 12 months ● New Oxford: during the first 2 years of life ● Hutchison: extensor plantar up to 18 months

Five of the eight reflexes carry more than one disappearance age. Both claims are shown. Never average them into a false consensus.

Rooting, sucking, Moro and palmar grasp genuinely disagree between texts. Babinski's four boundaries are complementary: a range, a broader range, an upper limit, a red flag.

Red flags. These three are the only ones sourced in this chapter, and all three come from Hutchison's Clinical Methods.

Sucking reflex absent beyond the 36th week of gestation.
Primitive reflexes persisting beyond the fourth month of life.
Babinski reflex persisting beyond the age of 2 years.

The fourth-month statement is a general screening prompt. It does not override the later reflex-specific expectations above for Moro, sucking and the extensor plantar response.

● expected: a typical infant, per the source ● expected range: the normal window ● upper limit: the outer bound of normal
○ construct not stated by the source: teach its own words, never convert it into a referral threshold

Every age is quoted from a named text and stays attached to it. Sources: Hutchison's Clinical Methods, Berk's Development Through the Lifespan, Tasman, Kaplan and Sadock, the New Oxford Textbook of Psychiatry, an atlas of neuroanatomy, and Morgan's Introduction to Psychology. Elicitation follows this chapter's text.

Not sourced and therefore not shown: an appearance age for plantar grasp, and any Indian normative reflex schedule. No Western age is relabelled as an Indian norm.

Fig 20.15 The primitive reflexes, with each age kept attached to the text that states it. Disappearance ages come from Hutchison's Clinical Methods, Berk's Development Through the Lifespan, Tasman, and the New Oxford Textbook of Psychiatry; appearance ages from Kaplan and Sadock, Tasman, the New Oxford Textbook of Psychiatry and Morgan. Dots mark what kind of number each age is, because an expected age, an upper limit and a red flag are not interchangeable. Where texts disagree, both claims are shown rather than averaged. The three red flags are the only ones sourced.

16.1 What primitive reflexes signify

They test maturation as well as pathway integrity. A primitive reflex is produced by a relatively fixed sensorimotor circuit that is clinically visible while **descending inhibition** is immature. With maturation, the response is inhibited, incorporated into voluntary movement or replaced by a more purposeful response. Thus, normal development has two examinable directions: an early reflex should be obtainable at the relevant stage, and it should later recede. Persistence, asymmetry, failure to elicit an expected response, or re-emergence after it has disappeared can each be abnormal, but they point to different problems.

Presence alone does not certify a normal nervous system. A response may be weak because the infant is drowsy, recently fed, unwell or poorly positioned; it may be absent because the stimulus was inadequate; and it may be asymmetric because of a peripheral injury even when central maturation is otherwise appropriate. Conversely, persistence suggests deficient inhibition only after the reflex-specific expectation and the rest of the neurologic examination are considered.

16.2 Examination technique: make the response interpretable

Standardise the infant's state before interpreting the movement. Examine in a warm, safe setting, preferably when the infant is awake and settled. Observe spontaneous posture and

movement first. Then apply one clear stimulus, support the head and trunk throughout, compare the two sides where the response permits, and describe the actual movement rather than merely writing “reflex present”. Repeat only when necessary, because habituation, crying and repeated stimulation can alter the response. Record gestational context and the infant's behavioural state.

RULE **First prove that the test was valid.** Name the stimulus, the motor response, its symmetry and the infant's state. Only then compare the finding with the expected disappearance age.

The usual bedside sequence is efficient: test the orofacial responses, then upper-limb grasp, the startle and postural responses, stepping, plantar grasp and the plantar response. This reduces unnecessary repositioning and makes side-to-side comparison easier.

16.3 Disappearance ages are source-specific constructs

Do not convert a textbook age into a referral threshold.

CONSTRUCT	MEANING
An “expected” disappearance	describes what the source presents as usual.
An “expected range”	describes a window.
An “upper limit”	marks the outer boundary of normal.
A “red flag”	is the point at which persistence or absence warrants concern.

These constructs are not interchangeable. If two books differ, retain both claims with attribution rather than creating a false consensus.

TRAP **“All primitive reflexes must disappear by the fourth month” is unsafe.** *Hutchison's Clinical Methods* gives persistence beyond the fourth month of life as a general red flag, but the same source and other textbooks give later reflex-specific expectations for Moro, sucking and the extensor plantar response. Use the general statement as a screening prompt, not as a universal cut-off that overrides the named reflex.

the fourth month of life	36th week of gestation	18 months of age	2 years
GENERAL RED FLAG	ABSENCE RED FLAG	UPPER LIMIT	RED FLAG

The disagreement often reflects differences in elicitation, the strength counted as “present”, whether a response has become voluntary, and the population or edition being described. The accompanying plate therefore keeps each age attached to its source. It should be read horizontally, one reflex at a time, not collapsed into a single disappearance rule.

16.4 Rooting and sucking: feeding-related primitive responses

Rooting is elicited by stroking the cheek or the corner of the mouth; the neonate turns toward the stimulus and opens the mouth. Its appearance is described in the neonate. Berk and a neuroanatomy atlas give markedly different disappearance points, shown with their attributions in the accompanying reflex table. These values should not be averaged. The difference may reflect

distinct operational boundaries between a reflexive turn and a residual feeding response, so the source must travel with the age.

Sucking is elicited by contact with the lips or palate and produces rhythmic sucking. Kaplan and Sadock describe its appearance in the neonate. *Hutchison's Clinical Methods* treats absence beyond the **36th week of gestation** as a red flag. Berk and the neuroanatomy atlas again give different expected disappearance points; retain both as source-specific values from the plate. The clinically important distinction is between an absent feeding response when it should be established and persistence of a reflexive pattern after voluntary feeding control develops.

16.5 Moro and asymmetric tonic neck reflex

Moro reflex is tested with the infant fully supported: a brief, controlled change in head position produces abduction and extension of the upper limbs, followed by adduction and flexion. The manoeuvre is a **supported head-extension stimulus**, never an actual drop. Tasman describes Moro as present in the neonatal period and gives an earlier disappearance point than Berk and *Hutchison's Clinical Methods*. The plate preserves both claims. Quote the source rather than turning either value into an unsupported universal limit.

For the asymmetric tonic neck reflex, turn the supine infant's head gently to one side. The limbs on the face side extend and those on the occipital side flex, producing the “fencer” posture. Tasman records its early presence without defining the normative construct; this must not be restated as a referral threshold. Berk supplies an expected disappearance point in the plate. Marked obligatory persistence can interfere with midline hand use and rolling, while asymmetry requires a broader neurologic and musculoskeletal assessment.

16.6 Grasp and stepping responses

Palmar grasp is elicited by placing a finger across the palm and applying gentle pressure; the fingers flex around it. Kaplan and Sadock describe appearance in the neonate. Berk gives an expected disappearance range, whereas *Hutchison's Clinical Methods* gives a different expected point; both remain source-labelled in the plate. For plantar grasp, pressure at the base of the toes produces toe flexion. Hutchison supplies its expected disappearance point, but no appearance age was available from the cited sources.

Stepping is elicited by supporting the infant upright, allowing the soles to contact a firm surface and inclining the body slightly forward; alternating step-like movements follow. Tasman describes it as expected in the neonatal period. Hutchison gives an expected disappearance point. Berk also describes disappearance in relation to weight gain but does not define the normative role of that statement, so it should not be converted into an upper limit or referral threshold. The exact source-specific entries belong to the accompanying plate.

16.7 Babinski response: expected early, concerning when persistent

The Babinski reflex, or **extensor plantar response**, is elicited by stroking the lateral sole from heel toward the forefoot and then medially. Extension of the great toe, often with fanning of the other toes, is expected in newborns according to the *New Oxford Textbook of Psychiatry*. It is

commonly taught beside the primitive reflexes because its interpretation changes with nervous-system maturation.

The sources offer complementary, not identical, boundaries, and the plate keeps them separate. Berk supplies an expected disappearance range, the *New Oxford Textbook of Psychiatry* gives a broader expected range, and Hutchison states that an extensor plantar response may occur up to **18 months of age**, an upper limit, while persistence beyond **2 years** is a red flag. Therefore an extensor response at the end of infancy is not automatically an upper motor neuron sign, whereas persistence beyond the sourced red-flag boundary requires neurologic assessment.

16.8 Clinical interpretation: pattern before label

Abnormality lies in the pattern. Bilateral absence of a response expected in a newborn raises questions about gestational maturity, arousal, systemic illness, medication effect or diffuse neurologic dysfunction. A consistently asymmetric Moro or grasp response raises a different set of possibilities, including a focal central lesion, peripheral nerve injury or painful limb movement. Persistence of several primitive responses, particularly with abnormal tone, posture or delayed voluntary motor control, is more concerning for impaired **central inhibition** than a single borderline response.

Re-emergence later in life is described as a frontal release sign. Grasping, rooting, snout and palmomental responses may appear with frontal or diffuse cerebral dysfunction, including neurocognitive disorders, but one isolated sign has limited specificity. In psychiatry, these signs strengthen a neurologic formulation only when they fit the cognitive examination, functional decline and the rest of the neurologic findings.

> **INDIA**
>
> The cited disappearance values are textbook schedules, not Indian normative percentiles. Do not manufacture an India-specific age conversion. In an Indian infant, retain the named source and interpret the response with gestational context, longitudinal development and the complete neurologic examination.

In a short case or viva, the highest-scoring formulation is compact: “I elicited the reflex with the appropriate stimulus; the response was present or absent, graded by quality and symmetry; I compared it with the source-specific disappearance expectation; and I interpreted it with tone, posture, voluntary movement and the rest of development.” That answer demonstrates technique, developmental reasoning and restraint. It avoids the two common errors: treating every age as a hard cut-off and diagnosing neurologic disease from one reflex in isolation.

17 . Adolescent development and identity formation

Adolescence is the developmental transition from childhood dependence toward adult roles, marked by pubertal change, reorganisation of cognition and emotion, increasing importance of peers and intimate relationships, and the construction of a more coherent identity. It is neither a prolonged childhood nor an incomplete adulthood. Development is asynchronous: physical

maturation, reward sensitivity, abstract reasoning, self-regulation, autonomy and social opportunity do not move in lockstep. The psychiatrist therefore judges the adolescent against developmental trajectory, pubertal status, context and functioning, not against a single stereotype of maturity.

How to use this page. Build the answer in **four** layers. Begin with puberty and Tanner staging, then explain the neurodevelopmental basis of context-sensitive risk-taking, then describe identity formation through Erikson and Marcia, and finally integrate gender, sexuality, peers, family and culture. Keep **three** distinctions intact: Tanner stage is based on physical characteristics rather than chronological age; exploration is not itself pathology; and gender identity, gender expression and sexual orientation are separate constructs.

The must-memorise line: Adolescence is an asynchronous transition in body, brain and social role, while identity is formed through exploration and commitment within family, peer and cultural relationships.

RULE **The psychiatrist therefore judges the adolescent against developmental trajectory, pubertal status, context and functioning, not against a single stereotype of maturity.** Development is asynchronous: physical maturation, reward sensitivity, abstract reasoning, self-regulation, autonomy and social opportunity do not move in lockstep.

TRAP **Exploration is not itself pathology.** Normal diversity in tempo and expression is expected, but marked distress, sustained impairment, coercion, regression or a clear episodic change requires assessment rather than automatic attribution to adolescence.

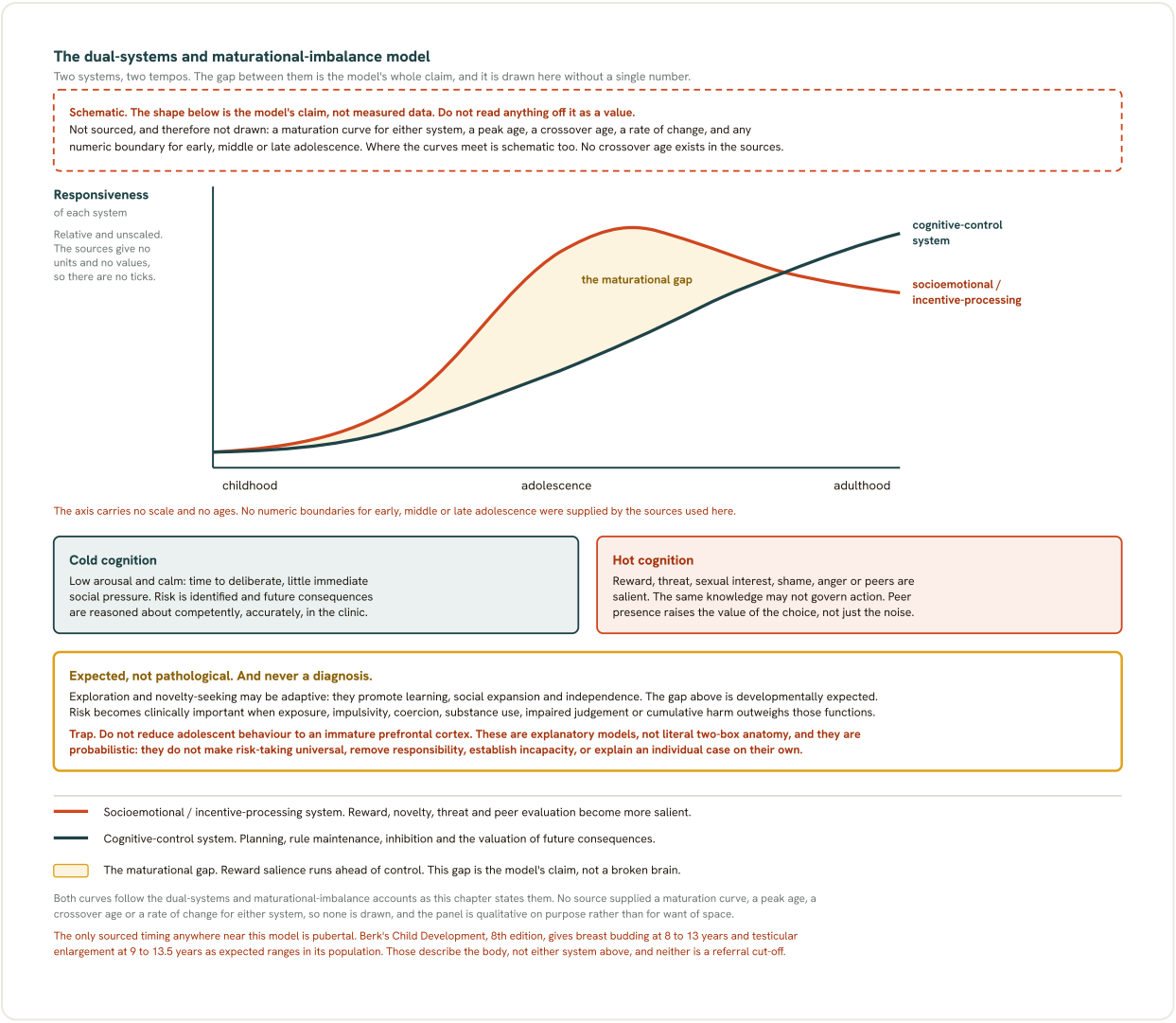


Fig 20.16 The adolescent dual-systems and maturational-imbalance model, drawn qualitatively. The curves carry the model's claim, that a fast-changing socioemotional system runs ahead of a more slowly stabilising cognitive-control system, and that the gap between them is the window in which risk-taking is developmentally expected rather than pathological. The shape is schematic: no source supplied a maturation curve, peak age, crossover age or rate for either system, so none is drawn and the axis carries no ages. The only sourced timing shown is pubertal, from Berk's Child Development, 8th edition, as expected ranges.

17.1 A developmental frame: simultaneous change across interacting systems

The central principle is uneven but coordinated development. Puberty changes the body, sleep, affective salience and how other people respond to the young person. Cognitive development expands hypothetical, future-oriented and self-reflective thought. Social development shifts toward greater privacy, peer affiliation, reciprocal intimacy and negotiation of authority. Identity development integrates bodily experience, values, relationships, education, work, culture, gender and sexuality into an account of who the person is and where life is going. Change in one system alters every other system: earlier or later pubertal change can affect body image and peer position, while family response can amplify or buffer its psychological impact.

Developmental tasks are therefore better treated as linked processes than as a checklist. The adolescent must:

- incorporate a changing body; become more autonomous without losing secure relatedness;

- form increasingly mutual peer relationships; develop values and future goals; regulate strong affect;
- make decisions under social pressure; establish a workable sense of self.

Progress is non-linear. A person may reason abstractly in a calm classroom yet decide impulsively in an emotionally charged group, appear independent with peers yet seek parental regulation during illness, or explore one identity domain while remaining committed in another.

The useful clinical model is **transactional**. Biological changes alter behaviour and social signalling; family, school, peers, media and culture shape the opportunities and meanings attached to those changes; repeated experiences then modify self-concept and regulation. Neither biology nor environment alone explains the outcome. Normal diversity in tempo and expression is expected, but marked distress, sustained impairment, coercion, regression or a clear episodic change requires assessment rather than automatic attribution to adolescence.

17.2 Puberty: biological maturation, variable timing and psychological meaning

Puberty is the biological process of sexual maturation, whereas adolescence is the broader psychological and social transition. Gonadal maturation produces secondary sexual characteristics and reproductive capacity; adrenarche is a related but distinct process involving adrenal androgen effects. The order and tempo of visible changes matter more clinically than a single calendar age. Pubertal events also acquire personal and social meaning through comparison with peers, cultural expectations, gender experience, body ideals, family communication and the adolescent's readiness for change.

Psychological effects depend on timing relative to peers and on context, not merely on whether a value falls inside a range. Ask about the adolescent's understanding of changes, body satisfaction, teasing, sexualisation, sports or school consequences, privacy, menstrual experience where relevant, and whether physical development is congruent with gender experience. Puberty may increase visibility and social expectations before cognitive or emotional capacities have developed to the same degree.

17.3 Cognitive and moral development: expanding capacity with uneven performance

Adolescent thought increasingly permits abstraction, hypothesis, metacognition and projection into possible futures. In Piaget's scheme this is **formal operational thought**: reasoning about propositions and possibilities rather than only concrete events. It supports scientific reasoning, ideological debate, imagining alternative selves and considering long-term consequences. It also enables heightened self-consciousness because the adolescent can represent how others might be evaluating them. Formal reasoning is not used uniformly; familiarity, education, emotion and task demands strongly influence performance.

Two classic descriptions help explain adolescent egocentrism. The **imaginary audience** is the sense of being continuously observed or judged, which can intensify concern about appearance and embarrassment. The **personal fable** is a felt uniqueness of one's experience and, at times, a sense that ordinary consequences do not fully apply. Neither construct should be used to

caricature all adolescents. Both are hypotheses about self-focused social cognition and must be distinguished from delusional conviction.

Kohlberg's moral development should be taught in sequence without invented numeric ages. Kaplan and Sadock describes:

LEVEL	KAPLAN AND SADOCK DESCRIPTION
Preconventional morality	before adolescence
Some second-level reasoning	in young adolescents
Third-level conventional reasoning	during adolescence
Fourth-level conventional reasoning	later in adolescence
Fifth-level postconventional reasoning	in late adolescence or early adulthood.

Moral reasoning on a dilemma is not identical to moral conduct: emotion, relationships, incentives, culture and power affect what a person actually does.

17.4 Erikson and Marcia: identity as exploration and commitment

Erikson locates the central psychosocial task of adolescence in identity versus role confusion. Identity is a workable sense of continuity and sameness across time, combined with a social recognition that one is the person one understands oneself to be. It integrates earlier identifications with present capacities and future roles. Role confusion refers to difficulty organising these elements into a sufficiently coherent direction, not ordinary uncertainty during exploration. Successful development yields fidelity, the capacity to sustain commitments while recognising ideological and interpersonal difference.

James Marcia operationalised identity through two processes: **exploration**, the active consideration of alternatives, and **commitment**, an investment in chosen goals, values or roles. Their combinations produce four **identity statuses**:

IDENTITY STATUS	DESCRIPTION
Identity diffusion	neither active exploration nor stable commitment.
Foreclosure	commitment adopted without meaningful exploration, often from family or authority expectations.
Moratorium	active exploration without a settled commitment.
Identity achievement	commitment formed after meaningful exploration.

four
IDENTITY STATUSES

These are statuses, not fixed personality types and not an irreversible staircase. The same adolescent may be achieved in religion, foreclosed in vocation, in moratorium regarding relationships and diffuse about politics. Status can change when education, migration, conflict, discrimination, illness or new relationships reopen a domain. Moratorium can be

developmentally productive, while commitment itself is not proof of maturity if it was coerced or cannot be revised in response to experience.

17.5 Identity develops in relationships, culture and digital spaces

Healthy individuation changes the form of attachment rather than requiring emotional separation from the family. The adolescent seeks greater privacy, agency and reciprocal negotiation while still using caregivers as sources of security, values and practical support. Conflict may increase around boundaries, education, relationships, technology and appearance, but conflict alone does not demonstrate dysfunction. The clinically useful questions are whether disagreement can be negotiated, whether the adolescent has a voice, whether caregivers remain available, and whether autonomy is expanding in a way that is safe and culturally intelligible.

Peers provide comparison, belonging, rehearsal of adult-like intimacy and feedback about possible selves. Close friendships become more reciprocal and self-disclosing; peer groups can support exploration but can also enforce conformity. Social exclusion, bullying and minority stress can become incorporated into self-concept. Digital spaces extend these processes through persistent audiences, curated self-presentation, rapid feedback and access to identity communities. Online identity is not necessarily false; it may be experimental, aspirational, fragmented or more authentic than the identity permitted offline.

INDIA

In Indian practice, identity may be negotiated within strong family interdependence, educational competition, linguistic and religious communities, caste and class location, migration, gendered expectations and collective decisions about work or relationships. Do not equate autonomy with Western-style separation or assume that family commitment means foreclosure. Ask what the commitment means to this adolescent, whether alternatives were thinkable, how much choice was available and what consequences followed dissent. Assess the young person privately as well as in the family context, while explaining confidentiality and its safety limits.

17.6 Gender identity and psychosexual development

Gender identity, gender expression and sexual orientation answer different questions.

Gender identity
is the person's internal sense of gender.

Gender expression
is how gender is communicated through appearance, behaviour, name or social role.

Sexual orientation
concerns patterns of romantic or sexual attraction.

None can be inferred reliably from the others, from Tanner stage, from play or clothing, or from a single sexual experience. Exploration or nonconformity is not in itself a disorder.

Psychosexual development during adolescence includes integration of the sexually maturing body, desire, fantasy, attraction, values, consent, boundaries, behaviour, intimacy and relationship expectations. Pubertal capacity does not equal emotional readiness, informed decision-making or

consent. History-taking should separate attraction, identity, behaviour and distress because they may not align, particularly where stigma or safety concerns limit disclosure. Ask neutrally about relationships, coercion, online contact, contraception and infection protection where clinically relevant, without assuming heterosexuality or sexual activity.

In Freud's historical stage scheme, the genital stage is placed in adolescence. This remains examinable as theory but is not a contemporary developmental norm and does not provide a clinical threshold. Current assessment focuses on the adolescent's lived development, bodily experience, relationships, safety and functioning. Distress associated with gender incongruence must be distinguished from distress produced by rejection, bullying, family conflict or discrimination. A respectful interview uses the adolescent's stated name and pronouns, establishes what can safely be shared with caregivers, and assesses mood, self-harm risk and support without treating identity diversity as pathology.

17.7 Clinical assessment: normal exploration, developmental vulnerability and disorder

The assessment unit is the adolescent in a developmental system. Interview the adolescent privately for at least part of the assessment, interview caregivers, and obtain school or other collateral information when indicated. Explain confidentiality at the outset and state the circumstances in which safety requires disclosure. Establish pubertal trajectory and body experience, sleep, nutrition, cognition and school function, family relationships, peers, romantic and sexual development, gender experience, online life, substances, risk-taking, values, future plans and identity commitments.

For any concerning behaviour, reconstruct the sequence: developmental baseline, onset, triggers, context, frequency, persistence, degree of control, consequences and recovery. Ask whether it occurs mainly in hot peer contexts or also in calm solitary settings; whether it is exploratory, compulsive, coerced, intoxication-related or driven by elevated mood, depression, anxiety, trauma or neurodevelopmental difficulty; and whether it produces sustained impairment. Episodicity, loss of previously stable functioning, pervasive impairment, dangerous consequences, marked distress or a pattern grossly discordant with context weighs against a purely normative explanation.

Pubertal assessment requires the same construct discipline. Record Tanner morphology and source-stated expected ranges, but do not diagnose from an endpoint that was not validated as a clinical cut-off. When timing, sequence or physical findings raise concern, undertake appropriate paediatric or endocrine evaluation rather than converting an expected range into a referral rule. Identity assessment likewise avoids premature closure: uncertainty may be normal exploration, a stable commitment may be healthy or coerced, and apparent confusion may reflect unsafe disclosure conditions rather than lack of identity.

17.8 Examination synthesis and retrieval spine

A complete long answer moves from maturation to meaning. Define adolescence as a broad biological, psychological and social transition. Describe puberty and Tanner staging, making clear that stages are morphological and components are scored separately. Explain dual systems and

maturational imbalance as context-sensitive accounts of risk-taking. Add cognitive and moral development, then make identity formation the centre of the answer through Erikson's identity versus role confusion and Marcia's exploration-commitment statuses. Finish with family, peers, culture, gender, psychosexual development and clinical differentiation from disorder.

MNEMONIC

"body, brain, bond, belief and becoming"

Body recalls puberty and Tanner morphology. Brain recalls control, reward and hot-context decisions. Bond recalls family, peers and intimacy. Belief recalls abstract thought, values and moral reasoning. Becoming recalls identity exploration, commitment, gender and future roles.

Final clinical synthesis. Normal adolescent development is organised variability, not uniform instability. The safe psychiatric formulation links bodily maturation, neurodevelopment, relationships and culture to the adolescent's pattern of exploration and commitment. It respects diversity, preserves confidentiality, identifies coercion and impairment, and avoids turning either an expected age range or an identity difference into a diagnosis.

18 . Puberty, neurodevelopment of adolescence and risk-taking behaviour

Adolescence is a developmental transition, not merely an age band. Three processes run together but are not interchangeable: **puberty**, the biological maturation of the reproductive system and secondary sexual characteristics; **adolescent neurodevelopment**, the continuing reorganisation of brain structure, connectivity and function; and psychosocial development, in which the young person negotiates autonomy, identity, sexuality, peer belonging and adult roles. Their partial mismatch explains much of normal adolescent behaviour. Reward, emotion and social evaluation can acquire unusual motivational force while cognitive control is still becoming more consistent across situations. The result is not global irrationality. It is a context-sensitive period in which judgement may be good in calm conditions and less reliable under arousal, peer observation, immediate reward or threat.

How to use this page. Keep five distinctions clean. Puberty is not the whole of adolescence. Gonadarche is not adrenarche. Tanner stage describes physical maturation and does not assign a chronological age. Capacity for abstract reasoning does not guarantee self-regulation under emotional load. Finally, risk-taking is neither inevitable nor uniformly pathological: some exploration is developmentally useful, but its probability and consequences depend on the person, the peer group, the family, the opportunity and the behaviour involved.

MNEMONIC

"Body, brain, context"

Puberty is the biological maturation of the reproductive system and secondary sexual characteristics; adolescent neurodevelopment is the continuing reorganisation of brain structure, connectivity and function; and psychosocial development is the negotiation of autonomy, identity, sexuality, peer belonging and adult roles. Their partial mismatch explains much of normal adolescent behaviour.

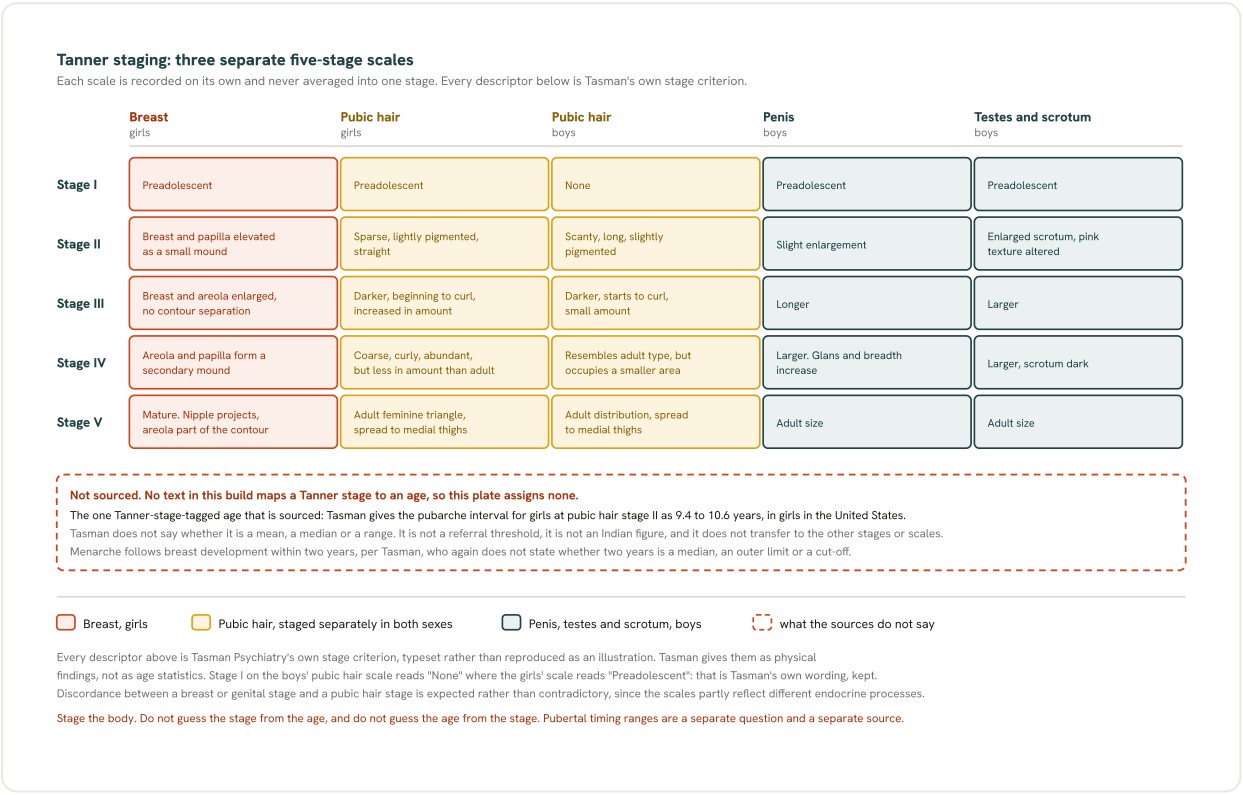


Fig 20.17 Tanner staging as three separate five-stage scales, after Tasman Psychiatry. The descriptors are typeset from Tasman's own stage criteria rather than reproduced as an illustration. No age is attached to any stage, because no source in this build maps one; the single Tanner-stage-tagged age that is sourced is named in the band below the grid, with the source's silence about what kind of number it is.

18.1 Puberty: endocrine activation and physical maturation

Puberty is driven by coordinated endocrine change, with gonadal and adrenal maturation proceeding through related but distinct pathways. Reactivation of the hypothalamic-pituitary-gonadal axis produces pulsatile gonadotropin-releasing hormone secretion, pituitary luteinising hormone and follicle-stimulating hormone release, and increasing gonadal steroid production. This **gonadarche** produces maturation of the testes or ovaries, the growth spurt and the development of secondary sexual characteristics. **Adrenarche** is the increase in adrenal androgen production; it contributes particularly to pubic and axillary hair, body odour and skin changes, but it is not evidence by itself that the gonadal axis has matured. Lewis describes adrenarche as beginning at **6 to 8 years**; because that source does not define the value as a normal limit or a referral threshold, it must not be used as either.

The observable sequence matters more than a single calendar age. In girls, breast development, pubic hair, acceleration in linear growth and menarche are related markers but need not advance in exact synchrony. In boys, enlargement of the scrotal-genital complex, pubic hair, penile growth, change in body composition, the growth spurt and spermarche similarly form a sequence rather than one event. Sex steroids also act on bone, muscle, adipose distribution, skin, sleep, sexual motivation and the brain. These biological effects interact with the meaning assigned to bodily change by the adolescent, family and peer culture. Thus an identical physical event can be experienced as welcome maturation, embarrassment, loss of control, gender incongruence or social advantage.

RULE **Stage the body; do not guess the stage from age.** Tanner stage is a physical examination description. Chronological age, menarche, height and the adolescent's own report may support the history, but none substitutes for the relevant stage criteria.

18.2 Tanner staging: what the five stages actually describe

Tanner staging uses separate five-stage scales for breast development, male genital development and pubic hair. Stage I is preadolescent. In girls, breast stage II is elevation of the breast and papilla as a small mound; stage III adds enlargement of the breast and areola without separation of their contours; stage IV produces a secondary mound of areola and papilla; and stage V is the mature contour, with a projecting nipple and the areola returning to the general breast contour. In boys, genital stage II is marked by scrotal enlargement with altered pink texture; stage III is characterised particularly by penile lengthening; stage IV adds increasing breadth and glans development with darker scrotal skin; and stage V is adult size. These are morphological descriptions, not age labels.

Pubic hair is staged separately in both sexes. Stage I has no pubic hair. Stage II is sparse and lightly or slightly pigmented hair, initially relatively straight. Stage III hair is darker, begins to curl and increases in amount. Stage IV is coarse, curly and adult-like but occupies a smaller area. Stage V has adult distribution, extending to the medial thighs; in girls it forms the adult feminine triangle. Discordance between genital or breast stage and pubic-hair stage is therefore not a contradiction: the scales partly reflect different endocrine processes. The examiner records each component separately rather than averaging them into a synthetic stage.

Use the Tanner reference plate for the visual sequence. Do not attach ages to its rows. Tasman states that menarche occurs within **2 years** after breast development, but the source does not identify that interval as a median, outer limit or referral cut-off; it should be repeated only as Tasman's descriptive statement. Menarche also does not mean that all physical maturation is complete.

Tanner stage is a clinical descriptor, not a judgement of psychological maturity, consent capacity, sexual experience or gender identity. Examination requires explanation, assent or consent as applicable, privacy, respectful exposure limited to what is necessary, and a chaperone according to clinical policy and the adolescent's needs. Self-assessment may support history-taking when

examination is not appropriate, but it is less reliable than a properly conducted clinical examination.

18.3 Pubertal timing: expected ranges, sequence and tempo

Normal timing is broad, and a range is not a diagnosis. Berk's *Child Development*, 8th edition, reports expected ranges for major pubertal events. These values describe windows in the cited population and must not be converted into medians, guarantees or stand-alone referral thresholds.

8 to 13 years
GIRLS: BREAST BUDDING AND ONSET OF THE HEIGHT SPURT

10.5 to 14 years
GIRLS: MENARCHE

9 to 13.5 years
BOYS: TESTICULAR ENLARGEMENT

12 to 16 years
BOYS: SPERMARCHE

SEX	PUBERTAL EVENT	EXPECTED RANGE
Girls	Breast budding and onset of the height spurt	8 to 13 years
Girls	Peak height spurt	10 to 13.5 years
Girls	Appearance of pubic hair	8 to 14 years
Girls	Breast-growth completion	10 to 17 years
Girls	Menarche	10.5 to 14 years
Boys	Testicular enlargement	9 to 13.5 years
Boys	Penile enlargement	10.5 to 14.5 years
Boys	Onset of the height spurt	10.5 to 16 years
Boys	Peak height spurt	12.5 to 15.5 years
Boys	Appearance of pubic hair	10 to 15 years
Boys	Spermarche	12 to 16 years
Boys	Completion of penile and testicular growth	12.5 to 16 years

Interpretation requires **timing**, **sequence** and **tempo**. Timing asks when change begins relative to the reference population; sequence asks whether expected components are appearing in a coherent order; tempo asks how the changes progress over time. A young person at one edge of a wide expected range may still be developing normally. Conversely, an unusual sequence, arrest or very rapid progression can warrant assessment even when one observed event happens within an expected range. Evaluation should integrate growth trajectory, nutrition and chronic illness, medication and substance exposure, neurological and endocrine symptoms, family pattern, psychosocial distress and examination findings. The ranges above are reference information, not permission to dismiss a concerning trajectory.

INDIA

No Indian population-specific pubertal timing ranges were available in the supplied sources. Do not silently relabel the ranges from Berk as Indian norms. In an Indian examination answer, state the source and population limitation, use the physical sequence and longitudinal growth record, and seek locally validated paediatric or endocrine guidance for clinical thresholds.

18.4 The adolescent brain: remodelling, connectivity and context

Adolescent neurodevelopment is network reorganisation, not simple growth of an unfinished brain. Experience-dependent synaptic stabilisation and pruning make frequently used circuits more efficient while reducing redundant connections. Progressive myelination improves the speed and reliability of long-range communication. White-matter organisation, cortical specialisation and integration among prefrontal, striatal, limbic and temporoparietal regions support gains in working memory, planning, response inhibition, error monitoring, future simulation, social cognition and emotion regulation. These processes do not mature in lockstep, and performance varies with task demands and emotional state.

The prefrontal cortex contributes to planning, rule maintenance, inhibition and valuation of future consequences. The ventral striatum and related dopaminergic circuits participate in reward anticipation, reinforcement learning, novelty and action selection. The amygdala and broader limbic circuitry help assign emotional salience, while medial prefrontal and temporoparietal systems contribute to self-referential and social inference. Development changes the balance and connectivity among these systems. Pubertal hormones can influence motivational and affective processing, but puberty and neural maturation are neither identical processes nor reducible to one hormone level.

A crucial distinction is between **cold cognition** and **hot cognition**. Cold cognition is reasoning under low arousal, with time to deliberate and little immediate social pressure. Hot cognition occurs when reward, threat, sexual interest, shame, anger or peers are salient. An adolescent may explain consequences accurately in the clinic and still choose differently in the heat of the real situation. The discrepancy does not prove deceit or incapacity. It shows that knowledge of risk and regulation of behaviour are separable functions.

TRAP **Do not teach adolescence as a defective-adult brain with a single completion age.** The examinable account is uneven, experience-sensitive network maturation. Adolescents can reason competently, especially in calm settings; vulnerability rises when immediate reward, emotion and peer evaluation load the system.

18.5 Dual-systems and maturational-imbalance models

The dual-systems family of models explains risk as a temporary imbalance between motivational drive and regulatory control. One system is often described as socioemotional or incentive-processing, involving reward-sensitive striatal and limbic circuits that become highly responsive to novelty, immediate gain and social evaluation. The other is a cognitive-control system, relying substantially on prefrontal and frontoparietal networks that support inhibition, planning and resistance to distraction. When incentive salience is high and control is not

consistently recruited, behaviour can shift toward immediate reward despite an intact verbal understanding of later costs.

The **maturational-imbalance model** makes the same broad point while emphasising developmental differences in the timing and coordination of subcortical affective systems and cortical control systems. Peer presence matters because it can increase the subjective value of reward and social approval rather than merely "pressure" the adolescent through explicit persuasion. A choice that looks reckless to an adult may therefore be locally rational within the adolescent's current valuation: the social reward is immediate, visible and identity-relevant, while the harm is delayed and probabilistic.

These models are useful, but they are not complete theories of every adolescent. They do not imply that all adolescents take more risks, that the brain mechanically causes misconduct, or that control always loses to reward. Risk depends on trait impulsivity and sensation seeking, prior adversity, mood and substance use, sleep and arousal, family monitoring, peer norms, opportunity, expected benefit and the severity and reversibility of possible harm. Nor do the models erase agency. They identify situations in which scaffolding, delay, environmental design and supportive adults can make self-control easier to deploy.

> **Must remember:** adolescent risk-taking is best understood as *context-sensitive motivational imbalance*, not absence of knowledge, absence of control or inevitable recklessness.

18.6 Gender identity and psychosexual development

Sex characteristics, gender identity, gender expression and sexual orientation are distinct constructs.

- Sex characteristics include chromosomal, gonadal, hormonal and anatomical features.
- Gender identity is the person's internal sense of gender.
- Gender expression is how gender is communicated through appearance, behaviour and social role.
- Sexual orientation concerns patterns of romantic or sexual attraction.

None can be inferred reliably from the others, and gender-nonconforming expression is not by itself psychopathology.

Puberty can make these domains more salient because the body changes visibly, sexual interest may intensify, peers classify one another more sharply and future relational roles become imaginable. For some adolescents, bodily change is congruent with identity; for others it produces or intensifies distress. The psychiatrist's task is not to force an identity conclusion. It is to clarify the adolescent's own experience over time, the degree of distress and impairment, body-related discomfort, family and peer response, bullying or violence, mood and self-harm risk, and the presence of coexisting neurodevelopmental or psychiatric needs without treating those needs as explanations that invalidate gender experience.

Psychosexual development includes integration of the sexually maturing body, attraction, fantasy, intimacy, values, consent, boundaries and responsibility. Freud's genital stage is historically examinable and is placed in adolescence, but it is not an adequate contemporary account of sexuality. A clinical formulation should instead be developmental, non-judgemental and safeguarding-aware. Ask in private, use the adolescent's terms, distinguish consensual exploration from coercion or exploitation, assess digital as well as in-person contexts, and explain confidentiality and its safety limits before eliciting sensitive information.

18.7 Risk-taking: adaptive exploration, hazardous exposure and individual difference

Risk-taking is any choice made under uncertainty in which an outcome of value is accompanied by a meaningful possibility of harm. It is broader than impulsivity. Impulsivity is poorly controlled action with insufficient forethought; sensation seeking is preference for novel, intense experience; risk-taking may be planned or spontaneous and may involve social, physical, sexual, financial, academic or legal consequences. Substance use, dangerous driving, unsafe sexual behaviour, aggression, self-harm challenges and online exposure are clinically important examples, but so are positive risks such as trying a difficult skill, leaving a familiar peer group or speaking publicly. Development requires exploration; prevention should reduce catastrophic and irreversible harm without attempting to abolish autonomy.

Risk rises when several layers converge. At the individual level consider reward sensitivity, impulsivity, attention and executive function, mood elevation or depression, trauma responses, substance intoxication, sleep loss and beliefs about invulnerability. At the interpersonal level consider peer norms, desire for status, romantic context, family conflict, supervision and modelling. At the environmental level consider access, anonymity, commercial persuasion, unsafe roads, weapons or substances, and online algorithms that amplify novelty and social comparison. Protective factors include a warm relationship with at least one dependable adult, clear and proportionate limits, prosocial peers, school connection, meaningful roles, future goals, emotion-regulation skills and practical barriers to the most dangerous opportunities.

The intervention follows the mechanism. Information alone is weak when the adolescent already knows the hazard. Use collaborative motivational interviewing, identify the reward the behaviour provides, rehearse implementation intentions, reduce access to lethal or irreversible means, create an exit plan for peer situations, move decisions out of high-arousal contexts and enlist supportive adults with the adolescent's participation whenever safety permits. Harm reduction and autonomy-supportive boundaries are often more developmentally effective than shame, surveillance without relationship or an abstract lecture about consequences.

18.8 Clinical assessment and the examination answer

Assess the adolescent confidentially, developmentally and systemically. Begin with the adolescent and caregiver together, then interview the adolescent alone for part of the consultation. Explain confidentiality and its limits in plain language before asking about risk. A HEEADSSS-style review keeps the field broad: home; education or employment; eating; activities and peers; drugs; sexuality; suicide, self-harm and mood; and safety. Add sleep, online

behaviour, bullying, violence, legal exposure, strengths and future goals. Obtain collateral information where necessary, but preserve a private space so disclosure is possible.

The formulation should connect the behaviour to development rather than merely name it. Describe pubertal status and trajectory, cognitive and neurodevelopmental strengths or vulnerabilities, identity tasks, emotional state, the immediate reward, peer and family context, access to means, previous consequences, protective factors and readiness to change. Separate experimentation from a persistent syndrome, and separate chronological age from decision-specific capacity. Capacity is functional: the young person must understand, retain, use or weigh relevant information and communicate a choice in the actual context being assessed.

For a long-answer question, use a disciplined sequence: define adolescence and puberty; describe gonadarche, adrenarche and Tanner staging; state the sourced timing ranges with their population limitation; explain pruning, myelination and changing frontostriatal-limbic connectivity; compare dual-systems and maturational-imbalance accounts; integrate identity, gender and psychosexual development; then finish with determinants, protective factors and clinical management of risk-taking. The highest-scoring conclusion is balanced: adolescence brings increased opportunity for hazardous behaviour, but also exceptional learning, flexibility, social sensitivity and capacity for growth. Developmental vulnerability is real without being destiny.

19 . Gender identity and psychosexual development in childhood

Gender identity and psychosexual development emerge through the continuing interaction of bodily maturation, cognition, attachment, learning, family relationships, peers and culture. They are not single milestones reached on a fixed birthday. The child gradually makes sense of bodily sex characteristics and social categories, develops an internal sense of gender, learns how gender is expressed and regulated in the surrounding culture, acquires privacy and interpersonal boundaries, and later integrates puberty, attraction, values, intimacy and consent into a more coherent identity. Variation is expected. The clinical task is to distinguish diversity and exploration from distress, impairment, coercion, trauma and disorder without making any one form of play, dress, friendship or attraction carry more meaning than it can support.

How to use this page. Begin by separating the constructs that examination questions often collapse. Then describe the major explanatory models, give Freud as a historical stage theory, outline expected sexual learning and boundary acquisition, and connect puberty and Tanner staging to adolescent identity. Finish with adolescent neurodevelopment, risk-taking and a developmentally informed clinical assessment. Throughout, hold **two** disciplines: Tanner stage is morphological rather than chronological, and gender expression or sexual behaviour cannot by itself establish gender identity, sexual orientation, abuse or psychopathology.

The must-memorise line: Separate body, identity, expression, attraction and behaviour, then interpret each against developmental context, consent, distress, impairment and safety.

19.1 The conceptual map: related domains that must not be collapsed

A high-scoring answer defines the constructs before explaining their development.

TERM	MEANING
Sex characteristics	include chromosomal, gonadal, hormonal and anatomical features; sex assignment at birth is a social and clinical classification usually made from observed anatomy.
Gender identity	is the person's internal sense of gender.
Gender expression	is the outward communication of gender through appearance, behaviour, name, language and social role.
gender role	is the culturally organised set of expectations attached to gender categories.

These domains interact, but none is a simple read-out of another.

Sexual orientation concerns patterns of romantic or sexual attraction. **Sexual behaviour** describes what a person does, while **sexual identity** is the label or self-understanding a person adopts. Attraction, behaviour and identity may not align, especially during development or where disclosure is unsafe. **Psychosexual development** is broader than genital maturation: it includes bodily awareness, pleasure, attachment, fantasy, attraction, gender, privacy, boundaries, consent, intimacy, values and the meaning assigned to relationships.

RULE **Ask five separate questions: body, identity, expression, attraction and behaviour.** Do not infer one from another. Tanner morphology does not determine psychological maturity; gender expression does not establish orientation; and a single behaviour does not establish a stable identity.

5
SEPARATE QUESTIONS

19.2 Development is transactional: biology, relationships and culture continually modify one another

No single-cause theory adequately explains gender identity or psychosexual development. Biological organisation supplies a sexed body and contributes hormonal and neurodevelopmental influences. The child experiences that body through touch, caregiving, language and other people's responses. Cognitive development permits classification, perspective-taking and an increasingly stable autobiographical self. Social learning supplies models, reinforcement and sanctions. Family, peers, school, religion, media and wider culture specify which expressions are encouraged, tolerated or punished. The child is active within this system, attending selectively, interpreting feedback and shaping the responses received from others.

A transactional model therefore replaces the false choice between nature and nurture. Bodily characteristics affect how others classify and treat a child; those responses influence opportunities and self-description; the child's preferences evoke further responses; and puberty

later changes both the body and its social meaning. Temperament, cognitive capacity, neurodevelopmental differences, family flexibility, peer acceptance and exposure to stigma alter the pathway. The same observable expression can consequently have different meanings in different children and settings.

Development also occurs within a hierarchy of contexts. Caregiver language and discipline operate at the immediate level; school rules and peer cultures organise daily belonging; media and institutions circulate ideals of masculinity, femininity and attractiveness; and legal, religious and economic conditions influence safety and disclosure. Culture is not an ornamental final paragraph. It helps determine which possibilities can be imagined, named and enacted.

19.3 Cognitive-developmental, social-learning and gender-schema accounts

The major theories differ in what they treat as the engine of development. In the cognitive-developmental account, the child actively constructs gender categories. The conceptual sequence is gender labelling, recognition that gender is stable across time, and gender constancy despite superficial changes in clothing, activity or appearance. Once the child regards a category as self-relevant, behaviour is organised toward consistency with it. This account explains active self-socialisation but may understate biological influence, early learning and the flexibility of real gender experience.

Social-learning theory emphasises observation, imitation, reinforcement and punishment. Children see which behaviours are rewarded in caregivers, siblings, peers and media figures; direct praise or ridicule then increases or suppresses expression. Social-cognitive theory adds expectations, self-efficacy and reciprocal influence, so the child is not merely a passive recipient of conditioning. These models explain how local gender conventions are acquired and why expression can change across settings, but learning a convention does not prove that the convention determines the child's internal identity.

Gender-schema theory links cognition and culture. Repeated cultural distinctions form organised schemas that guide attention, memory, interpretation and behaviour. Information marked as relevant to the self is noticed and remembered more readily, while schema-inconsistent examples may be overlooked or distorted. Schemas are efficient but revisable. Exposure to broader roles, flexible caregivers and counter-stereotypic models can enlarge the child's map of what is possible without dictating identity.

19.4 Freud's psychosexual theory: historically examinable, not a contemporary milestone schedule

Freud remains important for the history of developmental psychiatry and for examination essays, particularly his emphasis on early experience, conflict and unconscious meaning. His account is not a modern developmental surveillance tool. It gives neither a valid way to infer gender identity nor a clinical rule for deciding whether childhood sexual behaviour is expected. Contemporary formulation places the theory beside cognitive, learning, attachment, biological and sociocultural accounts rather than allowing it to stand as the sole explanation.

19.5 Sexual development in childhood: curiosity, privacy, boundaries and relationship learning

Childhood sexual development is broader than overt sexual behaviour. It includes learning the names and functions of body parts, recognising bodily differences, experiencing comfort and pleasure, asking questions, developing modesty, understanding private and public conduct, rehearsing family and relationship roles in play, and learning that bodies belong to their owners. Self-touch, curiosity and exploratory play can occur in development, but their meaning depends on context rather than on the behaviour label alone.

Assess behaviour along several dimensions: spontaneity, frequency, flexibility, mutuality, developmental similarity of the children involved, power difference, secrecy, coercion, emotional tone, explicitness, intrusiveness, response to calm redirection and effect on functioning. Developmentally understandable exploration is generally flexible, non-coercive and not organised around fear or a marked power imbalance. Concern rises with force, threats, injury, persistent distress, compulsive repetition, a substantial asymmetry in power or developmental capacity, explicit imitation beyond the child's likely experience, or behaviour that remains intrusive despite appropriate limits. No single sign proves abuse, but a concerning pattern requires careful safeguarding assessment.

Adults teach psychosexual safety through accurate language, matter-of-fact answers, respect for privacy, permission to refuse unwanted touch, distinction between safe privacy and unsafe secrecy, and consistent boundaries that do not shame the body. Excessive alarm can attach fear and guilt to ordinary curiosity; dismissiveness can leave the child without language for disclosure. The developmental aim is neither sexualisation nor silence, but embodied autonomy, appropriate privacy and the capacity to seek help.

19.6 Puberty and Tanner staging: physical maturation changes the developmental task

Secondary sexual characteristics make gender experience more immediate. See the Puberty topic.

19.7 Adolescence: identity formation, neurodevelopment and context-sensitive risk-taking

Normal adolescent development is asynchronous across body, brain and social role. Pubertal maturation increases the salience of body image, attraction, peer evaluation and belonging, while autonomy, intimacy, values and future roles are being renegotiated. In Erikson's account, the central conflict is identity versus role confusion. Identity integrates continuity across time with commitments in education, work, values, relationships, gender and sexuality. Ordinary uncertainty and exploration are not equivalent to role confusion.

19.8 Gender diversity, distress and contemporary classification

Variation in gender identity or expression is not itself evidence of mental disorder. A child may prefer activities, clothing, roles or companions that do not fit local stereotypes without experiencing incongruence or distress. Conversely, a child may experience a persistent difference between assigned sex and experienced gender even when expression is constrained. The clinician should explore the child's own account, consistency across contexts, bodily experience, family response, peer safety and functional impact without interrogating the child toward a predetermined conclusion.

WHO's ICD-11 places **gender incongruence** under conditions related to sexual health rather than mental and behavioural disorders, reflecting that transgender and gender-diverse identities are not conditions of mental ill-health. WHO also states that gender-variant behaviour and preferences alone are not a basis for assigning the diagnosis. The examinable distinction is therefore between identity diversity, incongruence and the presence of distress or clinical need. Distress may arise from bodily incongruence, but it may also arise from bullying, rejection, violence, shame or forced concealment; formulation must identify the source rather than attributing every symptom to identity.

TRAP **Do not diagnose from gender nonconformity.** Toys, clothing, mannerisms, friendships, fantasy play or one sexual experience do not by themselves establish gender identity, sexual orientation, abuse or disorder. The same rule prevents both pathologising diversity and missing genuine distress.

A developmentally competent interview uses the child's stated language where possible, avoids assumptions about heterosexuality or binary identity, and separates the young person's wishes from caregiver fears. Support does not mean forcing an identity label or predicting an adult outcome. It means maintaining safety, permitting honest exploration, reducing shame, treating co-occurring symptoms on their own merits and preserving access to appropriate specialist assessment when needed.

19.9 Clinical assessment, safeguarding and the Indian context

The assessment unit is the child within a developmental and relational system. Interview caregivers and the child, including time with the child separately when developmentally appropriate. Explain confidentiality and its safety limits. Establish the child's language for body and gender, pubertal status, body comfort, play and interests, attraction and relationships where relevant, family beliefs, peer response, school functioning, online exposure, privacy practices and sources of support. Ask what changed, when it changed, in which settings, what preceded it, how persistent and flexible it is, what meaning the child gives it, and whether distress belongs to the child, the family or both.

For sexual behaviour, reconstruct the event without repeated suggestive questioning. Assess the developmental capacities and power relationship of everyone involved, mutuality, coercion, threats, secrecy, explicitness, injury, emotional response, access to sexual material and the child's subsequent behaviour. Safeguarding concern requires a calm, child-centred response, careful documentation in the child's own words, attention to immediate safety and use of the appropriate multidisciplinary and statutory pathway. A behavioural sign neither proves nor excludes abuse.

INDIA

Gender and psychosexual development may be negotiated within joint or extended families, strong educational expectations, religious and linguistic communities, gendered household roles and unequal permission for autonomy. Ask who actually provides care, who controls disclosure and what consequences the child anticipates. Interviewing only the accompanying adult can erase the child's account; interviewing only the child can miss dependence and safety constraints. Use clear language in the family's preferred language, separate cultural meaning from coercion, and do not use "Indian culture" either to pathologise family interdependence or to excuse humiliation, violence or forced conformity. No Indian population-specific age sequence for gender labelling or identity consolidation is supplied, so none should be inferred.

Formulation should distinguish predisposing factors, current developmental tasks, precipitating events, maintaining responses and protective relationships. Screen for mood and anxiety symptoms, self-harm, trauma, bullying, family violence, neurodevelopmental differences, substance use and online exploitation when indicated. A sudden or episodic change, regression, pervasive impairment, marked distress, coercion, dangerous exposure or loss of previously stable functioning weighs against a purely normative explanation. Treatment targets the actual source of difficulty rather than trying to make identity or expression conform to a stereotype.

19.10 Examination synthesis: move from definitions to development, then to clinical discrimination

A complete long answer has a clear spine.

- Define sex characteristics, gender identity, gender expression, gender role, sexual orientation and psychosexual development.
- Explain transactional development through biological, cognitive, learning, family and cultural influences.
- Contrast cognitive-developmental, social-learning and gender-schema theories.
- Present Freud as a historical stage account with source-stated mappings, not as a milestone schedule. Describe childhood curiosity, privacy and boundary learning, then connect puberty and Tanner morphology to adolescent identity formation, dual systems, maturational imbalance and risk-taking. Finish by distinguishing diversity and exploration from distress, impairment, coercion, trauma and disorder.

MNEMONIC

"Body, self, signal, attraction, behaviour and safety"

Retrieval spine: *body, self, signal, attraction, behaviour and safety*. Body recalls sex characteristics, puberty and Tanner staging. Self recalls gender identity and identity formation. Signal recalls expression and gender roles. Attraction recalls orientation. Behaviour recalls what is enacted rather than assumed. Safety recalls consent, power, distress, impairment and safeguarding.

Final clinical synthesis. Gender identity and psychosexual development are developmental processes, not conclusions drawn from a single behaviour. Good psychiatry keeps constructs separate, respects bodily and identity diversity, reads puberty through morphology and source-stated ranges, and places every concern within relationships, culture, consent, distress, functioning and safety.

Development in context and clinical use

20 . Developmental red flags and warning signs

A developmental red flag is not simply a child who is slower than a remembered textbook average. It is a finding that raises the probability of a developmental disorder sufficiently to require prompt evaluation, or a pattern so biologically atypical that ordinary variation is an unsafe explanation. The examiner expects the resident to distinguish *variation* from *delay*, and delay from *deviance*, *dissociation*, *plateau* and *regression*. The central clinical question is therefore not, "Has the child crossed one age line?" but, "What is the trajectory, which domains are affected, and is the pattern compatible with normal variation?"

How to use this page. First learn the few findings that demand further evaluation, especially loss of acquired skills and the language-social warning signs. Then learn to recognise abnormal trajectories across gross motor, fine motor, language, social-adaptive and cognitive domains. Finally, separate **surveillance**, which is longitudinal and continuous, from **screening**, which applies a standardised tool, and from **diagnostic assessment**, which determines the developmental profile and cause. The milestone and primitive-reflex plates are memory maps; this page owns the clinical act of spotting deviation and deciding what happens next.

Loss of previously acquired language or social skills at any age is a red flag and requires prompt developmental evaluation.

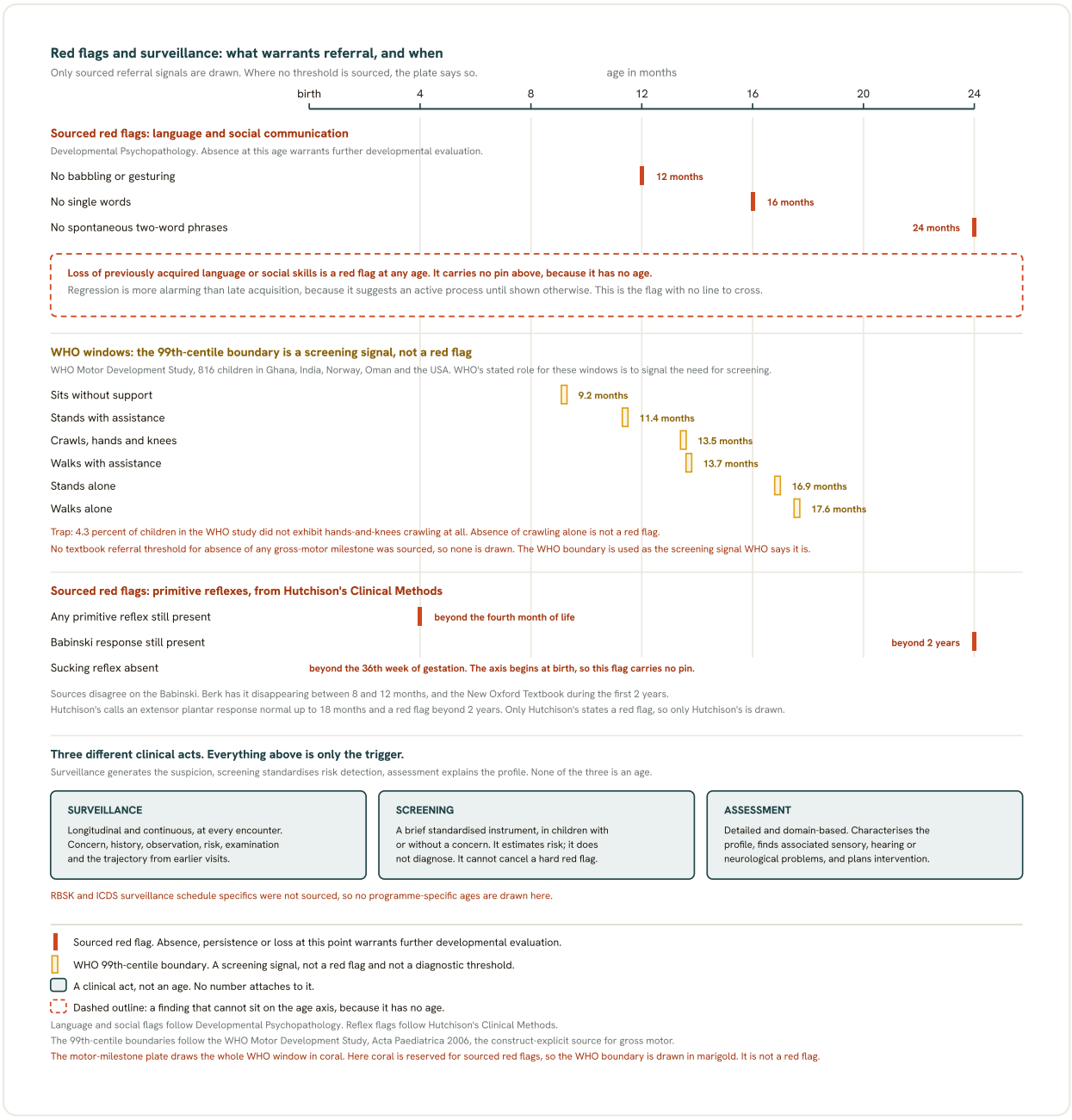


Fig 20.18 Red flags and surveillance, drawn so that only sourced referral signals appear. Coral pins are the language and social red flags from Developmental Psychopathology and the primitive-reflex red flags from Hutchison's Clinical Methods. Marigold markers are the 99th-centile boundaries of the WHO Motor Development Study windows, which WHO itself states are a signal to screen rather than a diagnostic threshold. No textbook referral threshold for absence of a gross-motor milestone was sourced, so none is drawn, and no surveillance schedule appears because RBSK and ICDS specifics were not sourced.

Developmental screening and assessment instruments: what is sourced, and what is not

One row carries real psychometrics. Three are almost empty. The empty cells are the finding, not an oversight: each property was searched for and no source states it.

Instrument	Age range	Items	Output and cut-off	Accuracy	Reliability
Trivandrum Development Screening Chart TDSC. A screening tool. Child Development Centre, Kerala.	Birth to 6 years	51	One item delay is a positive screen, called TDSC delay.	Sensitivity 84.62 percent Specificity 90.8 percent Negative predictive value 99.23 percent Negative likelihood ratio 0.17	Test-retest, intraclass correlation 0.77 Inter-rater, intraclass correlation 0.97
Developmental Assessment Scales for Indian Infants DASII. An assessment measure, not a screening test.	not sourced	not sourced	Two developmental quotients, Motor DQ and Mental DQ. A DQ below 85 is used as a delay marker.	not sourced	not sourced
Denver Developmental Screening Test II DDST-II. A screening test.	Birth to 72 months	not sourced	not sourced	not sourced	not sourced
Baroda Development Screening Test BDST. Introduced in 1991. India's first screening tool.	not sourced	not sourced	not sourced	not sourced	not sourced

The accuracy and reliability figures come from the chart's validation against the Denver Developmental Screening Test. The age range in the Denver row is sourced for the DDST-II.
No source states whether the version used as that reference standard and the DDST-II are the same. They are shown as two separate sourced facts rather than joined into one.

Named rather than hidden: what was searched for and is not sourced

DASII manual specifics. Administration age range, item count, norming sample, centiles, every cut-off other than the delay marker below 85, and all reliability and validity values.
TDSC item lines. The individual milestone items and their ages are not sourced. The psychometrics are; the contents are not, so the chart is described here and never reproduced.
The Denver test beyond its age range, and the Baroda test beyond its year and its primacy. Neither has a sourced item count, cut-off or accuracy figure.

not sourced. The property was searched for and no source states it. Nothing is supplied from memory to fill the cell.

Every other cell carries a value that appears in one of the sources named below. No instrument form is reproduced on this plate.

TDSC properties follow Nair and colleagues, Development and validation of the Trivandrum Development Screening Chart for children aged 0 to 6 years, Indian Journal of Pediatrics 2013.
The two DASII quotients follow Kadam and colleagues. The delay marker below 85 follows Shukla and colleagues. The Baroda test's year and primacy follow Shekhawat and colleagues.
The Denver age range follows Lewis, Child and Adolescent Psychiatry.

Screening estimates risk and does not diagnose. A negative screen does not overrule regression, an abnormal examination or persistent caregiver concern.

Fig 20.19 The developmental screening and assessment instruments compared by what is sourced. Only the Trivandrum chart carries validated psychometrics, from Nair and colleagues, and its accuracy is against the Denver Developmental Screening Test. The DASII contributes its two quotients and the delay marker below 85; the Denver test contributes only an age range; the Baroda test contributes only its year and its primacy. Dashed cells are properties that were searched for and are not sourced, left empty rather than filled from memory. No instrument form is reproduced.

20.1 Normal variation, delay and abnormal developmental trajectories

Development is a trajectory, not a checklist. A milestone age has meaning only when its construct is known.

MILESTONE CONSTRUCT	MEANING
A median	means that half of children have attained the skill by that age.
An expected range	describes a normal window.
An upper limit	is the outer bound regarded as normal.
A red-flag threshold	is an operational point at which further evaluation is warranted.

Converting an average or median into a referral threshold is a clinical error. Equally, being within an age window does not neutralise abnormal quality, asymmetry, regression or a concerning neurological examination.

Developmental delay is slower acquisition of skills in one or more domains while the usual sequence is broadly preserved. Global developmental delay describes substantial delay across multiple developmental domains in a young child, but the label does not state the cause.

Dissociation is unequal development between domains, such as relatively preserved motor ability with marked language-social delay. Deviance is an unusual sequence or quality of development rather than mere lateness. A plateau is failure to acquire new skills over time. Regression is loss of a skill that was convincingly acquired, and is more alarming than isolated late acquisition because it suggests an active or progressive process until shown otherwise.

RULE **Judge the child by trajectory, pattern and quality, not by one remembered average age.** A red flag can arise from absence, loss, asymmetry, abnormal sequence, abnormal movement quality or a widening gap between domains.

MNEMONIC

"Trajectory, pattern and quality"

Judge the child by trajectory, pattern and quality, not by one remembered average age. A red flag can arise from absence, loss, asymmetry, abnormal sequence, abnormal movement quality or a widening gap between domains.

20.2 Developmental surveillance, screening and assessment are different clinical acts

Developmental surveillance is the repeated, flexible clinical process conducted across encounters. It integrates parental concerns, developmental history, observation of the child, risk factors, physical and neurological examination, and the trajectory recorded at previous visits. Ask what the child can do spontaneously in daily life, not merely whether the child once performed a prompted task. Clarify onset, consistency, context, quality and whether any skill has been lost. Observe communication, play, reciprocity, posture, movement, hand use and problem-solving before directing the child, because spontaneous behaviour often contains the most valid developmental information.

Developmental screening is the use of a brief standardised instrument in children who may or may not already have an identified concern. It estimates risk; it does not diagnose. A negative screen does not overrule convincing regression, abnormal examination or persistent caregiver concern. Developmental assessment is the more detailed, domain-based evaluation used to characterise strengths and impairments, quantify development where appropriate, identify associated sensory or neurological problems, formulate differentials and plan intervention. Surveillance generates suspicion, screening standardises risk detection, and assessment explains the profile.

20.3 Spotting deviation: read the pattern before the individual milestone

Use five questions whenever development appears atypical.

1. Is this *absence* of a skill, *loss* of a skill, or merely inconsistent performance?
2. Is one domain affected or are multiple domains involved?
3. Is the sequence recognisable but slow, or qualitatively unusual?
4. Are there associated neurological signs, abnormal head growth, dysmorphism, feeding difficulty, poor vision or hearing, seizures, altered tone, weakness or asymmetry?

5. What is the functional consequence in communication, play, self-care, mobility, learning and participation?

Patterns narrow the differential. Predominantly motor delay with abnormal tone or reflexes points toward a motor-system disorder; language delay requires separation of hearing impairment, developmental language disorder, broader cognitive delay and autism-related social-communication difficulty; social-communication deviation with restricted or repetitive behaviour raises concern for autism; and global delay requires a broad biological and environmental assessment. In every pattern, check pregnancy and birth history, neonatal illness, seizures, infections, nutrition, medication or toxin exposure, family history, consanguinity, psychosocial deprivation and opportunities for learning. These factors modify interpretation but do not justify watchful waiting when a hard red flag is present.

Asymmetry is a warning sign even when an age threshold has not been crossed. Persistent one-sided hand use in infancy, unequal movement, early fixed hand preference, scissoring, persistent fisting, abnormal posturing or an abnormal gait directs attention to focal or motor-pathway pathology. Likewise, the manner of a skill matters: sitting with marked truncal instability and walking with an abnormal pattern are not made normal by timely onset.

20.4 Language and social-communication red flags: the hard thresholds

The most examinable age-linked warning signs are absence of early communication behaviours and loss of acquired social-communication skills. Developmental Psychopathology identifies the findings in the strip below as warranting further developmental evaluation. These are referral signals, not median attainment ages.

12 months	16 months	24 months	Any age
NO BABBLING OR GESTURING	NO SINGLE WORDS	NO SPONTANEOUS TWO-WORD PHRASES	LOSS OF LANGUAGE OR SOCIAL SKILLS

Interpret these against the quality of communication. Joint attention and pointing are expected around 12 months in most typically developing children according to the New Oxford Textbook of Psychiatry, and symbolic play is expected at 18 months in Dulcan's Textbook of Child and Adolescent Psychiatry. Concern rises when limited eye contact, poor response to name, absent sharing of interest, lack of communicative gesture, poor reciprocity or repetitive behaviour forms a coherent pattern. Do not diagnose autism from a single missed behaviour, but do not dismiss a convergent social-communication pattern because vocabulary appears adequate. The disorder itself, with its criteria and management, is developed in the Intellectual disability and autism spectrum disorder notes; this page owns only the act of noticing the pattern and referring.

Speech clarity must also be interpreted by construct. Kaplan and Sadock describes speech as about **50 percent** intelligible at 24 months, about **75 percent** intelligible to strangers at 36 months, and nearly **100 percent** intelligible to strangers by 4 years. These are expected values, not automatic referral thresholds. A child who is difficult to understand requires assessment of hearing, oral-motor function, speech-sound production, receptive and expressive language, and the effect on participation.

20.5 Gross-motor warning signs: use WHO windows as screening signals

The WHO Motor Development Study provides construct-explicit windows of achievement bounded by the 1st and 99th centiles. It followed children in Ghana, India, Norway, Oman and the USA, so India was part of the source population. Sitting without support occurred from 3.8 to 9.2 months, standing alone from 6.9 to 16.9 months, and walking alone from 8.2 to 17.6 months. A child beyond the upper boundary signals the need for appropriate screening, which is the role WHO itself states for these windows. They are screening signals, not diagnostic cut-offs and not independently sourced referral thresholds.

Gross-motor concern is strengthened by an abnormal neurological examination, loss of motor skills, persistent asymmetry, abnormal tone, weakness, poor antigravity movement, abnormal movement quality, feeding or respiratory difficulty, or delay in other domains. Conversely, an isolated variation in sequence can be benign. The gross-motor plate should be read as a set of windows rather than as a ladder of compulsory achievements.

TRAP **Hands-and-knees crawling is not universal.** In the WHO study, 4.3 percent of children did not exhibit it at all. Absence of crawling alone is therefore not a developmental red flag; judge the overall trajectory, movement quality and neurological findings.

20.6 Primitive reflexes: persistence, asymmetry and re-emergence matter

Primitive reflexes are expected in the newborn period and are progressively integrated as cortical control matures. Their interpretation is not a memory contest about disappearance ages alone. A reflex that is unusually persistent, strongly asymmetric, absent when it should be present, or re-emerges after integration may indicate neurological dysfunction. The primitive-reflex plate provides the expected sequence; the clinical examination must compare the reflex response with tone, posture, spontaneous movement, symmetry and the child's functional motor repertoire.

Hutchison's Clinical Methods treats persistence of primitive reflexes beyond the fourth month of life as a general warning sign, persistence of the Babinski response beyond 2 years as a red flag, and absence of the sucking reflex beyond the 36th week of gestation as a red flag. These sourced warning signs should not be replaced by conflicting remembered averages. A reflex abnormality warrants a neurological and developmental assessment rather than an isolated label.

20.7 Indian screening instruments: TDSC and DASII

The Trivandrum Development Screening Chart (TDSC), developed at the Child Development Centre, Thiruvananthapuram Medical College, is an Indian screening instrument for children from birth to 6 years. The validated chart contains 51 items, and **one item delay** constitutes a positive screen termed "TDSC delay". In its validation against the Denver Developmental Screening Test, sensitivity was 84.62 percent, specificity 90.8 percent, negative predictive value 99.23 percent, test-retest reliability 0.77, and inter-rater reliability 0.97. These properties make it useful for screening, but a positive result is not a diagnosis and a negative result cannot cancel a hard clinical red flag; the underlying theory of sensitivity, specificity, predictive value and reliability belongs to the Psychometry, Assessment and Descriptive Psychopathology notes.

The Developmental Assessment Scales for Indian Infants (DASII) yields separate **Motor DQ** and **Mental DQ**. Indian follow-up studies use a DQ below 85 as a marker of delay. DASII is an assessment measure rather than a substitute for surveillance, and the two quotients help display dissociation between motor and mental development. The Baroda Development Screening Test, introduced in 1991, was India's first developmental screening tool according to Shekhawat and colleagues. Keep the categories clear in an answer: TDSC and the Baroda instrument are screening tools; DASII provides domain-based developmental quotients.

20.8 When to refer and what the first evaluation must contain

Refer promptly when there is regression, a hard red flag, abnormal neurological findings, marked asymmetry, a deviant developmental sequence, multi-domain delay, or persistent concern despite a reassuring screen. Do not use "wait and watch" as a substitute for surveillance. If observation is appropriate for a borderline concern, it requires a documented baseline, an explicit review plan and instructions to return earlier if skills are lost or new warning signs appear. Early referral is not overdiagnosis: it opens the route to hearing and vision assessment, developmental and neurological evaluation, aetiological investigation where indicated, and early intervention while diagnostic clarification continues.

The initial doctor-facing work-up begins by verifying the concern with caregiver examples and direct observation, mapping skills across all domains, and establishing whether the course is delayed, dissociated, deviant, plateauing or regressive. Examine growth, head size and trajectory, dysmorphic features, skin markers, vision, hearing, oral-motor function, tone, power, reflexes, coordination, gait and asymmetry. Review antenatal, perinatal, neonatal, medical, seizure, nutritional, family and psychosocial history. Select investigations from the phenotype rather than ordering an indiscriminate panel, and refer to the appropriate developmental paediatric, paediatric neurological, audiological, ophthalmological, speech-language, occupational or mental-health service.

The viva answer. Define the warning sign, state whether the quoted age is an expected value, a range, an upper limit or a red-flag threshold, describe the whole developmental pattern, and finish with action. The safest closing line is: *I would not diagnose from a missed milestone alone, but I would not delay evaluation when there is regression, a sourced red flag, abnormal quality or a convergent multi-domain concern.*

21 . Effects of deprivation, institutionalization and early adversity on development

Early development depends not only on freedom from injury, but on the reliable presence of expected experience: responsive caregiving, language, touch, play, nutrition, safety and opportunities to explore. **Deprivation** is the absence or marked reduction of these expected inputs. **Threat** is the presence of experiences that signal actual or possible harm, such as violence or abuse. **Early adversity** is the broader term, covering deprivation, threat, loss, instability, discrimination, displacement, severe family stress and other conditions that exceed the child's available supports. These exposures often co-occur, but they are not interchangeable. The

distinction matters because a child lacking cognitive and social input may follow a different developmental pathway from a child repeatedly learning that the environment is dangerous.



Fig 20.20 Early adversity is not one exposure. Deprivation and threat can follow different developmental pathways, while the nature, timing, duration and severity of exposure and the availability of responsive caregiving shape both persistence and recovery.

How to use this page. Build the answer around **five** propositions.

1. Effects depend on the nature, timing, duration and severity of the adversity, not merely its presence.
2. **Institutionalization** is not a single exposure: it may combine rotating caregivers, low responsiveness, sensory monotony, crowding, malnutrition, illness and repeated loss.
3. The classical studies by Spitz and Harlow established the developmental importance of relationship and contact, but have major methodological and ethical limits.
4. The Romanian natural experiments show both persistent deprivation-related difficulties and substantial recovery after family placement.

5. **Resilience** is an outcome produced by interacting systems, not a fixed trait that makes a child invulnerable.

MNEMONIC

"NTDS"

Effects depend on the **N**ature, **T**iming, **D**uration and **S**everity of the adversity, not merely its presence.

five
PROPOSITIONS

21.1 Concepts and causal framework: deprivation is not the same as separation, poverty or threat

Define the exposure before attributing an effect. **Neglect** is a failure to meet a child's physical, medical, educational, emotional or supervisory needs. **Psychosocial deprivation** refers particularly to insufficient responsive interaction, stable attachment opportunities, language and cognitive stimulation. **Maternal deprivation** is the older historical label, but it is too narrow when it implies that only a biological mother can provide the necessary relationship. The developmentally relevant issue is the availability of a small number of stable, sensitive and committed caregivers. **Separation** is an event; its effect depends on what relationship is lost, what care replaces it, how predictable the transition is and whether reunion and continuity are possible. **Privation**, used in older literature, means that a selective attachment relationship was never adequately established, whereas deprivation may refer to loss of, or insufficient access to, an expected input.

Poverty increases exposure to nutritional compromise, environmental hazards, caregiver stress, disrupted schooling and reduced access to care, but poverty itself is not proof of neglect or deficient attachment. Likewise, institutional residence does not make every child's experience identical. Quality varies with caregiver continuity, responsiveness, group size, opportunities for play and language, health care and contact with family. The causal formulation therefore asks: *what input was absent, what threat was present, when and for how long, through which mediators, and what protective relationships remained?*

Sheridan and McLaughlin's dimensional model separates deprivation from threat.

DIMENSION	DEFINITION	DEVELOPMENTAL RELEVANCE
deprivation	the absence of expected social and cognitive inputs	Deprivation is especially relevant to language, executive function and higher-order cognitive development because the relevant circuits receive less patterned experience.
threat	experience involving harm or danger	Threat more directly calibrates fear learning, attention to danger and emotion-processing systems.

The model is not a claim of **one** exposure to one brain region. Real children commonly experience both dimensions, and development reflects their interaction with genes, prenatal conditions, nutrition, illness, relationships and later environments.

RULE **Exposure is not outcome.** Early adversity changes probabilities across several developmental domains; it does not establish inevitable damage, a particular diagnosis or poor parenting by inference.

21.2 Mechanisms: how early adversity becomes biologically and psychologically embedded

Adversity acts through repeated transactions between the child and the environment. A responsive caregiver ordinarily provides co-regulation: detecting the infant's state, reducing distress, organising sleep and feeding, sharing attention, naming experience and making exploration safe. When care is inconsistent or impersonal, arousal may remain poorly regulated and the child receives fewer contingent exchanges from which language, social prediction and self-regulation are learned. A threatening environment adds repeated detection of danger, narrowing attention toward immediate survival cues. The adaptations may be useful in the adverse setting while carrying costs in a safer one.

The stress-response system is one mediator. Repeated or uncontrollable stress can alter hypothalamic-pituitary-adrenal regulation, autonomic balance, immune and inflammatory signalling, sleep and metabolic function. The expected pattern is not simply "more cortisol": chronic exposure may produce elevation, flattening or blunted reactivity depending on timing, measurement and adaptation. At the neural level, studies report group differences in cortical and white-matter development, frontolimbic connectivity, reward learning and executive-control systems after severe deprivation. These are probabilistic associations, not a diagnostic brain signature. Prenatal risk, malnutrition, infection, genetic liability, placement selection and later experience can confound observed differences.

Learning mechanisms are equally important. Sparse language and play reduce opportunities to acquire vocabulary, causal models and executive strategies. Unpredictable care makes sustained attention and delayed reward less useful than rapid switching. Repeated caregiver loss can make adults unreliable sources of safety. Harsh or frightening care may produce hypervigilance, avoidance, dissociation, aggression or compulsive compliance. Epigenetic findings offer plausible

pathways by which experience can influence gene expression, but they do not justify claims that adversity permanently "rewrites" a child's genes. Biological embedding remains open to modification because the developing system continues to transact with later care.

21.3 Developmental phenotype: broad effects with marked individual variation

Severe deprivation can affect growth, cognition, language, motor development, attachment, emotion and behaviour at the same time. Physical findings include poor weight or linear growth, feeding and sleep disturbance, recurrent illness and stereotyped self-stimulation. Developmental effects may include delayed motor coordination, reduced language exposure and vocabulary, lower general cognitive performance, weak working memory, impaired sustained attention and executive dysfunction. School-age manifestations may include learning difficulty, inattention, impulsivity and problems with planning rather than a uniform global deficit.

Socioemotional development can follow more than one pattern. Some children are withdrawn, wary, emotionally constricted and do not reliably seek or accept comfort. Others show indiscriminate approach, reduced reticence with unfamiliar adults and poor checking back with a caregiver. In current classification these patterns are distinguished as reactive attachment disorder and disinhibited social engagement disorder, which are developed in the Child behavioural, emotional and other disorders notes. Both require a history of grossly insufficient care, but neither is diagnosed from that history alone. Assessment requires the child's actual pattern of behaviour, direct observation with current caregivers and exclusion of better explanations. Indiscriminate friendliness is not equivalent to secure attachment, and a child may develop a selective attachment to a new caregiver while disinhibited social behaviour persists.

Emotional and behavioural outcomes include anxiety, depressive symptoms, irritability, aggression, emotional dysregulation, dissociation, self-harm risk and later interpersonal difficulty. Early institutional deprivation has also been associated with a characteristic cluster involving inattention or overactivity, autistic-like social-communication features, disinhibited social behaviour and cognitive impairment. These are group-level patterns, not proof that every previously institutionalized child has a deprivation-specific syndrome. Development may show multifinality, in which the same adversity leads to different outcomes, and equifinality, in which a similar clinical presentation arises from different developmental routes.

21.4 Spitz: anaclitic depression and hospitalism

Spitz's observations made emotionally responsive care visible as a developmental necessity. René Spitz compared infants reared in different institutional settings and described deterioration after loss of a familiar caregiver despite provision of basic physical care. He used anaclitic depression for the syndrome following prolonged separation from an attachment figure: protest and weeping gave way to withdrawal, reduced responsiveness, disturbed feeding and sleep, developmental slowing and physical decline. Hospitalism described the more pervasive developmental deterioration seen with prolonged impersonal institutional care, including passivity, failure to thrive, susceptibility to illness and high mortality in the historical settings he observed.

The enduring inference is not that separation from the biological mother mechanically causes depression. It is that food, cleanliness and medical custody are insufficient without stable, contingent and affectionate human interaction. Spitz also helped shift hospital and residential practice toward caregiver access and relational continuity. His terms are historically examinable, but anaclitic depression is not simply the infant form of a current major depressive episode, and hospitalism is not a modern diagnostic category.

The limitations are substantial. The studies were observational, the institutional groups differed in more than caregiver contact, physical illness and nutrition were incompletely controlled, assessment was not blinded, and the interpretation was shaped by contemporary psychoanalytic theory. These weaknesses prevent precise causal estimates. The observations remain influential because later attachment research, adoption studies and intervention trials converge on the importance of stable, responsive care.

21.5 Harlow: contact comfort, fear regulation and the limits of animal evidence

Harlow showed that feeding alone does not explain attachment behaviour. Infant rhesus macaques were reared with inanimate surrogate mothers, one made of bare wire and another covered with soft cloth. Even when the wire surrogate supplied milk, the infants spent much more time clinging to the cloth surrogate. Under fear, they sought the cloth surrogate, and its presence supported exploration of an unfamiliar setting. Harlow called the relevant property contact comfort. The experiment directly challenged drive-reduction accounts in which attachment was merely learned because the caregiver relieved hunger.

Later social-isolation work showed disturbed social interaction, fear, repetitive behaviour and impaired mating and parenting in monkeys deprived of normal peer and maternal experience. Partial improvement after later social contact demonstrated both the cost of early deprivation and some capacity for recovery. The broader lesson is that attachment is supported by comfort, safety, reciprocal interaction and species-typical social experience, not by calories alone.

The evidence cannot be translated literally from macaques to children. Human caregiving includes language, culture, symbolic meaning, multiple attachment figures and institutions that vary widely. Rearing conditions were artificial, outcomes were partly species-specific, and the procedures caused severe suffering that would not meet contemporary ethical standards. Harlow's work therefore supports a mechanism, the motivational importance of comfort and relationship, but does not define a human sensitive-period cutoff or prove a deterministic human outcome.

TRAP **Spitz did not prove that only mothers matter, and Harlow did not prove that feeding does not matter.** Both challenged custodial models of care by showing that stable, responsive relationship and comfort are independent developmental needs.

21.6 Romanian natural experiments: ERA and the Bucharest intervention

The Romanian studies provide the clearest human evidence that severe institutional deprivation has causal developmental effects and that family care can produce substantial recovery. After the fall of the Romanian regime, many children who had experienced profoundly

understaffed, socially and cognitively sparse institutions entered adoptive families. The English and Romanian Adoptees study, or ERA study, followed Romanian adoptees placed in the United Kingdom and compared their development with adoptees who had not experienced the same severe deprivation. Because nutrition, prenatal risk and deprivation still varied, it was not a randomized experiment. Its strength was the unusual, time-limited exposure followed by generally well-resourced adoptive care and prolonged follow-up.

Many children showed striking catch-up in physical growth and cognitive performance after adoption, demonstrating that early effects were not fixed. A subgroup with more prolonged severe deprivation showed persistent or emerging difficulties in cognition, inattention or overactivity, disinhibited social engagement and autistic-like social communication. The ERA investigators described this as a deprivation-specific pattern. Some difficulties persisted into adult life even after years in supportive families, while emotional symptoms could become more apparent later. **Two** conclusions must be held together: recovery can be large, and residual vulnerability can remain.

The Bucharest Early Intervention Project added stronger causal evidence by randomly assigning institutionalized children to high-quality foster care or care as usual, with a never-institutionalized comparison group. Assignment to foster care produced better cognitive and physical outcomes and fewer attachment or social-relatedness difficulties and other psychopathology across follow-up. Studies also found more favourable trajectories in brain electrical activity and aspects of white-matter development. Placement timing and the subsequent quality and stability of care influenced some outcomes, but not every domain showed the same timing effect. It is therefore inaccurate to teach one universal age after which recovery is impossible.

The projects are complementary rather than interchangeable. ERA is an adoption-based longitudinal natural experiment with strong evidence of long-term developmental patterning. The Bucharest project is a randomized foster-care intervention that strengthens causal inference about the benefit of family placement. Ethical debate remains because the trial occurred in a setting where institutional care was still the prevailing care pathway, and researchers did not remove children assigned to care as usual. Its central clinical result is nevertheless clear: high-quality family care is an active developmental treatment, not merely a change of address.

21.7 Sensitive periods, cumulative risk and developmental timing

A sensitive period is a time of heightened plasticity, not an expiry date for recovery. During periods when attachment, language, sensory systems and stress regulation are being rapidly organised, expected input can have unusually strong effects. Earlier onset, greater severity, longer duration and involvement of multiple developmental systems generally increase risk. Yet the timing gradient differs by outcome: language, attachment behaviour, executive function, growth and emotional symptoms do not share one timetable. A single global cutoff converts a graded and domain-specific finding into a false rule.

The cumulative-risk model predicts increasing difficulty as adversities accumulate. It is useful for public-health stratification but an unweighted count hides whether the exposures were deprivation, threat or instability, their severity and duration, and the protective systems surrounding the child. Adverse childhood experience scores similarly describe population-level dose-response associations; they are not diagnostic tests, causal explanations or individual prognoses. Two children with the same count may have very different exposures, meanings and outcomes.

Development also involves experience-expectant plasticity, in which the brain anticipates common inputs such as patterned language and responsive interaction, and experience-dependent plasticity, in which individual learning modifies circuits throughout life. Early deprivation can therefore constrain the architecture on which later learning builds, while later relationships, education and treatment can still reorganise function. Recovery may be domain-specific: physical catch-up can coexist with executive or relational difficulty, and secure attachment to a new caregiver can coexist with persistent social disinhibition.

Must remember: early adversity is probabilistic, timing is domain-specific, and stable responsive caregiving is both the principal protective factor and the core intervention.

21.8 Clinical assessment, prevention and management

The clinical task is to reconstruct the developmental ecology, identify current needs and change the caregiving environment. Establish immediate safety first. Take a chronological account of prenatal and birth risk, nutrition, illness, developmental opportunities, separations, caregiver changes, institutional conditions, abuse or threat, schooling and current placement. Record the source and certainty of each claim because records may be incomplete and narratives may conflict. Assess growth, hearing, vision, sleep, feeding, neurological status, language, cognition, adaptive function, attachment behaviour, attention, mood, trauma symptoms, self-harm and social functioning. Observe the child with the present caregiver and obtain collateral information from school and previous services when appropriate.

Do not repeatedly elicit graphic trauma details when they are not required for care. Ask what happened, what continues, what triggers current difficulty and what helps. Separate a child's adaptations from moral judgement: food hoarding, watchfulness, indiscriminate friendliness, lying, emotional shutdown or controlling behaviour may have been functional in an unpredictable setting. Also avoid diagnostic overshadowing. Developmental disability, autism, attention-deficit/hyperactivity disorder, post-traumatic symptoms, depression, anxiety, malnutrition and sensory impairment may coexist with, resemble or occur independently of deprivation-related problems.

Management begins with a safe, stable, responsive family environment and the smallest feasible number of consistent caregivers. Prevent further placement disruption, support the caregiver-child relationship, coach caregivers in contingent responding and co-regulation, and establish predictable routines without punitive rigidity. Provide nutritional, medical, sensory,

developmental, speech-language and educational interventions according to need. Use trauma-focused treatment for clinically significant trauma symptoms, not simply because adversity occurred. Parent-child and attachment-focused work must be evidence-based and non-coercive; forced holding, induced regression and "rebirthing" practices are unsafe.

INDIA

In Indian practice, distinguish poverty and family stress from wilful neglect, and assess the wider caregiving network rather than assuming a nuclear-family model. Kinship care may preserve language, culture and continuity, but safety and caregiver capacity still require direct assessment. When residential care cannot be avoided, the developmental targets are caregiver continuity, responsive interaction, play and language, schooling, nutrition, health care, sibling and safe family contact, and an active plan toward stable family-based care. Coordination among paediatrics, psychiatry, clinical psychology, social work, speech and language services, education and child-protection systems is usually more important than any single test.

For an examination answer, define deprivation and distinguish it from threat; describe the multi-domain phenotype and mechanisms; present Spitz and Harlow with their limitations; compare the ERA natural experiment with the Bucharest randomized foster-care intervention; explain sensitive periods without a rigid cutoff; and finish with resilience, protective systems and family-based intervention. The mature conclusion is neither pessimistic nor sentimental: early severe deprivation can leave enduring developmental effects, but the developing child remains plastic, and timely, stable, high-quality relationships materially alter the trajectory.

22 · Resilience and protective factors in child development

Resilience is positive adaptation despite exposure to significant adversity. It is not invulnerability, a fixed temperament, or proof that adversity was harmless. It is a **dynamic developmental process** produced by transactions between the child and changing caregiving, family, school, peer, cultural and social systems. The same child may function well in one domain and struggle in another, and may show competence at one point but difficulty after a later developmental demand. The useful clinical question is therefore not, "Is this child resilient?" but, "What risks, resources and adaptive processes are operating now, in which domain, and what can be changed?"

How to use this page. Build the answer in **three** moves. First, establish both sides of the definition: meaningful adversity and demonstrable adaptation. Second, distinguish a factor that generally promotes development from one that specifically buffers the effect of risk. Third, move across ecological levels, from child capacities to at least one stable caring adult, family organisation, school belonging and community resources. The classic deprivation literature supplies causal clues, but its most defensible lesson is neither determinism nor romantic recovery: early relationships and stimulation matter greatly, developmental plasticity remains real, and earlier restoration of family care generally permits broader recovery.

3	5	4	3
RESILIENCE MODELS	ECOLOGICAL LEVELS	INTERVENTION TASKS	PREVENTION LEVELS

Resilience is not a trait inside the child: it is positive adaptation arising from dynamic child-context processes despite significant adversity.

22.1 Core concepts: risk, promotive factors, protective factors and vulnerability

The work of Norman Garmezy, Michael Rutter and Emmy Werner redirected research from cataloguing damage toward studying variation in outcome and the processes that alter risk pathways. Ann Masten's phrase *ordinary magic* captures the mature position: resilience usually arises from ordinary adaptive systems, not rare heroic qualities. It also differs from post-traumatic growth, which denotes perceived or demonstrable positive change after struggle; a child can be resilient without reporting growth, and claimed growth does not exclude distress.

A **risk factor** raises the probability of an adverse outcome; it does not make that outcome inevitable. Risks may be biological, psychological or social, and their meaning depends on timing, duration, severity and developmental context. **Cumulative risk** is often more informative than a single exposure because poverty, caregiver illness, violence, maltreatment, discrimination, disrupted schooling and unsafe neighbourhoods cluster and transact. **Equifinality** means that different developmental pathways can lead to a similar outcome, whereas **multifinality** means that the same early adversity can lead to different outcomes.

A **promotive factor** predicts better functioning across levels of risk. A **protective factor**, in the stricter research sense, modifies the effect of adversity: its benefit is especially evident when risk is present. A **vulnerability factor** amplifies the effect of risk. A resource such as good schooling may be promotive in most children and protective under family adversity, depending on the hypothesis and data. This distinction matters in an examination answer because merely listing desirable characteristics does not explain resilience.

RULE **Demonstrate adversity and adaptation separately.** Resilience can be inferred only when significant risk has occurred and the child shows adequate functioning in a specified domain, judged against developmentally and culturally appropriate expectations.

22.2 Models of resilience: how protection changes a developmental pathway

MODEL	HOW PROTECTION CHANGES THE PATHWAY
compensatory model	A positive influence has a beneficial effect independent of risk, partly offsetting its burden.
protective or buffering model	An interaction: the association between adversity and poor outcome is weaker when the protective process is present.
challenge, steeling or inoculation model	Manageable stress, successfully negotiated with adequate support, may strengthen later coping. It must not be used to justify preventable adversity; overwhelming or uncontrollable stress is not therapeutic.

Differential susceptibility and biological-sensitivity models add a further correction. A highly reactive child may fare worse in an adverse environment yet gain more from a supportive one. The same characteristic is therefore not always a vulnerability. Contemporary developmental psychopathology treats resilience as a changing trajectory generated by person-context transactions, developmental cascades and feedback loops. Improved caregiver responsiveness may strengthen regulation, which improves school participation, which then enlarges peer support and competence. Conversely, one failure can spread across domains if no system interrupts it.

22.3 Early adversity: threat, deprivation and biological embedding

Early adversity is heterogeneous. Experiences dominated by threat, such as violence or abuse, make harm salient and may bias fear learning, vigilance and emotion processing. Experiences dominated by deprivation, such as severe neglect or understimulation, remove expected cognitive, linguistic and relational input and may particularly affect learning and executive development. Most real children experience mixtures of both, so the distinction is a formulation aid rather than a diagnostic partition.

Repeated activation of stress-response systems without adequate co-regulation can produce toxic stress and allostatic load. Candidate pathways include altered hypothalamic-pituitary-adrenal regulation, autonomic reactivity, sleep disturbance, inflammatory signalling and experience-dependent changes in neural networks supporting attention, reward, memory and affect regulation. These are probabilistic mechanisms, not permanent lesions. Genes influence sensitivity to environments; environments influence gene expression and neural development; later caregiving and learning can alter the trajectory. This is the biological basis for holding risk and plasticity together.

22.4 Romanian orphan studies: the abstracted lesson

Developmental plasticity is real. Timing and the quality and stability of placement matter. Catch-up is domain-specific: catch-up in height or IQ does not prove recovery in attachment, attention, social functioning or later mental health.

TRAP **Do not turn deprivation research into either determinism or "complete recovery".** Group-level persistence does not fix an individual child's destiny, and catch-up in height or IQ does not prove recovery in attachment, attention, social functioning or later mental health.

22.5 Sensitive periods, developmental timing and recovery

A **sensitive period** is a phase during which experience has an unusually strong influence on a developing system; learning may remain possible later, but often requires more input or follows a different route. A **critical period** is a narrower claim in which an experience is required within a restricted window for typical development. Human psychosocial development usually warrants the more cautious term *sensitive period*. The institutional studies support timing effects, but they do not justify one universal cut-off for every function.

Different systems have different windows and recovery curves. Attachment organisation, language, executive function, growth, peer reciprocity and stress regulation need not recover together. Outcome depends on the nature of deprivation, its duration and severity, the child's prior condition, biological susceptibility, the timing and stability of placement, and the quality of later caregiving and education. Developmental cascades explain why early intervention has broad value: restoring caregiver regulation can improve attention and exploration, which expands learning, competence and relationships. The converse is also true, so later transitions can reveal difficulties that seemed absent earlier.

22.6 Protective processes across the child's ecology

- **Child level.** Cognitive ability, language, flexible problem-solving, self-regulation, sociability, realistic self-efficacy and the capacity to seek help can support adaptation. These are partly shaped by experience and should not be moralized as willpower.
- **Caregiver level.** The most consistently useful process is at least one stable, committed and emotionally available adult who notices the child, provides co-regulation, sets predictable limits and repairs relational ruptures.
- **Family level.** Warmth, routines, low conflict, safe housing, adequate material resources, shared meaning and support for caregivers reduce chaos and preserve developmental opportunity.
- **School and peer level.** A safe school, teacher attunement, academic support, opportunities for mastery, inclusive peer relationships and protection from bullying create competence and belonging.
- **Community and cultural level.** Accessible health and social services, safe neighbourhoods, social cohesion, mentors, recreation, faith or cultural networks, and policies that reduce poverty and discrimination operate upstream. Culture shapes which outcomes count as competent adaptation and which supports are acceptable.

A protective process is strongest when it is developmentally matched, available in ordinary settings and sustained across transitions.

INDIA

Formulate the ecology, not merely the child. Ask about caregiver mental illness and substance use, domestic violence, migration, caste or minority stress, gendered restriction, disability, school exclusion, examination pressure, digital and peer environments, and material insecurity. Then map usable protection: an extended-family adult, teacher, peer, Anganwadi or school support, paediatric and mental-health services, child-protection mechanisms and local community networks. Extended family can be protective, neutral or harmful; do not assume that family presence equals emotional safety. When abuse, exploitation or neglect is ongoing, safeguarding and reduction of exposure come before teaching the child coping skills.

22.7 Assessment: a strengths-based formulation without minimizing harm

Assessment begins with a timeline of exposures, developmental transitions and changes in functioning. Specify the adversity by type, severity, duration, proximity and current status; separate threat from deprivation where useful; and identify mediators such as sleep, caregiver responsiveness, school attendance and peer exclusion. Examine adaptation in multiple domains: symptoms, attachment and relationships, learning, behaviour, physical health, self-care and age-appropriate participation. Obtain accounts from the child, caregivers and school because competence and distress are context-dependent.

Then construct a resilience map: risks and vulnerabilities; existing resources; mechanisms through which they help; inaccessible or unstable supports; and leverage points that can change the trajectory. A resilience questionnaire may organize information but cannot certify a resilient personality. Cross-sectional good functioning may conceal effort, dissociation, parentification or a later cost, while symptoms in one domain can coexist with genuine competence in another. Trauma-informed assessment therefore combines safety, curiosity and developmental formulation without forcing disclosure or demanding a narrative of growth.

22.8 Intervention: reduce adversity, restore relationships and build adaptive systems

Intervention is not "resilience training" alone. The **first** task is to stop or reduce the active adversity: ensure safety, treat caregiver illness, address violence and substance use, secure nutrition, housing and schooling, and prevent repeated placement disruption. The **second** is to strengthen caregiving through responsive parent work, co-regulation, predictable routines and support for caregiver stress. The **third** is to build the child's skills in a developmentally fitted way, including emotion identification, problem-solving, executive supports, social competence, mastery and help-seeking. The **fourth** is to enlarge the ecology through school accommodations, mentoring, peer connection and coordinated health, education and social care.

MNEMONIC

"Reduce - Restore - Build - Enlarge"

Reduce the active adversity; restore relationships through responsive parent work, co-regulation, predictable routines and support for caregiver stress; build the child's skills; enlarge the ecology through school accommodations, mentoring, peer connection and coordinated health, education and social care.

Effective prevention combines universal supports for all children, selective interventions for groups exposed to elevated risk and indicated treatment for children already showing difficulty. Review outcomes over time and across domains, especially at transitions. The ethical endpoint is not to make children tolerate unsafe systems. It is to reduce preventable exposure, increase dependable protection and restore the ordinary relationships and opportunities through which development proceeds.

22.9 Exam synthesis

A complete long answer opens with resilience as a dynamic process, distinguishes promotive from protective effects, and gives compensatory, buffering and challenge models. It then explains cumulative risk, equifinality, multifinality and developmental cascades; uses Spitz, Harlow and the Romanian orphan natural experiments with their limitations; and links the ERA findings to sensitive periods without claiming a universal cut-off. Finish with child, caregiver, family, school and community protective processes, followed by assessment and intervention. The single sentence that rescues the answer from a list is this: **resilience emerges when ordinary adaptive systems, especially stable caregiving, regulation, learning, belonging and social protection, remain available or are restored under adversity.**

Apply and consolidate

23 . Apply: worked cases

These cases close the developmental arc by making the resident perform the decisions that lists of theories and milestones are meant to support. The sequence is deliberate: date a milestone without turning a typical age into a deadline, recognise a genuine referral signal, identify an attachment strategy from reunion behaviour, formulate temperament as a person-environment fit, and apply a developmental theory without pretending that it is a screening instrument.

MNEMONIC

"Phenomenon - construct - comparison - clinical action"

Identify the phenomenon actually being tested, name the relevant construct, compare it only with an age or pattern that measures the same construct, and state what follows clinically.

How to use this page. In each case, take the steps in this order.

WHAT TO ESTABLISH	TASK
Phenomenon	Identify the phenomenon actually being tested.
Construct	Name the relevant construct.
Comparison	Compare it only with an age or pattern that measures the same construct.
Clinical implication	State what follows clinically.

The answer comes last. A correct label without the intervening reasoning is fragile in a viva and unsafe in practice.

23.1 Milestone dating: late against a typical age, still within the WHO window

Presentation. A child at 15 months of age pulls to stand, cruises along furniture, stands briefly without support and communicates socially, but has not yet walked alone. There has been steady acquisition of skills, no loss, no asymmetry and no abnormality of tone or movement quality. The caregiver has read that children usually walk independently by **12 months** and asks whether this proves **developmental delay**.

Reasoning. The first task is to name what the two ages mean. Kaplan and Sadock describes independent walking as expected at 12 months and gives an expected range of 9 to 15 months. An **expected age** describes typical attainment; it is not a **referral threshold**. The WHO Motor Development Study gives a different and more construct-explicit measure: its 1st-to-99th-centile window for walking alone is **8.2 to 17.6 months**. WHO states that its upper boundary is a signal for appropriate screening when a child appears late, not a diagnostic cut-off.

The child is later than the typical 12-month anchor but remains within the WHO achievement window and at the end of Kaplan and Sadock's expected range. The preserved progression toward independent gait and the absence of regression, asymmetry or abnormal motor quality further reduce the force of a single late-looking date. This does not mean that development is ignored. Surveillance continues, and examination still covers all domains, hearing, vision and neurology. It means only that the typical age cannot be promoted into a referral rule.

Answer. This is a late-normal gross-motor attainment on the information given, not developmental delay established by the 12-month expected age. Continue developmental surveillance and reassess the trajectory. Crossing the WHO **17.6-month** boundary would be a screening signal, while regression or abnormal neurological findings would change the action immediately.

23.2 Deviation call: a sourced communication red flag

Presentation. A child at 24 months of age uses several meaningful single words and obtains desired objects by pointing, but never produces spontaneous two-word phrases. Motor development has progressed, and the caregiver reports no loss of previously acquired skills.

Reasoning. The finding is not judged from vocabulary size alone. Berk gives 18 to 24 months as an expected range for combining two words, but the clinically decisive statement is separate:

Developmental Psychopathology identifies absence of spontaneous two-word phrases at **24 months** as a **red flag** warranting further developmental evaluation. Here the age is explicitly a referral signal, not merely an expected attainment or median.

The threshold does not diagnose a language disorder or autism. The next step is to define the profile.

- Confirm whether phrases are truly spontaneous rather than imitated.
- Assess receptive language, gesture, joint attention, reciprocity and symbolic play.
- Establish language exposure across all languages used by the child.
- Examine hearing and oral-motor function.

Map gross motor, fine motor, cognitive or adaptive, and social-emotional development rather than inferring global delay from one communication finding. The absence of regression is reassuring about the course but does not cancel the hard red flag.

Answer. This is a developmental red flag requiring prompt hearing and developmental evaluation. It is a referral decision, not a diagnosis, and a reassuring motor history or a negative brief screen would not overrule it.

23.3 Attachment-pattern identification: contact sought but not used effectively

Presentation. During a Strange Situation observation, a young child explores little, becomes intensely distressed when the caregiver leaves, and hurries toward the caregiver on reunion. Once picked up, the child arches away, pushes against the caregiver, continues crying and does not settle sufficiently to return to play.

Reasoning. Separation distress alone cannot classify attachment. The reunion is more informative because it shows whether renewed access to the caregiver restores regulation. A secure child can seek and use comfort, then resume exploration. An avoidant child minimises overt proximity-seeking and may turn away or ignore the caregiver. This child instead maximises attachment signals: proximity is urgently sought, yet contact is mixed with anger or resistance and does not readily produce settling.

The simultaneous approach and resistance form a coherent strategy and therefore differ from **disorganisation**, where behaviour lacks a stable strategy and may include contradictory, apprehensive, frozen or disoriented sequences. The observed pattern describes this child's relationship with this caregiver in this procedure. It is not a diagnosis, a fixed personality trait or proof of inconsistent caregiving.

Answer. The pattern is ambivalent or resistant attachment, pattern C. The decisive clues are intensified proximity-seeking, resistance during contact and failure to use reunion effectively for soothing and renewed exploration.

23.4 Temperament and goodness of fit: the setting creates the difficulty

Presentation. A child watches an unfamiliar classroom activity from the edge, declines the teacher's first invitation and speaks little while everyone is watching. With advance warning, time

to observe and a quiet invitation from a familiar teacher, the child joins, completes the task and later participates comfortably. At home and with familiar peers, communication and play are fluent. The school has responded by calling the child stubborn and demanding immediate public participation.

Reasoning. Thomas and Chess directs attention to behavioural style before disorder. The initial response to novelty is withdrawal; the later capacity to join after familiarisation concerns adaptability. Because the response is cautious, improves gradually and is not described as an intense, persistently negative or globally dysregulated pattern, it is closer to a slow-to-warm-up temperament than to the classic difficult constellation.

The impairment is transactional. Immediate public performance and criticism create a poor **goodness of fit** by punishing the child's characteristic entry into novelty. Preparation, observation, phased entry and a familiar adult improve the fit without declaring that the child can avoid every demand. The cross-setting strengths argue against treating silence in the unfamiliar classroom as proof of a fixed language deficit, but persistent distress or impairment would still require assessment for anxiety, communication difficulty and other alternatives.

Answer. This is a **slow-to-warm-up temperamental pattern** made problematic by poor goodness of fit. Management should alter the transaction through predictable preparation and graduated participation while separately assessing any sustained impairment.

23.5 Theory application: supported performance is not a new Vygotskian stage

Presentation. A child cannot independently sort a mixed set of objects by a changing rule. The examiner first restates the goal, then models the opening move and finally uses a visual cue. With that graduated help, the child completes the remaining items and applies the same strategy to a related task. A static score records only the initial failure.

Reasoning. Vygotsky asks how performance changes through social mediation. The lower boundary is what the child can do independently; the upper boundary is what becomes possible with appropriate assistance. The distance between them is the zone of proximal development. The examiner's calibrated prompts are scaffolding: support is increased only as needed, then should be faded as responsibility transfers to the learner. Improvement that generalises to a related task is stronger evidence of an emerging strategy than completion achieved by simply giving the answer.

Piaget would ask what structure of classification or rule use the task requires, and a static assessment would describe unaided performance. Those are different questions. The assisted success must not be reported as independent mastery, but neither should the unaided failure be treated as the child's full learning capacity. Most importantly, Vygotsky proposed no age-linked stages, so the case cannot be labelled as entry into a new Vygotskian stage.

Answer. The case demonstrates performance within the **zone of proximal development**, revealed through **scaffolding** and dynamic assessment. Record independent and assisted

performance separately, fade help, test transfer and investigate language, attention, memory or task mismatch if well-calibrated support does not unlock performance.

RULE **An expected age describes typical attainment; it is not a referral threshold.** A typical age cannot be promoted into a referral rule.

TRAP **Do not report assisted success as independent mastery.** The assisted success must not be reported as independent mastery, but neither should the unaided failure be treated as the child's full learning capacity.

12 months	9 to 15 months	8.2 to 17.6 months	24 months
TYPICAL INDEPENDENT WALKING AGE	KAPLAN AND SADOCK EXPECTED RANGE	WHO WALKING WINDOW (1ST TO 99TH CENTILE)	TWO-WORD-PHRASE RED FLAG

HOLD THIS

A correct label without the intervening reasoning is fragile in a viva and unsafe in practice.

24 . Consolidation

This closing topic turns developmental psychiatry into a retrievable clinical map. The aim is not to recite every date in isolation. It is to recover **three** linked structures under examination pressure: which question each **developmental theory** asks, which observable functions belong to each **developmental domain**, and how the meaning of an age determines whether the doctor continues surveillance, screens or refers.

How to use this page. Learn the master mnemonic, cover the page and work through the answer-free prompts, then redraw the theory and milestone tracks from memory. On checking the redraw, be strict about construct.

TRAP **A typical age is not a deadline.** A WHO **99th-centile** boundary is a screening signal rather than a diagnosis, and only an explicitly sourced red flag supports an age-linked referral call.

three	five	1st-to-99th-centile
LINKED STRUCTURES	DEVELOPMENTAL DOMAINS	WHO GROSS-MOTOR CONSTRUCT

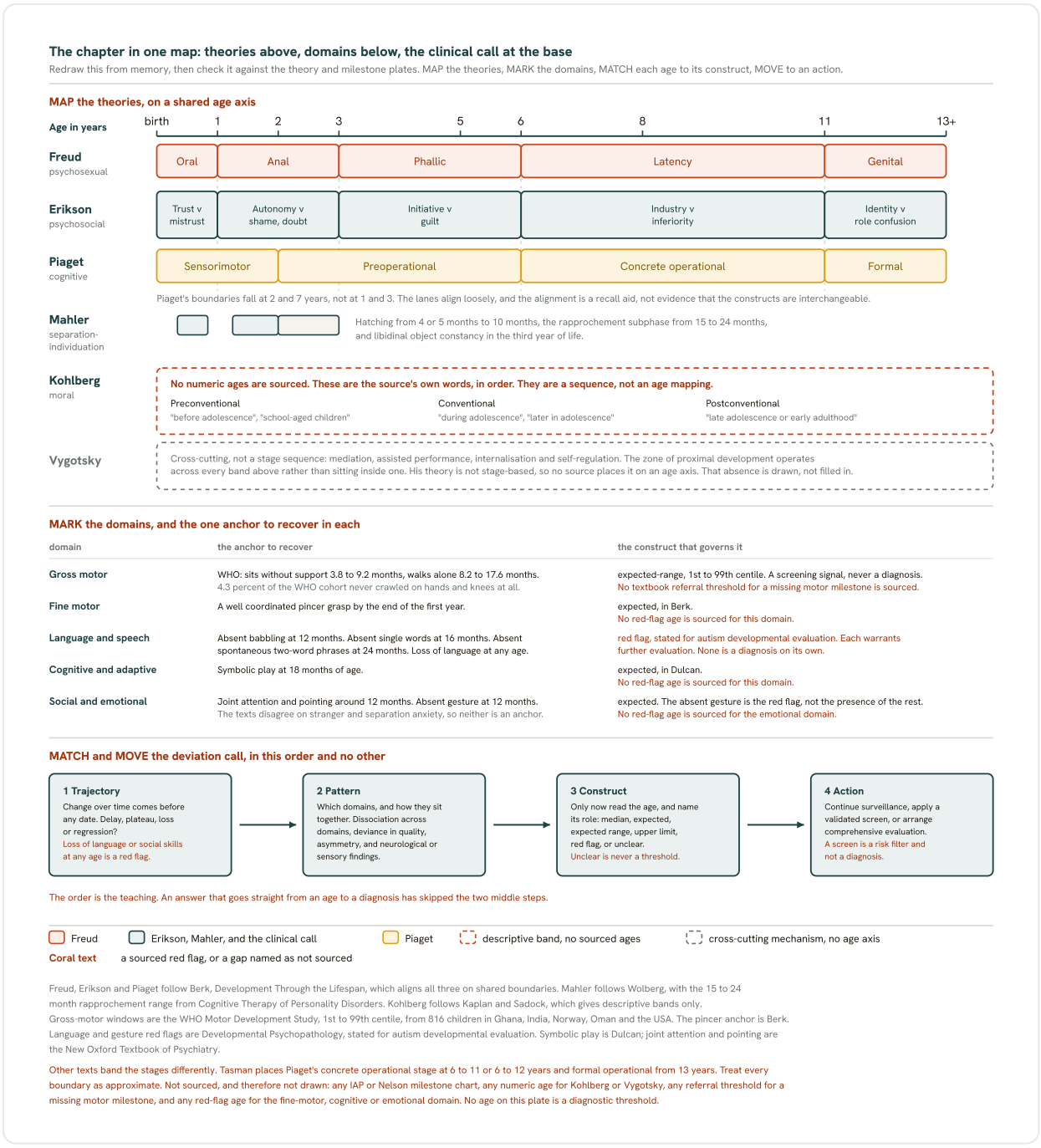


Fig 20.21 The whole-chapter synthesis map, drawn to be redrawn from memory. Theory lanes follow Berk, Mahler follows Wolberg, and Kohlberg sits in descriptive bands because no numeric ages are sourced for him. Vygotsky is drawn across the axis rather than on it, since his theory is not stage-based. Gross-motor windows are the WHO Motor Development Study, 1st to 99th centile; the language and gesture red flags are Developmental Psychopathology, stated for autism developmental evaluation. The plate carries one anchor per domain rather than the milestone tables, and names the domains for which no red-flag age is sourced.

24.1 The retrieval method: rebuild relationships, not isolated lists

Retrieve the map in a fixed clinical order. Start with the explanatory theories, move to observable development across domains, attach every age to its normative construct, and finish with the clinical action. This order prevents three common collapses: a theory stage becoming a milestone, an expected attainment becoming a referral threshold, and a positive screen becoming a diagnosis.

The theories answer different questions about the same developing person.

THEORY	QUESTION
Piaget	how cognition is organised
Erikson	which psychosocial conflict is foregrounded
Freud	how drive and conflict are organised
Mahler	how psychological separateness develops within relationship
Kohlberg	how moral decisions are justified
Vygotsky	what learning becomes possible through social mediation

HOLD THIS

Their temporal alignment is a recall aid, not evidence that the constructs are interchangeable.

24.2 Master mnemonic: MAP, MARK, MATCH, MOVE

MNEMONIC

MAP - MARK - MATCH - MOVE

MAP the theory lanes: cognition, psychosocial conflict, psychosexual organisation, separation-individuation and moral reasoning, with sociocultural mediation running across them. **MARK** observable development in the **five** domains: gross motor, fine motor, language and speech, cognitive or adaptive, and social and emotional. **MATCH** each age to its **normative construct**: median, expected attainment, expected range, upper limit, red flag or a source-stated age whose normative role remains unclear. **MOVE** from observation to action: describe the trajectory and quality, look for loss, asymmetry and multi-domain involvement, use screening as a risk filter, and refer for regression, a sourced red flag or a concerning neurological or sensory pattern.

The mnemonic contains the chapter's division of labour. The theory map explains; the milestone map describes; the construct check interprets; and the final verb commits the doctor to an action. If the answer jumps directly from an age to a diagnosis, one of the middle steps has been skipped.

24.3 Answer-free active recall

Cover the rest of the page and answer each prompt aloud or on paper. Check only after completing the retrieval attempt.

1. What distinct developmental question is asked by Piaget, Erikson, Freud, Mahler, Kohlberg and Vygotsky?
   How would you reconstruct the source-stated age lanes for Piaget, Erikson and Freud without turning theoretical brackets into clinical thresholds?
   What is the sequence of Mahler's separation-individuation account, and which two similarly named cognitive and relational constructs must not be confused?
   How are Kohlberg's levels and stages ordered, and what exactly is scored in a moral dilemma?

Where should Kohlberg and Vygotsky sit on a theories-by-age map, and why must neither be given an invented numeric row?

2. Name the five developmental domains and describe how a limitation in one can alter performance in the others.
   What do cephalocaudal and proximodistal organisation explain, and what do they not date?
   Reproduce the WHO gross-motor achievement windows from the milestone plate and state the clinical meaning of the upper boundary.
   Why is absence of hands-and-knees crawling alone an unsafe referral rule?
   Trace the communication sequence from prelinguistic exchange through words, combinations, grammar and intelligibility, preserving the construct attached to each anchor.
   Which communication findings are explicit age-linked red flags, and how would you evaluate a child who meets one?
3. How do **developmental delay**, **dissociation**, **deviance**, **plateau** and **regression** differ?
   How do **surveillance**, **screening** and **formal developmental assessment** differ in purpose and output?
   Which reunion behaviours distinguish secure, avoidant, ambivalent or resistant, and disorganised attachment?
   Name the Thomas-and-Chess dimensions, distinguish their three constellations, and formulate one example of goodness of fit.
   How do responsiveness and demandingness generate the parenting-style patterns, and why are outcome associations not deterministic?
4. How would you separate gender identity, gender expression, sexual orientation and sexual behaviour in a developmental assessment?
   Why must Tanner stage be assigned from morphology rather than chronological age or psychological maturity?
   How do dual-systems and maturational-imbalance accounts explain a difference between calm reasoning and behaviour in a highly charged peer context?
   Which features of deprivation, later care and protective relationships determine whether risk becomes persistent impairment or recovery?

24.4 The synthesis redraw: theories above, milestones below, action at the base

Redraw the synthesis as aligned horizontal tracks. Across the top, place the age axis from infancy through adulthood. Give Piaget, Erikson and Freud separate lanes using the source-stated stage bands, and give Mahler a shorter early relational lane using only its sourced phase timings. Place Kohlberg in ordered descriptive bands rather than numeric ages. Draw Vygotsky beside the entire axis as a cross-cutting process of mediation, assisted performance, internalisation and self-regulation. The alignment should make temporal overlap visible while keeping each theory's explanatory target separate.

Below the theory lanes, draw the five developmental domains. In the gross-motor lane, reconstruct the WHO windows from sitting without support through walking alone and label the **1st-to-99th-centile** construct. In the fine-motor lane, recover the sequence from grasp and

transfer through pincer control, construction, scribbling and copied forms. In the language lane, move from vocalisation and gesture through meaningful words, combinations, grammar and intelligibility. In the cognitive or adaptive lane, place symbolic representation, problem-solving and theory-of-mind anchors. In the social and emotional lane, move from reciprocity and selective attachment through shared attention, symbolic play, peer engagement and regulation. Use the existing milestone and reflex plates to check the redraw rather than recreating their source-labelled tables in prose.

Add a separate pubertal branch rather than forcing it onto the childhood milestone ladder. Record Tanner morphology by component, not by age, and place identity formation, relationships, gender and psychosexual development beside the adolescent body and brain changes. This preserves the central distinction: physical maturation, cognitive capacity, moral reasoning, identity and consent are related but are not interchangeable measures.

Finally, draw the clinical action rail beneath every domain. Its sequence is *trajectory, pattern, construct, action*. Mark regression, plateau, asymmetry, abnormal quality, sensory or neurological findings and unevenness across domains before checking a date. Then label the date honestly as expected, a range, an upper limit, a red flag or unclear. End with the appropriate move:

- continue surveillance or apply a validated screen
- arrange comprehensive developmental evaluation

RULE **Developmental psychiatry is not the memorisation of ages, but the disciplined interpretation of change over time.** The completed redraw should make one principle unavoidable.

Previously asked

This chapter is the one place in the series where the honest answer about past questions is that the examiner has not asked them here. Normal development is examined, and examined often, but it is examined as *psychology* under Paper I rather than as child psychiatry under Paper III. Every developmental question on record in the catalogue sits in the basic sciences and psychology section: Erikson's psychosocial stages has appeared four times, most recently in 2021 and before that in 2017 and twice in 2012, always as a ten-mark question; Jean Piaget was asked in 2011; and psychological development in adolescence, paired with its relation to psychiatric disorders in adolescence, came up in 2018 and again in 2020. Those questions and their model answers live where they were asked, in the General and Developmental Psychology notes, and they are not repeated here.

That distribution is worth reading rather than shrugging at, because it tells you how the material is tested. The theories are examined as theories, on their own terms, in a psychology paper: name the stages, get the order right, get the count right, say what each stage is *for*. What this chapter adds is the part the examiner does not ask directly and the clinic asks constantly, which is the deviation call. No question on record asks for a milestone table. Plenty of clinical practice asks

whether this particular child, at this particular age, is outside the normal window, and that judgement rests on knowing which of the ages you memorised is a typical attainment and which is a screening boundary. A candidate who can recite Piaget's four stages and still cannot say whether a fourteen-month-old who is not walking needs referring has learned the examinable half and missed the useful half.

ON THE THEORIES, EXAMINED UNDER PAPER I PSYCHOLOGY

Erikson and his psychosocial stages is the highest-yield developmental question in the catalogue, at four appearances for ten marks. Piaget follows. Both reward the same discipline: the stages in order, at their exact count, each with its central conflict or operation and its one clinical use. The age bands are the least reliable part of both answers and should be given as the approximate, source-dependent ranges they are. MUHS 2011, 2012, 2017, 2021

ON ADOLESCENCE, EXAMINED UNDER PAPER I PSYCHOLOGY

Psychological development in adolescence is asked with its psychiatric relation attached, which is the examiner signalling that normal adolescent development is the setup and the disorders are the payoff. The normal half is owned here: identity formation, the neurodevelopment of adolescence, the imbalance between a fast-maturing reward system and a slow-maturing control system, and why risk-taking is developmentally expected rather than pathological. The disorder half belongs to the disorder chapters. MUHS 2018, 2020

WHAT HAS NEVER BEEN ASKED, AND WHAT TO DO ABOUT IT

There is no question on record on the milestone tables, on the primitive reflexes, on attachment classification, on temperament, or on the developmental screening instruments. Two readings are available and both are worth holding. The first is that these are low-yield for the written paper and should be learned to a clinical rather than an examination standard. The second is that they are exactly the material a viva or a clinical case can turn on without warning, because they are what a child psychiatrist is assumed to know rather than asked to prove. Prepare the theories for the paper. Prepare the deviation call for the patient.

Quick review

DEVELOPMENTAL PSYCHIATRY: THEORIES, MILESTONES AND THE DEVIATION CALL	
THE INTERPRETIVE RULE	
CONSTRUCT BEFORE ACTION	**Median** means half have attained the skill; **expected** means usually attained; **expected range** is a normal window; **upper limit** is the outer normal bound; and **red flag** warrants further evaluation. If the source leaves the construct unclear, repeat only its own wording. Never turn it into a referral threshold.
WHAT EACH THEORY ASKS	
PIAGET	**How is cognition organised?** Sensorimotor action becomes preoperational representation, concrete operations bring reversible logic for tangible material, and formal operations extend reasoning to propositions and possibilities. The stage bands are theoretical descriptions, not milestone norms or referral ages.
ERIKSON	**Which psychosocial conflict is foregrounded?** Trust versus mistrust, autonomy versus shame and doubt, initiative versus guilt, industry versus inferiority, identity versus role confusion, intimacy versus isolation, generativity versus stagnation, and integrity versus despair. Use the conflict and strength for formulation, not diagnosis.
FREUD	**How are drive, bodily focus and conflict organised?** Oral, anal, phallic, latency and genital. Fixation is an enduring investment in an earlier mode; regression is movement back toward it under stress. These are historical psychosexual mappings, not developmental screening stages or Tanner stages.
MAHLER	**How does psychological separateness develop within relationship?** Distinguish separation, "I am not you," from individuation, "I am me." Object constancy is the affective capacity to retain a whole loved person across absence and frustration; it is not Piagetian object permanence.
KOHLBERG	**How is a moral judgement justified?** Preconventional reasoning moves from punishment to exchange; conventional reasoning from approval to social order; postconventional reasoning evaluates law through rights and principles. Score the reason, not the verdict. Kaplan and Sadock gives only descriptive bands: before adolescence, school-aged children, some young adolescents, during adolescence, later in adolescence, and late adolescence or early adulthood. There are no sourced numeric ages.

DEVELOPMENTAL PSYCHIATRY: THEORIES, MILESTONES AND THE DEVIATION CALL	
VYGOTSKY	**What becomes possible through social mediation?** The zone of proximal development lies between independent and assisted performance; scaffolding is contingent support that is faded; social speech becomes private and inner speech. Vygotsky proposed **no stages**, so he belongs beside an age axis as a cross-cutting mechanism.
LANGUAGE ACQUISITION	**Skinner**: operant contingencies shape verbal behaviour. **Chomsky**: innate grammatical preparedness supports generative language. **Vygotsky**: shared speech is socially mediated and internalised. Consequence, grammar and mediation answer different parts of the same problem.
ATTACHMENT	**Bowlby** asks how proximity to a familiar caregiver provides safe haven and secure base; internal working models carry expectations of self, others and help. In **Ainsworth's Strange Situation**, reunion distinguishes secure use of comfort, avoidant minimisation, ambivalent or resistant approach with resistance, and disorganised absence of a coherent strategy. These are relationship patterns, not diagnoses.
TEMPERAMENT AND PARENTING	**Thomas and Chess** ask how activity, rhythmicity, approach or withdrawal, adaptability, threshold, intensity, mood, distractibility, and attention span or persistence fit the environment. Easy, difficult and slow-to-warm-up are constellations; outcome depends on goodness of fit. **Baumrind** maps responsiveness and demandingness: authoritative is high-high, authoritarian low-high, permissive high-low, and uninvolved low-low.
ADOLESCENCE AND ADVERSITY	Adolescence is asynchronous change in body, reward, control, identity and relationships. Dual-systems and maturational-imbalance models explain context-sensitive risk, not global irrationality. Marcia separates exploration from commitment. Deprivation removes expected input; threat adds danger. Resilience is better-than-expected adaptation produced by dynamic child-context processes, especially stable responsive care, not an invulnerable trait.
SOURCED MILESTONE ANCHORS	
WHO GROSS MOTOR WINDOWS	The WHO 1st-to-99th-centile windows are: sitting without support **3.8 to 9.2 months**; standing with assistance **4.8 to 11.4 months**; hands-and-knees crawling **5.2 to 13.5 months**; walking with assistance **5.9 to 13.7 months**; standing alone **6.9 to 16.9 months**; walking alone **8.2 to 17.6 months**. Beyond an upper boundary signals the need for appropriate screening. It is not a diagnosis or an independently sourced referral threshold.

DEVELOPMENTAL PSYCHIATRY: THEORIES, MILESTONES AND THE DEVIATION CALL	
FINE MOTOR	Berk expects a well-coordinated pincer grasp **by the end of the first year**, vigorous scribbling between **10 and 21 months**, and a tower of two cubes between **10 and 19 months**. These are expected attainments or ranges, not referral thresholds. Observe vision, posture, symmetry, tone, comprehension and opportunity.
LANGUAGE AND SPEECH	Kaplan and Sadock expects cooing at about **3 to 4 months**, meaningful words at about **12 months**, and word combinations at **18 months**. Speech is expected to be about **25 percent** intelligible to strangers at **18 months**, **50 percent** at **24 months**, **75 percent** at **36 months**, and nearly **100 percent** by **4 years**. These are expected values, not referral cuts.
SOCIAL AND COGNITIVE	Berk gives the social-smile window as **6 to 10 weeks**. Joint attention and pointing are expected around **12 months** in the New Oxford Textbook of Psychiatry; Dulcan expects symbolic play at **18 months**; explicit false-belief performance is expected at **4 or 5 years** in the cited account. None is an automatic referral threshold.
PUBERTY AND TANNER	Tanner stage is morphological: record breast or genital development and pubic hair separately, never infer stage from age or psychological maturity. Berk's expected ranges include breast budding at **8 to 13 years**, testicular enlargement at **9 to 13.5 years**, menarche at **10.5 to 14 years**, and spermarche at **12 to 16 years**. These are expected ranges, not clinical cut-offs.
SCREENING SIGNALS, RED FLAGS AND REFLEXES	
WHO SCREENING SIGNAL	The gross-motor windows describe variation and signal screening when a child appears late. About **4.3 percent** of children in the WHO study never exhibited hands-and-knees crawling, so absence of crawling alone is not a red flag. Judge progression, transitions, symmetry, tone and movement quality.
COMMUNICATION RED FLAGS	Arrange prompt developmental evaluation for no babbling or gesturing at **12 months**, no single words at **16 months**, no spontaneous two-word phrases at **24 months**, or loss of language or social skills at **any age**. These Developmental Psychopathology thresholds are referral signals, not diagnoses.
EXPECTED REFLEX DISAPPEARANCE	Keep the source attached: rooting at **3 weeks** in Berk; sucking after **4 months** in Berk; palmar grasp at **3 to 4 months** in Berk; stepping at **2 months** in Hutchison's Clinical Methods; asymmetric tonic neck reflex at **4 months** in Berk; Moro at **12 weeks** in Tasman but **6 months** in Berk and Hutchison. Do not average disagreement.

DEVELOPMENTAL PSYCHIATRY: THEORIES, MILESTONES AND THE DEVIATION CALL	
BABINSKI AND REFLEX RED FLAGS	Berk gives Babinski disappearance at **8 to 12 months**; Hutchison gives the extensor plantar response an upper limit of **18 months** and calls persistence beyond **2 years** a red flag. Hutchison also flags absence of sucking beyond the **36th week of gestation** and gives persistence of primitive reflexes beyond the **fourth month of life** as a general warning. Reflex-specific expectations, symmetry, tone and the neurological examination still govern interpretation.
THE DEVIATION CALL	
NAME THE TRAJECTORY	**Delay** is slow acquisition with broadly preserved sequence; **dissociation** is uneven development between domains; **deviance** is an unusual sequence or quality; **plateau** is failure to acquire new skills; **regression** is loss of a convincingly acquired skill. Also act on marked asymmetry, abnormal tone or movement, sensory concern, neurological findings and convergent multi-domain difficulty.
SURVEILLANCE TO ASSESSMENT	**Surveillance** repeatedly integrates concerns, history, observation, examination and trajectory. **Screening** applies a standardised risk filter and does not diagnose. **Assessment** characterises strengths and impairments across domains and investigates cause. A negative screen never overrules regression, a sourced red flag, abnormal examination or persistent concern.
INDIAN PATHWAY	The Trivandrum Development Screening Chart covers birth to **6 years**; **one item delay** is the positive screen termed TDSC delay. DASII yields Motor DQ and Mental DQ; Indian follow-up practice uses **DQ below 85** as a delay marker. A positive screen or quotient is not a diagnosis.
FINAL ACTION	Use **trajectory, pattern, construct, action**. Continue surveillance for a coherent progressing course within an expected window; screen when a WHO upper boundary is crossed; arrange comprehensive evaluation for regression, an explicit red flag, marked asymmetry, abnormal quality, neurological or sensory findings, multi-domain delay, or persistent clinical concern.

References

Normal development is a chapter where the sources disagree with each other more than they admit, and the reference list is built to show that rather than hide it. Every age, stage boundary, reflex age and instrument property in these notes was taken from a named source and checked against it; where two standard texts give different bands for the same stage, both are reported and neither is presented as the answer. The depth bar for the theories is Berk's *Development Through the Lifespan*, which is the source that aligns Freud, Erikson and Piaget on shared boundaries and therefore the source the alignment plate follows. Tasman and Kaplan and Sadock carry the

psychiatric framing, Lewis and Cicchetti's *Developmental Psychopathology* the child-psychiatry depth and the language red flags, Wolberg the Mahler subphases, Hutchison's *Clinical Methods* the primitive reflexes and their persistence, Schunk's *Learning Theories* the Vygotskian material, and Kaufman's *Clinical Neurology for Psychiatrists* the early-handedness sign. The Indian frame comes from the Indian Psychiatric Society child and adolescent guideline and from the primary validation literature for the Indian instruments.

Two sources carry more weight than the rest and deserve naming for what they are. The WHO Motor Development Study is the only source in this chapter that states the normative role of its own numbers: its windows are bounded by the 1st and 99th centiles, it followed children in Ghana, India, Norway, Oman and the USA, and it says in its own words that the windows exist to signal the need for screening rather than to diagnose. Every gross-motor boundary taught here comes from it, and comes labelled as what it is. The Trivandrum validation is the only Indian screening instrument in this chapter with published psychometrics, and its sensitivity, specificity and predictive values are reported from the primary paper rather than from a secondary summary.

Three absences are load-bearing and are stated rather than papered over. Nelson's *Textbook of Pediatrics*, the source a paediatric milestone chapter would normally lean on, was not available; the milestone ages here come from the developmental psychology and psychiatry texts instead. No Indian Academy of Pediatrics milestone chart was available, so no IAP milestone age is stated anywhere in this chapter. The DASII manual was not available, so its administration range, item structure and norming sample are not stated; only its two developmental quotients and the delay marker used in Indian follow-up practice are given, from the applied literature. Where a value could not be sourced, it was left out.

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PART II

II

Intellectual Disability and Autism Spectrum Disorder

Intellectual disability and autism: how each is defined and assessed, what lies beneath them, and what can actually be done.

01 Intellectual disability: the concept and its measurement

02 The causes of intellectual disability

03 Living with intellectual disability

04 Autism: concept, causes and criteria

05 The clinical picture of autism and how it is recognised

06 Managing autism and its outcome

07 Discriminate, apply and consolidate

PAPER III

Intellectual disability & autism spectrum disorder

Six bands . one complete notes document

Intellectual disability: the concept and its measurement

1 · The neurodevelopmental frame

Begin with the person, not the label. Intellectual disability and autism spectrum disorder are developmental presentations that demand careful formulation rather than rapid categorisation. The marks lie in showing that one can move from a concern raised by a family or school to a coherent account of abilities, everyday functioning, communication, behaviour, context and need. A diagnosis may organise that account, but it does not replace it.

This chapter is best read as a clinical sequence. It first establishes the language and measurement needed to describe intellectual disability, then considers causes, associated psychiatric and practical concerns, and care across settings. It then develops autism spectrum disorder from its diagnostic framework through recognition, assessment, intervention and outcome. The final task is discrimination: deciding which explanation best fits the observed developmental pattern and what the distinction changes for the person and family.

ID	ASD	PERSON
CONCEPT AND MEASUREMENT	RECOGNITION AND FORMULATION	FUNCTION BEFORE LABEL

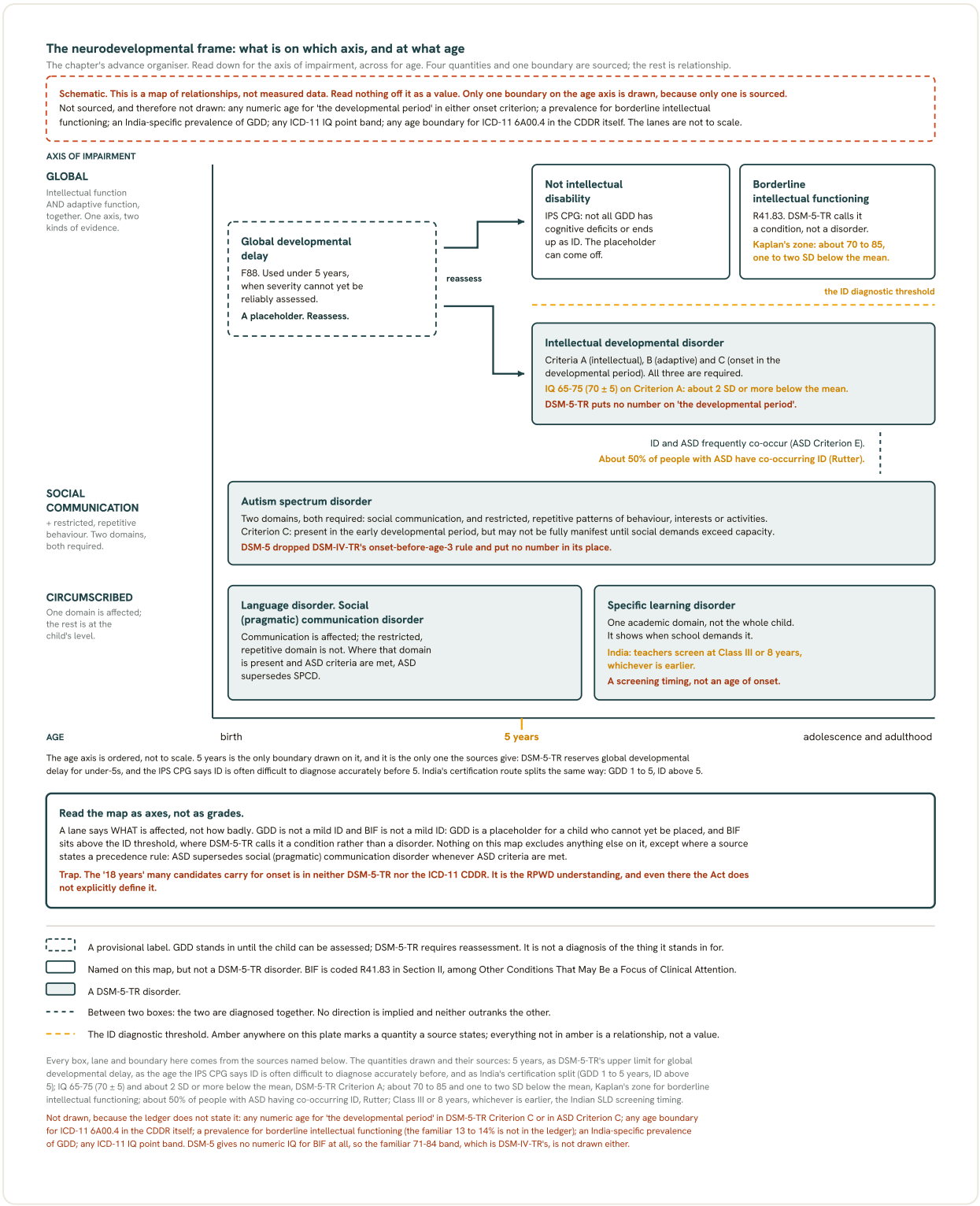


Fig 21.1 **The neurodevelopmental frame.** The chapter's advance organiser: age runs across, the axis of impairment runs down, and every entity the chapter teaches has a place on both. Global developmental delay is drawn with a dashed border because it is a placeholder, not a diagnosis, and it forks on reassessment; intellectual developmental disorder and autism spectrum disorder sit in different lanes and are joined by a dashed rule because they are diagnosed together rather than ranked; borderline intellectual functioning sits on the same global axis as ID but above the diagnostic threshold, where DSM-5-TR calls it a condition and not a disorder. The age axis is ordered rather than scaled, and carries the single boundary the sources give.

1.1 The organising clinical question

A **developmental formulation** is a working explanation of how a person has developed, what they can do in ordinary settings, what creates difficulty, and what may help. It is deliberately

broader than a diagnostic label. It prevents a clinician from mistaking a test result, a conspicuous behaviour, or a single historical detail for the whole clinical picture.

RULE **Formulate functioning in context before using a diagnostic label to organise the next step.** A label becomes clinically useful only when it clarifies the pattern of difficulty, the questions still to be answered, and the support that may be needed.

At the outset, hold several strands together:

- the **presenting concern** in the words of the person, family, school or referrer;
- a **longitudinal history** that asks how the current pattern emerged and changed;
- the person's **functional profile** across their actual environments; and
- the **contextual formulation** of relationships, opportunity, stress, culture and available support.

Developmental expectations belong in *the Normal child development and milestones notes*. A full child psychiatric assessment, service response and safeguarding approach belong in *the Child psychiatry: assessment, treatment, services and protection notes*. Those cross-references matter because a developmental formulation is only as good as the history and context on which it rests.

1.2 A map of the chapter

The chapter separates related questions so that each can be answered precisely. The following map is a reading aid, not a diagnostic algorithm.

CLINICAL QUESTION	CHAPTER FOCUS	WHY THE DISTINCTION MATTERS
How should intellectual ability and everyday functioning be described?	Concept, criteria, assessment and adaptive behaviour	Description needs interpretation in the person's life context.
What may account for the developmental presentation?	Causes and syndrome-specific discussions	Explanation can alter investigation, anticipatory care and counselling.
Is autism spectrum disorder the best account of the observed developmental pattern?	Diagnostic framework, clinical picture and assessment	Recognition requires a pattern-based judgement rather than an isolated feature.
What should change in the person's everyday life?	Interventions, health review, family support and prognosis	A **support plan** translates formulation into feasible action.

The questions interact, but they should not be collapsed. A person may need more than one explanatory frame, and the clinician must decide what each frame adds. Assessment methods, severity language, aetiological work-up and intervention are therefore developed in their own sections rather than treated as interchangeable.

TRAP **Examination trap:** do not let an early label replace description of the observed problem. Establish the pattern first, then use the relevant framework to explain it.

1.3 Reading findings without reductionism

GOOD TO REMEMBER

Interpret clinical information together: history may reveal a developmental trajectory; direct observation may show communication and response to change; assessment may characterise ability or practical skill; and collateral may reveal demands invisible in the consulting room. Check **ecological validity**: the account should fit the person's life outside the clinic as well as the clinician's impression inside it.

Use the chapter to ask progressively sharper questions: What is the pattern of strength, difficulty and participation? What information would materially change the formulation? Which co-occurring concerns require active recognition rather than attribution to the developmental diagnosis? What support is needed now, and what should be reviewed as circumstances change?

This approach resists **diagnostic reductionism**: the error of allowing one diagnosis to explain every difficulty, behaviour or need. It also makes room for the person's preferences and the family's realities. Good developmental psychiatry is exact about constructs while remaining practical about lives.

1.4 Master mnemonic: MAP

A compact way to retain the chapter. Use **MAP** as a sequencing aid when approaching a developmental presentation. It is not a substitute for assessment; it is a safeguard against beginning in the wrong place.

MNEMONIC

MAP

Map the developmental and functional story.
Ask which framework best explains the pattern.
Plan support around the person, family and participation.

The first step keeps the account anchored in lived function. The second directs the clinician to the chapter's conceptual and diagnostic material without forcing a premature conclusion. The final step prevents assessment from becoming an endpoint: the relevant outcome is a more useful, humane and workable response.

The durable answer in developmental psychiatry is a formulation that explains function, recognises pattern and directs support.

2 · Global developmental delay concept

Global developmental delay is a clinical description for an early developmental presentation, not a shortcut to a settled prognosis. It is used when a child has not acquired expected developmental abilities across several areas, but the clinician cannot yet make a reliable statement about the severity of intellectual impairment. The label is valuable precisely because it

preserves that uncertainty. It allows the record to acknowledge a real developmental concern, organise the next clinical steps, and communicate need without pretending that a premature measurement has answered the longer-term question.

The topic is frequently examined because it tests clinical reasoning at the boundary between observation and diagnosis. Candidates must distinguish a broad developmental delay from a definitive intellectual-developmental diagnosis, explain why early assessment can be limited, and avoid converting a description of current functioning into a prediction about lifelong ability. In DSM-5-TR, global developmental delay is recorded with the code **F88**. The code should serve the formulation, not replace it.

F88	below 5 years	between 3 months and 5 years	at least 2 domains
DSM-5-TR GDD CODE	DSM-5-TR AGE USE	INDIAN GUIDELINE WINDOW	OPERATIONAL THRESHOLD

2.1 What the label is for

Global developmental delay is reserved in DSM-5-TR for a child **below 5 years** when the clinical severity of intellectual impairment cannot yet be assessed reliably. This is not merely a matter of a child being young. The label is appropriate when the child has failed to achieve expected milestones in several areas of intellectual functioning and cannot undergo a systematic assessment that would permit a dependable severity judgement. Developmental variation, limited cooperation, sensory or physical difficulties, and the practical limits of formal assessment can all make an apparently precise conclusion unsound.

The key idea is **assessability**. A clinician may have persuasive evidence that development is not proceeding as expected while lacking a valid way to quantify the enduring intellectual and adaptive picture. The correct response is neither to deny the concern nor to force a severity label. Global developmental delay creates an honest interim formulation: there is a clinically meaningful developmental problem, its pattern must be described, and the formulation must remain open to revision.

RULE **Defining principle.** Use global developmental delay when delay is evident but a reliable developmental severity judgement cannot yet be made; make reassessment part of the diagnosis from the outset.

GOOD TO REMEMBER

Families often arrive seeking a definitive answer after a milestone concern, a referral from an educational setting, or an earlier clinical opinion. The psychiatrist must hold uncertainty without sounding evasive. Explain what has been observed, what remains difficult to judge, and what information will make the formulation more robust. A diagnostic label should reduce confusion, not offer a false certainty that later requires withdrawal.

Developmental expectations and their usual sequence belong in *the Normal child development and milestones notes*. The full approach to history-taking, examination, assessment planning, services and protection belongs in *the Child psychiatry: assessment, treatment, services and protection notes*. This section focuses on the conceptual work: when to use the label, what it means, and what it does not mean.

2.2 Why early developmental uncertainty is clinically real

Early childhood is a period of rapid acquisition, uneven performance and changing demands. A child may demonstrate an ability in a setting but not another, or show an emerging skill that cannot yet be relied upon in everyday life. Conversely, a striking delay may be clear before the clinician can determine whether it reflects a broad and persistent intellectual-developmental difficulty, a transient lag, a limitation of the available assessment, or a combination of these. The purpose of global developmental delay is to represent this clinical state accurately.

IN INDIA

The Indian guideline makes the same practical point: although intellectual disability may be recognisable early in development, it is often difficult to diagnose it accurately before 5 years of age. This is why the guideline uses global developmental delay as a **surrogate marker between 3 months and 5 years**. "Surrogate" should be read carefully. It means the term can organise recognition and follow-up during a period when the final intellectual-developmental formulation is not yet reliable. It does not mean that the two labels are interchangeable.

Diagnostic uncertainty is not diagnostic inaction. A useful **developmental formulation** states the abilities that are emerging, the activities that remain difficult, the contexts in which difficulty is most evident, and the collateral information needed to clarify the pattern. It also records uncertainty explicitly. This protects against a common clinical drift in which a provisional descriptive term is treated as though it had already settled questions about intellectual ability, adaptive functioning, cause or prognosis.

A child who cannot complete a systematic assessment should not be described as "untestable" and then left outside a formulation. The more accurate question is what has prevented a valid assessment on this occasion and how the clinician can obtain a better account of function over time. That may involve observation in familiar settings, informed collateral accounts, repeated contact, and attention to communication, motor, sensory and behavioural barriers. The methods and interpretation of intelligence testing are dealt with in the chapter's assessment material; the present point is that a score is not required before a developmental concern can be named responsibly.

TRAP **Examination trap:** do not write that global developmental delay is simply "intellectual disability in a young child". It is the appropriate label when the developmental concern is clear but the enduring degree of intellectual impairment cannot yet be judged reliably.

2.3 Operationalising a broad developmental delay

The Indian guideline cites **Shevell et al. (2008)** for an operational definition. In that approach, significant delay must be present in **at least 2** developmental domains. This is an operational framework for describing global delay, not a substitute for the diagnostic rationale about why a reliable severity assessment cannot yet be made. In an answer, it is good practice to name the framework being used rather than silently combining criteria from different systems.

The listed areas form a **developmental profile**, not a checklist to be ticked without context. A delay in a domain may affect performance in another. For example, limited motor opportunity can alter what is observed in self-care, and reduced communication can obscure social participation. The clinician's job is to decide whether the observed pattern reflects broad developmental delay rather than merely adding isolated concerns together.

DEVELOPMENTAL AREA	QUESTION FOR THE CLINICAL FORMULATION	COMMON REASONING ERROR TO AVOID
Gross and fine motor	What movement and hand-use abilities are established in ordinary routines?	Assuming that limited opportunity and intrinsic delay are automatically the same.
Speech and language	How does the child understand, express and use communication in context?	Equating a language difficulty with global delay without reviewing the broader profile.
Social and personal functioning	How does the child participate with familiar people and manage age-expected interactions?	Explaining every social difficulty through a single diagnostic label.
Cognition	How does the child learn, solve everyday problems and generalise an acquired ability?	Treating an isolated observed success or failure as the whole cognitive account.
Activities of daily living	What can the child do in dressing, feeding, routines and other everyday tasks?	Ignoring environmental support or opportunity when judging independence.

The table is deliberately descriptive. It does not convert the domains into a severity scale, an intelligence test, or a statutory disability assessment. Those are different constructs and are treated elsewhere in the chapter. For this topic, the useful result is a coherent account of which developmental abilities have not emerged as expected, which strengths are already present, and why the available evidence supports a broad developmental concern.

- Describe abilities in the child's actual routines rather than using only a global label.
- Identify whether delays are spread across the developmental profile or confined to a more limited concern.
- Record factors that may make observed performance underestimate the child's capacity on that occasion.
- State what should be reviewed when more reliable developmental information becomes available.

2.4 A provisional formulation, not a forecast

Global developmental delay is often clinically adjacent to intellectual developmental disorder, but adjacency is not identity. DSM-5-TR notes that some children younger than 5 years whose later presentation meets criteria for intellectual developmental disorder first meet criteria for global developmental delay. This is an account of a possible developmental pathway, not a rule that every child with global delay will later receive that diagnosis.

The Indian guideline is explicit about **prognostic non-equivalence**: global developmental delay is not an inevitable precursor to intellectual disability. Some children described as having global delay will not have cognitive deficits that persist as intellectual disability. This caution is more than a prognostic nicety. If the early label is treated as a permanent verdict, the family may be given an unnecessarily narrowed view of the child's possibilities, while the clinician may stop looking for change, emerging skills or a more differentiated explanation.

Equally, the opposite error is harmful. Because some developmental delays may change over time, clinicians should not minimise a broad delay in the hope that it will resolve without review. A longitudinal formulation balances both risks: it recognises current impairment and need, avoids premature permanence, and specifies the questions that subsequent assessment must answer. It is a way of being precise about the present without claiming ownership of the future.

MNEMONIC

PAUSE when the early developmental picture feels uncertain

Profile the child's functioning in ordinary settings.
Ask whether current assessment is genuinely valid.
Use uncertainty honestly rather than forcing a severity label.
See whether delay extends across developmental areas.
Evaluate again as the profile becomes clearer.

This is not a substitute for assessment. It is a guard against the familiar tendency to make the label carry more certainty than the evidence can support. The careful clinician does not wait passively for certainty; the clinician makes the uncertainty visible, develops a plan to reduce it, and documents the child's current needs in the meantime.

2.5 Reassessment is part of the diagnosis

The DSM-5-TR conditions of use for global developmental delay include **reassessment** after time has passed. That is not an administrative afterthought. The diagnosis has been chosen partly because present methods cannot support a reliable severity judgement; repeating the same unsupported conclusion at later contacts defeats its purpose. Reassessment asks whether the developmental trajectory has clarified, whether systematic assessment has become feasible, and whether the child's everyday functioning now supports a more definite formulation.

Good documentation makes this possible. It separates what was directly observed from what was reported, identifies the developmental areas of concern, records strengths and contextual supports, and states why the assessment could not yet be definitive. It also avoids language that

freezes a child into an early label. “Current presentation is consistent with global developmental delay; reassessment is planned as developmental information becomes more reliable” is clinically more useful than either an unsupported categorical diagnosis or a vague note that offers no plan.

The review is not solely a search for a new diagnostic name. It should ask whether the formulation has become more specific, whether the child’s functional needs have changed, and whether the initial pattern needs to be reconsidered. A broad developmental concern can coexist with communication, motor, sensory, medical or contextual contributors that alter what is seen. The fuller developmental and psychiatric assessment belongs in *the Child psychiatry: assessment, treatment, services and protection notes*; this label should prompt that work rather than close it down.

TRAP **Examination trap:** “provisional” does not mean “wait and see without a plan”. It means document the current developmental concern, address present need, and arrange the reassessment that the provisional formulation requires.

2.6 Coding boundaries and classification caution

Classification systems do not always provide a direct vocabulary correspondence for the same clinical presentation. DSM-5-TR supplies global developmental delay as F88 for the early-childhood situation described above. By contrast, the **ICD-11 CDDR** contains no category named global developmental delay. The safe clinical conclusion is not to invent a correspondence. Describe the child’s developmental presentation clearly, use the classification framework required in the setting, and record why diagnostic certainty is limited.

A related DSM-5-TR category is **Unspecified Intellectual Developmental Disorder**, coded **F79**. It is reserved for exceptional circumstances in an individual above 5 years when locally available procedures cannot establish the degree of intellectual developmental disorder because associated impairments or severe problem behaviours make this difficult or impossible. It also requires reassessment. This is a different problem from the expected early-childhood uncertainty represented by global developmental delay, and the age boundary should not be reversed in an examination answer.

CLINICAL SITUATION	LABELING LOGIC	ESSENTIAL CAUTION
Early childhood with broad developmental concerns and unreliable severity assessment	DSM-5-TR global developmental delay, F88, for a child below 5 years.	It is a provisional developmental formulation that needs review.
Later assessment made impracticable by associated impairments or severe problem behaviours	DSM-5-TR unspecified intellectual developmental disorder, F79, in exceptional circumstances above 5 years.	Do not use it as a routine substitute for a proper assessment.
ICD-11 terminology	The CDDR has no category named global developmental delay.	Do not assert an unverified direct counterpart.

Kaplan and Sadock's summary describes an ICD-11 provisional disorder-of-intellectual-development category for a child below 4 years when there is evidence of disorder but it is difficult to know whether observed impairments may be transient. This is a useful reminder of the underlying clinical problem, but it does not resolve the naming discrepancy in ICD-11. The relevant **provisional category** reflects uncertainty about whether early impairment will persist, rather than a licence to treat every early delay as a definite disorder of intellectual development.

2.7 Clinical communication and the referral-to-support link

The value of recognition is practical. Identifying global developmental delay gives the clinician a shared language for referral, follow-up and communication with caregivers. It tells other professionals that developmental concerns extend beyond an isolated complaint and that the child needs an organised account of function. It also preserves the imperative to review the formulation as the child becomes more assessable. That combination of recognition and openness is the clinical strength of the term.

Conversations with families should be clear about what is known and what is not. Avoid implying that a descriptive early label proves a fixed lifelong outcome. Avoid the opposite reassurance that a broad delay needs no active response because the future is uncertain. Explain that the current pattern warrants attention, that abilities and needs should be described in everyday terms, and that later reassessment can refine the understanding. The family's observations of what the child can do, what needs assistance, and which settings make participation harder are central clinical data, not decorative collateral.

Why identifying global developmental delay matters for referral and **early intervention** is developed in the management section of this chapter. The present diagnostic task is more limited: make the developmental concern visible early enough that appropriate support is not postponed while diagnostic certainty is still evolving. The service model, its evidence and its Indian delivery context belong to that owner section and should not be inferred from the label alone.

- Communicate the present developmental profile in plain, functional language.
- State clearly that global developmental delay is an interim formulation rather than a prediction of a fixed outcome.
- Document the reason a definitive severity judgement is not yet reliable.
- Build reassessment into the plan and record what information should clarify the next formulation.

> Global developmental delay names a genuine broad developmental concern while protecting the child from a severity judgement that the available evidence cannot yet support.

3 · Definition and diagnostic criteria of intellectual disability (DSM-5 and ICD-11)

The diagnostic task is to establish a developmental disorder of functioning, not to attach a label to a low test score. Intellectual disability is diagnosed when limitations in intellectual

functioning, adaptive functioning, and developmental onset form the same clinical picture. The criteria are deliberately conjunctive: each protects against a different error. Intellectual testing without functional assessment can medicalise a score; functional difficulty without developmental onset may represent an acquired disorder; and a developmental history without evidence of current limitation does not itself establish the diagnosis.

For examination answers and clinical records, the useful sequence is therefore simple: establish the nature of the intellectual limitation, establish its consequences for everyday independence and social responsibility in the person's sociocultural setting, and establish that the pattern began in development. The DSM formulation calls the condition **intellectual developmental disorder**, with intellectual disability retained in parentheses; the ICD formulation uses the equivalent term disorders of intellectual development. The difference in wording should not obscure their shared clinical core.

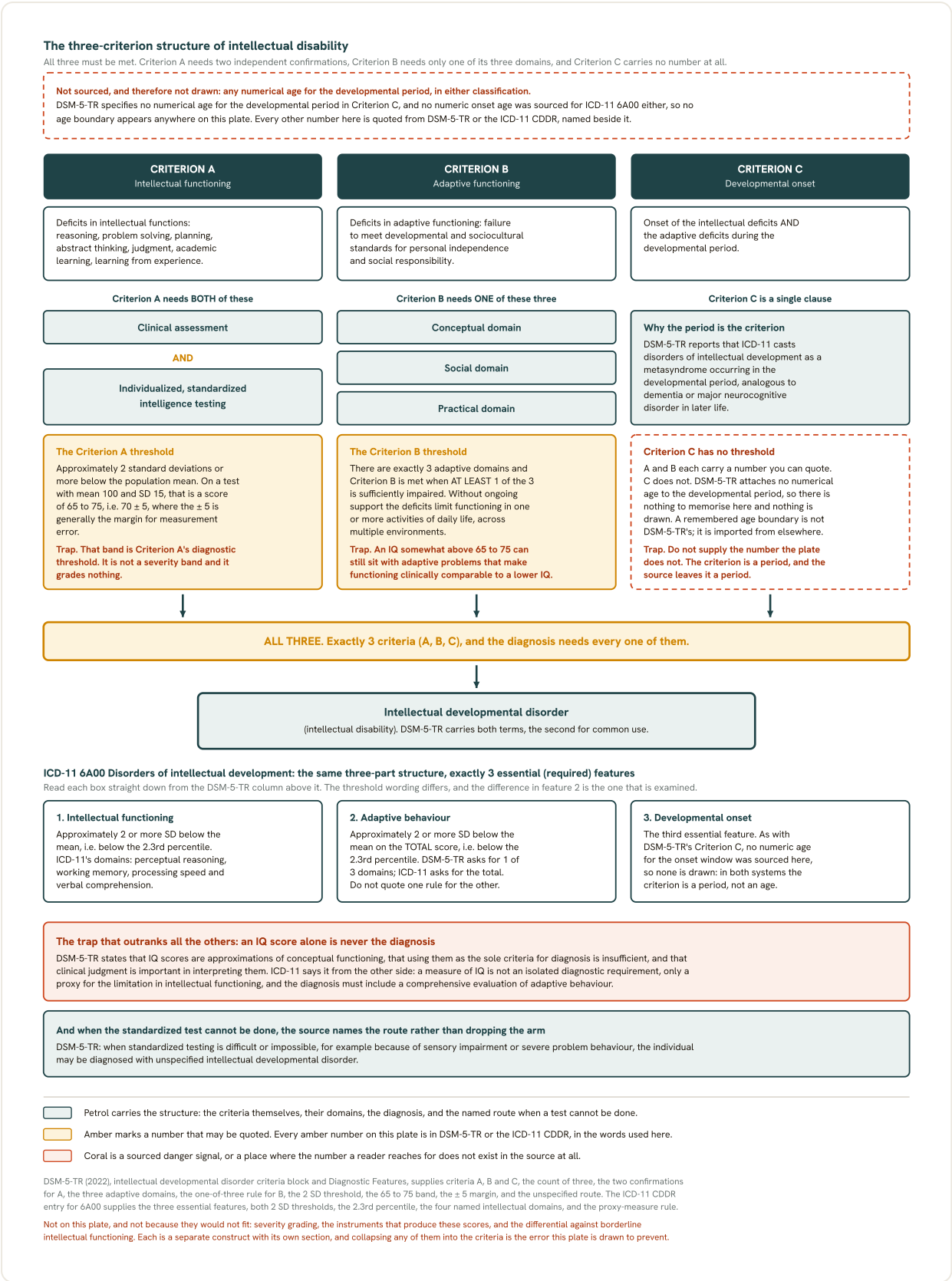


Fig 21.2 **The three-criterion structure of intellectual disability.** Criteria A, B and C are joined by a conjunction, not a menu: DSM-5-TR requires all three, and the two internal rules that decide A and B are examined more often than the criteria themselves. The ICD-11 6A00 strip reads straight down from each DSM column so the one real divergence stands out.

3.1 What the diagnosis is designed to capture

The diagnosis is about a persistent limitation in the person's capacity to understand, learn, reason and manage the ordinary demands of life, where that limitation has developmental origins. It is

neither a synonym for educational underachievement nor a shorthand for disadvantage, illness, sensory disability, behavioural disturbance, or inadequate opportunity. Each of these may complicate assessment, and some may impair performance in a testing situation, but none can substitute for the full diagnostic formulation.

DSM expresses this through **three** criteria that must all be met. Their structure is clinically elegant. The intellectual criterion asks whether the relevant cognitive functions are impaired. The adaptive criterion asks whether that impairment matters in real life. The onset criterion prevents an acquired cognitive disorder from being placed in a developmental category. The diagnosis consequently rests on convergent evidence, not on one encounter or one instrument.

RULE **Diagnostic principle:** diagnose intellectual disability only when intellectual limitation, adaptive limitation and developmental onset are demonstrated together.

This formulation is especially important where a family requests a certificate, school accommodation, or diagnostic clarification after a long period of difficulty. The clinician should keep the diagnostic question separate from the administrative question of whether services are known to the family or available locally. Service contact may reveal need, but it does not create the disorder. Conversely, absence of prior contact does not negate a developmental disability.

3.2 DSM diagnostic criteria: the diagnostic formulation

Criterion A concerns deficits in intellectual functions. In practice, the clinician looks for difficulty in reasoning, problem solving, planning, abstract thinking, judgment, academic learning, or learning from experience, and confirms the finding through both clinical assessment and individually administered standardised intelligence testing. The word “both” matters. A formal result gives disciplined comparison with an appropriate normative group, whereas the clinical assessment asks whether the result is coherent with the history, observed performance, language, education, sensory status and opportunities to learn.

Criterion B concerns **adaptive functioning**. The relevant question is whether deficits lead to failure to meet developmental and sociocultural expectations for personal independence and social responsibility. Without continuing support, the deficits must limit activity in everyday life across multiple settings. This moves assessment from an abstract estimate of ability to the person’s actual functioning at home, in education or work, and in the community. The criterion can be met where there is sufficient impairment in at least one adaptive domain; the domains are conceptual, social and practical.

Criterion C requires onset of both intellectual and adaptive deficits during the **developmental period**. This is a historical criterion, so it requires collateral. Developmental records, school reports, informant accounts and prior assessments may be more informative than a patient’s retrospective account alone. The question is not whether the person was ever labelled, but whether the characteristic pattern was present in development.

- Ask whether the cognitive difficulty is broad enough to affect reasoning and learning rather than reflecting a circumscribed academic problem.

- Ask what the person can do independently, what they can do only with prompting, and what remains unsafe or unachievable despite ordinary opportunities.
- Seek a developmental history from someone who knows the person's earlier functioning, while recognising that documentation may be incomplete.

The criteria are not a checklist to complete mechanically. A person may perform poorly because of an acute mental state, language mismatch, sensory limitation, poor engagement or an unsuitable test. Equally, a person may show apparently acceptable performance in a familiar, highly supported routine while being unable to generalise skills or assume responsibility in less structured settings. Clinical synthesis is what decides whether the three criteria describe one developmental condition.

3.3 Interpreting the intellectual-functioning criterion

Criterion A is met when intellectual functioning falls **two or more standard deviations below the population mean**. That is a diagnostic threshold, not a severity grade, and it must not be turned into one: this chapter grades severity by adaptive functioning, and the reasons are set out above. What an IQ score actually is, how far it can be trusted, and what makes an obtained score misleading are the business of the clinical-assessment section, which takes the normative distribution, the error margin around a score, the **Flynn effect**, practice effects and the instruments that cannot carry a diagnostic opinion in turn. Read it before you act on any number.

TRAP **Examination trap:** an IQ score is evidence for Criterion A, not a stand-alone diagnosis and not a substitute for adaptive assessment.

One consequence belongs here rather than there, because it is a statement about the criterion itself and not about the instrument. Discordance between intellectual testing and everyday performance deserves active thought rather than reflexive exclusion: DSM recognises that a person whose score lies somewhat above the conventional Criterion A band may nonetheless have adaptive problems so substantial that their actual functioning resembles that of people with lower scores. The response is not to lower a threshold by intuition. It is to review test validity, collateral information, the quality of adaptive evidence, and the developmental course before reaching a defensible formulation. The criterion is a floor for evidence, not a verdict delivered by a number.

3.4 Adaptive functioning and onset: turning scores into a diagnosis

Adaptive functioning is the bridge between ability and lived consequence. It asks whether the person can meet the expectations of independence and social responsibility that are reasonable for their developmental stage and sociocultural context. It is assessed through functioning, not inferred from social class, literacy, diagnosis already recorded in a file, or the wishes of a caregiver. The clinician should distinguish lack of opportunity from inability, and a task performed under extensive supervision from a task performed independently and reliably.

GOOD TO REMEMBER

Adaptive functioning asks what the person can do in everyday life across settings without ongoing support. Assess the quality and consistency of functioning, the scaffolding supplied by relatives or institutions, and what happens when that scaffolding is withdrawn. Measurement of adaptive behaviour belongs alongside, rather than in place of, this clinical enquiry. The framework specifies three domains: conceptual, social and practical.

Developmental onset has a second purpose beyond classification. It forces a chronological formulation. If the observed cognitive and functional decline is new, fluctuating, or clearly follows a later medical or psychiatric event, the clinician must consider an acquired cause rather than assume an intellectual developmental disorder. If early difficulties were present but were never assessed, the absence of a historic score should not itself defeat the diagnosis. What matters is whether reliable developmental evidence can establish the required pattern.

MNEMONIC

Think "mind, mastery, maturation"

Intellectual functions describe the mind; adaptive functioning demonstrates mastery of everyday demands; developmental onset establishes maturation as the time-course. The elements must point in the same direction.

In documentation, state the evidence for each criterion separately before writing the diagnosis. This prevents a report from using one broad phrase, such as "poor functioning," to conceal which element has actually been demonstrated. It also makes the reasoning reviewable when informants disagree, records are sparse, or testing conditions were imperfect.

3.5 ICD diagnostic framework

ICD-11 groups the condition under **6A00 Disorders of intellectual development**. It describes the construct as a **metasyndrome** occurring in the developmental period: a clinically useful reminder that the diagnosis identifies a pattern of developmental functional impairment, not a single aetiology. The aetiological formulation must therefore remain open and be pursued separately when indicated.

ICD specifies three essential features: significant limitation in intellectual functioning, significant limitation in adaptive behaviour, and onset during the developmental period. Its intellectual-functioning feature explicitly includes perceptual reasoning, working memory, processing speed and verbal comprehension. These named areas should not be substituted for the DSM Criterion A list, which is framed differently. The two systems overlap clinically but phrase their intellectual evidence in distinct ways.

DIAGNOSTIC QUESTION	DSM FORMULATION	ICD FORMULATION
Intellectual limitation	Deficits in intellectual functions, supported by clinical assessment and individual standardised testing.	Significant limitation in intellectual functioning, including the specified cognitive areas.
Functional consequence	Adaptive deficits that compromise expected independence and social responsibility.	Significant limitation in adaptive behaviour.
Time-course	Intellectual and adaptive deficits begin during development.	Both limitations have developmental onset.
Use of IQ	Interpret in clinical context; never use as the sole basis.	Treat as a proxy for intellectual limitation, alongside comprehensive adaptive evaluation.

ICD indicates significant limitation in intellectual functioning at approximately **two or more standard deviations below the mean, or below the 2.3rd percentile**. It uses the same statistical convention for a total adaptive-behaviour score. These thresholds describe the boundary with expected functioning; they do not remove the requirement for comprehensive clinical interpretation.

3.6 Assessment at the boundary: reliability, culture and unavailable tests

Both systems reject the seductive but unsafe idea that IQ alone separates disorder from normality. ICD states that IQ is a proxy measure rather than an isolated diagnostic requirement at this boundary, and diagnosis must include a comprehensive evaluation of adaptive behaviour. This protects against the false certainty produced when a numerical score is detached from language, culture, education, health, developmental opportunity and everyday functioning.

Scores may vary substantially across development. ICD consequently advises testing on repeated occasions across the developmental trajectory when a reliable estimate is required. A child can appear to meet diagnostic requirements at one assessment and not another; the clinician should interpret change before declaring either recovery or error. **Reassessment** is particularly valuable when the initial assessment was constrained by unfamiliarity, illness, poor engagement, communication difficulty, or an unstable environment.

Where appropriately normed standardised tests are unavailable, ICD places greater weight on **clinical judgement**, including behavioural indicators supplied in its diagnostic guidance. This is highly relevant to heterogeneous linguistic and educational contexts. Clinical judgement here means explicit, accountable reasoning from history, observation and functional evidence. It does not mean replacing assessment with a casual impression, assuming disability from poverty, or assigning a label merely because a formal test cannot be obtained.

- Record why a particular test result is credible, limited, or unavailable.
- State whose account supports developmental onset and what setting each adaptive observation represents.

- Describe the language and sociocultural context relevant to interpretation, rather than treating them as background decoration.

When standardised testing is difficult or impossible, such as in the presence of sensory impairment or severe problem behaviour, DSM permits the diagnosis of **unspecified intellectual developmental disorder**. This is a category for genuine diagnostic limitation, not a shortcut around careful clinical work. The report should make clear what cannot currently be established, what evidence is present, and what reassessment could clarify.

3.7 Terminology, prevalence and the distinction from service counts

Terminology has changed because diagnostic language affects how people are understood in families, services and law. DSM uses intellectual developmental disorder to align with ICD-11, while retaining intellectual disability because it remains widely used by professionals, advocacy groups and the public. In a clinical record, use respectful current terminology and describe the person's functioning and support context rather than allowing a historical label to stand in for a formulation.

Prevalence needs a denominator before it can be interpreted. DSM estimates overall general-population prevalence at approximately **10 per 1,000**, but figures derived from registers, schools or service rosters answer a different question from population studies. The concept of **administrative prevalence** concerns the people for whom a community would need services, and in practice often those whose needs are known to providers. It is useful for planning, but it should not be presented as an intrinsic biological rate.

10 per 1,000	16 per 1,000	9 per 1,000
DSM OVERALL ESTIMATE	DSM MIDDLE-INCOME ESTIMATE	DSM HIGH-INCOME ESTIMATE

IN INDIA

Reported Indian point prevalence lies between 1/1,000 and 32/1,000. A cited meta-analytic estimate is 10.37 per 1,000. In high-income settings, reported figures are 9.2 per 1,000 across all ages, 18.3 per 1,000 in child and young-person populations, and 4.9 per 1,000 in adult-only populations. The breadth of such estimates, including the reported Indian range, should make the reader ask how cases were defined, what population was sampled, and whether ascertainment relied on services, schools or household assessment. This is not pedantry. A prevalence figure used without its case definition and denominator can distort planning, obscure unmet need, or create a misleading comparison between settings.

Must remember: a low IQ score can support the diagnosis, but intellectual disability requires a developmental history and demonstrable adaptive limitation as well.

3.8 A defensible diagnostic conclusion

A high-quality conclusion names the diagnostic framework used, then shows how the evidence meets each required element. It identifies the source and limitations of intellectual assessment, gives a function-based account of adaptive impairment in relevant settings, and states the

developmental evidence. It should also acknowledge uncertainty when the evidence is incomplete. This is more clinically useful than a conclusion that merely reproduces a test result.

Do not use the diagnostic threshold to assign a severity category. The grading of intellectual disability is based on adaptive functioning and is addressed in the severity classification section. Do not confuse the diagnosis with borderline intellectual functioning, which is considered in the differentiation section. If the broader assessment has not yet been completed, say what is provisional and what collateral, functional assessment or repeat testing is still needed. The full assessment framework is covered in the Child psychiatry: assessment, treatment, services and protection notes.

4 · Severity classification (mild, moderate, severe, profound) by IQ and adaptive functioning

Severity is a description of lived support need. In intellectual disability, a severity label should help the clinician communicate what is difficult in everyday life, anticipate the breadth of assistance required, and organise a realistic plan with the person and family. It is not a shorthand for worth, potential, behaviour, or prognosis. The same label can conceal very different strengths, vulnerabilities, opportunities and barriers if it is treated as an identity rather than a clinical formulation.



Fig 21.3 Contemporary severity grading in intellectual disability is based on adaptive functioning across conceptual, social and practical domains. IQ contributes evidence but does not by itself determine the level of support a person needs.

The familiar grades run across **four** levels: mild, moderate, severe and profound. Their enduring examination relevance is that older systems linked them closely to IQ bands, whereas contemporary diagnostic practice grades severity through functioning in ordinary settings. Candidates need to be able to state both schemes, distinguish their purposes, and explain why the second is clinically more useful.

4	Adaptive	IQ	Supports
RECOGNISED SEVERITY GRADES	BASIS FOR CONTEMPORARY GRADING	SUPPORTING CLINICAL EVIDENCE	PRACTICAL CONSEQUENCE OF THE GRADE

4.1 What a severity classification is for

A **severity classification** is a communication tool, not a substitute for assessment. It gives a shared language for describing the extent of impairment, but the clinical account must still say what the person can do independently, what they can do with prompting or teaching, and where

risk or dependence becomes important. A label that is not linked to concrete functional information has little value to the family, school, employer or care team.

Severity must therefore be used at the level of the individual. It should be informed by functioning across conceptual, social and practical domains. Conceptual functioning includes the use of knowledge in everyday demands. Social functioning concerns interpersonal judgement, communication in relationships and the ability to understand social situations. Practical functioning concerns self-care, routine, safety, work-related tasks and participation in community life. These domains may be uneven. A person may show a relative strength in one setting and substantial dependence in another, particularly when a familiar and supportive environment masks difficulty that becomes apparent with changing demands.

The clinician's task is to translate this profile into a defensible grade without reducing the profile to the grade. Good documentation makes clear which examples support the judgement: what was directly observed, what reliable informants describe, and what the person manages when environmental scaffolding is withdrawn or new demands arise. It also separates lack of opportunity, sensory or motor limitations, language mismatch, physical illness and psychiatric symptoms from limitations attributable to intellectual disability. Otherwise severity can be overstated by deprivation or understated by unusually protective care.

RULE **Grade severity by the person's adaptive functioning, then use the IQ result as supporting clinical evidence.**

GOOD TO REMEMBER

This rule protects against a common distortion. A psychometric result can be highly informative, but it does not by itself show how the person manages money, relationships, self-care, safety, travel, routine, communication or unexpected change. Conversely, an apparently competent routine may depend on extensive family organisation and may not generalise beyond a familiar context. Severity is therefore a clinical judgement grounded in the person's actual life, not merely an arithmetic location on a test distribution.

4.2 The contemporary adaptive-functioning approach

Adaptive functioning is the organising principle of contemporary severity grading. The DSM-5-TR severity table describes each grade through conceptual, social and practical functioning rather than through an IQ column. This makes the table clinically legible: severity is not simply a description of test performance but a description of the gap between the person's abilities and the demands of their usual environment.

The reason for this shift is pragmatic as well as conceptual. Support needs are determined by what the person can and cannot accomplish safely and consistently in daily life. An IQ score contributes evidence about intellectual functioning, but it does not directly specify supervision, teaching, environmental adaptation, decision support or the degree to which another person must take responsibility for safety. In this approach, the grade predicts the nature of help that has to be planned, not a fixed ceiling on learning.

Adaptive information should be interpreted in context. The same skill may be performed independently in a familiar home and not be available in a more demanding environment. Families may compensate so effectively that important dependence is missed, while social exclusion or inadequate education may produce apparent deficits that are not a stable reflection of underlying capacity. The assessor should therefore ask about performance across settings, response to ordinary change, consistency over time and the amount of cueing, monitoring or physical assistance required. This is why collateral history is central rather than decorative.

The grading rule also prevents false precision. Two people with similar test results may differ materially in social judgement, practical safety, communication, co-occurring illness, sensory impairment, motor disability or access to support. Conversely, a person whose score is difficult to interpret because of language, behaviour or physical limitations may still have a clear adaptive profile. The clinical formulation should acknowledge uncertainty where it exists, rather than force a spurious numerical conclusion.

TRAP **Examination trap:** do not write that a contemporary severity grade is "based on IQ." State that severity is based on adaptive functioning, while IQ informs the wider assessment.

For DSM severity terminology, the crucial distinction is that the grade is decided from adaptive deficits. This is a useful sentence to carry into a long answer because it explains why the classification has clinical purpose. It also guards against a mechanical answer in which a candidate recites IQ ranges without demonstrating that they understand the modern framework.

4.3 DSM severity labels and coding language

The diagnostic labels are familiar, but they should be treated as severity specifiers attached to an individualised functional account. The codes below are useful for records and examinations. They do not replace a narrative description of the person's functioning, current supports, vulnerabilities or strengths.

The linked coding language is F70 for mild, F71 for moderate, F72 for severe, and F73 for profound. Pair the code and label with the adaptive profile and the help required in real settings. The code identifies a category; the formulation tells another clinician how to care for the person.

In clinical writing, the label should lead to action. A bare diagnosis may be sufficient for a register, but it is insufficient for care planning. The formulation should say which tasks need teaching, which require environmental adaptation, which need supervision, and which are currently managed with assistance. It should also identify how communication, choice and autonomy will be protected. Severity is most useful when it improves coordination between psychiatry, family, education, rehabilitation and community services.

Do not infer a person's adaptive profile from the label alone. Higher-grade disability can coexist with preferences, learning and meaningful participation, and lower-grade disability can be accompanied by marked risks in social judgement, exploitation or practical safety. The label alerts the team to likely breadth of need; the assessment tells the team what that need actually is.

4.4 IQ-based severity bands: their place and their limits

IQ-based severity bands belong to the older classification logic and remain examinable because they appear in legacy records, teaching material and administrative language. They are best presented as a historical mapping, then immediately qualified: a score range is not a contemporary severity judgement. The IQ construct, its interpretation and the choice of intelligence testing are addressed in the clinical assessment section; here the concern is only the mapping of an IQ result to a grade.

LEGACY GRADE	IQ BAND IN ONE REPORTED ICD-10 SCHEME	CLINICAL READING
Mild	**50-69**	Use as a historical IQ band, not as the sole current severity determinant.
Moderate	**35-49**	Interpret alongside the person's actual adaptive functioning.
Severe	**20-34**	Do not assume practical abilities from the band alone.
Profound	**below 20**	Functional observation remains indispensable, especially when testing has limits.

The legacy statement that the IQ cut-off is 70 is often quoted alongside the claim that ICD-10 categorised the grades by IQ. That statement accurately captures the older scheme, but should not be carried forward uncritically into contemporary diagnostic phrasing. The meaningful clinical question is not only where a score lies, but whether the individual can meet culture-appropriate everyday demands without assistance.

A source discrepancy deserves explicit caution. Another textbook presentation places the upper end of the mild band at 50-70, rather than at the upper boundary shown in the preceding table. This is not a reason to blend the two into an invented compromise. In an answer, name the classification framework being used, give its band accurately, and then state that contemporary severity is determined from adaptive functioning. That is safer than presenting a disputed edge value as universal fact.

The deeper lesson is that score bands create an appearance of sharp boundaries where clinical reality is continuous and context-dependent. Borderline intellectual functioning is a separate boundary concept and should not be folded casually into intellectual disability; its definition belongs in the differential-diagnosis discussion. Likewise, a test result affected by language, behaviour, fatigue, sensory limitations or unfamiliarity with the testing context should prompt careful interpretation, not an automatic severity label.

4.5 ICD-11: severity across ability and adaptive behaviour

The **ICD-11 approach** assigns severity according to the level in which the majority of the person's intellectual ability and adaptive-behaviour skills fall across conceptual, social and practical domains. This is an important refinement of single-score thinking. It accepts that a

profile can be uneven, yet asks the clinician to identify the level that best represents the predominant pattern rather than choosing the most impaired isolated skill or the most successful isolated activity.

The numerical bands in ICD-11 are expressed as distance from the mean and corresponding percentile information. They should be read as psychometric context, not as a replacement for the adaptive judgement. The accompanying table is deliberately dense because the codes and bands are examination material; in practice, the functional formulation remains the more clinically useful document.

ICD-11 GRADE	PSYCHOMETRIC BAND	CODE	KEY IMPLICATION
Mild	2-3 SD below the mean; approximately 0.1-2.3 percentile	6A00.0	Assign the grade with the adaptive profile in view.
Moderate	3-4 SD below the mean; approximately 0.003-0.1 percentile	6A00.1	Do not let the numerical band eclipse functional variation.
Severe	4 or more SD below the mean; less than approximately the 0.003rd percentile	6A00.2	Distinguish this grade through adaptive behaviour.
Profound	4 or more SD below the mean; approximately less than the 0.003rd percentile	6A00.3	Distinguish this grade through adaptive behaviour.

The apparent overlap between the highest-grade psychometric bands is deliberate and clinically instructive. Severe and profound are separated exclusively by adaptive-behaviour differences, because available standardised intelligence tests cannot reliably and validly distinguish people at the extreme lower end of intellectual functioning. This is not a defect to be repaired by making the score seem more exact. It is a recognition that the most meaningful discrimination at this level concerns what the person is able to do and the support required for comfort, safety, communication and participation.

ICD-11 also provides 6A00.4 for a provisional grade and 6A00.Z for an unspecified grade. These should be used thoughtfully when a definitive grade cannot yet be assigned, rather than guessing from incomplete information. A provisional label preserves diagnostic honesty while assessment continues. An unspecified label should prompt the clinician to record what information is missing and what will be needed to clarify the person's profile.

For longitudinal records that need a crosswalk to legacy coding, the mappings are 6A00.0 to F70, 6A00.1 to F71, 6A00.2 to F72, 6A00.3 to F73, 6A00.4 to F78, and 6A00.Z to F79. A crosswalk translates administrative language; it does not change the adaptive-functioning basis on which the current clinical grade is reached.

4.6 Reconciling discordant evidence in Indian practice

Apparent disagreement between intellectual testing and social-maturity findings is not unusual. It should not be treated as a nuisance to be averaged away. First check whether either result is invalid or unrepresentative because of communication barriers, behaviour, physical limitations, fatigue, unfamiliarity or an unsuitable testing context. Then return to the central clinical question: how does the person meet everyday demands in their own cultural and environmental setting?

IN INDIA

Where IQ and social-maturity results indicate different grades, the Indian guideline directs the clinician to decide in favour of the **social-maturity result**. The rationale is clinically coherent: social maturity reflects the degree to which the person meets culture-appropriate demands of daily life and generally better represents severity in ordinary circumstances. This is not an invitation to dismiss intellectual assessment. It is a reminder that the outcome of classification should describe functioning, not reward a deceptively precise test number.

The assessment method, the score it yields and its limitations belong in the adaptive-behaviour assessment section. Statutory disability quantification is a separate legal process and must not be confused with clinical severity or with adaptive functioning. In a clinical report, make the distinction explicit: describe the diagnostic severity formulation, describe the evidence used to reach it, and deal with certification through the relevant disability-certification pathway.

- Check that the intellectual and functional information reflects the person's usual, not merely best or worst, performance.
- Explain discordance rather than concealing it behind a single label.
- Prefer the evidence that best captures everyday functioning when a severity judgement is required.
- Record strengths, communication preferences and environmental supports alongside limitations.

4.7 From severity label to support profile

A grade becomes clinically useful only when it changes the plan. It should lead the team to ask what support is needed to enable learning, choice, health care, family participation, education, work, relationships and safety. The answer should be revisited as circumstances change. Severity is relatively stable as a description of pervasive need, but support can be improved through accessible communication, structured teaching, environmental adaptation and respect for the person's established competencies.

The **AAIDD** classification links the grades to a **profile of supports** instead, and is multidimensional rather than categorical. Its four intensities of support, in ascending order, are **intermittent, limited, extensive and pervasive**. Two qualifications keep that list honest. It belongs to the ninth edition of the AAIDD system and was not carried into the later editions, which found it lacked the standardised data to support graded intensities, so it is a historical

scheme that remains examinable rather than a current classification. And it is a description of what a person needs, not a fifth way of grading them: the four intensities are often lined up against mild, moderate, severe and profound, but the mapping is a convenience and the whole point of a supports model is that two people at the same severity grade may need very different support. Reproduce the four-word list as written: one widely used textbook prints extreme supports at the severe tier, but the term in general use, and the one an examiner expects, is extensive. These words should not be used as a rigid prescription for any one person. They are a reminder to specify intensity, consistency and context of help rather than to leave the plan at the level of a diagnostic adjective.

A support profile is also more humane than deterministic language. It turns the clinical focus from what the person lacks to the conditions under which the person can participate. It permits planning around autonomy as well as risk: who should provide information in an accessible form, how decisions can be supported, what routines promote competence, what supervision is proportionate, and how family burden can be recognised without erasing the person's voice.

MNEMONIC

GRADE

Ground the decision in daily functioning; Reconcile discrepant evidence; Avoid IQ-only classification; Describe supports; Explain the functional basis in the record.

The defensible severity statement is the one that explains the person's adaptive functioning and consequent support needs, not merely the one that reports an IQ range.

4.8 A disciplined answer and documentation approach

For a short-answer question, begin with the names of the grades, state the modern principle that adaptive functioning determines severity, and then contrast this with the legacy IQ-linked scheme. If asked for a classification table, present the requested framework cleanly. If the question is clinical, move beyond the table: identify the adaptive domains affected, state the basis for the grade, and outline the supports that follow. This sequence shows the examiner that the candidate understands both taxonomy and clinical reasoning.

For a case record, avoid language that makes the severity label sound final in isolation. State the diagnosis, the current grade, the evidence from functioning, the degree and type of assistance required, relevant contextual modifiers, and the plan to address identified needs. Be cautious when information comes only from one informant or one setting. A carefully qualified assessment is stronger than a confident but unsupported label.

The same discipline protects against two opposite errors. One is overmedicalisation, in which a score becomes the whole person. The other is under-recognition, in which a person's dependence is minimised because they have learned familiar routines or because relatives quietly perform the demanding parts of daily life. Both errors lead to mismatched care. Severity classification is

valuable precisely because, done well, it keeps clinical language anchored to the reality of support.

5 · Clinical assessment and IQ testing in ID

Assessment is a clinical act, not a score-collecting exercise. In suspected intellectual disability, the psychiatrist has to decide whether an observed difficulty represents a broad limitation in intellectual functioning, a barrier to showing ability in the assessment setting, a circumscribed learning problem, or a mixture of these. The task is therefore to obtain a valid account of how the person reasons and learns, and then to set that account beside history, observation, collateral information and adaptive-behaviour assessment. The numerical result matters, but it is never self-interpreting.

The marks in this area are usually won by showing disciplined interpretation. A candidate should be able to explain what an IQ score represents, why it is reported as an interval rather than treated as an infallible point, how a poor-quality administration can mislead, and why a patterned profile may be more clinically useful than an overall score. The assessment must also stay within its proper boundary: severity grading and the formal measurement of adaptive behaviour are separate tasks, addressed elsewhere in this chapter.

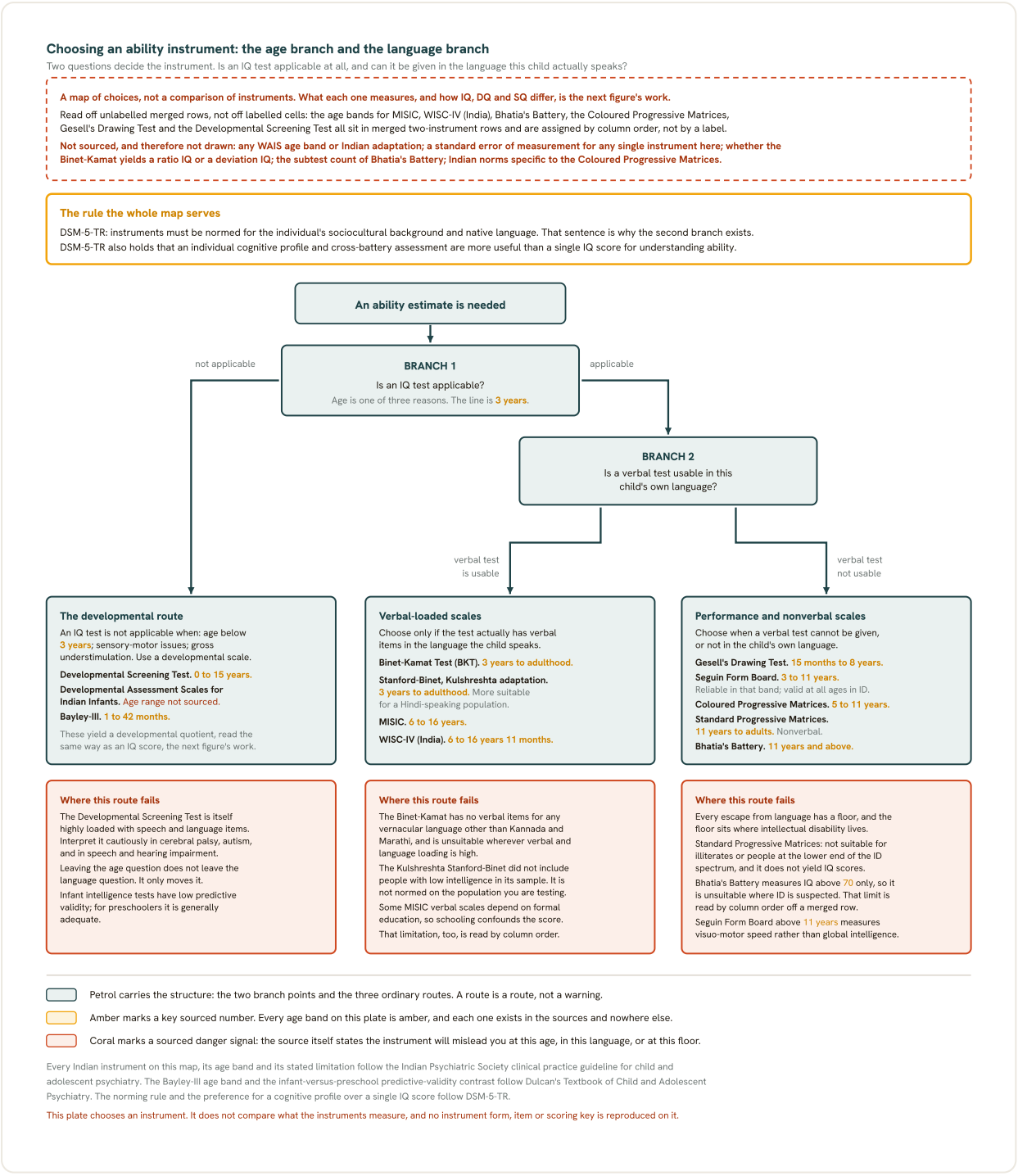


Fig 21.4 Choosing an ability instrument by age and by language. Two branch points, not a catalogue: whether an IQ test applies at all, and whether a verbal test can be given in the language the child actually speaks. Each of the three routes is named with its instruments and their sourced age bands, and each is drawn with the limit its own source states, because every escape from the language problem has a floor and the floor sits where intellectual disability lives.

5.1 The clinical question before testing

Begin with the referral question. “What is the IQ?” is usually an impoverished question. The useful question is: what decision will a careful estimate of intellectual functioning help the team make? The answer may concern the nature of a broad learning difficulty, the credibility of an apparent decline, the meaning of an uneven school record, the person’s capacity to engage with an explanation, or the supports that should be considered. Stating the question first protects the assessment from becoming an administrative ritual.

Intelligence can be understood clinically as a broad capacity to act with purpose, reason coherently and deal effectively with the environment. An intelligence test samples that capacity under defined conditions; it does not sample every ability a person possesses, every opportunity they have had, or every demand made by ordinary life. The psychiatrist should therefore ask what the test performance means in this person's lived context rather than asking the score to speak beyond its remit.

The first interview establishes whether testing is likely to answer the question. Clarify the presenting concern in the informant's own language, the course of learning and functioning, the educational and occupational setting, sensory or motor barriers, communication style, behaviour during unfamiliar tasks, and the person's current mental and physical state. Review available records for consistency rather than assuming that a label in a previous document is a conclusion. A recent deterioration in performance, acute distress, reduced alertness or inability to engage may change the meaning of a low obtained score. The full developmental history and child psychiatric assessment framework belong in the *Child psychiatry: assessment, treatment, services and protection notes*; here, their relevance is that they determine whether a test session is interpretable.

RULE **Use psychometry to refine clinical judgment, not to replace it.** A score becomes useful only when the referral question, the testing conditions and the person's real-world functioning have been considered together.

- Formulate the decision that testing is meant to inform before selecting the assessment.
- Establish whether communication, sensory, motor, emotional or situational factors could distort performance.
- Obtain collateral evidence sufficient to judge whether the test result fits the longitudinal clinical picture.
- Keep the estimation of intellectual functioning distinct from adaptive-behaviour measurement and from severity grading.

5.2 What an IQ score is, and what it is not

An IQ is a standardised comparison of an individual's performance with that of the reference group used by the test. Its clinical value lies in making the comparison explicit and reproducible. It is not a direct measure of worth, potential, character, family effort or entitlement to care. Nor does an overall score reveal the route by which a person reached it. People with a similar overall result may have quite different cognitive strengths, educational experiences, communication demands and support needs.

Older teaching may describe **ratio IQ** using the expression IQ = (mental age / chronological age) x 100. This formulation is historically useful because it explains the term "IQ", but it should not be casually substituted for the standard-score framework used in contemporary interpretation. A clinician should state which metric the report provides rather than sliding between different meanings of the same abbreviation.

For the test metric assumed when deriving the diagnostic convention, the mean is 100 and the standard deviation is 15. The phrase “standard deviation” expresses the spread of scores around the mean in the reference population. It allows a clinician to describe the distance of a result from the population average without converting that distance into a moral or deterministic statement about the person.

100	15	≥2 SD below population mean	65-75
ASSUMED TEST MEAN	ASSUMED STANDARD DEVIATION	CLINICAL CONVENTION	SCORE INTERVAL REQUIRING INTERPRETATION

The intellectual-functioning convention lies **approximately 2 standard deviations or more below the population mean**. This is a convention for interpreting a result in relation to a population distribution, not permission to diagnose from arithmetic alone. The clinician still asks whether the obtained result is valid, whether the reference group is appropriate, and whether the person’s presentation is consistent with the assessment as a whole.

A report should name the metric before interpreting it. This is especially important because a composite score and a subtest score are not interchangeable. The overall number is a summary; it should not erase clinically meaningful variation within the assessment. Equally, a striking isolated weakness is not automatically evidence of a broad intellectual impairment. Interpretation requires pattern recognition, corroboration and restraint.

5.3 Measurement error and the discipline of reporting a range

An obtained score is an estimate. Every psychometric result contains uncertainty arising from the instrument, the testing occasion and the person’s performance on that occasion. The relevant question is therefore not “what is the person’s true IQ?” but “what range of intellectual performance is reasonably supported by this assessment, given its quality and context?” This language is more accurate and prevents a falsely precise clinical conclusion.

The generally applicable margin around an obtained full-scale score is **plus or minus 5 IQ points**. Thus, once measurement error is considered, the score interval associated with the intellectual-functioning criterion is **65-75**. The range must be read as an interval requiring clinical interpretation, not as a new single cut-off and not as a device for negotiating a preferred label.

GOOD TO REMEMBER

A result near the relevant convention calls for particularly careful attention to the quality of administration, the person’s engagement, collateral evidence and adaptive-behaviour assessment. An isolated point score does not settle a complex clinical question: explain how the assessment was conducted and what may have affected it.

TRAP **Examination trap:** treating an IQ result as exact. A technically sound answer states the obtained score, acknowledges measurement error, interprets the interval, and then integrates the wider assessment.

INTERPRETIVE QUESTION	WHAT THE ASSESSMENT CAN CONTRIBUTE	WHAT STILL REQUIRES CLINICAL JUDGMENT
Is the score low?	It locates performance relative to relevant norms.	Whether the administration and norms make that comparison valid.
Is the result stable enough to use?	It provides an estimate with a stated margin of uncertainty.	Whether state factors or testing conditions make the estimate misleading.
Is there a broad difficulty?	It summarises performance across sampled tasks.	Whether the pattern fits history and everyday functioning.
Does a single total tell the whole story?	It offers a convenient summary score.	Whether uneven abilities make the profile more informative than the summary.
What support is needed?	It may identify cognitive demands likely to be difficult.	Adaptive-behaviour assessment and the real-world support context.

5.4 Selecting and conducting a valid assessment

Choice of assessment follows the person, not the convenience of the clinic. Select an individually administered, appropriately standardised measure that can address the referral question and can be administered meaningfully to the person in front of you. Language, communication access, sensory and motor capacity, familiarity with formal testing, educational opportunity and current state all affect the evidentiary weight that can be placed on an obtained result.

Norming for sociocultural background and native language is a requirement, not a courtesy. A score derived from unsuitable norms risks measuring distance from the test's expected experience rather than the intellectual ability the clinician intends to estimate. This is particularly important when the assessment language is not the person's strongest language or when the testing situation makes culturally specific knowledge carry disproportionate weight. The report should make any limitation transparent rather than concealing it behind a number.

Standardisation means that the conditions of administration, scoring and comparison are controlled as far as possible. In clinical practice, that does not mean rigidly ignoring a person's needs. It means recording adaptations, interruptions and barriers, then judging whether they preserve or weaken the interpretability of the score. Rapport, a quiet setting, comprehensible instructions and adequate opportunity to respond are not cosmetic features. They are part of the validity of the encounter.

Observe the process as carefully as the final result. Does the person understand the task? Do they persist, become overwhelmed, guess rapidly, seek repeated reassurance, lose the instruction, or show a discrepancy between verbal explanation and non-verbal problem solving? Such

observations can clarify a profile, expose a threat to validity or indicate the need to defer a conclusion. They should be documented in clinically intelligible language, not reduced to a vague statement that the person was “cooperative”.

Assessment should be paced to protect effort without coaching the answer. The examiner may clarify the task only within standardised rules, attend to physical comfort, and recognise when fatigue or distress has made further performance unrepresentative. If a session is not interpretable, the responsible clinical conclusion may be that the assessment has not answered the question yet. A forced total score is not more scientific than an honest limitation.

- Explain the purpose of the assessment in language the person and family can understand.
- Record the assessment language, relevant accommodations and any barriers to participation.
- Describe behavioural observations that bear on validity, rather than using generic reassurance.
- State clearly when a result should be treated as provisional or when re-assessment is needed.

5.5 Composite scores, subtests and cognitive profiles

Do not confuse the ruler with its markings. A composite or index score uses a different metric from an individual subtest scaled score. **Wechsler composite and index scores: mean 100, SD 15**; **Wechsler subtest scaled scores: mean 10, SD 3**. Mixing these metrics is a basic interpretive error: a subtest value should not be read as though it were an IQ, and a composite should not be treated as though it describes a single task.

A **cognitive profile** is the pattern of relative strengths and weaknesses across the assessment, interpreted cautiously in context. It directs attention to how the person approaches demands rather than merely where the overall score falls. Profiles are most useful when they explain an observed clinical discrepancy, guide further assessment or suggest a practical way to communicate and support learning. They are least useful when they are turned into speculative labels unsupported by history or observation.

The preference for individual cognitive profiles over a single IQ is reflected in **cross-battery intellectual assessment**, which is more useful for understanding intellectual abilities than a single overall score alone. This does not mean that every patient needs an elaborate battery. It means that the breadth of assessment should match the clinical ambiguity. Where the total score and the observed person tell the same coherent story, a focused assessment may suffice. Where they diverge, the divergence is data, not an inconvenience to be averaged away.

Large differences across tasks require interpretation before the full-scale result is treated as a stable global estimate. Highly discrepant individual subtest scores may make an overall IQ score invalid. The key word is “may”: discrepancy prompts clinical scrutiny rather than an automatic rejection of the entire assessment. Consider whether the pattern is understandable from language demands, attention, motivation, sensory or motor factors, emotional state, educational experience or a specific cognitive weakness. The conclusion should describe what is known and what remains uncertain.

This distinction prevents a common diagnostic shortcut. Specific learning disorder may show a verbal-performance discrepancy, usually with performance IQ higher, and an ACID pattern of relative weakness in Arithmetic, Coding, Information and Digit-span. It may also show weaknesses in verbal comprehension, working memory and processing speed. These findings concern an uneven learning profile; they must not be converted mechanically into a severity statement about intellectual disability. The broader formulation belongs with the educational and communication assessment described in the *ADHD and specific learning/communication disorders notes*.

5.6 Threats to validity and misleadingly high or low results

Flynn effect refers to the risk of spuriously high IQ scores when test norms are out of date. It is a norms problem, not a personal change in ability. **Practice effects** are different: repeated testing can yield spuriously high scores because the person has learned from prior exposure. The distinction matters because the remedy is different. In one situation the concern is the currency of the reference norms; in the other it is the interpretive impact of repeated familiarity with the material.

Before accepting an unexpectedly high or low score, ask whether the test was suitable and whether the score was generated in a valid way. A brief intelligence screening test or group test may produce an invalid IQ score. Such tools can be useful for triage or as one source of information, but they do not automatically carry the evidentiary weight of a comprehensive individual assessment. The report should identify the method used and resist upgrading a screen into a definitive estimate simply because it has yielded a number.

Other validity threats are often visible in the room. A person who cannot hear or understand the instruction, whose motor difficulty prevents the intended response, or whose distress and fatigue collapse effort may obtain a result that reflects the barrier more than the target ability. The same caution applies when language mismatch or unfamiliarity with the testing format changes what is being sampled. The clinical response is not to “correct” the score by intuition. It is to document the limitation, seek appropriate assessment conditions and integrate other evidence.

Validity is not an all-or-none property. Some results provide useful minimum estimates, some are broadly representative but qualified, and some should not be interpreted as an IQ estimate at all. This graded approach is more honest than either rejecting every imperfect assessment or accepting every printed total. It also makes the report usable to colleagues: they need to know how much confidence to place in the result and why.

> An IQ score is clinically meaningful only when the test, norms, administration and interpretation are all appropriate for the individual.

5.7 Integrating and communicating the result

The final account should read like a clinical formulation, not a laboratory slip. Start with the reason for referral and identify the assessment method and conditions. State the obtained result as an estimate, include its uncertainty where relevant, describe important profile findings, and

explain the factors that strengthen or limit confidence. Then integrate this with the history, observation, collateral information and adaptive-behaviour assessment. This sequence allows another clinician to see how the conclusion was reached and where its boundaries lie.

Families commonly hear an IQ result as a verdict. The psychiatrist's language can either amplify that harm or restore accuracy. Explain that the assessment describes performance on a defined set of tasks compared with relevant norms. Discuss strengths as well as difficulties, avoid presenting a score as a ceiling on development, and translate findings into practical implications. Do not use technical uncertainty as evasiveness: it can be explained plainly as the ordinary fact that a single testing occasion estimates rather than perfectly captures ability.

When a low score appears inconsistent with everyday functioning, do not decide in advance which source is wrong. Re-examine the referral question, test validity, language and norming, profile variability, collateral quality and the possibility that a different condition is influencing performance. When everyday difficulties seem greater than the score would predict, the same discipline applies. Intelligence testing and adaptive-behaviour assessment answer related but non-identical questions; neither should be used as a shortcut for the other.

Finally, communicate the scope of the opinion. A psychometric assessment may inform diagnosis and care planning, but it does not replace medical evaluation, aetiological work-up or adaptive-behaviour measurement. The laboratory investigation of possible causes is addressed in the etiological work-up section of this chapter, and formal adaptive-behaviour instruments are addressed in the adaptive behaviour assessment section. Keeping these strands separate while integrating their conclusions is the hallmark of a defensible intellectual-disability assessment.

5.8 Choosing intelligence instruments in Indian practice

IN INDIA

Selection is a clinical discrimination: fit the instrument to age, language and schooling, not departmental familiarity. A verbal age scale may be technically well administered yet answer the wrong question when the child is being tested outside the language of its norms. Conversely, a performance measure is not a lesser substitute for a "real" intelligence test when language is the obstacle: it samples ability through a different route. Before choosing a battery, decide whether the task requires a broad verbal and performance profile, a brief performance estimate, or a nonverbal reasoning measure, and be explicit about what the chosen instrument actually reports.

RULE **Choose the instrument by construct, age and language before choosing it by familiarity.** The score is interpretable only when the test's norms and task demands fit the child in front of you.

INSTRUMENT	AGE BAND AND FORM	WHAT IT YIELDS	WHEN IT IS THE BETTER FIT - AND ITS LIMIT
Binet-Kamat Test of Intelligence	**3 years to adulthood**; a **predominantly verbal age scale**.	**Age-scale estimate**, not a language-free performance measure.	Use only when the verbal demands and language are appropriate. Its verbal items are unavailable in vernacular languages other than **Kannada and Marathi**.
Stanford-Binet, Kulshreshta Indian adaptation	**3 years to adulthood**; **predominantly verbal age scale**.	**Age-scale assessment**.	It is more suitable for a **Hindi-speaking population**; its norms did not include people with low intelligence.
Malin's Intelligence Scale for Indian Children	**6-16 years**; **Indian adaptation of the original Wechsler child scale**.	**Performance IQ, Verbal IQ and Full-scale IQ**.	Useful when a Wechsler-style profile is needed, but some verbal scales depend on **formal education**.
Bhatia's Battery of Intelligence	**standardised on Indian boys aged 11 to 16**, though the Indian guideline prints the range as 11 years and above; **indigenous performance battery**.	**Performance-based intelligence assessment**.	Choose it when verbal load is the principal barrier. It measures IQ only **above 70**, so it is unsuitable for establishing lower-range intellectual functioning.
Seguin Form Board	Reliable at **3-11 years**; valid across age groups of people with ID.	**Performance test and quick measure of general intelligence**.	A valuable low-verbal-demand option. Above **11 years**, it increasingly reflects visuo-motor speed rather than global intelligence.
Raven's Standard Progressive Matrices	**11 years to adulthood**; **nonverbal matrices**.	**Does not yield an IQ score**.	Assesses general ability through form comparison and analytical reasoning. It is not suitable for **illiterates or people at the lower end of the ID spectrum**.
Raven's Coloured Progressive Matrices	**5-11 years**.	**Percentile ranks**, not an IQ.	Use when a developmentally younger child needs a matrix task, while reporting the actual metric rather than relabelling it as IQ.

INSTRUMENT	AGE BAND AND FORM	WHAT IT YIELDS	WHEN IT IS THE BETTER FIT - AND ITS LIMIT
WISC-IV India	**6 years to 16 years 11 months**; a full child battery.	A full-scale score with an index profile, reported in this edition as **verbal comprehension, working memory and processing speed** alongside perceptual reasoning.	Use where age and language permit a full child battery. Do not describe this edition's output as a verbal/performance split: that is the older Wechsler structure, and some Indian teaching sources still print it. Do not wrongly transfer Bhatia's stated **above-70 floor** to WISC-IV India.

The **Binet-Kamat** and the **Kulshreshta Stanford-Binet adaptation** are the classic age-scale choices, but both are predominantly verbal. That is their clinical cost. If the child cannot comprehend the assessment language with the same ease as the norm group, a low result may partly index linguistic distance, schooling or test familiarity rather than the intended construct. Binet-Kamat's language restriction makes this concern concrete. The Hindi orientation of the Kulshreshta adaptation is similarly a selection rule, not a minor reporting footnote. Neither should be used merely because it is available in the department.

MISIC is often the most useful familiar-scale option for a school-age child because it derives from the Wechsler child scale and separates performance, verbal and full-scale results. The separation matters clinically: an uneven verbal-performance pattern can signal that the overall total conceals how the child is managing the tasks. It does not remove the education dependence of some verbal scales. A child with limited formal schooling should not be made to look globally less able because a verbally loaded test has been treated as culture-free.

The performance instruments address this problem directly. **Bhatia's Battery** includes many indigenous subscales and is the performance route for an older child, within its norms. Two limits govern its use and both are examinable. Its stated floor prevents it from being the decisive measure when lower-range intellectual functioning is suspected. And although the Indian guideline prints its range as 11 years and above, the battery was standardised on Indian boys aged 11 to 16 in the 1950s, so reading an adult against it applies sixteen-year-old norms to a grown patient. That is an extrapolation beyond the instrument, not normative adult use, and the open-ended phrasing of the guideline is exactly what invites it. The **Seguin Form Board** is a quick performance measure, useful where verbal demands obstruct assessment, but its changing emphasis after the relevant age means that fast visuo-motor work must not be misread as a global estimate of intelligence.

TRAP **"Raven's gives an IQ" is wrong. Standard Progressive Matrices does not output an IQ**. Do not convert a percentile or a matrix result into an IQ merely because the test is familiar.

Raven's Standard Progressive Matrices has Indian norms and is culture-fair to a large extent, but that does not make it universally suitable or make it an intelligence quotient. It evaluates form comparison and analytical reasoning, and its limits in illiteracy and more severe intellectual impairment are clinically important. **Coloured Progressive Matrices** supplies percentile ranks for younger children. State the result in the metric provided. Finally, **WISC-IV India** offers a full child battery across its specified age range, reporting a full-scale score with an index profile rather than the verbal/performance split of the older Wechsler editions. It may be the appropriate comprehensive choice only after language, schooling and tolerance of formal testing have been considered. Selection is a defensible match between construct and patient.

6 · Adaptive behaviour assessment (Vineland, DST, VSMS, Gesell)

The question is not merely what the person can do in a testing room. Adaptive-behaviour assessment asks how a person manages the ordinary demands of life in the setting in which they live. It therefore supplies information that a performance score cannot supply: whether an observed difficulty is translated into dependence in self-care, communication, social participation, safety, or practical daily routines. For intellectual disability, this is clinically decisive because support planning must follow real-world functioning, not the elegance of a single test result.

The instruments often grouped together in examination answers do not measure one thing. A developmental screen estimates developmental progress; a social-maturity scale yields a social quotient; an adaptive-behaviour scale documents functioning through an informant; and a drawing screen provides only a screening impression. The candidate who first identifies the construct, the respondent, and the output is much less likely to call a developmental quotient an IQ score or to use a social-maturity result as though it were a statutory disability percentage.

0-15	0-15	0-90
DST AGE SPAN, YEARS	VSMS AGE SPAN, YEARS	VINELAND-3 AGE SPAN, YEARS

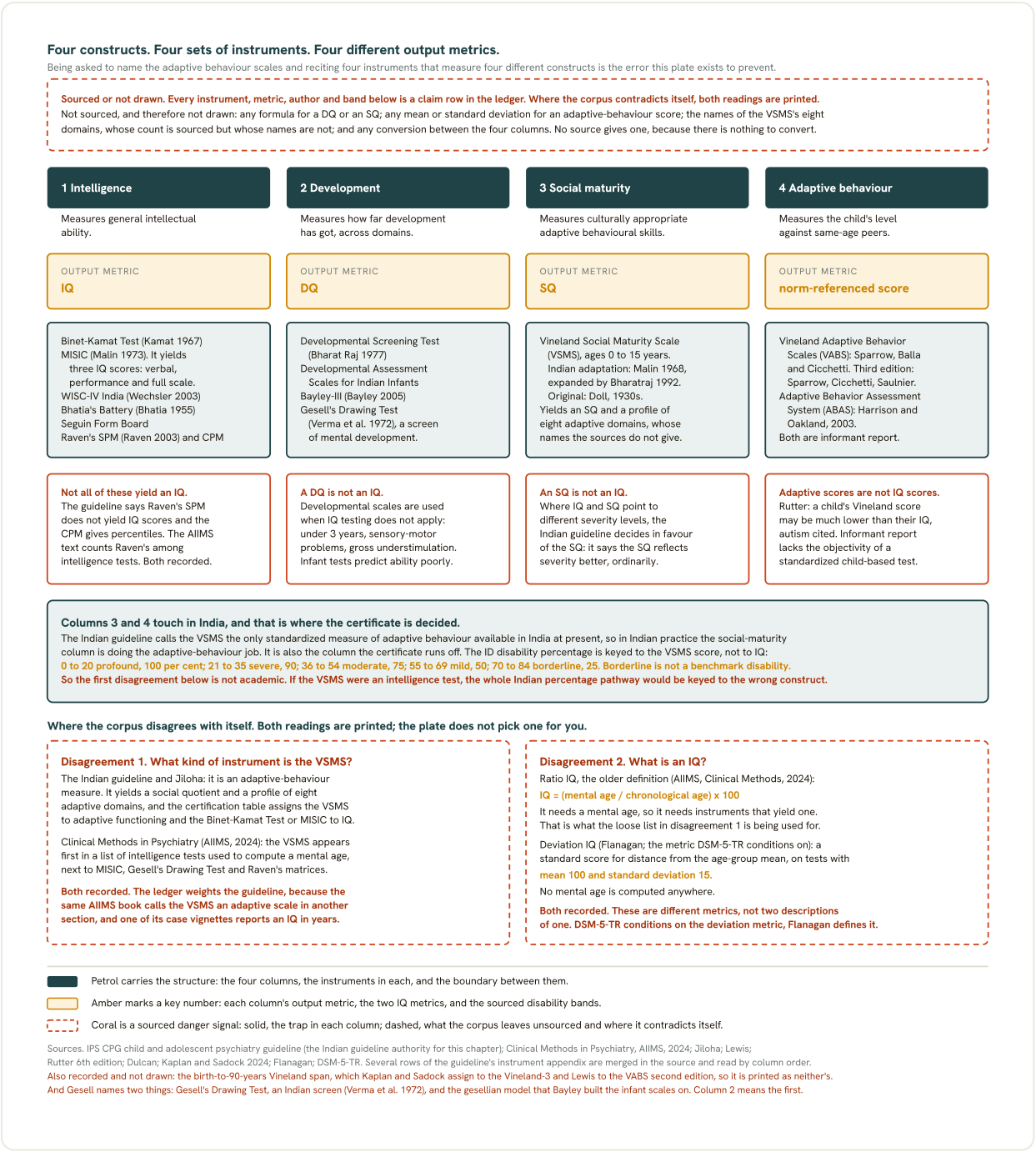


Fig 21.5 **Four constructs, four instruments.** Intelligence, development, social maturity and adaptive behaviour are four separate constructs with four separate instrument sets and four different output metrics, and no score in one column converts into a score in another. The plate also prints the two places the corpus contradicts itself, rather than resolving them: whether the VSMS is an intelligence test or the adaptive-behaviour instrument, and whether an IQ is a ratio of mental to chronological age or a deviation score with a mean of 100 and a standard deviation of 15. Choosing an ability instrument by age and language is the previous plate's job; this one is only about what each column measures and what it reports.

6.1 Begin with the construct, not the familiar name

Adaptive-behaviour measurement is a structured account of habitual functioning. It is not an abbreviated intelligence test. The best information comes from a respondent who has seen the person across ordinary situations and can distinguish what is done independently, what is done with prompting, and what is not yet part of the person's routine. The assessor then integrates this account with direct observation, history, opportunities for learning, physical or sensory

limitations, and the quality of the informant's knowledge. A score may be useful, but the clinical formulation is stronger when it retains the profile behind the score.

This distinction matters especially when opportunity and capacity have been confused. A person may fail to perform a task because it has never been taught, because the setting does not permit it, because the task is inaccessible, or because of a primary developmental limitation. Conversely, an apparently competent answer from a family member may describe what the family does for the person rather than what the person can actually do. Adaptive assessment should therefore examine typical performance, not an idealised report and not a one-off best performance in clinic.

RULE **Rule:** treat an adaptive score as an organised summary of everyday functioning, then return to the underlying profile whenever the score and the clinical picture do not fit.

The terminology itself provides a useful safeguard. **Developmental quotient** is the output of developmental testing and is interpreted in the same metric logic as an IQ score, but it describes developmental assessment rather than a conventional intelligence battery. **Social quotient** is the output of the Indian social-maturity scale. Neither label should be casually substituted for the other. A developmental result, a social-maturity result, and a formal ability result answer overlapping but non-identical clinical questions.

CLINICAL QUESTION	APPROPRIATE CONSTRUCT	ILLUSTRATIVE OUTPUT	WHAT IT MUST NOT BE CALLED
Has the child's overall development progressed as expected?	**Developmental screening**	DQ	An IQ result
How does the person manage socially and practically in their milieu?	Social maturity and adaptive profile	SQ with domain profile	A developmental quotient
What is the person's functioning across adaptive domains by informant report?	Adaptive behaviour	Adaptive profile	A direct performance battery
Is a rapid developmental screen needed before fuller assessment?	Performance screening	Screening impression	A definitive diagnostic quotient

6.2 The Indian social-maturity scale in practice

The **Vineland Social Maturity Scale**, in its Indian adaptation, is the central practical instrument for this purpose. The adaptation is attributed to Malin and was later expanded by Bharatraj. It assesses culturally appropriate adaptive behavioural skills across **eight** important domains and yields an SQ. The domain profile is often more clinically useful than a compressed global statement because it shows where the person is independent, where cueing is enough, and where sustained assistance is needed.

IN INDIA

In the cited guideline, the VSMS has a unique place among standardised adaptive-behaviour measures in India. This gives it an established role in Indian assessment, without implying that every clinical population, language group, or contemporary setting is equally represented. Document the sociocultural context of responses: functioning is enacted in a household, school, neighbourhood, and set of expectations.

GOOD TO REMEMBER

Administration is not a mechanical interview. Identify who knows the person's usual functioning best, and ask for concrete examples. Caregiver disagreement may reveal different opportunities, supervision, or settings, or an informant who has not observed the task. Test implausibly high or low responses with observation and collateral information rather than forcing premature consensus.

- Ask what the person does on an ordinary occasion, not what they have done once under exceptional help.
- Clarify whether initiation, sequencing, supervision, and completion are independent.
- Separate lack of opportunity from inability, while recording both as clinically relevant.
- Interpret a scattered profile as a starting point for formulation and support planning, not as a nuisance to be averaged away.

The VSMS is an adaptive-behaviour instrument: it yields a social quotient plus a profile of 8 domains of adaptive behaviour, never an IQ. Naming it, the DST or Gesell among intelligence tests is the single commonest error in this topic, and where a social quotient and an IQ disagree the severity decision is made on adaptive grounds, as the severity discussion sets out.

This is a measurement rule, not a licence to ignore contradictory evidence. Discordance should prompt a review of language demands, test engagement, motor or sensory barriers, educational opportunity, and the reliability of the informant account. It should also prompt a return to the person's actual support needs. Grading intellectual disability is dealt with separately; the point here is narrower but essential: everyday adaptation has priority when the two numerical summaries pull in different directions.

If the scale cannot be administered, the recommended fallback is to ask socioculturally relevant questions and use DSM-5 severity specifiers as an interim clinical reference, pending ICD-11 guidance. This fallback must be documented as a clinical assessment rather than presented as a scored scale. It is particularly important to make explicit who supplied the history, which settings were represented, and which ordinary activities could not be meaningfully assessed.

6.3 Vineland scales: distinguish the scale family from the Indian VSMS

The **Vineland Adaptive Behavior Scales** are distinct from the Indian VSMS despite their similar names. The scale family is associated with Sparrow, Balla and Cicchetti; later editions are separately attributed in the source. The earlier social-maturity tradition is associated with Edgar Doll. In a viva, naming "Vineland" without specifying which instrument invites avoidable ambiguity about the form, the respondent, the norms, and the result being discussed.

The Vineland scales assess adaptive capacities for self-sufficiency across domains that include **communication, daily living skills, socialization, and motor skills**. They can be administered as a survey interview, expanded interview, informant-administered rating form, or teacher rating form. This range is clinically useful because the person's everyday capacities are often expressed differently at home and in an educational setting. It also creates an interpretive obligation: a discrepancy between parent and teacher reports should be explored as a context effect, not dismissed as an error.

Vineland-3 provides an age-normed framework for adaptive functioning and has self-report, parent-report, and teacher-rated youth forms. Its reported age span runs from **birth to age 90**. The strikingly broad span is a reminder that adaptive behaviour is not a childhood-only construct. Nevertheless, a score gains meaning only when the clinician considers the person's communication style, culture, opportunities, environmental supports, and the informant's frame of comparison.

Informant scales can compare a child with peers of the same age, but their parent-report basis lacks the objectivity of standardised child-based assessment. This is not a reason to discard informant data. It is a reason to use it intelligently. Direct testing samples what the person can show under examination conditions; an informant scale samples what is habitually enacted across time. These evidence streams should be reconciled, not forced into a false competition.

TRAP **Examination trap:** do not use VSMS and VABS as interchangeable labels. They are distinct instruments with different stated adaptations, formats, and assessment frameworks.

6.4 Developmental assessment: where the DST and DQ belong

The **Developmental Screening Test** was developed by Bharat Raj. It uses developmental tasks to assess global development across the stated childhood age range. The result is developmental screening, not an IQ test. This distinction is not semantic fussiness. A developmental screen is appropriate when the clinical question is whether development is globally delayed and whether fuller assessment is needed; it should not be made to carry a conclusion that its construct does not support.

Developmental scales are used when formal IQ tests are inapplicable, including very young age, sensory-motor issues, and gross understimulation. The Indian instruments named for this role are the Developmental Screening Test and the Developmental Assessment Scales for Indian Infants. Such selection is clinical reasoning, not a lesser substitute for formal testing. If a child cannot access the demands of an ability test, the clinician should choose a measure that captures the available developmental evidence and record why the conventional approach was not suitable.

The DST is highly loaded with speech and language items. It therefore requires cautious interpretation in cerebral palsy, autism, speech impairment, and hearing impairment. A low score in these circumstances may reflect the route through which the test asks for competence rather than the global developmental capacity one is trying to understand. The report should make the limitation visible and integrate nonverbal observation, history, and relevant specialist assessment. It should not quietly convert a language-loaded result into a global intellectual conclusion.

SITUATION	ASSESSMENT IMPLICATION	CLINICAL SAFEGUARD
Very young child, sensory-motor difficulty, or gross understimulation	Developmental scales can replace inaccessible IQ testing.	State why a conventional ability test could not answer the question.
Marked speech or language limitation	DST results need guarded interpretation.	Do not equate verbal loading with global developmental capacity.
Need for an adaptive account in an Indian setting	VSMS supplies the adaptive component.	Keep its SQ and profile separate from an IQ result.
Motor deficit affects an ability-test performance	Binet-Kamat profile analysis can separate a motor contribution.	Refer detailed IQ-instrument selection to the clinical assessment and IQ testing discussion.

6.5 Gesell: developmental model, drawing screen, and infancy

The **Gesellian model** starts with the newborn and tracks normal developmental trends across distinct but interrelated domains, rather than reducing infancy to a single factor of intellectual ability. This is a conceptual advance worth retaining in practice. Infancy is a period in which posture, movement, communication, social engagement, regulation, and emerging problem solving may develop unevenly. A developmental account should preserve that pattern rather than overstate the precision of an infant intelligence label.

The older infant-IQ model did not successfully extend conventional IQ assessment into infancy and has largely fallen out of use. The practical lesson is modest: report developmental findings with appropriate caution about what they predict, and explain the functional significance of the observed pattern. Prediction from infant intelligence testing is limited, whereas preschool testing is generally more informative. This is why longitudinal clinical review and repeated observation often matter more than attaching undue certainty to an early numerical label.

The **Gesell's Drawing Test** is an Indian screening instrument adapted by Verma and colleagues and later revalidated by Venkatesan. It is a performance screen for mental development in the stated age span. It obtains a rough estimate of intelligence from the child's ability to draw age-expected shapes. That word "rough" is the safeguard: the task can orient an assessment, but it cannot carry the authority of a comprehensive diagnostic conclusion.

Drawing performance is inseparable from opportunity and motor access. The test is not valid for children with no school attendance, no experience with a pencil, or specific finger-dexterity problems. A poor drawing response in such circumstances should be treated as a limitation of the

method, not as evidence of global inability. The same discipline applies to all brief screens: a screen should direct the next clinical question, never close it.

In the broader infant-assessment lineage, Nancy Bayley drew heavily on Gesell's developmental tasks and techniques. The Bayley-III assesses **five** domains: cognitive, language, motor, adaptive behaviour, and social-emotional functioning. It is reported for children from **1 to 42 months**. This breadth explains why infant assessment cannot be compressed into the question, "What is the IQ?" The clinician must communicate which developmental dimensions were sampled and which require follow-up.

6.6 Selecting and reporting measures when access is uneven

Test choice should begin with access to the task. Vision, hearing, motor control, expressive language, familiarity with materials, schooling, and cooperation can all change what a score represents. For screening in intellectual disability alone or with visual impairment, the stated pairing is DST with VSMS. With hearing impairment, the guideline pairs Gesell's Drawing Test and Seguin Form Board with VSMS; with cerebral palsy or locomotor difficulty, it pairs DST and Gesell's Drawing Test with VSMS. These are selection aids, not substitutes for clinical judgement about whether the child could genuinely engage with each task.

The Binet-Kamat Test may be unsuitable where its verbal and language demands dominate the child's route to a response. Detailed selection among IQ instruments belongs with formal clinical and IQ assessment; the important point here is to resist an instrument's familiar name when its route of administration is mismatched to the child. A defensible report says what was selected, why it was selected, what barriers remained, and how the barriers temper the conclusion.

A good report makes uncertainty useful. State the construct assessed, the source of information, the settings represented, any access barriers, and the practical implications of the profile. Avoid converting a screening estimate into a diagnostic certainty, an informant account into an objective observation, or an adaptive score into a legal percentage. The final formulation should identify present abilities, difficulties, supports, and the next assessment step. It should also state which conclusions are well supported, which remain provisional, and what observation or collateral history would reduce the uncertainty. That is more clinically valuable than a crowded list of scales.

TRAP **Examination trap:** DST, VSMS, and Gesell's Drawing Test are not interchangeable IQ tests. They respectively address developmental screening, social maturity and adaptive profile, and developmental screening.

The causes of intellectual disability

7 · Etiology of intellectual disability (genetic, prenatal, perinatal, postnatal)

Aetiology is clinical work, not a label-collecting exercise. Intellectual disability (ID) is the final common developmental outcome of heterogeneous influences on the developing brain. The

useful question is not merely “what diagnosis does this person have?”, but whether the history, examination and targeted investigations can identify a cause that changes care, anticipatory guidance, recurrence discussion, or surveillance. A causal formulation should preserve timing, mechanism and certainty. It should also distinguish a demonstrated cause from an associated finding and from an unexplained presentation.

For the examination candidate, a timing-based account gives a dependable spine: prenatal influences, events around birth, and postnatal acquired influences. This is not a claim that every presentation fits a clean compartment. Developmental vulnerability may begin before birth and become clinically apparent later; genetic susceptibility and environmental exposure can coexist. The classification is useful because it structures the history, directs investigation, and keeps preventable acquired causes visible without reducing a complex developmental history to a single event.

50-70% ESTIMATED PRENATAL CONTRIBUTION	**10-20%** ESTIMATED PERINATAL CONTRIBUTION	**5-10%** ESTIMATED POSTNATAL CONTRIBUTION	**25-50%** GENETIC CAUSES OVERALL

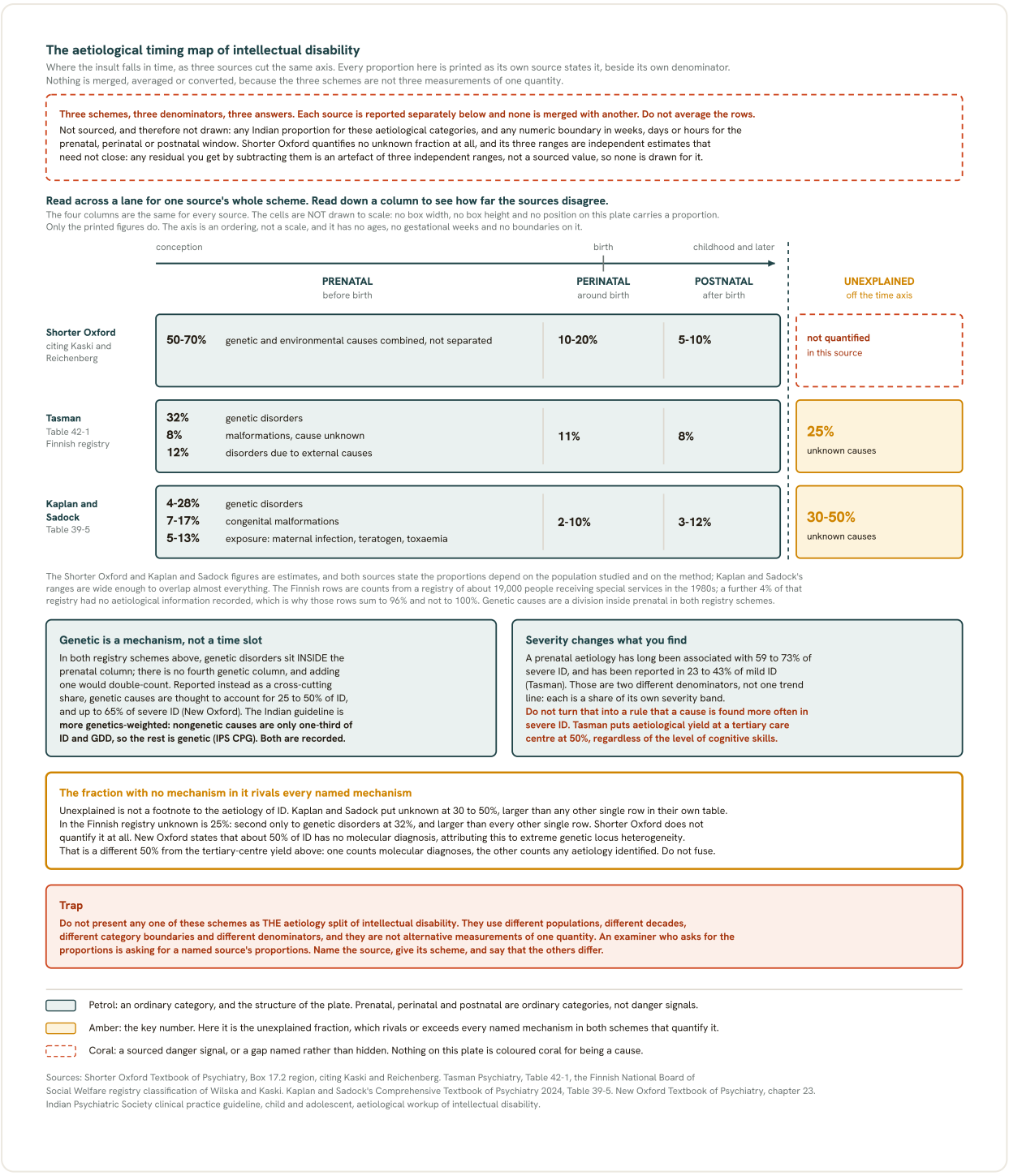


Fig 21.6 **The aetiological timing map of intellectual disability.** The causes of ID sorted by when the insult falls, and the reason a single answer does not exist: three sources cut the same axis with different category boundaries, different populations and different denominators, so their proportions are reported lane by lane and never merged. The plate teaches three things at once. Genetic is a mechanism that sits inside the prenatal column, not a fourth time slot. Severity shifts the prenatal and genetic share upward without licensing the conclusion that a cause is found more often. And the fraction with no mechanism in it rivals or exceeds every named mechanism in both schemes that quantify it. Shorter Oxford quantifies no unknown fraction, and none is inferred for it here.

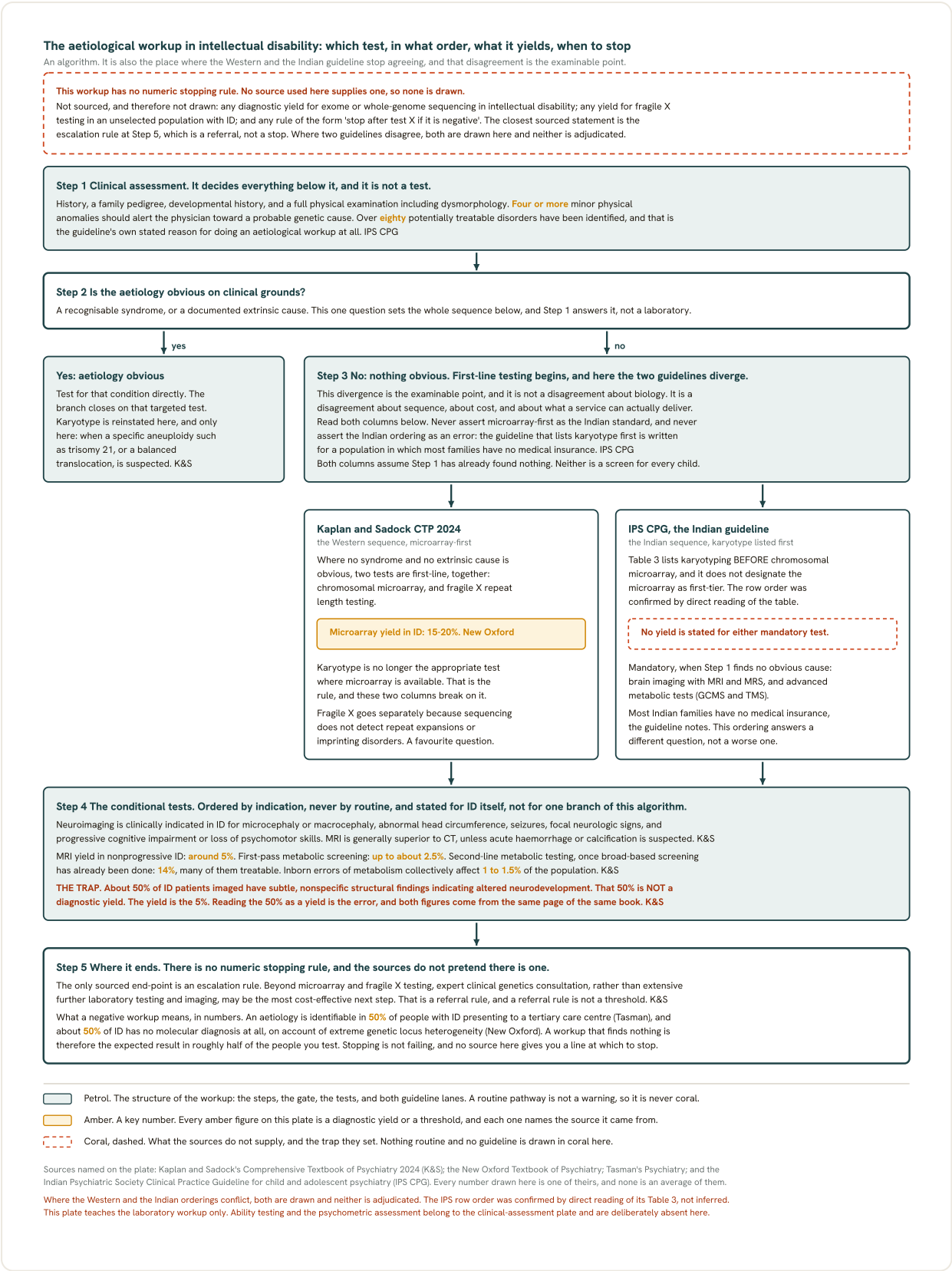


Fig 21.7 The aetiological workup in intellectual disability. The sequence a clinician actually runs: clinical assessment first, then a single gate that asks whether the aetiology is already obvious, then first-line testing, where the Western and the Indian guideline diverge and both orderings are drawn without either being called correct. Each test carries its own sourced diagnostic yield, and the yields are deliberately shown to be small. The workup ends not at a threshold but at a referral, because no source used here supplies a numeric stopping rule, and because an aetiology is found in only about half of the people tested.

7.1 A timing-based causal framework

Prenatal aetiology includes genetic causes, congenital malformations and adverse intrauterine exposures. Across all severities, prenatal factors are estimated to account for 50-70% of cases. The figure is best read as an orientation, not as a prediction for an individual patient. It combines genetic and environmental pathways, and its apparent size will vary with ascertainment, availability of neonatal care, diagnostic methods and the population being studied.

Perinatal aetiology refers to influences operating around birth. It is estimated to contribute 10-20% of ID overall. The central clinical discipline is temporal: obtain the obstetric and neonatal narrative carefully, but do not convert a difficult delivery into a causal conclusion without corroborating developmental, neurological and investigation findings. A birth complication may be relevant, incidental, or one part of a broader developmental disorder.

Postnatal aetiology comprises acquired influences after birth that affect brain development. It is estimated to account for 5-10% of cases. In practice, the history asks whether there was a previously acquired skill that was lost, a period of severe illness or injury, or evidence that development changed trajectory. Such questions protect against prematurely calling a presentation genetic or unexplained.

Causal language should match the evidence. A documented exposure or event can be part of the history without being sufficient to explain the developmental phenotype. Concordance matters: the proposed timing, neurological findings, developmental course and investigation results should tell a coherent story. Where they do not, retain alternative explanations and revisit the formulation as new records or findings become available. This avoids both diagnostic anchoring and the equally unhelpful practice of listing every historical event as a cause.

RULE **Timing is a map for enquiry, not proof of causation.** The history proposes a mechanism; examination and appropriately chosen tests decide how securely it can be attributed.

The categories also overlap in a meaningful way. A congenital brain malformation is prenatal in origin even if recognised only after delivery. A genetic condition may make a child more vulnerable to an intercurrent insult. Conversely, an exposure can cause a developmental phenotype without yielding a pathognomonic laboratory result. Good formulation therefore states the strongest supported explanation and records residual uncertainty honestly.

7.2 Reading frequencies without misreading the patient

Published distributions are not interchangeable. In a broad classification, prenatal genetic disorders were estimated at **4-28%**, congenital malformations at 7-17%, and prenatal exposure at 5-13%. The wide ranges are themselves the lesson: aetiological proportions are shaped by what a service can recognise and whom it sees. The same classification estimated perinatal causes at 2-10%, postnatal causes at 3-12%, and unknown causes at 30-50%.

Severity also changes the diagnostic landscape. Prenatal aetiology has been reported in **59-73%** of severe ID and in 23-43% of mild ID. This does not make mild ID “non-biological”, nor does it authorise an assumption that a severe presentation must be genetic. It means the threshold for

pursuing a careful aetiological workup should remain high across presentations, while the pattern of findings and the probable yield may differ.

CLINICAL QUESTION	WHAT IT PROTECTS AGAINST	HOW TO USE THE ANSWER
When did concern first become apparent?	Assigning timing from a single memorable event	Place the concern beside pregnancy, birth and developmental history.
Was development static, delayed, or did skills diminish?	Missing an acquired or progressive process	Use the trajectory to decide how urgently neurological and metabolic causes need consideration.
Are there family, physical or neurological clues?	Calling a pattern idiopathic before examining it	Integrate inheritance, morphology and examination into the testing plan.
Is a cause demonstrated, probable, or still unknown?	Overstating causality to families	Document the degree of certainty and keep a route for review.

Unknown cause is not synonymous with inadequate care. It can reflect extreme genetic heterogeneity, limitations of the available test, incomplete historical information, or an interaction of influences that cannot be disentangled. In tertiary care, an aetiology is identifiable in 50% of people presenting with ID, yet about 50% of cases may lack a molecular diagnosis. These statements refer to different denominators and endpoints. One is a clinically identifiable cause; the other is a molecular answer. They should never be treated as competing estimates of the same thing.

7.3 Genetic architecture: why no single test tells the whole story

Genetic does not mean simple inheritance. Genetic causes are thought to account for **25-50%** of ID overall, and family and twin studies suggest heritability between 30-90%, depending on diagnostic category and study design. These broad estimates should not be turned into an individual recurrence estimate. They establish that inherited and newly occurring genomic changes deserve active consideration, particularly when the phenotype, family history or examination points in that direction.

Copy number variation refers to a deletion or duplication of genomic material. Cumulatively, CNVs are described as the commonest genetic abnormality class causing ID. Array-based CNV analysis identifies microdeletions or duplications in approximately **15-20%** of tested patients with ID. This is why a genomic test that can detect dosage imbalance belongs early in the assessment rather than being reserved only for those with striking dysmorphism.

Single-gene heterogeneity is equally important. Mutations in more than 700 genes are estimated to be capable of causing ID. In severe sporadic non-syndromic ID, trio-based exome sequencing has identified de novo heterozygous variants or small indels in 13-55%. The range should prevent opposite errors: neither assume that an apparently isolated case lacks a genetic explanation, nor promise that sequencing will always deliver a definitive answer.

X-linked intellectual disability provides a reason to elicit family history with attention to affected males and the maternal lineage. Mutations in known X-linked genes account for **10-12%** of males with ID, and yet no single one of those X-linked genes explains more than **0.1%** of intellectual disability. This is locus heterogeneity in practical form: a recognisable inheritance pattern does not identify the molecular diagnosis by itself. The syndrome-specific genetics and recurrence counselling belong with the relevant syndrome discussions, not with a generic workup.

Autosomal recessive intellectual disability deserves particular attention when the pedigree suggests shared ancestry or recurrence among siblings. In outbred populations it may account for 10-20% of ID; autosomal recessive disorders are reported to be up to threefold more frequent among inbred than non-inbred cases. The history must be asked respectfully and documented neutrally. Its purpose is to guide diagnosis and counselling, never to assign blame.

7.4 From phenotype to an ordered genetic evaluation

The diagnostic interview begins before the requisition form. Obtain a pregnancy and birth history, a developmental trajectory, a pedigree, previous records and the parents' account of strengths as well as difficulties. On examination, look for growth pattern, head size, minor anomalies, skin findings and focal neurological signs. The presence of at least four minor physical anomalies should alert the clinician to a probable genetic cause. The value of this threshold is not that it diagnoses a syndrome; it is that it changes the prior probability and supports a more deliberate genetic examination.

In a person without an obvious syndrome or clear extrinsic cause, **first-line genetic testing** comprises chromosomal microarray and fragile X repeat-length testing.

> **GOOD TO REMEMBER**
>
> These tests answer different questions and are complementary: microarray looks for chromosomal copy-number abnormalities, whereas a separate fragile X assay addresses a repeat-length abnormality. Do not assume that one result substitutes for the other merely because both are called genetic tests.

Karyotyping is no longer the appropriate routine test when chromosomal microarray is available. It remains indicated when a specific aneuploidy or a balanced translocation is suspected. This is a test-selection distinction, not a hierarchy of "old" and "new" medicine: the suspected abnormality determines which technique can answer the question.

TRAP **Examination trap:** a normal sequencing result does not exclude every genetic mechanism. Currently available sequencing tests do not detect **repeat expansions and imprinting disorders**.

After initial testing, a negative result should trigger re-phenotyping and **expert clinical genetics consultation**, rather than indiscriminate laboratory panels and imaging. A genetics assessment can refine the phenotype, determine whether a different genomic method is appropriate, revisit

the pedigree and frame the residual uncertainty for the family. This is also the right setting for generic counselling: explain what is known, what remains unresolved, and why recurrence discussion must be based on the established or suspected mechanism rather than on a generic population figure.

Test ordering should remain hypothesis-led. A phenotype can make a particular mechanism more plausible, but it should not be used as a gate that excludes broad genetic evaluation solely because dysmorphism is subtle or family history is unrevealing. Conversely, a long list of investigations is not a substitute for a better history and examination. Reassessment after each result is often more informative than simply adding tests: ask whether the new finding explains the developmental picture, whether it is concordant with the family history, and whether it creates an actionable surveillance or counselling question. This is how the workup stays both clinically rigorous and proportionate.

> A negative initial genetic screen ends neither the clinical search nor the duty to explain uncertainty clearly.

7.5 Metabolic and neuroimaging pathways

Inborn errors of metabolism are individually uncommon but collectively affect 1-1.5% of the general population. Their importance in ID is disproportionate to their frequency because some are potentially modifiable and because clinical clues may be subtle. First-pass metabolic screening accounts for up to approximately 2.5% of screened patients with ID. A low yield is not an argument for abandoning clinical reasoning; it is an argument against indiscriminate testing in the absence of a phenotype-driven question.

When broad screening has already been undertaken, second-line metabolic testing identified an IEM in **14%** of those tested, many of which were treatable. Progressive change, loss of psychomotor skills, episodic deterioration, unusual neurological features or a family pattern should therefore prompt reconsideration of metabolic disease. The detailed disorders and their treatment are addressed in the section on inborn errors of metabolism; here, the point is to keep an aetiology that may alter outcome within the diagnostic field of view.

Neuroimaging is clinically indicated with microcephaly or macrocephaly, abnormal head circumference, seizures, focal neurological signs, progressive cognitive impairment, or loss of psychomotor skills. MRI is generally superior to CT, except when acute haemorrhage or calcification is suspected. Imaging must answer a clinical question. Subtle nonspecific findings may support altered neurodevelopment without establishing a diagnosis, whereas a structural abnormality may reorganise the entire workup.

Guidelines can differ by setting and resource pathway. The candidate should state the local recommendation accurately while retaining the principle that testing is most useful when integrated with phenotype and clinical trajectory.

IN INDIA

Where obvious clinical aetiologies are not found, the Indian Psychiatric Society guideline designates **brain MRI with MRS and advanced metabolic tests using GCMS and TMS** as mandatory investigations.

7.6 Prenatal, perinatal and acquired causes in the clinical narrative

After the genetic and structural possibilities have been considered, return to the developmental history and ask what may have acted before birth, around birth or after birth. Prenatal exposure categories include maternal infection, teratogen exposure and toxaemia. The purpose of asking is to establish timing and biological plausibility, not to retrospectively place moral responsibility on a mother or family. The same non-judgemental stance applies to histories of substance exposure, obstetric difficulty, neonatal illness and later acquired insults.

Perinatal history should be reconstructed from records wherever possible. The more remote the event and the less specific the account, the more cautious the attribution should be. The examiner's answer becomes stronger when it separates a reported event from evidence of its neurological consequence. Likewise, a postnatal history should seek changes in development, neurological symptoms and the sequence between illness and altered functioning. Aetiological formulation can then state whether the acquired explanation is established, plausible or insufficiently supported.

- Start with timing, then ask what mechanism could link the event to altered development.
- Seek corroboration from records, examination and the developmental trajectory before naming causation.
- Keep genetic and acquired explanations open together when the evidence supports neither as exclusive.

This approach matters especially when families arrive with a single explanatory story, such as a difficult delivery or a relative with developmental problems. Both may be important. Neither should stop the clinician from completing the rest of the formulation. The respectful task is to test the story, preserve what is supported, and correct what is overconfident without making the family feel dismissed.

7.7 Aetiological formulation and communication

A useful written formulation has a layered structure: developmental phenotype, best-supported timing category, demonstrated mechanism where available, associated comorbid findings, and a statement of certainty. It is better to write "ID with a probable prenatal genetic aetiology under evaluation" than to attach a speculative syndrome name. This language guides follow-up and is safer for families, schools and other clinicians who may read the record later.

Explain the purpose of testing before ordering it. Families should understand that testing may identify a diagnosis, clarify future health needs, inform recurrence discussion, or remain non-diagnostic. They should also be prepared for findings whose significance is uncertain. Counselling is a process of interpretation and decision support, not simply the handing over of a laboratory

report. When a family pattern is suspected, referral allows the family to discuss who else may benefit from assessment without converting a probability into a certainty.

The clinical payoff is precision with humility. Aetiology helps prevent a treatable contributor from being missed, prevents unnecessary investigations from accumulating, and makes recurrence counselling more honest. Yet the person's current needs do not wait for molecular closure. Diagnostic workup should proceed alongside support planning and management, with each service informed by the level of certainty rather than delayed by it.

8 · Down syndrome and other chromosomal causes

Why this cause deserves its own clinical frame. Down syndrome is the chromosomal condition most likely to turn a general discussion of intellectual disability into a real consultation: the clinician has to recognise a developmental profile, separate appearance from diagnosis, look for treatable contributors to disability or behavioural change, and explain why the cytogenetic result matters to a family. It is therefore not enough to say that the person has an extra chromosome. The mechanism determines the meaning of the result for relatives and future pregnancies.

For the psychiatry candidate, the useful mental model is a sequence: establish the syndrome and its chromosome mechanism; understand the pattern of associated health needs; then interpret new symptoms against the person's usual functioning. Intellectual disability is part of the presentation, but its definition, assessment and severity grading belong in their respective sections. Equally, a behavioural change should not be dismissed as an inevitable consequence of the syndrome. It may be the presentation of an associated medical disorder, sensory loss, or a co-occurring psychiatric condition.

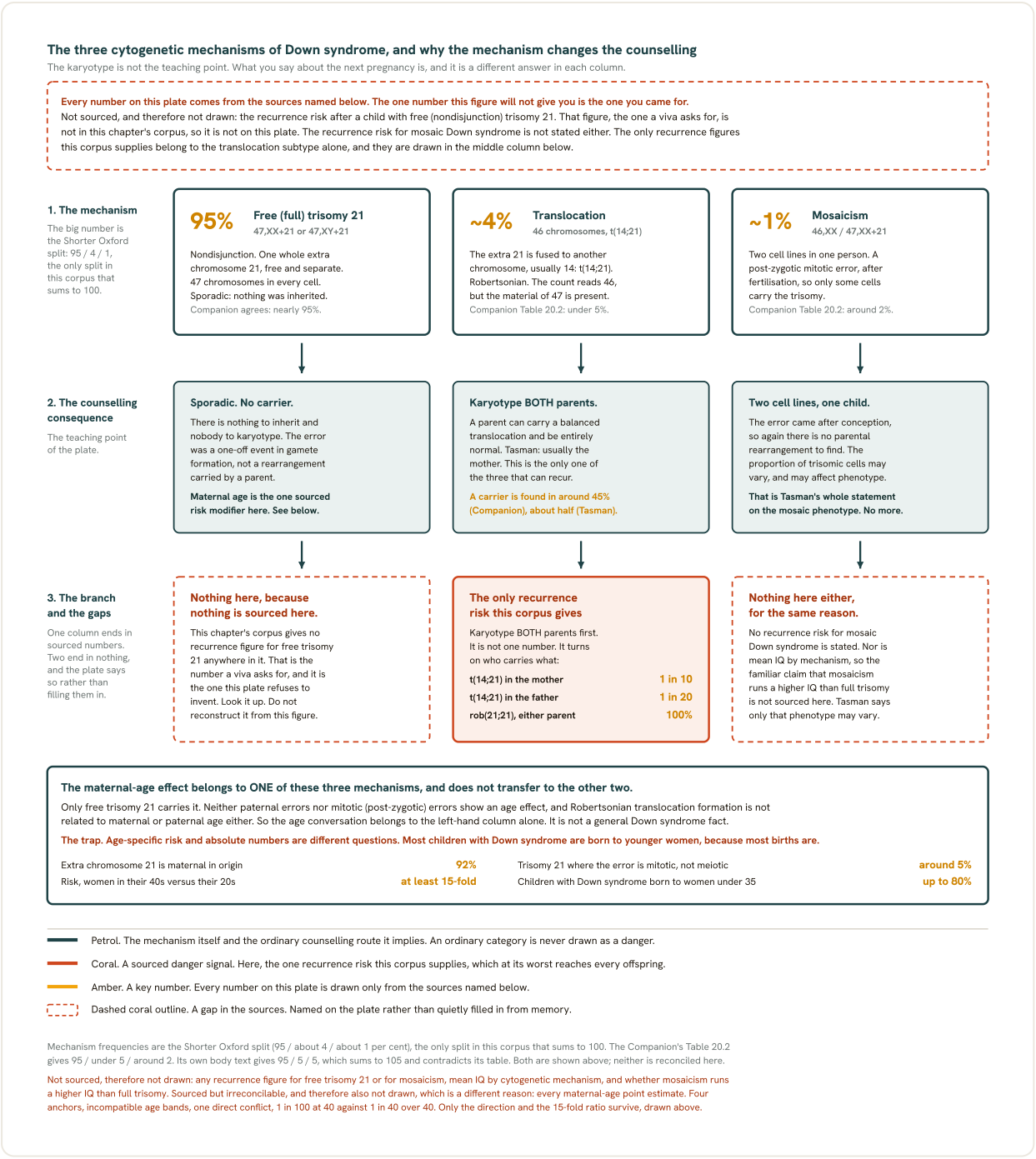


Fig 21.8 The three cytogenetic mechanisms of Down syndrome. Free trisomy, translocation and mosaicism read across from the karyotype to the only thing that changes management, which is what you tell the parents about the next pregnancy. The plate is built so the three columns diverge exactly where the counselling diverges: only the translocation column earns a parental karyotype, and only that column ends in recurrence figures the sources actually supply. The other two columns end in a named gap, because this chapter's corpus states no recurrence risk for free trisomy 21 and none for mosaicism, and the plate declines to supply from memory the figure a viva asks for. The maternal-age effect is shown last and bound to one mechanism only.

8.1 Epidemiological position and clinical significance

Down syndrome is a leading chromosomal cause of intellectual disability and is clinically important precisely because it is common enough to be encountered across child, adult and liaison settings. Textbook birth estimates differ: Shorter Oxford gives about **1 in 650** live births, whereas Tasman gives **1 in 800** live births. These are not competing bedside tests. They illustrate that a quoted frequency depends on the source population and the outcome counted. A figure

expressed per pregnancies must not be treated as interchangeable with a live-birth figure: a cited source estimates trisomy 21 at 1.5 in 1000 pregnancies.

Within the population of people with intellectual disability, Down syndrome accounts for between **6-8%**. That burden explains why psychiatrists need fluency in its medical context, not only recognition of its phenotype. The consultation often occurs at a transition point - concern about development, a new behavioural presentation, family anxiety about recurrence, or declining function in an adult - when an apparently familiar label can obscure the actual clinical question.

95%	about 4%	about 1%
FREE TRISOMY 21	TRANSLOCATION	MOSAICISM

8.2 Cytogenetic architecture: the mechanism is the counselling clue

RULE **State the chromosome mechanism before discussing recurrence: the phenotype may be similar, but the family implication is not.**

Down syndrome results when there is extra chromosome 21 material. In **full trisomy 21**, the additional chromosome is present as a separate chromosome. This is the usual arrangement and, in the source cited here, applies to nearly 95% of people with Down syndrome. The extra material arises through a chromosome-separation error, conventionally termed **nondisjunction**. The molecular event makes it essential to distinguish this arrangement from a structural rearrangement identified in a parent.

In **translocation Down syndrome**, the extra chromosome 21 material is attached to another chromosome, usually chromosome 14, designated t(14;21). The total count can still be 46 chromosomes, but chromosomal material from 47 is present. This is the exam discriminator: counting chromosomes alone does not tell the whole genetic story. The relevant question is whether the chromosome complement is balanced in a parent or unbalanced in the child. The answer changes the recurrence discussion and is why a cytogenetic report must be read rather than merely filed.

Mosaicism means that different cell lines are present. Its presence should prompt precision in description rather than casual prediction from appearance or a presumed developmental outcome. The safe clinical teaching point is not to manufacture a hierarchy of functioning from a mechanism alone. Mechanism informs counselling; it does not replace individual assessment of development, communication, adaptive functioning and health.

CHROMOSOME ARRANGEMENT	WHAT THE REPORT MEANS CLINICALLY	WHY PSYCHIATRY SHOULD CARE
Full trisomy	An extra chromosome 21 is present as a separate chromosome.	It frames the syndrome but does not predict an individual's support needs.
Unbalanced translocation	Extra chromosome material is attached to another chromosome.	Parental chromosome studies become central to the family discussion.
Mosaicism	Different cell lines are present.	Do not infer clinical ability from the label alone; assess the person.

The accompanying figure is useful as a memory aid because it puts these arrangements beside their counselling consequence. It should prevent a common error: treating every Down syndrome result as if it carried the same familial implication.

Read the report in a clinically disciplined way. **Cytogenetic interpretation** starts by identifying whether it describes a separate extra chromosome, attached extra material, or differing cell lines. Next ask whether the wording establishes a structural rearrangement that could also be present in a parent. Finally, distinguish what the report establishes from what still needs direct clinical assessment. A chromosome result explains the syndrome's mechanism; it does not by itself describe communication, capacity, family resources, psychiatric symptoms or the cause of a new behavioural change. This prevents genetic language from becoming a shortcut around formulation.

The same distinction helps when communicating with other clinicians. “Down syndrome confirmed” may be adequate as a diagnostic headline but is incomplete as a handover when the mechanism has not been stated. Record the arrangement in words, note whether parental studies are relevant, and separate known information from questions that remain open. This makes later counselling more coherent and stops a vague family-history statement from acquiring unwarranted certainty as it passes between services.

8.3 Origin of the extra material and maternal-age reasoning

Most molecularly studied trisomy 21 cases have an extra chromosome of maternal origin, reported as 92%. Maternal meiotic error is therefore the dominant framework, but a candidate should avoid turning that into an indiscriminate statement about every pathway. Around 75% of nondisjunction errors are reported at the first maternal meiotic division, although the cited source does not make the denominator sufficiently explicit to claim more than that. In contrast, 60% of paternal meiotic errors occur at the second meiotic division, and mitotic error is estimated in around 5% of trisomy 21 cases.

The maternal-age association belongs mainly to the maternal meiotic pathway. **Paternal and mitotic errors do not show an age effect, and Robertsonian formation is not related to parental age.** This distinction matters because a risk factor should be linked to the biological pathway it plausibly modifies, not applied as a universal explanation after the event.

Age-specific risk rises substantially. Shorter Oxford reports about 1 in 2000 live births among mothers aged 20-25, compared with 1 in 30 among those aged 45 years or over. Another table gives 1 in 2000 at maternal age 30 and 1 in 100 at age 40. The direction is the high-yield point, not the temptation to merge differing source anchors into a fabricated universal rate. Women in their forties have at least a 15-fold increase in risk compared with women in their twenties.

TRAP **Do not confuse high age-specific risk with where most affected children are born.**

Up to 80% of children with Down syndrome are born to mothers under 35. This is not a paradox. Population impact depends on both individual risk and the number of births in each age group. It is the cleanest way to explain why counselling cannot be reduced to stereotypes about maternal age.

8.4 Phenotype, development and associated health needs

The physical phenotype is a recognition aid, not a diagnostic algorithm. Individual signs vary, and no individual sign is universal. The most consistent physical feature, upslanting palpebral fissures, is still restricted to 80% of people with Down syndrome. A transverse palmar crease occurs in 53%, while a protruding tongue is present in fewer than 50%. The practical implication is simple: absence of a familiar sign should not overrule a chromosome result, and presence of an isolated sign should not be treated as proof of the syndrome.

Intellectual ability varies considerably. Tasman reports a mean IQ of approximately 50, but the number is not a prognostic verdict for an individual and must not be used to grade intellectual disability. The clinician should describe present skills, communication, daily functioning and the support environment. The sections on clinical assessment, IQ testing and adaptive behaviour explain how to do that without mistaking a test score for the person.

ASSOCIATED FINDING	REPORTED FREQUENCY	CLINICAL CONSEQUENCE IN A PSYCHIATRIC ASSESSMENT
Congenital heart disease	40-50%	Medical history and exertional symptoms shape both assessment and treatment planning.
Gastrointestinal atresias	12%	Past surgical and nutritional history can clarify the developmental context.
Hearing loss	75%	Often conductive and related to otitis media; it can mimic inattention, withdrawal or a language problem.
Ocular findings	approximately 50%	Visual difficulty may alter engagement, learning and apparent behaviour.
Gluten intolerance	4-20%	Gastrointestinal symptoms should not be reduced to a behavioural complaint.
Autoimmune thyroid dysfunction	up to 20%	In adolescents and adults, consider it when behaviour, mood or cognition changes.

GOOD TO REMEMBER

These are not decorative associations. Hearing and visual difficulty alter how a person is read in the clinic. Pain, discomfort or endocrine disturbance may appear as irritability, reduced participation, slowing, sleep change or loss of previously reliable skills. In particular, thyroid dysfunction is a crucial differential when behavioural disturbance, depression or an apparent dementia presentation emerges. Start with a change from baseline and ask what has changed in the body, the sensory environment and the person's routines before assigning a psychiatric explanation.

Some children with Down syndrome also meet criteria for autism spectrum disorder, estimated at approximately 7%. Autism should be assessed using its own diagnostic framework. The diagnostic criteria, clinical features and differential diagnosis of autism are dealt with in the autism sections of this chapter. Here the point is narrower: a known chromosomal diagnosis does not make an additional neurodevelopmental diagnosis impossible, nor does it make assessment dispensable.

8.5 A psychiatry assessment that does not miss the treatable problem

RULE **A new symptom is a clinical question, not an automatic feature of Down syndrome.**

Begin by identifying the change in observable terms: what is different from the person's own baseline, where it occurs, and what has altered in eating, sleep, activity, communication, comfort or social participation. A **baseline comparison** prevents the interview from confusing a lifelong trait with a fresh symptom. Establish the time course from people who know the person well, but

do not let collateral description substitute for direct engagement. A quieter person may be depressed, unwell, hearing less well, overwhelmed, or responding to a changed environment. These possibilities require clinical discrimination.

- Review hearing and vision when apparent inattention, language difficulty or withdrawal is new or worsening.
- Ask about physical discomfort and gastrointestinal symptoms when behaviour becomes irritable or avoidant.
- Consider thyroid dysfunction when there is behavioural disturbance, depressive symptomatology or cognitive decline.
- Keep autism assessment criterion-based rather than treating the chromosomal diagnosis as either proof or exclusion.

This approach guards against diagnostic overshadowing, discussed fully in the dual-diagnosis section. The syndrome-specific safeguard is especially important here because associated health conditions can change behaviour without announcing themselves in conventional psychiatric language. The clinical record should preserve the observed baseline, the reported change, the relevant physical and sensory questions, and the working explanation. Doing so makes it possible for the next clinician to see whether the proposed explanation accounted for the change or merely accompanied it.

MNEMONIC

CHROME

: **C**hromosome mechanism; **H**earing and vision; **R**eview change from baseline; **O**rgan-system contributors; **M**ood and mental-state assessment; **E**xplain the recurrence implication. Use it as an interview sequence, not as a substitute for examination.

When behaviour changes in Down syndrome, look for a change in health, sensory input or environment before attributing it to the syndrome.

8.6 Family implications of translocation Down syndrome

The family conversation becomes most specific when a translocation is identified. In about half of translocation Down syndrome cases, a parent has a balanced translocation; a related source estimates that around 45% of Robertsonian translocation Down syndrome cases are inherited from a balanced carrier parent. The practical message is not that every parent is a carrier, but that parental chromosome status is material to that particular family's recurrence discussion.

For a balanced **t(14;21) translocation**, the cited recurrence risk for a subsequent child with Down syndrome is **1 in 10** when the mother carries the translocation and **1 in 20** when the father carries it. These are mechanism-specific figures. They must not be offered as the risk after ordinary full trisomy, nor copied into a discussion before the parental studies have established the relevant arrangement.

A familial balanced **rob(21;21) fusion** has a qualitatively different implication: all offspring will have Down syndrome (100%). This is exactly why wording matters. “Down syndrome runs in the family” is too imprecise to guide care. The chromosome report, the parent who carries any balanced rearrangement, and the specific rearrangement together determine what can responsibly be said.

Refer families for genetic counselling and interpret recurrence as a syndrome-specific issue, not as a generic estimate. The general approach to aetiological investigation and counselling referral is covered in the etiology of intellectual disability section. The psychiatrist's contribution is to recognise when the mechanism makes that referral urgent, to communicate uncertainty honestly, and to ensure that distress does not prevent the family from receiving a clear explanation.

8.7 Examination synthesis: how to write the answer safely

A strong answer begins with Down syndrome as a chromosomal cause of intellectual disability, then moves from cytogenetics to clinical care. Describe full trisomy, translocation and mosaicism as different chromosome arrangements; explain that translocation has particular implications for parental studies and recurrence; then show why sensory, endocrine, gastrointestinal and cardiac associations matter to psychiatric formulation. Finish with the warning against diagnostic overshadowing. This structure demonstrates reasoning rather than reciting a facial-feature list.

TRAP **The classic examination mistake is to give a single recurrence figure for every form of Down syndrome.**

That answer is unsafe because it erases the distinction that the cytogenetic result is meant to reveal. A further mistake is to treat the physical phenotype as diagnostic while ignoring the associated health review. The better answer states that phenotype prompts recognition, cytogenetics establishes mechanism, and longitudinal assessment identifies the problem requiring action now.

Other chromosomal causes of intellectual disability need syndrome-specific evidence on their phenotype, mechanism and recurrence patterns. This fragment deliberately does not generalise Down syndrome data to them. Where a person has a chromosomal finding without the characteristic Down syndrome arrangement, the clinical task is to read the individual report and pursue the aetiological pathway rather than forcing it into a familiar template.

9 · Fragile X syndrome

Why this syndrome deserves a deliberate search. Fragile X syndrome is a recognisable cause of intellectual disability, but it cannot safely be reduced to a facial gestalt or a single childhood phenotype. It is the most common inherited cause of intellectual disability, while among all specific causes it is described as second to Down syndrome. Its importance extends beyond the proband: the same locus can produce a developmental disorder in one family member and late-life neurological or reproductive disorders in relatives who carry a premutation.

The useful clinical stance is therefore syndromic and family-based. Recognise the developmental and behavioural pattern, examine without over-relying on dysmorphology, confirm the molecular finding with an appropriate repeat-expansion assay, and explain that molecular category and parent of origin determine the implications. The accompanying figure can be used to hold the relationship between repeat expansion, gene silencing and the distinct premutation disorders in mind.

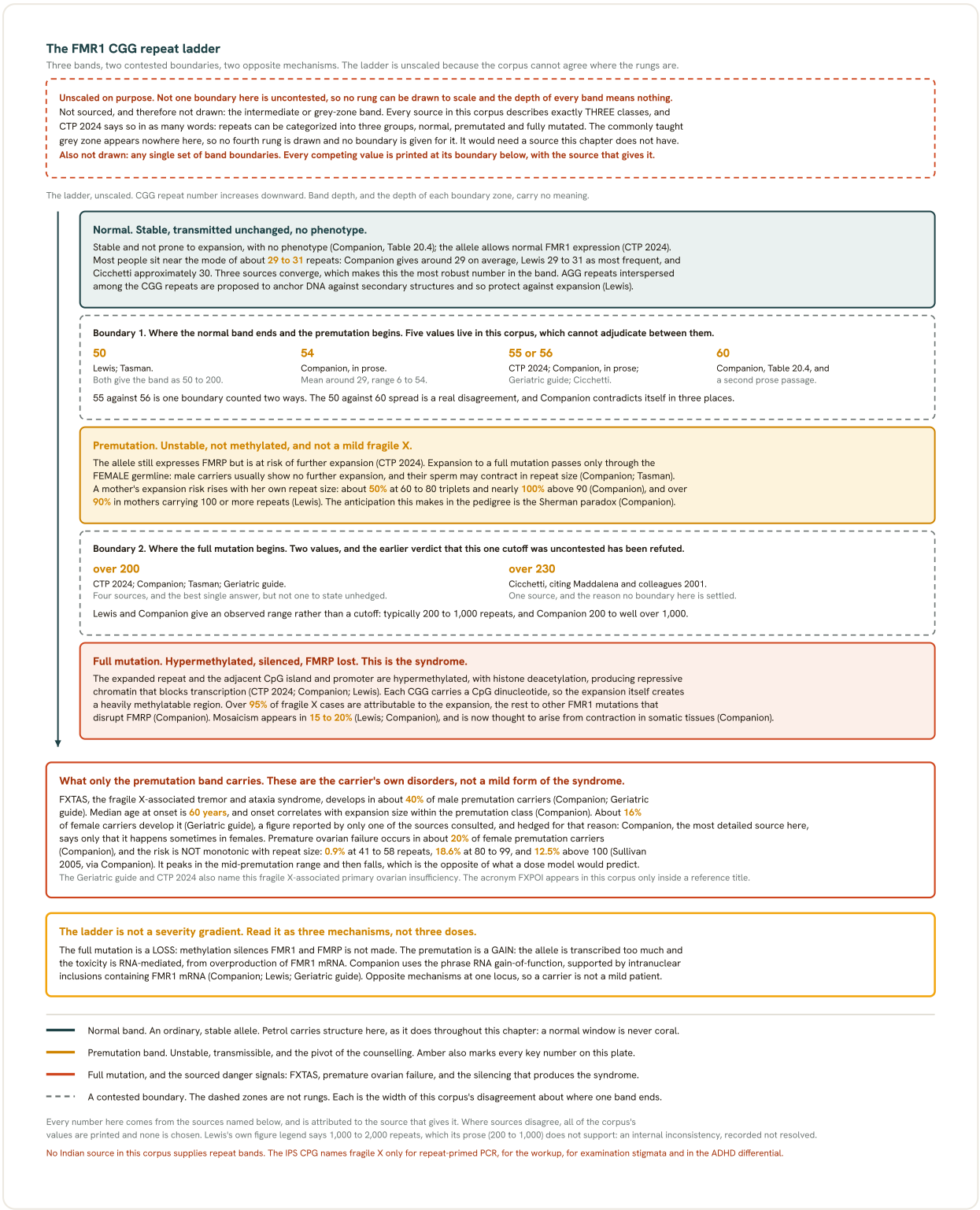


Fig 21.9 The FMR1 CGG repeat ladder. The three repeat classes this corpus supports, what each one carries, and the fact that neither boundary between them can be stated as a single number.

9.1 Molecular lesion and its consequences

Fragile X syndrome results from loss of function of **FMR1 (fragile X mental retardation gene 1)**, located at **Xq27.3**. The unstable sequence is a **CGG (cytosine-guanine-guanine)** repeat in the promoter-adjacent 5' untranslated region. It is worth retaining the anatomical wording rather than insisting on a single exon label, because the sources differ at that finer level while agreeing that the repeat is non-coding and close to the promoter.

Repeat expansion accounts for **more than 95%** of affected cases. In the full-mutation state, the expanded sequence and neighbouring regulatory region become hypermethylated; histone deacetylation and repressive chromatin then prevent transcription. Thus the mutation is not simply a long piece of DNA. It converts a transcriptionally active locus into one that is functionally silent. The extent of methylation is directly related to the loss of functional protein, which helps explain why repeat size alone is not a complete clinical predictor.

The protein product, **FMRP, an RNA-binding protein**, normally binds polyribosomes in dendrites and synaptic spines and largely restrains local translation of synaptic proteins. Loss of that restraint provides a coherent bridge from molecular change to altered synaptic maturation, learning, attention and behaviour. It also prevents a simplistic conclusion that every clinical feature is fixed at birth: the disorder concerns regulation of developing neural systems and its expression changes with development.

RULE **Full mutation means loss of FMRP through epigenetic silencing; premutation disorders arise through excess FMR1 messenger RNA, not a mild form of the same process.**

This distinction is the organising principle of the chapter. In a premutation, the locus is not silenced in the same way. Instead, **RNA-mediated toxicity from overproduction of FMR1 mRNA** is implicated. Calling a premutation carrier “mildly affected with fragile X syndrome” is therefore biologically misleading and clinically unhelpful. One state is principally a protein-loss developmental disorder; the other is an RNA gain-of-function state with its own age-related and reproductive associations.

9.2 Repeat categories, instability and anticipation

Repeat-length bands are useful in laboratory interpretation, but their lower boundaries vary modestly across reference texts. A normal stable allele is reported in ranges such as 5-55 CGG repeats, while a commonly used premutation band is **55-200 repeats**. The clinically robust distinction is that a full mutation is generally defined as more than 200 repeats, although a cited source uses a higher threshold. A report must be interpreted using the laboratory’s stated classification rather than by treating a disputed boundary as a universal biological cliff.

Normal alleles tend to be stable. **AGG interruptions** interspersed within the repeat are proposed to stabilise the sequence by reducing secondary structures during replication. Long uninterrupted stretches are more prone to expansion. This is why molecular counselling cannot be reduced to a family member’s label alone: the repeat architecture and its transmission context matter.

The inheritance is **X-linked**, but it does not behave like a simple static X-linked mutation. Expansion from a premutation to a full mutation occurs through the female germline; male carriers usually transmit without further expansion and may show contraction in sperm. This parent-of-origin effect explains the apparently paradoxical pedigree in which an unaffected transmitting man has daughters who are carriers, yet the more severely affected descendants emerge through subsequent maternal transmission.

TRAP **Do not infer full-mutation risk from "X-linked" alone.** The relevant question is whether the premutation is being transmitted through a woman, because that is the route in which expansion to a full mutation occurs.

The historical pattern of worsening expression in successive generations is called the **Sherman paradox**. It was an observation before it had a molecular explanation. The repeat-expansion mechanism now turns that observation into a counselling problem: a pedigree should be drawn across generations, noting cognitive and developmental histories as well as tremor, ataxia and early ovarian failure in relatives. Recurrence counselling should be syndrome-specific and undertaken with clinical genetics support; the generic framework belongs in the etiological assessment discussion.

- Ask which side of the family carries the molecular result and whether transmission has been maternal or paternal.
- Obtain an extended pedigree history rather than stopping at developmental delay in the child.
- Explain that a premutation and a full mutation have different clinical implications.
- Offer cascade evaluation to relatives through an appropriately supported genetics service.

9.3 Population burden and the diagnostic place of fragile X

Published prevalence estimates differ because ascertainment and molecular methods have changed. A sensible examination answer is to state the estimate with its denominator: fragile X syndrome occurs in about 1 in 4,000 males and around 1 in 8,000 to 1 in 9,000 women. Female prevalence is described as approximately one-half of the male rate. These figures refer to the syndrome, not to premutation carriage, which is much more frequent and has a different sex distribution.

1 in 4,000	1 in 8,000-9,000	~40%	~20%
MALES WITH SYNDROME	WOMEN WITH SYNDROME	MALE PREMUTATION CARRIERS WITH FXTAS	FEMALE PREMUTATION CARRIERS WITH POF

The distinction between affected syndrome and carrier state changes the conversation with families. Premutation carriage is reported at 1 in 150-200 females and 1 in 400-450 males in the general population. It should not be quoted as the prevalence of fragile X syndrome, nor should syndrome prevalence be used to dismiss the relevance of a premutation in an extended family.

Fragile X is also clinically relevant in autism assessment. It is described as the most commonly known single genetic cause of autism spectrum disorder. The direction of the statistic is the trap:

the proportion of people with fragile X who meet autism criteria is not the same as the proportion of autism attributable to fragile X. Reported rates of autism-spectrum diagnosis within fragile X vary substantially with the diagnostic construct and method, so they should be read as evidence of overlap rather than as a single invariant percentage. The medical and genetic workup of autism is addressed in the autism workup section.

9.4 Recognising the phenotype without overcalling it

The physical phenotype is developmental and variable. In adults, the familiar pattern includes an elongated face, prominent or cupped ears, a high arched palate and connective-tissue features. **Large anteverted ears, smooth velvet-like skin, hyperextensible finger joints, flat feet and mitral valve prolapse** are the useful connective-tissue cluster. Macro-orchidism becomes relevant after pubertal development and should be asked about and examined for sensitively, with appropriate consent and privacy.

ADULT PHYSICAL FEATURE	APPROXIMATE FREQUENCY AMONG ADULT CASES	CLINICAL USE
Macro-orchidism	~90%	Most evident after puberty
Elongated face	~80%	Supports, but never establishes, suspicion
Prominent or cupped ears	~65%	Look for it in the broader phenotype
High arched palate	~60%	Examine as part of a general dysmorphology review
Flat feet	~60%	Connective-tissue clue rather than a diagnostic sign

GOOD TO REMEMBER

These are group frequencies, not a checklist diagnosis. Up to 20% of affected children may have no obvious physical features, while individual facial or connective-tissue traits occur in many people without the syndrome. Developmental history, family history and a coherent behavioural phenotype raise suspicion; molecular testing establishes the diagnosis.

Associated physical morbidity deserves ordinary clinical attention. Seizure disorder occurs in 20% of individuals with fragile X syndrome. Visual and hearing assessment, cardiac review when indicated, and review of neurological symptoms should be integrated into care rather than deferred because the presenting concern is developmental. The specific diagnostic approach to epilepsy in autism belongs to the autism medical-workup section, but a seizure history in fragile X is directly relevant to this syndrome review.

9.5 Cognitive, language and behavioural profile

In males with a full mutation, intellectual disability is often moderate, with an average IQ of **about 40**; individual functioning is nevertheless broad and must not be assumed from a molecular result. In females with a full mutation, random X inactivation offers partial protection,

and cognitive impact is correspondingly variable. The assessment of IQ, adaptive behaviour and intellectual-disability severity is covered elsewhere in this chapter; here, the key point is that the fragile X profile is uneven, not merely globally delayed.

Short-term memory, visuomotor coordination, arithmetic and sequential processing are relative weaknesses, while simultaneous processing and long-term storage or retrieval may be relative strengths. This matters clinically. A child may do better when information is presented as a whole visual structure than when it is delivered as a long serial verbal sequence. It also matters in the consultation: apparently inconsistent performance can be a profile effect rather than evidence of poor effort or oppositionality.

The behavioural phenotype has a distinctive social-anxious quality. **Gaze aversion or reduced eye contact, shyness and social anxiety, hand-flapping and repetitive mannerisms, hyperactivity with short attention span, and poor peer relations** can co-occur. These features invite diagnostic shadowing in both directions: gaze avoidance and repetitive behaviour can be assumed to establish autism, while an established genetic diagnosis can lead the clinician to overlook a co-occurring autism-spectrum condition. Evaluate the person's actual social communication, restricted behaviour and functional needs rather than using the syndrome label as a shortcut.

Disruptive behaviour is reported to peak in preschool years and to decline progressively with age, although attentional difficulties may remain. This course is useful when setting family expectations: a difficult early behavioural phase does not predict a static trajectory. ADHD itself and its formal assessment are dealt with in the ADHD and specific learning/communication disorders notes. In fragile X, practical supports should take account of attention, anxiety, sensory responses, communication and the relative cognitive profile rather than treating "behaviour" as a single symptom.

MNEMONIC

FRAME the consultation

Family transmission, **R**epeat category, **A**ppearance across development, **M**ind and behavioural profile, **E**xtended-family premutation effects. This is a clinical sequence, not a diagnostic score.

9.6 Females, mosaicism and the premutation family phenotype

Female presentation requires particular care because it is often quieter and more variable. **Random X inactivation (lyonization)** protects many full-mutation females from full clinical expression. About half of females with the full mutation show cognitive deficits. A clinician should therefore neither assume that all female relatives are unaffected nor equate absence of intellectual disability with absence of a meaningful molecular result.

Mosaicism is described in 15-20% of individuals with FMR1 mutations. Different cell lines can carry different molecular profiles, which is one reason phenotype, repeat length and methylation pattern may not align in a simple linear fashion. The clinical response to an apparently

discordant result is not to reject it, but to interpret it with the reporting laboratory and genetics team in the context of the person's functioning and family history.

Premutation-associated disorders are not peripheral footnotes. **FXTAS (fragile X-associated tremor/ataxia syndrome)** is a late-onset neurodegenerative syndrome in premutation carriers, characterised by intention tremor and cerebellar ataxia, with later neuropathy, autonomic symptoms and cognitive or behavioural change in some individuals. Its median onset is 60 years. When an adult relative of a child with fragile X reports these symptoms, the family history has become a neurological referral issue, not merely background information.

Female premutation carriers may also develop premature ovarian failure, also termed fragile X-associated primary ovarian insufficiency. Around **20%** are reported to develop premature ovarian failure. The risk does not rise in a simple straight line with repeat size, so counselling should avoid a crude "more repeats always means more ovarian risk" message. Reproductive, neurological and developmental implications should be held together in family counselling while respecting the different needs of each relative.

9.7 Confirmation, interpretation and management

Confirmation is molecular, not morphological. The diagnostic method of choice is **DNA-based fragile X repeat-length testing, using PCR and/or Southern blot methods including repeat-primed PCR**. Cytogenetic fragile-site methods are historical: culturing lymphocytes without sufficient folic acid made an apparent X-chromosome breakpoint visible, but that laboratory phenomenon is not a treatment rationale. In particular, folic acid should not be prescribed as therapy for the primary disorder on the basis of the old cytogenetic technique.

Testing is especially appropriate when intellectual disability is unexplained, when the developmental and behavioural pattern is suggestive, or when the pedigree contains compatible developmental, neurological or reproductive histories. The broader etiological workup for intellectual disability is covered in the causes-and-workup discussion; this section's responsibility is to ensure that the fragile X assay is a dedicated repeat-expansion test. Routine sequencing alone may not detect repeat expansions, so the test request must match the suspected mechanism.

The written report should be read as a molecular category, not merely as a positive or negative result. A full mutation directs attention to the developmental phenotype and its supports; a premutation redirects the family conversation toward transmission, reproductive implications and later neurological symptoms. Mosaic findings require correlation rather than dismissal. This interpretive step protects against two opposite errors: making the molecular result the whole explanation for a person's needs, or treating a clinically relevant finding as incidental because the current phenotype is subtle.

TRAP **A normal-looking child does not exclude fragile X, and a standard sequencing result is not automatically a fragile X test.** Suspect from the phenotype and pedigree; confirm with the repeat-expansion assay.

There is no established treatment for the primary disorder; management is of associated conditions. This is not therapeutic nihilism. It means that care is organised around developmental assessment, communication support, educational adaptation, treatment of target symptoms and associated medical conditions, and genetic counselling for the family. Developmental interventions and educational planning belong to the management section of this chapter. A syndrome diagnosis should improve the precision of that plan, not replace person-centred assessment.

Must remember: Fragile X is an X-linked repeat-expansion disorder in which maternal transmission can convert a premutation into a full mutation; full mutation silences FMR1 and reduces FMRP, whereas premutation disorders are mediated by toxic excess messenger RNA.

10 · Inborn errors of metabolism causing ID (PKU and others)

Why this group earns disproportionate attention. Inborn errors of metabolism are individually uncommon causes of intellectual disability, but they matter because a metabolic diagnosis may change the trajectory of a child and the advice offered to the family. The useful clinical question is not whether every person with developmental difficulty has a metabolic disorder. It is whether the pattern contains enough biological coherence to make a potentially modifiable cause worth pursuing. For the psychiatrist, these disorders are also a reminder that intellectual disability can be the long-term expression of a disturbance in a biochemical pathway rather than a fixed label detached from mechanism.

Inborn errors of metabolism are best approached as disorders in which a missing or ineffective metabolic step has consequences for the developing brain and, often, for other organs. Their psychiatric relevance lies in the combination of developmental phenotype, neurological signs, behaviour, systemic clues and the possibility of pathway-directed treatment. A good answer therefore does more than list syndromes: it links substrate, enzyme, clinical pattern and the therapeutic implication.

1 in 10,000 to 1 in 20,000	first 3 months	below 20%
PKU BIRTH INCIDENCE	LATEST WINDOW TO BEGIN PKU DIETARY RESTRICTION	ADULTS WITH PKU PERHAPS MAINTAINING DIETARY CONTROL

10.1 Clinical frame: think pathway, phenotype and treatability

Metabolic disorders should not be reduced to an examination catalogue. They are a way of thinking about causation. A child may have global developmental difficulty or established intellectual disability as one part of a wider disorder, while another person may present later to psychiatry because attentional, behavioural or affective symptoms have become more conspicuous than the developmental history. The history and examination should therefore remain alert to discordance: a developmental presentation that sits alongside altered growth, pigment, eyes, skeleton, movement, episodic illness or a distinctive form of self-injury deserves a broader explanatory frame.

The pattern matters more than any isolated sign. A physical clue is not merely a dysmorphology spotter's flourish; it can identify the organ system in which the metabolic disturbance is declaring itself. Similarly, an apparently psychiatric symptom may be a direct consequence of altered neurochemistry, a response to neurological disability, or both. This is why a formulation should preserve the medical diagnosis, the developmental phenotype and the current mental-state problem as separate but connected layers.

RULE **Define the problem by the disrupted pathway, then ask what can still be modified.** The same developmental endpoint can arise from very different biochemical mechanisms, and treatment must follow the mechanism rather than the behavioural surface.

There is an important boundary here. The detailed sequence of aetiological tests and the general genetic-counselling process belong to the wider intellectual-disability assessment. This section instead explains the recognised metabolic conditions and the clinical reasoning that makes their recognition consequential. When a metabolic disorder is known or suspected, psychiatric care works alongside paediatrics and metabolic medicine, rather than attempting to translate a complex behavioural presentation into a purely psychiatric diagnosis.

10.2 Phenylketonuria: the prototype of preventable metabolic neurodevelopmental injury

Phenylketonuria (PKU) is an autosomal recessive disorder and remains the classic example of a biochemical defect in which early recognition changes neurodevelopmental outcome. It is described as the commonest inborn error of metabolism. Textbook estimates give an incidence between **1 in 10,000 and 1 in 20,000 births**; a further estimate is 1 in 10,000 live births. These figures are useful as scale, but the clinical lesson is larger: rarity at the level of an individual clinic does not make a reversible diagnosis unimportant.

The primary defect is deficiency of **phenylalanine hydroxylase**, a hepatic enzyme. In ordinary biochemical terms, this enzyme mediates conversion of phenylalanine to tyrosine. The relevant gene is the PAH gene, located on chromosome 12, with a reported locus at 12q22-24.1. This is not genetic detail for its own sake. It explains why the disorder is familial in pattern and why a diagnosis has implications beyond the presenting child.

When this metabolic conversion fails, the brain is affected through more than one route. Low tyrosine contributes to depletion of central monoamines, including dopamine and serotonin. Reduced availability of large neutral amino acids also compromises synaptogenesis and myelination. That dual mechanism makes sense of a phenotype that crosses developmental cognition, attention, executive control and behaviour. It also prevents a simplistic conclusion that a child who survives the early developmental period without profound disability has necessarily escaped neurocognitive consequences.

MNEMONIC

PKU clinical spine: pathway, prevention, persistence

Start with the failed phenylalanine-to-tyrosine step; connect it to early dietary treatment; then remember that later executive, attentional and affective symptoms still deserve active review.

10.3 PKU phenotype: untreated disease and the treated survivor are different clinical questions

Untreated PKU is associated with intellectual disability and developmental delay. The recognisable untreated phenotype may include reduced pigment with fair or blond hair and blue eyes, microcephaly, eczema, epilepsy, growth retardation and hyperactivity. These features should be understood as clinical clues within a syndrome, not as a diagnostic shortcut. No one sign establishes the diagnosis, and a psychiatric assessment should not turn a physical sign into a substitute for biochemical confirmation.

The name itself reflects the secondary pathway. **Phenylketones**, produced through phenylpyruvic acid in the secondary pathway, are excreted in urine. This is a compact but useful examination link between the disease name and its biochemistry. It also illustrates a broader metabolic principle: once the usual route is blocked, diversion products can become clinically informative.

The early-treated adult or adolescent requires a different formulation from the untreated child described in older accounts. Even with early treatment, there can be subtle reductions in IQ with executive and attentional impairment. The psychiatrist should therefore ask concrete functional questions about planning, sustained attention, error monitoring, academic or occupational organisation, adherence to a demanding diet and the emotional burden of living with a lifelong disorder. This avoids two equal errors: attributing every difficulty to PKU, or dismissing cognitive and emotional concerns because gross intellectual disability has been prevented.

TRAP **Examination trap:** do not present early-treated PKU as synonymous with absence of neuropsychiatric morbidity. Early treatment changes the expected phenotype; it does not make follow-up unnecessary.

There is evidence of elevated depression, anxiety disorders, particularly agoraphobia, and attention-deficit disorder in early-treated adolescents with PKU compared with matched healthy individuals. In practice, this means that a symptom review needs ordinary psychiatric discipline. Establish the symptom's time course and impairment, consider medical and psychosocial contributors, and do not write off distress as an inevitable accompaniment of a metabolic label.

10.4 PKU screening and treatment: timing is part of the treatment

PKU illustrates why a metabolic diagnosis must be made early enough for the intervention to matter. Neonatal screening uses blood or urine. For prevention of severe, irreversible cognitive deficit, dietary phenylalanine restriction must begin within the **first 3 months of life**. The phrasing is deliberately temporal: a correct diet begun too late cannot be assumed to restore an already altered developmental pathway.

A low-phenylalanine diet maintained for at least the **first decade of life** is associated with an essentially normal cognitive outcome. The diet is not a casual instruction to avoid a food group. It is a sustained medical treatment whose implementation, monitoring and acceptability need specialist support.

IN INDIA

In the Indian Psychiatric Society clinical practice guidance, tetrahydrobiopterin with a low-phenylalanine diet is listed as a small-molecule intervention for PKU.

Longitudinal care needs to acknowledge that adherence can become difficult when parents no longer organise every meal and social life broadens. Perhaps **below 20%** of adults with PKU maintain dietary control throughout adulthood. This is not a reason to moralise about non-adherence. It is a reason to explore practical constraints, autonomy, cognition, family support, mood and the person's own understanding of risk. The psychiatrist's role includes making these barriers discussable while ensuring that metabolic management remains with the specialist team.

The broader lesson is that screening, diagnosis and treatment cannot be separated into unrelated facts. In PKU, the specimen identifies the condition, the biochemical pathway explains the diet, and the time window explains why developmental prevention is possible. That integrated chain is what candidates should reproduce rather than a bare list of enzyme and symptoms.

10.5 Homocystinuria: systemic clues should change the psychiatric formulation

Homocystinuria is an important contrast to PKU because the developmental presentation sits alongside striking extra-central-nervous-system findings. These include ocular lens dislocation, pectus excavatum, and a tall, thin, long-limbed Marfan-like stature. It is also associated with strokes in young and middle-aged adults.

GOOD TO REMEMBER

In a psychiatric setting, this combination should prevent diagnostic compartmentalisation: intellectual disability, compulsive symptoms or altered personality should not obscure systemic vascular and physical risk.

Intellectual disability occurs in almost all cases, and the behavioural phenotype can include obsessive-compulsive symptoms and personality disorders. These associations do not permit a psychiatrist to infer homocystinuria from an obsessive-compulsive presentation. They do, however, show why apparently ordinary phenomenology becomes diagnostically different when it appears with developmental and somatic clues.

Treatment may include pyridoxine, or vitamin B6, which increases homocysteine metabolism and reduces methionine and homocysteine. The Indian guidance also lists pyridoxine with vitamin B12 and folate among small-molecule approaches. Pyridoxine reduces these biochemical levels in approximately **50%** of patients. This is a treatment-response fact, not a licence for a psychiatrist to manage metabolic therapy independently.

A particularly useful negative finding is that folate plus vitamin B6 does not reduce stroke risk in adults with elevated homocysteine. The distinction matters because biochemical improvement and clinical vascular protection cannot simply be treated as interchangeable outcomes. It is the kind of nuance that strengthens an answer and, more importantly, prevents overconfident counselling.

10.6 Other named metabolic disorders: recognise the syndromic pattern

DISORDER	METABOLIC BASIS	CLUES THAT SHOULD REDIRECT THE FORMULATION	SPECIFIC THERAPEUTIC IMPLICATION
Galactosaemia	Autosomal recessive deficiency of one of three enzymes in galactose metabolism, including GALT	After milk introduction: failure to thrive, hepatosplenomegaly and cataracts	Galactose-free diet; if treated, intellectual disability is usually mild.
Lesch-Nyhan syndrome	X-linked mutation of the HGPRT gene causing a purine-metabolism defect with excessive uric acid production and excretion	Severe self-injurious behaviour with compulsive biting of fingers and lips, with spastic cerebral palsy and choreoathetoid movements	Behavioural risk management must be integrated with neurological and metabolic care.
Hurler syndrome (MPS I)	Autosomal recessive alpha-L-iduronidase deficiency	Storage disorder phenotype requires a multisystem formulation rather than an ID-only label.	Enzyme replacement for MPS and bone marrow transplantation for MPS I are listed interventions.

Galactosaemia teaches the importance of a feeding-linked systemic presentation. The triad of failure to thrive, hepatosplenomegaly and cataracts after milk introduction should redirect attention from an isolated developmental formulation toward galactose metabolism. The therapeutic link is equally direct: removing galactose is an intervention aimed at the pathway, not merely at a developmental consequence.

Lesch-Nyhan syndrome is especially memorable because the self-injury is severe and compulsive, rather than a generic behaviour problem. The child may be normal at birth before developing low-to-mild intellectual disability. The associated movement disorder and self-biting should prompt a syndrome-level formulation. In the consultation room, the practical priority is safety without losing explanatory precision: pain, communication difficulty, environmental response and the underlying neurobiological disorder can all shape the observed behaviour.

For the mucopolysaccharidoses, **Hunter syndrome (MPS II)** and Sanfilippo syndrome (MPS III) are both described as milder than Hurler syndrome (MPS I). The examination value is to recognise that MPS is a family of disorders rather than an eponym to be memorised in isolation. The clinical value is to retain the possibility that a developmental and behavioural presentation belongs to a multisystem storage disorder.

10.7 Treatability across metabolic disorders: use a mechanism-led therapeutic map

The key contrast across these conditions is not simply treated versus untreated. It is the kind of intervention that fits the disrupted biology. The Indian Psychiatric Society guidance identifies special or modified diets for many organic acidurias and aminoacidopathies, including PKU, glutaric aciduria type 1 and maple syrup urine disease. This should be read as an illustrative list, not as a claim that every metabolic disorder responds to dietary restriction.

- Replacement of deficient molecules includes thyroxine for hypothyroidism, enzyme replacement for mucopolysaccharidoses and copper histidine for Menkes disease.
- Small-molecule therapy includes creatine monohydrate for cerebral creatine deficiency syndromes and pyridoxine, vitamin B12 and folate for homocystinuria.
- Bone marrow transplantation is listed for alpha-mannosidosis and MPS I.
- Pharmacotherapy with vigabatrin and chelation of excess metals for Wilson disease and manganese transporter deficiency are further listed approaches.

These modalities are conceptually useful because they prevent therapeutic nihilism while also preventing indiscriminate treatment. A diet is appropriate when the disease mechanism supports dietary modification; replacement is appropriate when a missing molecule can be supplied; chelation addresses a harmful excess. The psychiatrist needs this map to understand why treatment is being offered and to recognise how psychiatric symptoms, adherence and family burden may affect it. Selecting the regimen, monitoring response and managing disease-specific risk remain specialist tasks.

> When intellectual disability is linked to a metabolic pathway, the decisive question is whether recognition permits pathway-directed treatment before or alongside irreversible developmental consequences.

10.8 Psychiatric practice: formulate, do not overshadow

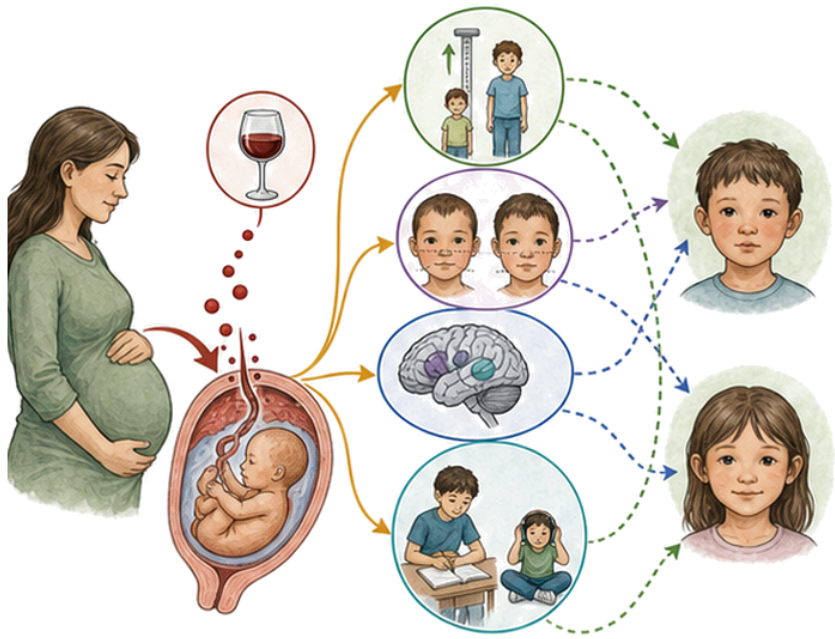
Metabolic diagnosis should sharpen psychiatric assessment, not end it. A person may require assessment for depression, anxiety, attentional difficulty, obsessive-compulsive symptoms, personality change, severe self-injury or behavioural distress. The diagnosis helps the clinician ask better questions about timing, cognitive baseline, neurological change, diet, treatment burden and family interpretation. It must not become a blanket explanation that erases a treatable psychiatric syndrome or a preventable safeguarding problem.

Conversely, a familiar psychiatric label should not absorb clues that point beyond psychiatry. In PKU, executive and attentional impairment can coexist with mood and anxiety disorders. In homocystinuria, a psychiatric presentation sits beside ocular, skeletal and vascular clues. In Lesch-Nyhan syndrome, self-injury needs immediate compassionate management, yet its form and accompanying neurological signs carry diagnostic information. The senior clinical move is to hold both truths at once: symptoms deserve direct care, and their biological context may alter risk, referral and prognosis.

For examination writing, organise the answer around the prototype, then demonstrate range. Begin with PKU - inheritance, enzyme, biochemical block, phenotype, newborn screening and dietary treatment. Use homocystinuria to show why systemic findings and psychiatric symptoms must be integrated. Add galactosaemia, Lesch-Nyhan syndrome and mucopolysaccharidoses as concise pattern-recognition examples, and finish with the principle of mechanism-matched intervention. That organisation conveys clinical understanding rather than memorised accumulation.

11 · Fetal alcohol spectrum disorder

Why this diagnosis earns its place in an intellectual-disability chapter. Fetal alcohol spectrum disorder (FASD) is the clinical umbrella for developmental consequences attributed to prenatal alcohol exposure. It matters because the developmental phenotype is often broader than the visible phenotype: a child may have substantial difficulty with learning, regulation and everyday functioning without displaying the full facial pattern of fetal alcohol syndrome (FAS). Conversely, the recognisable physical pattern should prompt a careful account of neurodevelopment, rather than being treated as a diagnosis made from appearance alone. FAS is **probably the most common nongenetic cause of intellectual disability**, but FASD must not be reduced to intellectual disability alone.



- Prenatal alcohol exposure
- Growth
- Facial pattern
- Brain development
- Function may be impaired without facial signs

Fig 21.10 Fetal alcohol spectrum disorder is an umbrella for developmental consequences associated with prenatal alcohol exposure. Neurodevelopmental impairment may occur without the complete growth and facial pattern of fetal alcohol syndrome.

The useful clinical stance is therefore developmental and longitudinal. Ask whether prenatal exposure is documented, look deliberately for the phenotype, establish whether growth or brain-development indicators are present, and describe the functional profile in its own right. The label should bring order to a scattered presentation; it should not become a shortcut that explains every behaviour, nor should an absent facial phenotype be used to dismiss a credible exposure-related neurodevelopmental disorder.

11.1 Scope, language and diagnostic lineage

FASD is an umbrella, not a synonym for FAS. Its subdiagnoses include FAS, partial FAS (PFAS), alcohol-related neurodevelopmental disorder (ARND), alcohol-related birth defects (ARBD), and neurobehavioural disorder associated with prenatal alcohol exposure (ND-PAE). This terminology is clinically useful because it separates a full syndromic presentation from partial physical phenotypes and from neurodevelopmental presentations in which physical signs are not

demonstrable. ARBD is primarily a physical diagnosis and is not the focus of this neurodevelopmental discussion.

The original FAS criteria were set out by **Jones and Smith in 1973**. Contemporary clinical criteria are commonly described as the **Hoyme criteria**, updated from earlier Institute of Medicine criteria. For examination answers, the important point is not to recite a lineage of labels. It is to show that FASD diagnosis is organised around a coherent set of diagnostic domains: prenatal alcohol exposure, facial anomalies, growth deficiency, deficient brain growth or abnormal morphogenesis, and neurobehavioural impairment. These domains provide the framework for deciding which diagnosis best fits the available evidence.

RULE **Diagnostic principle.** In FASD, exposure history, physical findings and neurodevelopmental findings are interpreted together; none should be allowed to stand in for the others.

This framework also explains an apparently counterintuitive feature of the full syndrome. A diagnosis of **FAS** rests on the characteristic physical and neurobehavioural domain combination, so documentation of confirmed prenatal alcohol exposure is not required for that diagnosis. That is not permission to treat exposure history as unimportant. It reflects the specificity attributed to the combination when it is present, while recognising that reliable retrospective histories can be unavailable.

MNEMONIC

Use the spine, not a checklist blur

Think *exposure, face, growth, brain, behaviour*. It keeps the assessment ordered and makes it less likely that a clinician will mistake a single facial observation or a behavioural complaint for the whole diagnosis.

11.2 Biology and the syndromic phenotype

Alcohol is a developmental teratogen, so the clinical phenotype should be understood as the outcome of disruption during development rather than as a static cosmetic syndrome. A proposed mechanism is inhibition of **NMDA receptors** that mediate postsynaptic excitatory effects of glutamate, with effects on cell proliferation. This provides a biologically intelligible bridge between structural findings and later developmental difficulties. It does not, however, permit one to infer a particular cognitive profile from mechanism alone. Developmental outcomes are heterogeneous, and clinical formulation remains more informative than mechanistic shorthand.

Recognising the face requires discipline. The classic sentinel pattern is a **triad of short palpebral fissures, a smooth philtrum and a thin upper lip**. These are midfacial findings, not a general impression that a child "looks dysmorphic". The examiner should observe and document each component carefully, because casual facial judgement is vulnerable to expectation, ancestry-related variation and poor-quality photographs. In the facial-anomaly domain, **at least two** characteristic features are required. A palpebral fissure length at or below the **10th centile**

qualifies as a facial feature; a thin vermilion border or smooth philtrum is assessed on a racially normed lip-philtrum guide at **rank 4 or 5**.

TRAP **Examination trap.** Do not diagnose FASD from a nonspecific statement such as "typical facies". State the individual facial findings, then relate them to the wider diagnostic domains.

Growth and brain-development indicators add clinical weight when present. Growth deficiency is represented by height or weight at or below the 10th centile. Deficient brain growth or abnormal morphogenesis may be reflected by head circumference at or below the 10th centile, structural brain abnormalities, or recurrent nonfebrile seizures. These are diagnostic indicators, not interchangeable measures of the same process. A growth measurement answers a different question from head growth, and neither replaces a careful account of neurobehavioural functioning.

DIAGNOSTIC DOMAIN	WHAT THE CLINICIAN ESTABLISHES	WHY IT CHANGES REASONING
Prenatal alcohol exposure	A reliable history when it is available.	It is essential for some FASD diagnoses and strengthens causal attribution.
Facial anomalies	The sentinel midfacial pattern, measured rather than guessed.	It distinguishes a recognisable physical phenotype from a purely behavioural presentation.
Growth deficiency	Appropriate anthropometric evidence.	It contributes a separate developmental domain.
Brain growth or morphogenesis	Head-growth, structural or seizure indicators.	It links the physical assessment to neurodevelopmental risk.
Neurobehavioural impairment	Impairment on a global estimate or a relevant neurobehavioural or behavioural domain.	It prevents the diagnosis becoming a morphology exercise.

The threshold for neurobehavioural impairment in this clinical framework is performance at least 1.5 SD below the mean on a global cognitive estimate or on a single relevant neurobehavioural or behavioural domain. The key clinical inference is modest but important: a child can require a detailed functional evaluation even when the physical findings are incomplete. The physical phenotype and the developmental phenotype overlap, but they are not identical.

11.3 Distinguishing FAS, partial FAS and ARND

The diagnostic categories are best used as descriptions of the configuration before you, not as a hierarchy of "real" and "less real" disorders. FAS is the full syndromic pattern described above. PFAS retains facial anomalies and neurobehavioural impairment in the presence of confirmed exposure. When exposure is not confirmed, PFAS requires those findings together with impairment in either growth or brain growth. This additional requirement is logically necessary: without a documented exposure history, the clinician needs a more specific configuration before making an exposure-attributed diagnosis.

Alcohol-related neurodevelopmental disorder is made in the absence of the physical indicators of face and growth, but requires confirmed prenatal alcohol exposure and neurobehavioural impairment. This category is especially important because it captures children whose most disabling difficulties are cognitive, behavioural and functional rather than dysmorphic. Its existence protects against a common diagnostic error: assuming that the absence of the FAS face excludes alcohol-related neurodevelopmental harm.

- For FAS, look for the characteristic syndromic combination and do not make documented exposure a false prerequisite.
- For PFAS, decide first whether prenatal exposure is confirmed, because that changes the required domain configuration.
- For ARND, do not demand facial or growth indicators when a documented exposure history and neurobehavioural impairment are present.

These distinctions should improve the quality of documentation. Record what was observed, what was measured, which part of the exposure history is corroborated and which diagnostic domain is not established. That language is more clinically defensible than forcing a label from an incomplete record. It also keeps diagnostic uncertainty visible, which is preferable to either overcalling a syndrome or making a false reassurance from an absent physical feature.

11.4 ND-PAE: the proposed neurodevelopmental diagnosis

Neurobehavioural disorder associated with prenatal alcohol exposure is placed in the DSM appendix under Conditions for Further Study, with proposed rather than full diagnostic criteria. This status matters in a written answer: ND-PAE is a structured clinical construct, but it is not a full DSM diagnosis. It should therefore be described accurately rather than presented as though it had identical nosological standing to every routine DSM diagnosis.

Its exposure criterion specifies more-than-minimal gestational exposure as more than 13 drinks per month during pregnancy, or more than 2 drinks on any one occasion. This threshold is a criterion for the proposed diagnosis, not a declaration that exposure below it is safe. There is **no established safe threshold** or safe period of gestational alcohol exposure. The effects of exposure remain difficult to reduce to a single number because developmental stage and maternal and fetal factors modify risk.

The ND-PAE structure makes the clinical interview more precise. It requires impairment in at least one neurocognitive domain, at least one self-regulation domain, and at least two adaptive-functioning domains, one being communication or social communication and interaction. The neurocognitive domains include global intellectual performance, executive functioning, learning, memory and visual-spatial reasoning. The self-regulation domains include mood or behavioural regulation, attention and impulse control. Adaptive difficulties can involve communication, social communication and interaction, daily living skills or motor skills.

Global intellectual performance may be demonstrated by an IQ or comprehensive developmental standard score at or below 70. That is one route within the neurocognitive criterion, not the

definition of the whole condition. A sound assessment asks which abilities fail in ordinary demands and whether the pattern coheres with the exposure history. Neurocognitive deficits, regulation problems and adaptive limitations are clinically separable, though they often compound one another in a child's life.

Diagnosis should be deferred at or below 3 years, because reliable neurocognitive assessment is limited at that stage. Deferral is not abandonment. It means recording exposure and developmental concerns, following the child's profile over time, and avoiding a prematurely fixed label. ND-PAE can be diagnosed in alcohol-exposed children with or without FAS, including those without facial dysmorphology. That independence is precisely why the clinician must inspect the neurodevelopmental phenotype rather than use the face as a gatekeeper.

11.5 Cognitive and behavioural clinical correlation

FASD creates a frequent conceptual trap in intellectual-disability teaching. The presence of FASD does not mean that every affected child has intellectual disability, and a normal-looking child should not be assumed to have intact higher functions. The majority of children with FASD do not have IQ below 70; observed ability spans from severe intellectual impairment to average performance. In children with FAS, the average full-scale IQ is around 72, compared with around 80 in children with heavy prenatal alcohol exposure without FAS. Intellectual disability in FAS is usually mild to moderate, though it may be severe.

Interpretation of intelligence testing itself belongs in the intellectual-disability assessment material.

GOOD TO REMEMBER

Do not let a single global score decide whether FASD is clinically important. A child with broadly higher measured ability may still struggle with executive demands, new learning, memory, visual-spatial reasoning, attention, impulse control or social communication. Translate these findings into difficulties at school, with home routines and in judgement; do not misread them as wilful noncompliance.

Psychiatric comorbidity adds a second layer of complexity. **Attention-deficit/hyperactivity disorder** is the most common co-occurring psychiatric diagnosis, with reported prevalence among children with FASD between 44% and 96%. Mental health problems have been identified in more than 90% of people with histories of significant prenatal alcohol exposure. These figures should not invite indiscriminate diagnostic labelling. They should prompt the clinician to ask whether attention, impulsivity and emotional dysregulation are being described carefully, rather than folded uncritically into a single explanatory story.

The absence of the classic face does not exclude an alcohol-related neurodevelopmental disorder; assess exposure history and functional phenotype together.

11.6 Differential diagnosis and disciplined attribution

Attribution is a clinical conclusion, not a moral judgement. Prenatal alcohol exposure may be difficult to establish and the behavioural presentation is not pathognomonic. The diagnostic task is therefore one of pattern recognition followed by active exclusion of alternatives. A credible history is valuable, but history alone cannot establish that every developmental difficulty is caused by alcohol. Equally, uncertainty in history should not lead to a careless assumption that a distinctive physical and neurobehavioural pattern is irrelevant.

The named differential includes genetic conditions such as Williams syndrome, Down syndrome and Cornelia de Lange syndrome, and other teratogenic conditions such as fetal hydantoin syndrome and maternal phenylketonuria. These conditions can share physical and behavioural characteristics with ND-PAE. The practical lesson is to seek positive evidence for the proposed diagnosis and contradictory evidence for alternatives. “Alcohol exposure reported” is not a substitute for a differential diagnosis; “facial features absent” is not a substitute for one either.

TRAP **Examination trap.** A documented exposure history does not remove the need for differential diagnosis, and an undocumented history does not automatically rule out FAS when the required syndromic configuration is present.

- Separate observations from inferences: document anthropometry, facial examination, neurodevelopmental findings and exposure evidence distinctly.
- Ask whether each finding belongs to the FASD configuration or whether it suggests an alternative developmental or teratogenic condition.
- State the limits of the available evidence rather than converting an uncertain history into false certainty.

For a broader developmental formulation, use the relevant sections of the *Child psychiatry: assessment, treatment, services and protection notes*. Assessment of adaptive behaviour, intellectual testing and the multidisciplinary management of intellectual disability are deliberately treated elsewhere in these notes. Here, the point is narrower: recognise when alcohol-related developmental injury is a plausible organising diagnosis and describe why.

11.7 Epidemiology, prevention boundary and clinical significance

Reported prevalence varies greatly with population, case definition and completeness of assessment, so a single headline figure can mislead. The mean global general-population prevalence of FASD reported for 2012 was 7.7 per 1,000. The corresponding mean for the Americas was 8.8 per 1,000. In the United States, FASD has been estimated at between 1.1% and 5.0%, whereas the reported estimate for FAS itself is between 2 and 7 per 1,000 children. These are not competing answers. They measure differently framed populations and, crucially, the spectrum is wider than the full syndrome.

7.7 per 1,000	8.8 per 1,000	1.1% to 5.0%	251.5 per 1,000
FASD: GLOBAL MEAN	FASD: AMERICAS MEAN	FASD: UNITED STATES ESTIMATE	ND-PAE: CHILDREN IN CARE SETTINGS

Ascertainment is not a technical footnote. ND-PAE estimates in fully evaluated children have ranged between 31.1 and 98.5 per 1,000, and a meta-analytic estimate among children in care settings was 251.5 per 1,000. The latter should never be generalised to all children. It does, however, underline why a high-risk care context should lower the threshold for a thoughtful developmental history and a careful search for unmet needs.

The clinical preventive message is uncomplicated: there is no established safe threshold or safe period for alcohol exposure in pregnancy. The public-health framework for prevention is addressed in the *Prevention of intellectual disability* material. In this section, the practical diagnostic corollary is that clinicians should discuss exposure without blame. Shame drives concealment, while accurate histories and respectful care improve recognition of children who need a fuller developmental evaluation.

12 · Tuberous sclerosis, neurofibromatosis and neurocutaneous syndromes in ID

Why these disorders matter in intellectual disability. Neurocutaneous syndromes make the aetiological assessment of intellectual disability clinically visible. The examination of skin, eyes and nervous system can connect a developmental presentation to a multisystem disorder, while the psychiatric formulation must remain alert to seizures, cognitive change, behaviour, family burden and the practical implications of a long-term condition. They reward disciplined observation: a lesion on the skin is not a diagnosis by itself, but it may be the clue that makes the whole developmental history intelligible.

These syndromes are especially useful for teaching this approach. **Tuberous sclerosis complex** brings developmental, epileptic and systemic manifestations into a formulation. **Neurofibromatosis type 1** likewise has cutaneous signs that may point to neurodevelopmental and neurological needs. The task for the psychiatrist is neither to reduce the patient to a syndrome nor to overlook the syndrome while treating only behaviour.

1 in 7000	**about 70%**	**above 90%**	**50%**
TSC POPULATION PREVALENCE	TSC DE NOVO MUTATIONS	TSC SEIZURES AT PRESENTATION	NF1 NEW CASES IN UNAFFECTED FAMILIES

12.1 Neurocutaneous syndromes as a clinical frame

A neurocutaneous syndrome should be approached as a pattern across organ systems rather than as a dermatological label. In a person with intellectual disability, the clinician asks whether physical stigmata, epilepsy, cognition and change in functioning can be explained by a shared condition. This is useful because the consequences of an established syndrome are not merely diagnostic. It changes the threshold for collateral history, medical liaison and surveillance for new symptoms.

For tuberous sclerosis, older texts may use **epiloia** or tuberose sclerosis. The classical teaching spine comprises **three** linked manifestations: epilepsy, intellectual disability and facial angiofibromas on the malar surface. It remains a memorable clinical entry point, but it is not a substitute for examining the person or for recognising that features evolve across development.

In particular, facial angiofibromas may first become apparent in adolescence; their absence earlier in life should not falsely reassure the clinician.

MNEMONIC

E-I-F for the classical TSC spine

epilepsy, intellectual disability and facial angiofibromas. Use it to prompt a whole-person review, not as a rule-out checklist.

RULE **When intellectual disability coexists with characteristic skin or neurological signs, formulate the syndrome as a multisystem condition and reassess for changing neurological function.**

Physical signs are most useful when they sharpen the examination rather than when they create diagnostic tunnel vision. In tuberous sclerosis, look deliberately for facial angiofibromas, hypomelanotic macules including ash-leaf spots, shagreen patches over the lower trunk or buttocks, ungual fibromas and retinal phakoma. These findings support a coherent clinical hypothesis, yet the psychiatrist should also document what they mean functionally: distress about appearance, stigma, pain, caregiving burden and barriers to education or work can all influence the presenting complaint.

12.2 Tuberous sclerosis complex: genetics and mechanism

Tuberous sclerosis is inherited in an **autosomal dominant** pattern, although many presentations are sporadic. What varies between affected people, and even within one family, is the **expressivity** of the disorder rather than its penetrance: current genetic sources put penetrance at essentially complete, so a relative who carries the pathogenic variant is affected, but the severity and organ pattern of that involvement differ widely. Older texts, including some in common examination use, describe this as variable penetrance. Say expressivity, and know why the distinction matters: it means a mildly affected parent is affected, not a non-penetrant carrier, and their apparently trivial skin sign is a reason to examine them properly. This matters when taking a family history: the history may be apparently negative without making a genetic disorder implausible. In conventional testing, an alteration in TSC1 or TSC2 is identified in 80% to 90% of people with the condition. The choice and sequence of tests belong to the ID aetiological work-up; the syndrome-specific result is interpreted alongside phenotype and family context rather than in isolation.

TSC1, located at 9q34, encodes hamartin. **TSC2**, located at 16p13, encodes tuberin. Their products act as tumour suppressors that restrain Rheb-mediated mTOR kinase activity. This molecular account is clinically valuable because it explains why mTOR-directed treatment has a rational place in selected manifestations; it does not imply that every cognitive or behavioural difficulty is directly reversible by treating a lesion.

The broad developmental lesson is that a molecular diagnosis describes risk and mechanism, not destiny. Cognitive ability in tuberous sclerosis has been reported as bimodally distributed, with a

group having normal IQ and another in the profoundly affected range. Such heterogeneity makes an individual developmental and adaptive assessment indispensable. It also prevents the opposite errors of assuming that every person with the syndrome has intellectual disability, or overlooking substantial support needs in someone whose physical signs dominate the consultation.

GENETIC OR BIOLOGICAL LEVEL	CLINICAL MEANING	PSYCHIATRIC IMPLICATION
TSC1 and TSC2 encode hamartin and tuberin	The disorder has a defined tumour-suppressor pathway	Family history and physical findings should be integrated with the syndrome phenotype
The complex restrains mTOR activity	Selected structural manifestations have a pathway-based treatment rationale	Do not equate lesion-directed treatment with a complete explanation or cure for developmental needs
Variable penetrance and sporadic presentation	A negative family history does not settle the question	Give counselling within the wider genetic-work-up framework and avoid premature certainty

12.3 TSC phenotype: seeing the syndrome without missing the person

The skin examination is often the most accessible part of recognition. **Facial angiofibromas** are classically malar, while hypomelanotic macules, shagreen patches and ungual fibromas provide other cutaneous clues. Describe what is actually seen rather than using a label as shorthand. A careful record helps later clinicians distinguish longstanding stigmata from new change and allows the family to understand why a psychiatric consultation involves a full physical review.

Central nervous system lesions account for much of the developmental and neurological burden. Subependymal tubers may line the ventricles. Their reported size is **1 to 3 cm**, but the clinical question is not their size alone: one must ask whether a growing lesion could be producing seizures, headache, altered alertness, loss of skills or progressive cognitive impairment. **Subependymal giant cell astrocytomas** may compress and irritate adjacent cortex, and obstruction at the foramen of Monro can cause obstructive hydrocephalus. New deterioration should therefore trigger medical rather than purely behavioural attribution.

TRAP **Do not call a new behavioural change "part of the intellectual disability" before considering seizure activity, lesion-related change or hydrocephalus in a person with TSC.**

Systemic review is equally important. Tuberous sclerosis can involve renal cysts and angiomyolipomas, and cardiac rhabdomyomas that may cause dysrhythmias. These are not incidental facts for the psychiatrist. Pain, sleep disruption, repeated admissions, frightening cardiac symptoms and treatment demands can present indirectly as irritability, avoidance, low mood or family conflict. A liaison formulation distinguishes a psychiatric syndrome from a psychological response to a medical burden, while allowing both to be present.

Liaison also requires intellectual humility. Each specialty may see a valid but partial account of the person: the lesion, the seizure, the renal issue, the visible skin finding, the behaviour, or the

family's exhaustion. The psychiatric assessment can integrate these accounts around daily functioning and distress. It should make uncertainty explicit, identify the next clinically answerable question and avoid implying that a behavioural description can settle a neurological concern.

For candidates, the practical inference is simple: findings in brain, skin, heart, eye and kidney make the syndrome multisystem. The specialist medical team directs organ surveillance. Psychiatry contributes longitudinal developmental description, a baseline of behaviour and cognition, assessment of emotional symptoms at the person's communication level, and support for carers faced with uncertainty.

12.4 Epilepsy, intellectual disability and behaviour in TSC

Epilepsy is central to the neuropsychiatric phenotype of tuberous sclerosis. Partial motor and complex partial seizures are particularly characteristic. Other seizure forms may occur, with classic absence seizures a probable exception; severe presentations may begin with infantile spasms. This seizure history should be taken with attention to onset, semiology, treatment response, injuries, sleep, postictal behaviour and apparent developmental plateau or loss. A family's account of "spells" may be much more informative than a single label in an old record.

Vigabatrin is particularly effective for infantile spasms in tuberous sclerosis. A randomised, single-masked trial in young children found the subgroup with TSC-related spasms particularly responsive. This is a responsiveness observation, not a licence to treat without specialist epilepsy oversight.

IN INDIA

The Indian psychiatric guideline also lists tuberous sclerosis among its relevant uses.

The limitation is clinically serious. Vigabatrin can cause progressive, permanent bilateral vision loss, including concentric visual field constriction. It has also been associated with behavioural disturbance or ADHD symptoms, depression and psychosis, with no beneficial psychotropic effect reported.

GOOD TO REMEMBER

When behaviour worsens after an antiseizure treatment change, the formulation must consider medication effect as well as seizure control, environment and the person's baseline vulnerabilities.

- Obtain a careful seizure and medication chronology before attributing agitation or decline to a primary psychiatric disorder.
- Ask carers for concrete examples of change in sleep, attention, mood, behaviour and daily functioning.
- Escalate new focal neurological symptoms or progressive cognitive change to the relevant medical team.

There are useful risk associations, but they must not become deterministic predictions. TSC2 mutations are associated with more severe epilepsy and cognitive impairment; moderate to severe intellectual disability is more common in people with infantile spasms. These associations support vigilance and early support planning; they do not replace an assessment of the individual's communication, strengths, behaviour or family resources.

TSC also has a limited reverse relationship with autism at population level: **less than 4%** of all autism is attributable to TSC. The point is diagnostic humility. TSC may be relevant to autism in an individual with the syndrome, but it does not explain autism generally, and autism assessment should still be conducted on its own clinical evidence.

12.5 TSC management: targeted treatment and longitudinal formulation

The psychiatric role in a multisystem syndrome is coordinative and longitudinal. First, identify the current problem in concrete terms: seizure-related risk, a change in cognition, behavioural disturbance, emotional symptoms, school or vocational difficulty, caregiver strain, or difficulty navigating multiple specialties. Next, establish the baseline against which change can be judged. Finally, communicate concerns in a form useful to neurology, paediatrics, dermatology, ophthalmology, cardiology and renal services as appropriate.

For subependymal giant cell astrocytomas, the mTOR inhibitors everolimus and sirolimus can shrink the lesion. Topically applied mTOR inhibitors can reduce facial angiofibromas. These examples clarify an important distinction: a medicine can be directed at a structural or skin manifestation, while the psychiatrist still addresses developmental support, distress, adherence, family understanding and the lived effects of a chronic disorder.

In TSC, a change in behaviour or cognition is a clinical event to explain, not a baseline feature to dismiss.

Generic genetic counselling principles and the sequence of laboratory investigation are addressed in the ID aetiological work-up. In this syndrome-specific setting, the clinician should explain that inheritance may be variable and that sporadic presentation is common, then ensure that the family receives appropriately coordinated counselling. Avoid giving a falsely precise recurrence discussion from a psychiatric interview alone, especially when the molecular result and the family phenotype have not yet been clarified.

12.6 Neurofibromatosis type 1: recognition and diagnostic reasoning

NF1 is associated with the tumour-suppressor gene product **neurofibromin**, at 17q11.2. Neurofibromin is involved in regulation of cell division and tumour suppression. As in TSC, the psychiatric significance lies in recognising a medical context for developmental and behavioural needs while retaining ordinary clinical discipline: a person can have NF1 and an independent mood, anxiety, psychotic or behavioural disorder.

Diagnosis usually requires **at least two** diagnostic features from the established list. The recognised features span skin lesions, peripheral tumours, regional freckling, ocular findings, optic-nerve involvement, bony lesions and an affected first-degree relative. The list is best used as

a structured prompt for referral and documentation, not as an invitation for the psychiatrist to make a final diagnosis without appropriate examination.

NF1 FINDING DOMAIN	FEATURES TO LOOK FOR OR ELICIT	WHY IT MATTERS IN AN ID ASSESSMENT
Skin	**Café-au-lait macules**, axillary or inguinal freckling	May supply the first clue to a syndromic formulation
Peripheral tumours	Neurofibromas, including **plexiform neurofibroma**	Symptoms and visible difference may affect distress, self-image and help-seeking
Eye, bone and family history	Lisch nodules, optic nerve glioma, bony lesions, affected first-degree relative	Signals the need for appropriately coordinated specialist assessment

The café-au-lait threshold is a common recall point but should be applied with precision. The cited criterion specifies **six or more** lesions, larger than 5 mm before puberty or 15 mm after puberty. An alternative source frames the sign as more than six lesions, each larger than 5 mm in children and 1.5 cm in adults, and notes that individual café-au-lait spots occur in normal individuals. Therefore, a single lesion should not be over-interpreted; the pattern, associated signs and clinical context matter.

TRAP **Do not diagnose NF1 from an isolated café-au-lait spot, and do not mistake a referral criterion for a psychiatric explanation.**

12.7 A psychiatrist's practical synthesis

When a neurocutaneous syndrome is known or suspected in a person with intellectual disability, begin by separating the immediate clinical question from the aetiological label. Is the consultation about new seizures, progressive cognitive difficulty, aggression, emotional distress, medication adverse effects, family conflict or a support failure? That distinction prevents a syndrome name from becoming a catch-all explanation and makes the response clinically useful.

A good formulation has parallel layers. The biological layer records the established or suspected syndrome, current neurological concerns and treatment exposure. The developmental layer records the person's baseline abilities, communication and pattern of support. The psychological layer asks how the person understands symptoms, procedures, visible differences and restrictions. The social layer identifies who observes change, who carries care and what makes access to coordinated treatment difficult. Writing these layers separately helps the team avoid both diagnostic overshadowing and fragmented, organ-by-organ care.

Communication with families deserves the same precision as communication with specialists. Explain why a new symptom is being taken seriously, what the immediate safety concern is, and which clinician will address it. Invite carers to retain their observations rather than dismissing them as vague. In people with limited spoken language, an account of altered routine, sleep, facial expression, mobility, appetite, engagement or self-care may be the earliest available evidence of a

medical or emotional change. The psychiatrist's value is often to translate this observation into an actionable question for the wider team.

- Examine and document relevant skin signs, while asking what they mean to the patient and family.
- Seek a longitudinal account of development, seizures, cognition, behaviour and treatment exposure.
- Compare the present state with the person's own baseline rather than with an abstract stereotype of the syndrome.

These disorders are a reminder that psychiatry in intellectual disability is whole-person medicine. The syndrome gives a framework for anticipation; it does not erase the individual's personality, preferences, communication style, social context or capacity for psychological distress. The best answer in the examination, and the best practice in the clinic, links a recognisable phenotype to a thoughtful developmental and psychiatric formulation without claiming more certainty than the evidence supports.

13 · Behavioural phenotypes of genetic syndromes

The useful question is not "what behaviour does this syndrome cause?" A behavioural phenotype is a clinically recognisable pattern that can sharpen observation, guide anticipatory enquiry and prevent diagnostic overshadowing. It is not a substitute for seeing the person in front of us. In intellectual disability, knowing the aetiology may provide **clues to psychiatric comorbidity**, because some syndromes are repeatedly associated with particular behavioural patterns. The practical gain is disciplined curiosity: ask about the pattern that is plausible, then establish whether it is actually present, distressing and functionally important.

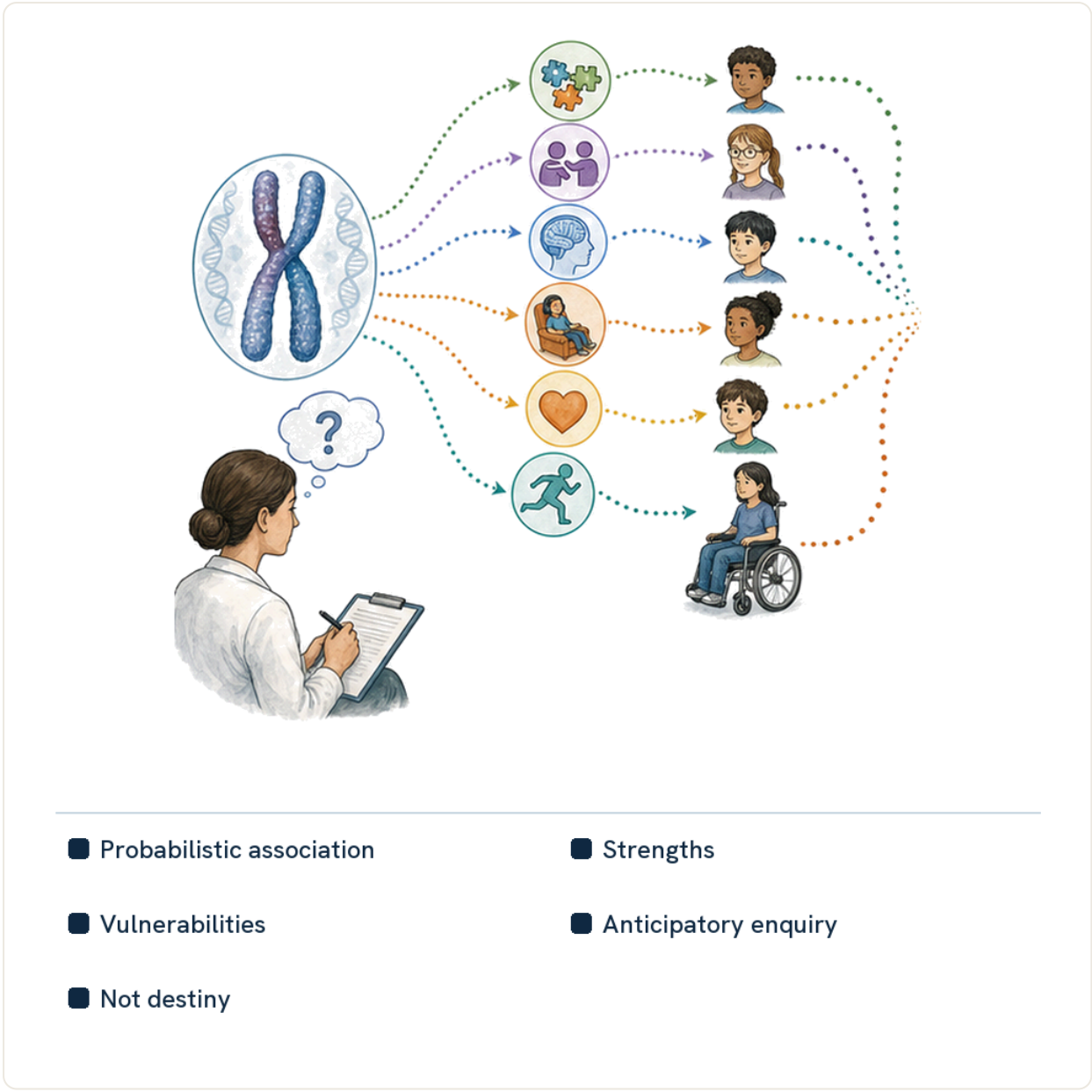


Fig 21.11 A behavioural phenotype is a raised probability of a pattern, not a behaviour caused in every person by a syndrome. It guides anticipatory enquiry while preserving individual strengths, context and diagnostic assessment.

The term **behavioural phenotype** was introduced by Nyhan. Earlier clinical observers such as Penrose had noted a distinctive social presentation in Down syndrome, but the modern concept is broader and more cautious. Its working definition is associated with Dykens: a syndrome is associated with a raised likelihood of a behavioural or developmental outcome when compared with people without that syndrome. That is a **probabilistic association**, not a diagnostic label attached to every individual.

13.1 What the concept does - and does not - mean

A behavioural phenotype is best understood as a pattern of vulnerabilities, strengths and recurrent clinical problems that occurs more often in a defined condition than outside it. This distinguishes a useful phenotype from an attractive anecdote. The clinician is looking for the **combination of features and its association with a condition**, rather than claiming that an isolated common symptom identifies a syndrome. Attentional difficulty, social anxiety, sleep

disruption, stereotypy and self-injury all occur across diagnostic groups. Their meaning comes from their form, timing, associated features and clinical setting.

RULE **A behavioural phenotype changes prior probability; it does not determine the individual's behaviour.**

The concept explicitly rejects genetic determinism. Behavioural expression is shaped by developmental level, communication, physical illness, sensory experience, family responses, opportunity and the person's own temperament. A syndrome may create a particular vulnerability while the environment influences how often it is triggered, how it is understood and how much disability follows. This is why a behavioural phenotype should lead to more careful assessment, not to premature explanation.

Equally, no behavioural phenotype is invariant. The absence of a familiar feature should not be used to dismiss a molecular or clinical diagnosis; its presence should not be used to make one. This is especially important in adults, in people with co-occurring sensory or neurological problems, and where developmental history is incomplete. The phenotype is a clinical map, not a gatekeeping criterion.

Specificity lies on a spectrum. A broad feature may be shared across several syndromes, whereas a particular form of that behaviour may be unusually informative. For example, a particular form of stereotyped hand wringing is almost invariably seen in Rett syndrome, even though hand stereotypies occur in many clinical contexts. The distinction protects against the common error of treating the category "stereotypy" as though it carried the specificity of its most characteristic form.

TRAP **Do not turn a phenotype into a personality stereotype.** A recurring association may help formulate a question, but it never excuses failure to assess pain, communication, mood, safeguarding, environmental demands or co-occurring psychiatric illness.

13.2 How to use a phenotype in assessment

Use the syndrome to improve the interview, not to abbreviate it. Start with a baseline account of communication, adaptive functioning and the person's usual temperament. Then ask about the behaviours linked to the syndrome in a neutral, concrete way: their form, onset, antecedents, consequences and effect on family life, education, work and health. A behavioural signature has most value when it prompts a question that might otherwise not have been asked.

When a behaviour is established, the next task is formulation. Food-seeking, self-injury, withdrawal, agitation or sleep disruption can be part of a phenotype, but can also signal an untreated medical problem, a mismatch between demands and ability, a communication failure or a psychiatric disorder. The syndrome changes the differential weighting; it does not make competing explanations disappear. The assessment of psychiatric comorbidity in intellectual disability is addressed in the chapter's discussion of dual diagnosis, and the general assessment framework belongs in the Child psychiatry: assessment, treatment, services and protection notes.

- Describe the behaviour precisely before naming it as syndrome-related.
- Establish what has changed from the person's own baseline and what has changed around them.
- Look for the linked behavioural cluster, not an isolated headline symptom.
- Use the formulation to anticipate risk and support needs without attributing blame.

This approach matters to families. A **strong behavioural phenotype** describes a vulnerability that may be evident even in a supportive environment. In such situations, parents and teachers who have worked hard should not be invited to conclude that the behaviour proves a failure of care. The right message is more exact: environment still matters greatly for safety, distress and functioning, but it may not fully remove a syndrome-linked vulnerability.

The historical literature illustrates why this caution is necessary. Reviews in the 1970s discussed only **five** chromosomal syndromes in this context. The concept has since become clinically richer, but a larger catalogue does not make its inferences categorical. The contemporary task is to be specific enough to notice a pattern and humble enough not to overread it.

13.3 Cross-syndrome signatures: a working comparison

The table is a pattern-recognition aid, not a diagnostic algorithm. It deliberately pairs the most discriminating feature with the clinical caution that prevents overclaiming. Several entries contain symptoms that are common in many people with intellectual disability; their value comes from the surrounding phenotype.

SYNDROME	USEFUL BEHAVIOURAL OR COGNITIVE SIGNATURE	CLINICAL READING
Down syndrome	Relative strength in social communication, with a wide variety of behaviour.	Do not replace assessment with the old "very sociable" personality stereotype.
Fragile X syndrome	Gaze aversion, shyness, social and performance anxiety, social withdrawal and hyperarousal, often with attention and activity difficulties.	Social avoidance can coexist with interest in others and must not be equated automatically with autism.
Prader-Willi syndrome	Hyperphagia with food seeking, foraging or hoarding, and lifelong food preoccupation.	Food access and supervision are central environmental issues, while the wider formulation must also consider distress and routine.
Angelman syndrome	Episodic paroxysmal or inappropriate laughter with absence of speech.	The apparently happy expression should not conceal major communication needs.
Williams syndrome	High, sometimes indiscriminate sociability with reduced social flexibility.	Warm approach behaviour can coexist with poor peer relationships, anxiety and vulnerability in unfamiliar social settings.

SYNDROME	USEFUL BEHAVIOURAL OR COGNITIVE SIGNATURE	CLINICAL READING
Smith-Magenis syndrome	Severe self-injury, disruptive or aggressive outbursts, tantrums and hyperactivity.	Ask specifically about sleep, because disturbed sleep can amplify daytime behavioural difficulty.
Cri-du-chat syndrome	High-pitched cat-like cry in infancy.	This is an early developmental clue; later assessment should address language, attention and activity rather than treating the cry as a complete phenotype.
Lesch-Nyhan syndrome	Severe self-injury, typically compulsive biting of fingers and lips.	Its form and apparent compulsion make this a high-priority safety phenotype.
22q deletion syndrome	Childhood ADHD, autistic features and mood swings, with an important later psychosis vulnerability.	Developmental and psychiatric surveillance must extend across developmental transitions.
Rett syndrome	Loss of purposeful hand skills, replaced by stereotyped hand wringing and clapping.	The course and the exact hand phenomenology matter more than the label “stereotypy”.
Cornelia de Lange syndrome	Self-injury, autistic features and pleasurable responses to vestibular stimulation.	Communication may be disproportionately impaired relative to adaptive function, which should shape the formulation.

Attentional problems demonstrate the point about shared symptoms: they are frequent in fragile X, Williams and cri-du-chat syndromes. They are therefore clinically important but not syndrome-specific. By contrast, relatively characteristic forms include the unusual hand behaviour in Rett syndrome and extreme hyperphagia in Prader-Willi syndrome. An examination answer is stronger when it says whether a feature is shared, relatively specific or simply one component of a wider pattern.

13.4 The phenotype is often richer than its headline feature

The classic “Down personality” stereotype is difficult to verify. A safer clinical account is that Down syndrome has a relative social-communication strength and a broad behavioural range. It is also associated with less frequent and less severe psychopathology than in other groups with intellectual disability, while still requiring ordinary clinical vigilance. In later life, the phenotype includes high rates of dementia or Alzheimer disease in middle-aged to late adulthood. The teaching point is not that people with Down syndrome are protected from psychiatric problems; it is that group-level tendencies should never flatten individual presentation.

Fragile X syndrome is often recognised through its anxious, avoidant social style. In full-mutation males, the tabled phenotype also includes anxiety, perseverative language, an ADHD-like presentation, aggression, stereotypies and ASD-like behaviours. Yet men with fragile X syndrome are usually affectionate and lack the aloof quality typical of autism, despite social impairment.

This is a useful discriminator, not a rule that excludes autism. It directs the clinician to observe the quality of social engagement rather than inferring it from gaze aversion alone.

The food phenotype of Prader-Willi syndrome extends beyond hunger. Skin-picking, hoarding, concerns with symmetry, exactness, ordering, cleanliness and sameness, tantrums, aggression, stubbornness, underactivity and emotional lability may form part of the behavioural picture. Sleep also deserves active enquiry: excessive daytime sleepiness with sleep-architecture abnormalities can contribute to apparent inattention, irritability or reduced participation. The assessment should separate an environmental response to restricted food access from a mood, anxiety or behavioural disorder, while recognising that these may coexist.

In Angelman syndrome, laughter is only the opening clue. Other observed features include overactivity with short attention span, enjoyment of social and physical contact, mouthing objects and fascination with water. The older label “happy puppet” arose from a particular combination of nonverbal presentation, ataxia, frequent laughter and flexed arms. It may help recall the history, but it is not respectful shorthand for the person’s needs. The clinically relevant point is severe to profound intellectual disability with absence of speech, requiring an active search for nonverbal communication and distress signals.

Williams syndrome is another corrective to superficial impressions. It may show loquaciousness with “cocktail party manners” and a relative strength in language, auditory processing and music alongside poor visuospatial performance. However, friendliness may coexist with anxiety, including specific phobia and generalized anxiety. Treating verbal fluency as evidence of social comprehension is the trap. The person may initiate readily yet struggle with reciprocal flexibility, boundaries or sustained friendships.

13.5 Self-injury, stereotypy and sleep: read the mechanism before the behaviour

Self-injury is a description, not an explanation. Its diagnostic and safety significance depends on form, function and context. Lesch-Nyhan syndrome illustrates a highly characteristic pattern: stereotypic dystonic movements and self-mutilation of fingers, lip biting and other self-injury occur unless the individual is restrained. This is not interchangeable with all self-injury in neurodevelopmental conditions. It should prompt urgent attention to tissue protection, pain, oral injury, family burden and specialist coordination.

In Rett and Cornelia de Lange syndromes, self-injury may arise secondarily from hand-to-mouth stereotypies. The mechanism matters because it changes the clinical questions: is the injury a direct repetitive motor act, a response to distress, a communication of pain, or an outcome of a hand-to-mouth movement? The same visible lesion may therefore require very different prevention plans.

Contrasting source lists make a useful methodological warning. The DSM-5-TR names Lesch-Nyhan, Rett, fragile X, Cornelia de Lange and Smith-Magenis syndromes as examples of neurogenetic disorders with stereotypies. Another source instead names Cornelia de Lange, fragile X, Smith-Magenis, cri-du-chat and Rett syndromes in relation to stereotypic movements and self-injurious behaviour. Neither list should be treated as an exclusion list. They illustrate

overlapping clinical territory, while the detailed phenotype supplies the discriminating information.

Smith-Magenis syndrome is especially instructive because its phenotype links daytime behaviour and sleep. Alongside self-injury and outbursts, a **self-hug** can be a useful signature gesture, and the sleep problem may include absence of REM sleep. The reported disruption of melatonergic control of the sleep cycle provides a plausible bridge between sleep management and behavioural or cognitive functioning. This is not an invitation to prescribe from a syndrome name; it is a reminder that sleep assessment may be central rather than incidental.

MNEMONIC

PATTERN before label

Precise form, **A**ntecedents, **T**rajectory, **T**riggering pain or sleep problem, **E**ffect on function, **R**elated syndrome features, **N**eeds and safety.

13.6 Developmental trajectories and later psychiatric risk

Some phenotypes are defined as much by change over time as by a single behaviour. In Rett syndrome, loss of hand skills occurs with language regression, communication deficits, social withdrawal, hyperventilation or breath-holding, bruxism, sleep irregularities and some autistic symptoms. The early withdrawal should not be read as a fixed autism phenotype: socialization may later improve, with intense eye gaze in many patients. Rett syndrome itself is considered in the regression discussion elsewhere in this chapter; here, its course demonstrates why a behavioural phenotype must be longitudinal.

For 22q deletion syndrome, the crucial temporal pattern is a childhood developmental and behavioural presentation followed by risk of psychosis in adolescence or adulthood. About **25%** develop schizophreniform psychosis. At the same time, no other single risk factor is so strongly associated with psychosis. These findings belong together: striking association does not imply universal penetrance.

nearly 100%	~25%	up to 30%
OBESITY RISK IN PRADER-WILLI SYNDROME WITHOUT AGGRESSIVE DIETARY INTERVENTION	SCHIZOPHRENIFORM PSYCHOSIS IN 22Q DELETION SYNDROME	MAJOR PSYCHIATRIC ILLNESS IN VELOCARDIOFACIAL SYNDROME

The final statistic measures a broader outcome. In velocardiofacial syndrome, up to **30%** develop major psychiatric illness, a category that includes schizophrenia and bipolar disorder. It must not be substituted for the figure for schizophreniform psychosis. This is a classic exam error: the number may be familiar, yet the construct and denominator are wrong. Anticipatory follow-up should therefore ask about emerging psychotic and affective symptoms without assuming that developmental or autistic features are their explanation.

13.7 Communicating the formulation without blame or fatalism

A syndromic formulation can be relieving when it gives a family language for a pattern that had previously been interpreted as wilfulness, poor parenting or inevitable deterioration. It should be

communicated as a vulnerability profile: “this condition makes this cluster more likely; we will look carefully at it and address what is modifiable.” That preserves realism and agency. It also makes room for strengths, relationships and the person’s own preferences, which a list of syndrome behaviours can easily erase.

GOOD TO REMEMBER

Use the phenotype to organise monitoring, environmental support and safety planning. For a food-related phenotype, explore access, supervision and conflict around food. For self-injury, define the topography, injuries, pain and immediate safeguarding needs. For a sleep-related phenotype, obtain a sleep history before interpreting daytime behaviour as purely psychiatric. For social disinhibition or withdrawal, assess vulnerability, consent, peer context and anxiety. These are clinical applications of the phenotype, not a generic management programme.

Be precise when discussing uncertainty. “Characteristic” does not mean inevitable; “shared” does not mean trivial; and “not specific” does not mean unimportant. The most defensible clinical note describes observed behaviour, names the syndrome-linked hypothesis, records alternative explanations and states what will be monitored. This reasoning protects the person from diagnostic overshadowing as well as from ignoring a syndrome-specific safety signal.

Must remember: A behavioural phenotype is a raised probability of a characteristic developmental or behavioural pattern, not genetic predestination. Read the whole cluster, its course and its context - then use it to anticipate needs without stereotyping the individual.

Living with intellectual disability

14 · Comorbid psychiatric disorders in ID (dual diagnosis)

Dual diagnosis is ordinary psychiatry, adapted rather than abandoned. In intellectual disability (ID), a psychiatric disorder may coexist with the developmental condition and must be sought as an additional clinical problem. In this setting, **dual diagnosis** means the coexistence of ID with an identifiable mental illness or personality disorder. The phrase originated in learning-disability psychiatry, although it has subsequently acquired a different substance-use meaning; state the context whenever using it.

The examination task is not to label every difficult behaviour as illness, nor to excuse illness as inevitable in ID. It is to establish whether there has been a meaningful change from the person's usual functioning, determine the function and context of that change, exclude physical and environmental explanations, and then decide whether a psychiatric syndrome is present. This is clinically consequential because communication differences can alter both the account available to the clinician and the outward form of distress.

3-5-fold	40%	9-18%
RELATIVE RISK OF ANY PSYCHIATRIC DISORDER	AROUND CUMULATIVE PREVALENCE	ESTIMATED ADHD IN ID

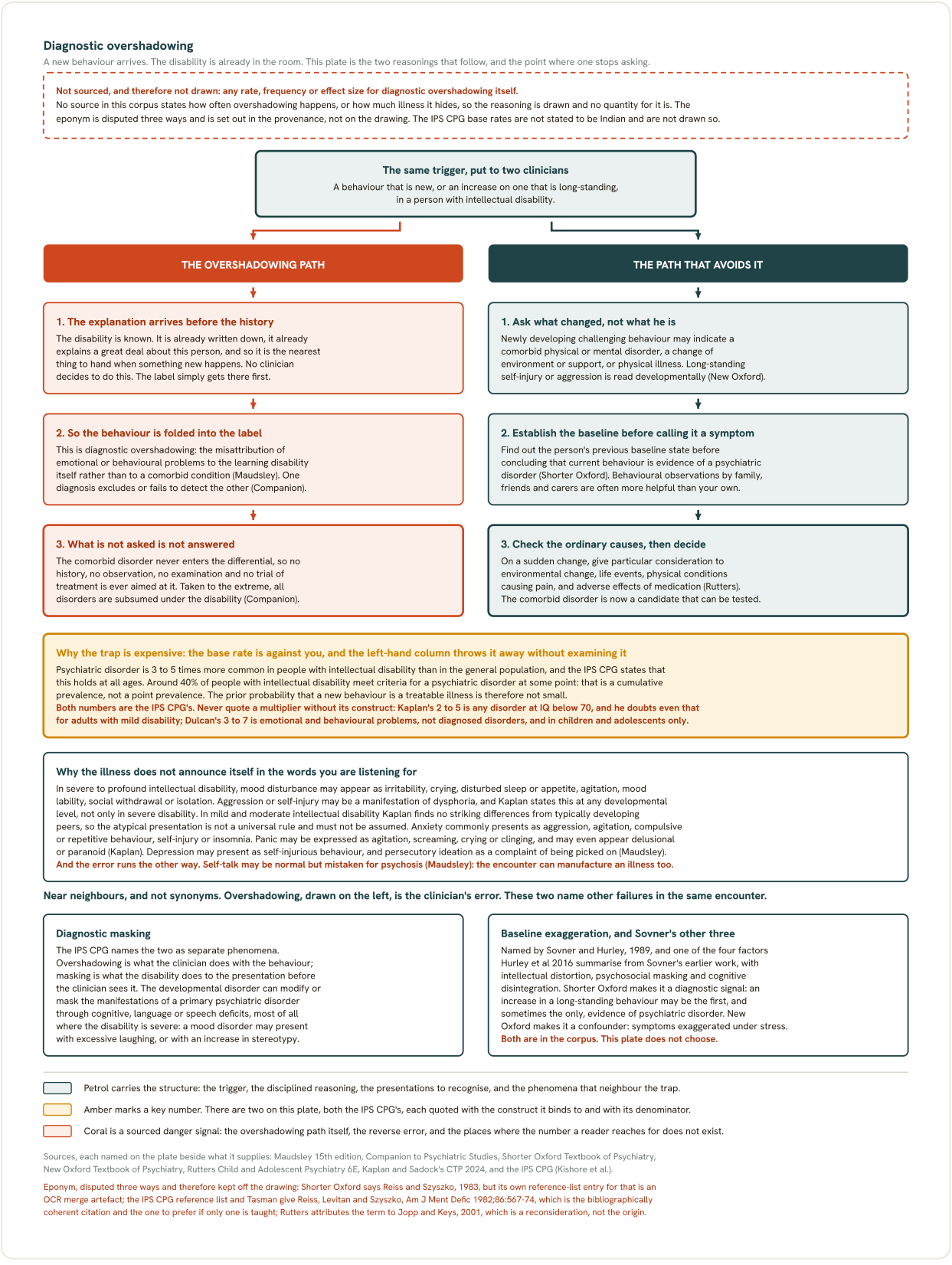


Fig 21.12 Diagnostic overshadowing, drawn as the reasoning it actually is. One trigger, a behaviour that is new or an increase on a long-standing one in a person with intellectual disability, is put to two clinicians, and the plate follows each of them through three steps to a different place. The amber strip is why the error is expensive: on the IPS CPG's figures psychiatric disorder is 3 to 5 times more common in intellectual disability and around 40% meet criteria at some point, a prior probability the left column discards. No rate for overshadowing itself is drawn, because no source in this corpus gives one.

14.1 Burden and the meaning of excess risk

Psychiatric comorbidity is not an occasional complication of ID. Across the lifespan, the relative risk of any psychiatric disorder is **3-5**-fold that in the general population. In children and adolescents, studies similarly report a 3-5-fold excess compared with typically developing peers. These figures should change the clinician's threshold for asking an additional psychiatric question, but not the threshold for making a diagnosis without evidence.

Prevalence estimates differ substantially between studies, with reported values ranging from **10-39%**. The variation is informative: samples differ in age, severity of disability, setting, informants, case definitions, and whether the measure captures a current disorder, symptoms, or cumulative morbidity. A rate is therefore a prompt to assess, not a shortcut to diagnosis. Historical comparisons also remind us that ascertainment matters. In an Isle of Wight comparison, psychiatric disorder was identified in **50%** of children with intellectual disability and in 7% of children with normal IQ.

Risk is unevenly distributed. The severity gradient reported across epidemiological studies means that psychiatric disorder is more often identified with greater intellectual impairment. By contrast, the evidence is less clear for excess prevalence in adults with mild ID. Child and family risk markers include more substantial intellectual impairment, adaptive-behaviour and language difficulties, poor socialisation, and adverse family social circumstances. These are not diagnostic criteria and not explanations that make a person's symptoms less worthy of assessment. A co-occurring autistic spectrum disorder is itself an important risk context for anxiety and depression, bipolar-spectrum presentations, severe obsessional behaviour, anger disorders, and psychosis-like episodes that do not meet schizophrenia criteria.

RULE **Rule:** treat a changed mental state or behaviour in ID as a clinical question with several possible answers, not as proof of either psychiatric illness or developmental disability.

14.2 Diagnostic overshadowing, masking and the baseline

The central diagnostic hazard is **diagnostic overshadowing**: emotional or behavioural problems are attributed to ID itself instead of being considered as a coexisting disorder. At its extreme, the developmental diagnosis becomes so dominant that a second condition is never detected. Overshadowing is a clinician error of attribution. It can lead to a missed depressive episode, psychosis, anxiety disorder, delirium, pain state, or an environmental crisis because the referral is prematurely translated into “part of the disability”.

Diagnostic masking is different. Here, a developmental disorder modifies or obscures the manifestations of a primary psychiatric illness through cognitive, language, or speech limitations, particularly when disability is more severe. The illness has not been dismissed as ID; rather, it is harder to recognise because its usual verbal and phenomenological markers are inaccessible or altered. A mood disturbance, for example, may appear as excessive laughter or an increase in stereotyped behaviours rather than as a verbally reported low mood.

A third concept is **baseline exaggeration**. An increase in a long-standing behaviour may be the first, and occasionally the only, evidence of psychiatric disorder. Thus an established repetitive

act, irritability, aggression, or self-injury should not be dismissed merely because it is familiar. The question is whether its frequency, intensity, setting, consequences, or controllability has changed. The baseline is not background detail. It is the reference point that converts a behaviour into a possible symptom.

TRAP **Examination trap:** "Self-injury in a person with ID" is a presenting problem, not a diagnosis. Do not infer a psychiatric syndrome from the behaviour alone, and do not use the developmental diagnosis to end the enquiry.

PROBLEM IN REASONING	WHAT GOES WRONG	CORRECTIVE CLINICAL MOVE
Diagnostic overshadowing	A new psychiatric or physical problem is assigned to ID.	Ask what is new, then actively consider coexisting illness.
Diagnostic masking	The primary disorder has an altered, less verbal presentation.	Use behaviour, chronology, and informants alongside the interview.
Baseline exaggeration	A familiar behaviour is treated as clinically meaningless.	Compare current frequency, intensity, context, and impact with baseline.
Intellectual distortion	Answers to mental-state questions are overinterpreted.	Adjust language and seek corroboration rather than forcing adult phenomenology.
Psychosocial masking	Developmental symptom expression is mistaken for mental illness.	Interpret the observation in developmental context before diagnosing.
Cognitive disintegration	Acute disorganisation is equated immediately with chronic psychosis.	Assess for an evolving illness, stressor, physical cause, and change in supports.

14.3 Why the mental-state examination needs translation

Increasing severity of ID and associated communication impairment make diagnosis more complex. This does not imply that psychiatric diagnosis is impossible. It means that the clinician must translate the clinical question from a reliance on subjective report to a synthesis of observable behaviour, longitudinal change, collateral history, environmental context, and the person's own communication at their best level.

One useful framework describes **four** sources of diagnostic uncertainty: baseline exaggeration, **intellectual distortion**, **psychosocial masking**, and **cognitive disintegration**. Intellectual distortion concerns how the person understands a question about mental state and whether its implication can be appreciated. Psychosocial masking, in this formulation, describes developmental symptomatology that is misconstrued as mental illness. Cognitive disintegration describes disproportionate disorganisation during an emerging mental illness when cognitive reserve is limited, which can make the person look apparently psychotic. These are prompts for better assessment, not alternative diagnoses.

Behavioural equivalents are particularly important when verbal description is limited. In severe to profound ID, mood disturbance may be signalled by irritability, crying, dysregulation of sleep or appetite, agitation, mood lability, withdrawal, or isolation. Aggression or self-injury may express dysphoria at any developmental level, but neither is specific to mood disorder. Anxiety may present with aggression, agitation, compulsive or repetitive behaviour, self-injury, or insomnia. Panic may appear as agitation, screaming, crying, or clinging and may even look paranoid or delusional to an unwary observer.

Conversely, unfamiliar does not mean pathological. Self-talk can be a normal behaviour that is mistaken for psychosis. A complaint of being picked on may be the accessible form of persecutory ideation, but it also needs ordinary contextual testing. The task is phenomenology by approximation: ascertain what the person experiences where possible, establish what others observe, and decide whether the whole pattern forms a syndrome over time. In mild to moderate ID, mood disorders do not show striking differences in expression from those of typically developing peers; do not exoticise a presentation simply because ID is present.

14.4 A disciplined assessment sequence

Begin with change, not with labels. Assessment begins with the individual's baseline and interprets change with collateral information, behavioural observation, and context.

> **GOOD TO REMEMBER**
>
> Before treating current behaviour as psychiatric evidence, establish the person's previous baseline state. Family, friends, and carers often provide observations more useful than the brief assessment encounter. Use the interview alongside a period of behavioural observation. From first contact, consider approach, activity level, attachment to the informant, response to transitions, spontaneous communication, affective range, and reaction to demands against that baseline.

Build the history around the following dimensions rather than around a checklist of adult symptoms:

- onset and chronological evolution of the change;
- intensity and frequency of the behaviour or symptom;
- the context in which it appears and what follows it;
- precipitating factors, including changes in relationships, routine, supports, or expectations;
- relieving factors and the response to ordinary environmental adjustment.

This sequence gives the history a causal structure. Newly developing challenging behaviour can indicate a comorbid physical or mental disorder, an environmental or support change, or physical illness. Long-standing self-injury or aggression is more often understood developmentally or behaviourally. When change is sudden, give particular consideration to environmental changes, life events, painful physical conditions, and medication adverse effects. In the most disabled person with sensory deficits, exclude physical illness and stressful events before considering whether communicative frustration and understimulation are contributing.

Antecedent-Behavior-Consequences analysis is a functional method for clarifying what precedes a behaviour, what the behaviour achieves, and what consequences may maintain it. It is not a substitute for diagnosis. It prevents a false dichotomy: a psychiatric disorder can coexist with behavioural reinforcement, and a behaviour with an understandable function can still be an expression of distress. Prospective simple ABC or sleep charts are particularly useful when the care environment produces discrepant staff reports, since variation may reflect differing tolerance thresholds or attributions.

> The most reliable discriminator is a documented departure from the individual's own baseline, interpreted with collateral observation and context.

14.5 Disorder patterns: recognise without overcalling

Detection of psychiatric syndromes in ID is shaped by communication, developmental level, and context. Schizophrenia should be diagnosed from a coherent longitudinal syndrome rather than from odd behaviour, self-talk, or a single report of suspiciousness. In a community sample of people with learning disability, point prevalence of schizophrenia was **over 4%**. Among people with learning disability and schizophrenia, auditory hallucinations are reported in around 90%; this is helpful when a reliable account can be obtained, but its absence or inaccessibility cannot settle the diagnosis.

Attention-deficit/hyperactivity disorder is also relevant: estimated prevalence among people with ID is 9-18%. The core diagnostic safeguard is developmental proportionality. Symptoms must be excessive for the person's mental age, and the threshold should be higher in severe to profound ID. Inattention, overactivity, impulsivity, poor frustration tolerance, and a chaotic environment can mimic each other. The clinician should seek a pervasive pattern rather than equating high activity in one setting with ADHD.

Anxiety estimates vary widely, from 1-25%, in part because diagnosis is difficult. This is a reminder to search for anxiety when distress is expressed behaviourally, not a basis for diagnosing it indiscriminately. Mood symptoms require the same restraint. Appetite and sleep change, social withdrawal, loss of usual enjoyment, tearfulness, agitation, or altered stereotyped behaviour gain significance when they are new, clustered, sustained, and not better explained by pain, medication, or altered circumstances.

TRAP **Examination trap:** do not diagnose psychosis from self-talk, depression from self-injury, or ADHD from activity level without establishing change, phenomenology, developmental proportionality, and context.

14.6 Instruments and adapted diagnostic systems

Questionnaires and structured interviews designed for children of average ability have a serious norming limitation in ID: almost none are normed for ID populations, and their scores or cut-offs may therefore be invalid. They may inflate symptoms or underestimate them depending on the setting. Use them as aids to gathering information, never as a rule-in or rule-out mechanism. This caution does not mean that all measures are unsuitable. The **Developmental Behavior**

Checklist is comprehensive and provides norms and subscales for the ID population, making it particularly useful where general-population measures fit poorly.

The clinical interview, observations, informant account, and functional data must retain primacy. ID-specific instruments may identify general psychopathology, yet studies do not show clear agreement between such instruments in detecting specific psychiatric disorders. A positive screen should trigger a more focused assessment; a negative screen should not override a persuasive longitudinal history. This is why an apparent numerical score is less important than the quality of the behavioural description from which it arose.

Modified diagnostic systems can support clinical reasoning where conventional criteria rely heavily on subjective experience or developmentally inappropriate thresholds. **DC-LD** was developed to address diagnostic issues in moderate to severe learning disability. **DM-ID** is another adapted diagnostic resource. Such systems do not create a separate psychiatry for ID; they make explicit the adaptations required to apply psychiatric nosology fairly. For eating disorders whose criteria depend substantially on subjective experience, conventional diagnoses such as anorexia nervosa and bulimia are effectively precluded in severe or profound ID. Pica is perhaps the most common eating disorder in this population.

14.7 Formulation and diagnostic accountability

A defensible formulation has parallel tracks. One track describes the person's developmental profile and baseline repertoire. A second describes the current change in behaviour, affect, cognition, biological rhythm, and functioning. A third examines physical illness, pain, sensory impairment, epilepsy, medication effects, interpersonal stress, care environment, and reinforcement contingencies. A fourth asks whether the data support a psychiatric syndrome, and if so what evidence distinguishes it from the alternatives. Writing these tracks separately prevents the developmental diagnosis from swallowing the entire formulation.

Behaviour that challenges has person-specific associations, including male sex, lower adaptive functioning, poorer communication, autism, and painful physical conditions. Unlike oppositional defiant or conduct disorder, it is not associated with family adversity. This distinction guards against importing a formulation from typically developing populations without testing whether it fits. Similarly, a psychiatric presentation may coexist with environmental contingencies; neither cancels the other.

Carefully document the source of every observation, the degree of confidence in the person's self-report, baseline evidence, collateral agreement or disagreement, and the physical and environmental exclusions considered. This makes diagnostic reasoning reviewable and protects against therapeutic drift toward medication for an unclearly defined target. Management of ID itself, including multidisciplinary support and educational planning, is addressed in the management section of this chapter. The full child psychiatric assessment battery, services and protection are covered in the Child psychiatry: assessment, treatment, services and protection notes.

Formulation should also preserve the person's perspective. A carer's account may be essential, but it should not replace direct engagement with the person. Adapt the pace, language, and mode of communication; allow time for response; and test important inferences gently rather than relying on a single answer. The purpose is not to force adult verbal psychopathology into a developmentally mismatched interview. It is to make the available evidence as fair, transparent, and clinically useful as possible. Where uncertainty remains, state it explicitly, define what further observation would discriminate between competing explanations, and avoid converting uncertainty into a confident label.

The practical standard is neither diagnostic minimalism nor diagnostic enthusiasm. It is intellectual humility with enough structure to notice a second disorder. When the pattern, chronology, collateral history, and context converge, people with ID deserve the same diagnostic seriousness afforded to anyone else.

15 · Management of ID (multidisciplinary, early intervention, special education)

Management is the organisation of opportunity. Intellectual disability is not managed by a single clinic, a prescription, or a school placement in isolation. The clinical task is to turn an assessment of abilities, barriers, health and family circumstances into a coherent plan that improves participation and preserves dignity. This makes management a longitudinal exercise: the clinician must help the person acquire useful skills, reduce avoidable barriers, respond to mental or physical illness when present, and keep the family able to continue caring.

Marks are usually earned by showing this architecture rather than by naming a succession of therapies. A good answer begins with coordinated goals, places early intervention and education within the person's everyday settings, explains how behaviour is understood before it is treated, and recognises that medical treatment has a limited, target-led role. Severity should be named only as a descriptor of support need; its classification belongs with the assessment and severity sections of this chapter.

15.1 The multidisciplinary plan

Multidisciplinary care is the appropriate treatment model because intellectual disability has biological, psychological, social and developmental consequences at the same time. It is therefore multimodal: psychoeducation, psychological work and medication, where indicated, are coordinated rather than offered as competing alternatives. The plan also has to restore wellbeing within the family system. In practice, the psychiatrist's distinctive contribution is diagnostic clarification, assessment of mental and physical contributors to change, risk formulation, judicious prescribing, and helping the team keep a shared hierarchy of goals.

The team should not be imagined as a referral list. Its work is to translate a common formulation into actions that can actually happen at home, in education, and in the community. For optimal management, coordination includes at least six disciplines, including psychiatry, psychology, occupational therapy, speech and language therapy, genetic counselling and nursing. This is not an exhaustive job description. It illustrates why a locally available team should be assembled around the person's needs rather than around an idealised service chart.

RULE **Rule:** Start with shared functional goals, then assign one accountable person for coordination; referrals without a joint plan merely move fragmentation from one service to another.

SERVICE FUNCTION	CLINICAL PURPOSE	WHAT COORDINATION PREVENTS
Prevention and prompt recognition	Identify needs before they become fixed barriers to development or participation.	Late referral after family strain or school failure has already escalated.
Strengthening family capacity	Make everyday care, communication and goal-setting possible.	Advice that is technically sound but impossible to sustain.
Learning and productive roles	Build participation and future roles around meaningful skills.	Care that remains custodial when the person can learn more.
Health and mental-health care	Address health needs and emotional or behavioural presentations without diagnostic overshadowing.	Attributing a new problem automatically to the disability.
Living support and self-care	Match support to real-world functioning and safety.	Discharge plans that fail because ordinary living demands were ignored.

The level of specialist involvement should follow complexity. Mainstream mental-health services may prescribe for mild or borderline intellectual impairment, while assessment and treatment of behavioural or emotional disorders in more marked or atypical cognitive impairment should be undertaken with specialist clinical input. This is a service-triage principle, not a claim that a mainstream clinician should work alone when communication barriers or atypical presentation make assessment uncertain.

Family work is clinical work. Families need an explanation that can be revisited, not a single overwhelming disclosure. Parents may require repeated discussion before the implications can be absorbed; the clinician should return to prognosis, available help and the family's active role as understanding changes. Family support must be individualised to the caregiving burden and its meaning for that particular household. Parents and primary caregivers should also be routinely screened for stress-related disorders. This is not a courtesy add-on: depleted carers have less capacity to implement a plan, and their distress deserves treatment in its own right.

15.2 Early intervention as a developmental service

Early intervention begins before a child has entered an educational system. The Indian guideline permits a starting point from the prenatal period, with recognition of high-risk pregnancies, appropriate health care and attention to psychosocial adversity. After birth, the plan is not simply stimulation exercises. It begins with accurate identification of developmental and associated needs, then creates opportunities for sensory-motor, communication and socioemotional development in the child's ordinary relationships and routines.

The central relational mechanism is healthy bonding and attachment between the child and mother. The practical implication is important: early stimulation can also be delivered by any

stable caregiver. Programmes should stabilise current developmental achievements while opening the next achievable task. Play-based work and culturally rooted early-child-care practices are often more usable than imported materials; when materials are inaccessible or culturally mismatched, parents can become overwhelmed and the programme loses its place in daily life.

Evidence supports a measured, not triumphalist, account. **Family-centred intervention** can be effective, but uncertainty remains about the active components and how help is best delivered. This is why the clinician should set observable functional goals and revise them with the family, rather than promise a uniform developmental result. One intensive compensatory-education experience illustrates both the possibility and the limits of inference: teaching began at 3 months; at a later preschool assessment the intervention group had a mean advantage of 27 IQ points over controls. The finding does not prove a durable individual IQ gain, and its design limitations matter. Its defensible teaching point is that sustained, skilled effort with socially disadvantaged families can make a meaningful difference.

3 years	3-6	6-18
INITIAL LEARNING PHASE	SCHOOL-READINESS PHASE	CONSOLIDATION PHASE

A life-span skill plan has three **developmental stages**. In the initial years, work addresses sensory-motor ability, socio-communication, basic self-help and concepts. The subsequent school-readiness period emphasises readiness skills and culturally appropriate adaptive behaviour. Later childhood and adolescence consolidate academic and independent personal skills in preparation for vocational training, employment and adult living. These are organising priorities, not rigid age-based ceilings. The immediate task is always to find the skill that will increase autonomy in the child's own context.

IN INDIA

For formal early intervention in India, referral can be made to the District Early Intervention Centers of the Rashtriya Bal Swasthya Karyakram and the Anganwadi Centers of the Integrated Child Development Services. The referral should carry a concise developmental formulation and the family's priorities, so that the service encounter becomes part of a continuing plan rather than a one-time certification exercise.

The clinical details of normal milestones and attachment are covered in the Normal child development and milestones notes.

15.3 Education, participation and placement

Normalization is the guiding principle of arranging a pattern of life as close to ordinary life as possible, supported by specialist help that allows the person to reach potential. It directs attention away from segregation as a default and toward family life, community participation, education, work and self-advocacy. It does not mean pretending that support needs do not exist. Normalisation becomes clinically useful only when the necessary teaching, communication support, supervision and environmental adjustments are actually provided.

Placement is a clinical and ethical judgement. Ordinary-school education may offer more normal social surroundings, social integration, expectation of progress and learning for peers that participation is ordinary. It may also lack the teaching skills, equipment and methods required by some learners, particularly where specific language and communication teaching is needed. The evidence cited here does not settle which children benefit from ordinary schooling. Therefore, do not turn inclusion into a slogan or special education into a failure. Consider the child's learning needs, social experience, available supports and family preference, then review the placement when the fit changes.

TRAP **Exam trap:** "Mainstream" and "beneficial" are not synonyms. Educational inclusion without the support needed to learn or remain safe is not meaningful participation.

The ethical tension is real. In secondary schools, children with special needs were reported to be bullied **three times more often** than other children. This should prompt active safeguarding and a discussion of the individual child's present interests, not a simplistic conclusion that community education is always unsafe. At a service level, a systematic review found better outcomes with community-based services than with institutional care. The practical inference is to design community support well, monitor the child's experience, and address exclusion rather than treating it as inevitable.

Education should be functional. Literacy, numeracy, communication, self-care and social learning have value insofar as they enlarge the person's choices in daily life. At the end of school, reassessment and vocational guidance are necessary before a young person is expected to make an adult transition. Opportunities should be ambitious but realistic, and should not be narrowed merely because others hold limited expectations. The fuller approach to disability certification, benefits and statutory entitlements belongs in the disability certification and benefits section of this chapter.

15.4 Behavioural formulation before behavioural control

Behaviour that challenges is a question, not a diagnosis. Its onset or worsening should lead first to a search for communication difficulty, environmental demand, reinforcement, health problems and mental disorder. A **comprehensive personalised functional assessment** considers behaviour in its setting and improves the chance of a plan that can be managed psychologically and environmentally. It can consequently reduce, and sometimes remove, the need for psychotropic medication.

Functional behaviour analysis asks what consequence may be maintaining the behaviour. Challenging behaviour may serve three functional classes: obtaining a social positive reinforcer such as attention, escaping a demand through social negative reinforcement, or obtaining sensory reinforcement. These possibilities are hypotheses to test against observation, not labels to attach from a brief history. Parents, teachers and other caregivers are indispensable informants because they see the antecedents and consequences that a clinic visit cannot reproduce.

The behavioural plan should be least intrusive and culturally appropriate. The Indian guideline describes **three** linked levels: restructure the environment to alter antecedents, reinforce adaptive behaviour differentially, and prevent inappropriate reinforcement of problematic behaviour. Its basic premise is functional substitution. If a problematic behaviour communicates a need, the plan must create and reinforce a socially acceptable behaviour that serves the same function. Suppression alone leaves the original need unanswered and is likely to fail once the therapist has left.

- Define a small number of observable target behaviours in the settings where they occur, and prioritise those causing exclusion, stigma or interference with learning.
- Record antecedents, behaviour and consequences with carers, then decide which maintaining contingencies are plausible.
- Teach and reinforce an adaptive alternative that achieves the relevant function more safely.
- Change environmental triggers and caregiver responses together, then review whether the person's participation has improved.

Positive behavioural support is a useful framework because it combines reinforcement with changes to triggers, minimal use of aversive strategies and planned reactive responses such as distraction. Its components should not be applied as a menu of techniques. Selection follows the formulation. Techniques using negative reinforcement should not be used. A discipline-heavy behaviour programme is best developed and implemented by a behavioural psychologist or board-certified behavioral analyst, although psychosocial interventions delivered by non-specialist carers can produce better outcomes than no treatment or treatment as usual. In settings with few specialists, this supports task-sharing with supervision and training, not abandonment of formulation.

15.5 Medication stewardship and specialist liaison

GOOD TO REMEMBER

Medication treats a defined target symptom, coexisting mental disorder or physical contributor; it does not replace a formulation of behaviour. **Psychological intervention**, including functional behavioural analysis, should be considered first-line when no identifiable mental illness with clear treatment implications is present, except in the most serious or intractable behavioural disturbance. The same discipline applies when diagnostic information is inadequate: try psychosocial intervention before converting uncertainty into a prescription.

Antipsychotics remain the most widely prescribed psychotropic class in intellectual disability, yet their current positioning is as a later option for older children or adults when intensive behavioural intervention or other medication options have failed. This apparent contradiction is a warning about service reality, not a reason to disregard behavioural care. A functional formulation may reveal a modifiable trigger that makes medication unnecessary, whereas a clear psychiatric syndrome or severe risk may require simultaneous medical treatment and behavioural support.

When a dopamine antagonist is considered for behaviour that challenges, the NICE guideline NG11 identifies **three** alternative qualifying circumstances: psychological or other intervention alone has not changed the behaviour within an agreed time, treatment of a coexisting mental or physical problem has not reduced it, or risk is very severe. These are alternatives, not a checklist in which every condition must be met. Once medication is begun, prescribe the lowest possible dose and reassess whether continuation remains justified after target symptoms improve, when there is non-response, or when adverse effects affect functioning or quality of life.

> The management sequence is: clarify function and illness, strengthen environmental and behavioural supports, prescribe only for a defined target, and keep asking whether the drug is still needed.

Deprescribing needs the same care as initiation. The NICE guideline NG54 suggests slow withdrawal of antipsychotics for people without psychotic symptoms. This does not mean that withdrawal is consequence-free: discontinuation studies commonly, though not invariably, show re-emergence of problem behaviours. The appropriate response is preparation, monitoring of the original target behaviour, and readiness to revise environmental support, rather than assuming either that every drug must continue or that every drug can be stopped without difficulty. The UK STOMP programme promotes antipsychotic deprescribing but also shows a crucial pitfall: an antipsychotic may be replaced by another psychotropic rather than reducing overall medication burden.

Drug choice for a diagnosed condition may in general resemble practice in the wider population, but good prescribing practice is to start at lower doses and increase more slowly. This distinction resolves an apparent contradiction between using standard treatments and being more cautious in a person who may have communication barriers, neurological vulnerability or difficulty reporting adverse effects. A review should document the target symptom, benefit, adverse effects, family observation and whether non-drug supports remain active. Annual health checks are generally recommended for people with intellectual disability; they are health surveillance, not a substitute for medication review whenever treatment changes.

15.6 Continuity into adult life

Management succeeds when it survives transitions. A community-care model is judged less by its label than by the detail of planning and the commitment with which it is carried out. Planning needs both an understanding of the local population and an individual account of what this person can do, wants to do, and needs help to do. A named coordinator can prevent families from receiving inconsistent advice across health, education, social and voluntary-sector services.

Families often need additional help at puberty and school leaving; moving from child to adult services can be especially stressful. These periods should trigger anticipatory planning rather than a crisis referral. Reassessment and vocational guidance before school leaving protect against the common drift from education into inactivity. For school leavers with mild intellectual disability, vocational planning may lead to ordinary or sheltered work; adults with severe

disability are more likely to need the support of a day centre. The point is not to predict a person's future from a label, but to plan enough support for a real adult role.

Referral and linkage in India should map the person's needs to education and vocational routes, rehabilitation centres, national institutes and local nongovernment agencies. Whenever possible, link the family to agencies in their locality so that rehabilitation costs and travel do not quietly defeat the plan. The clinician should retain a longitudinal role: explain the plan repeatedly, detect emerging health or psychiatric problems, coordinate with the relevant team, and protect the person's right to participate in family and community life.

16 · Prevention of intellectual disability

Prevention is a life-course clinical task. Prevention of intellectual disability is not a promise that every case can be avoided. It is the organised reduction of preventable risk before conception, during pregnancy and birth, through the newborn period, and after disability is recognised. The examination value of the topic lies in distinguishing prevention of a condition from prevention of avoidable functional disadvantage once a person already has intellectual disability. A good answer therefore shows a framework, gives a few high-yield examples at the correct level, and retains ethical humility.

The field uses several overlapping taxonomies. The most useful approach in an intellectual-disability answer is to state the purpose of the intervention rather than force every programme into a label. Public health measures reduce exposure to risk; screening creates an opportunity for timely action; and habilitative care limits the secondary disabilities that arise when a person's needs are neglected. These are connected steps in one pathway, not competing lists.

16.1 What prevention means in intellectual disability

The conventional framework has **three** categories. **Primary prevention** acts before a disorder develops, so its clinical purpose is to reduce new cases. For intellectual disability, this means combining medical care with public-health, educational and social measures before an avoidable insult has produced disability. The point is causal timing: an intervention is primary when it removes or reduces the exposure before the outcome arises.

Secondary prevention aims to reduce the burden of established disease in the general terminology, but the intellectual-disability application is more clinically practical: recognise a condition that can lead to disability as early as possible and treat it before disability follows. This makes screening meaningful only when a result can lead to confirmation, treatment, counselling or follow-up. A test with no route to action may collect information, but it does not by itself achieve prevention.

Tertiary prevention concerns disability associated with an existing illness. In intellectual disability it is best understood as **habilitation**: helping the person attain the best attainable functioning despite the disability. This includes biomedical and sociocultural work, but it is not a synonym for cure. The target is participation, competence and protection from avoidable loss of function.

RULE **Rule:** Classify a preventive intervention by its intended point of action: before disability arises, while a remediable pathway is still open, or after disability is present to prevent additional functional loss.

PREVENTIVE LEVEL	CLINICAL QUESTION	INTELLECTUAL-DISABILITY APPLICATION	COMMON ERROR
Primary prevention	Can the causal exposure or pathway be avoided?	Genetic counselling, population health, safer pregnancy, nutrition, immunisation and prevention of toxic or traumatic injury.	Calling every antenatal test prevention without asking what action follows, or filing genetic counselling under care that comes after a diagnosis.
Secondary prevention	Can a disorder that may cause disability be found and treated early?	Early recognition and treatment of metabolic conditions or congenital hypothyroidism.	Equating screening with treatment.
Tertiary prevention	How can further functional disadvantage be reduced after disability is present?	Habilitation, education, family support and treatment of comorbid conditions.	Presenting support as an afterthought rather than prevention of secondary disability.

The alternative language of universal, selective and indicated prevention is also useful in public health. Universal work reaches whole populations, selective work addresses groups with increased risk, and indicated work is directed at people with individual evidence of heightened risk. Do not casually equate every use of indicated across classifications. The later Institute of Medicine model, published in 1994, uses indicated intervention for people with early or prodromal symptoms, whereas the earlier approach used it for asymptomatic people identified as higher risk. The boundary between selective and indicated work can be clinically blurred; the safer answer is to state the target population and the reason for intervention.

TRAP **Exam trap:** Primary, secondary and tertiary prevention are not interchangeable labels for antenatal, postnatal and rehabilitation services. Timing matters, but the decisive issue is what the intervention is meant to prevent.

16.2 Primary prevention before and during pregnancy

Primary prevention begins before pregnancy is recognised. Good preconception and antenatal care allows the clinician to identify modifiable risks, improve maternal health and support informed reproductive decisions without converting counselling into coercion. The Indian guideline specifically identifies malnutrition, diabetes, teratogenic drugs and substance use as maternal factors that may be treatable or preventable in subsequent pregnancies. A prior child with intellectual disability should prompt a respectful etiological review and a plan for the next pregnancy, not an assumption of parental fault. That review is where **genetic counselling** belongs, and it belongs here rather than later: the standard account of primary prevention opens with genetic counselling and continues with education of pregnant women about behaviours that may put the fetus at risk, early detection of fetal abnormalities during pregnancy, and good

obstetric and perinatal care. Counselling a couple before a further conception acts on the next pregnancy, so it removes the exposure before the outcome arises, which is the test this section has just set. Reading it as an after-the-fact service, because the conversation happens after a diagnosis in an older child, is the classic misplacement, and naming the primary preventive measures is a canonical examination question whose first answer is this one.

Risk reduction works through ordinary care. Primary measures include prevention of lead poisoning, avoidance of substance exposure during pregnancy, prevention of teenage pregnancy, improved neonatal care and injury prevention such as infant car seats. Prenatal vitamin supplementation is included because it prevents neural tube defects. The phrasing matters: prenatal supplementation should not be inflated into a guarantee against all developmental disorders. Likewise, childhood lead exposure is a risk factor for low IQ and intellectual disability, which supports environmental prevention without claiming that every exposed child will develop disability.

Maternal infections are another preventable pathway. Toxoplasmosis, cytomegalovirus, rubella and herpes are recognised maternal infections associated with infant morbidities that include intellectual disability. Rubella immunisation is therefore an important prevention measure. Prenatal care may begin before conception, including rubella immunisation for women without immunity. Prevention of rhesus sensitisation uses **anti-D antibody**. These examples should be used to show an integrated maternal-health strategy, not as a memorised infection list detached from antenatal care.

Alcohol deserves direct enquiry in all settings where it is accessible. In such societies, alcohol is the leading toxin cause of intellectual disability. Fetal alcohol syndrome has an incidence of **0.5-3 per 1000 births** and may account for as much as 3 percent of all intellectual disability. These are different denominators, and they must not be swapped. Apparent rates also depend on diagnostic practice: use of both physical signs and a history of heavy prenatal alcohol exposure produces lower rates than use of exposure history alone, with underdiagnosis and overdiagnosis possible at the two extremes.

Nutritional prevention has its own logic. Iodine deficiency is described as the most common preventable cause of learning disability worldwide. Where endemic iodine deficiency threatens pregnancy, periconceptional injection of **iodized oil** has attenuated endemic cretinism and subsequent intellectual disability in at-risk populations. A pharmacology source also states that daily maternal iodine intake of **150-200 microgram** can prevent endemic goitre and cretinism due to iodine deficiency, with iodised edible salt as the preferred delivery method. This is a prevention claim, not an invitation to prescribe an unsupervised supplement outside local obstetric and public-health practice.

one-third	over eighty	over 50
ID/GDD CASES WITH NONGENETIC CAUSES	POTENTIALLY TREATABLE DISORDERS IDENTIFIED	CONDITIONS DETECTED BY CONTEMPORARY NEWBORN SCREENING

The limits are as important as the opportunities. Nongenetic factors account for approximately one-third of ID/GDD cases, so environmental prevention is necessary but cannot remove all intellectual disability. At the same time, advances in therapeutics have identified over eighty potentially treatable disorders. This justifies careful diagnosis and prompt action without selling prevention as total control. Prevention priorities differ by setting: maternal and perinatal health are central public-health opportunities in low- and middle-income countries, while reduction of genetic causes of severe intellectual disability remains important in high-income countries. It is unlikely, however, that prevention can substantially alter the incidence of mild intellectual disability.

16.3 Antenatal screening, diagnosis and ethical care

Non-invasive prenatal screening is based on cell-free fetal DNA in maternal plasma. Its value is risk estimation and selection for counselling or diagnostic evaluation, not a diagnosis by itself. First-trimester screening combines an ultrasound marker with maternal blood testing. An ultrasound assessment for major malformations is often performed at approximately 20 weeks of gestation. These routes should be explained as complementary rather than as competing tests.

CLINICAL ROUTE	WHAT IT CAN CONTRIBUTE	TEACHING POINT
First-trimester screening	Risk assessment through ultrasound and maternal blood analytes.	A positive screen requires counselling and a diagnostic pathway.
Mid-trimester AFP testing	Screening for neural tube defects in the specified screening context.	An analyte result is not a diagnosis and is not specific to one disorder.
Amniocentesis	Diagnosis of chromosomal and metabolic disorders.	Use the test for the question it can answer.
Chorionic villus sampling	Chromosomal and molecular genetic studies.	Do not transfer amniocentesis metabolic role to CVS.

In one psychiatric-text account, amniocentesis or chorionic villus sampling is recommended for all women aged **35 years or more**. Another account frames amniocentesis as an indication-based decision for pregnancies with relevant prior or familial history, or a clinically significant current risk. The defensible clinical response is to know that recommendations are guideline- and context-dependent, establish the indication, explain benefits and limitations, and refer for current specialist obstetric or genetics advice rather than use a textbook threshold as a stand-alone rule.

Screening needs careful language. Maternal serum alpha-fetoprotein is a marker with more than one possible clinical explanation; it is not a disease label. For in-utero diagnosis of Down syndrome, the source describes a blood-based route, ultrasound assessment and invasive testing. These options differ in what they establish and what follow-up they entail. Carrier screening should be offered to all persons in high-risk populations, but named examples should follow locally relevant, verified services rather than stereotype or assumption.

Prenatal diagnosis followed by elective termination raises a boundary that clinicians should not obscure. It is a matter of deeply personal values because termination prevents childbirth rather than treating or preventing the disorder in the fetus. The psychiatrist's role is to support informed, non-directive decision-making, recognise family distress, avoid coercive framing, and ensure that a decision is not driven by misinformation about disability or by a lack of support for families who continue a pregnancy. The syndrome-specific genetics and recurrence discussion belongs with the relevant aetiology sections of this chapter.

16.4 Newborn screening and time-sensitive treatment

Newborn screening refers to tests undertaken within the first hours or days of life when early action can prevent severe health problems. Contemporary systems detect over 50 different conditions. A blood spot collected by heel stick is the established specimen method in the settings described in the source.

> **GOOD TO REMEMBER**
>
> An abnormal screen is a signal for confirmation, not a diagnosis or a moral judgement about the family. Communicate promptly and compassionately, then ensure confirmatory testing, treatment and longitudinal follow-up.

Congenital hypothyroidism illustrates the time-sensitive logic. With newborn screening, levothyroxine may be initiated by **4-6 weeks of life**. Screening of neonates is described as the best preventive strategy for cretinism. This should not be reduced to a prescription detail: early identification links a population programme to a child developmental outcome. The quoted treatment timing is not the time at which the blood sample must be collected.

The overall verdict on newborn metabolic screening is appropriately strong but bounded: it has been extremely successful in reducing the incidence and severity of some intellectual-disability syndromes. The qualifier some is crucial. A screening programme may also generate false-positive results, which can produce acute parental distress and unnecessary follow-up unless communication is prompt and compassionate.

Phenylketonuria is a classic screenable metabolic disorder, but its genetic mechanism and diet belong in the inborn errors of metabolism section. Here, the prevention lesson is narrower: early diagnosis and treatment of PKU, other metabolic conditions and congenital hypothyroidism are examples of secondary prevention because they intervene before disability develops.

16.5 Preventing secondary disability after diagnosis

Once intellectual disability is present, the preventable outcome is often loss of function rather than intellectual disability itself. Tertiary prevention therefore uses early support, education, family support and timely attention to mental or physical conditions that suppress functioning. This is habilitation in action. It safeguards developmental opportunity and reduces the additional disability created by untreated epilepsy, pain, sensory difficulty, psychiatric illness, behaviour problems, exclusion or caregiver exhaustion.

Do not wait for a crisis to begin support. Early intervention may start in the prenatal period by identifying high-risk pregnancies, arranging appropriate health care and addressing psychosocial adversities.

IN INDIA

For formal early intervention, the guideline names the District Early Intervention Centres of the Rashtriya Bal Swasthya Karyakram and the Anganwadi Centres of the Integrated Child Development Services. The preventive point is timely connection before a modifiable disadvantage becomes entrenched.

The service model, developmental methods and general evidence for early intervention are covered in the management section of this chapter.

Comorbidity management is central, not peripheral. Epilepsy affects 15-30 percent of persons with intellectual disability. Problematic behaviours may occur in 20-80 percent of the ID population. These figures do not authorise diagnostic overshadowing. A new behavioural change may be communication of pain, distress, environmental difficulty or mental illness. Prevention in tertiary care means looking actively for such contributors and treating them before they further reduce learning, relationships or family capacity. The psychiatric-comorbidity assessment itself is addressed in the dual-diagnosis section of this chapter.

Families may need genetic counselling alongside causal investigation and reproductive planning. It should be offered without blame and without making a risk discussion substitute for the family's own values or choices. The generic genetic-counselling process and diagnostic work-up are developed in the aetiology section.

16.6 Public-health priorities and realistic expectations

Prevention is most effective when it reaches the conditions in which children develop. ID risk factors are considerably increased in low-income countries, contributing to their increased rate of intellectual disability. This is why a prevention answer should move beyond rare disorders and include maternal health, nutrition, safety, infection control, toxic exposure and access to perinatal and neonatal care. It is also why prevention must be paired with equity: a family cannot implement advice that depends on services, food security or safe housing it cannot access.

Evidence supports interventions at more than one level. Programmes aimed at psychosocial stimulation were more effective than nutritional supplementation for improving both cognition and behaviour in growth-retarded children in the cited comparison. This does not diminish nutrition. It teaches that development depends on both biological provision and responsive social experience, and that a single nutrient-focused programme may not repair the effects of deprivation. Similarly, prevention programmes should be evaluated for whether they can be delivered consistently and whether they improve real developmental participation.

A comprehensive service begins with prevention and early detection and then connects families to the educational, health, social and practical supports that sustain participation. Prevention is therefore the first element of a continuum of care, not a separate campaign that ends after a

screening test. Appropriate referrals should follow the person across early, educational and adult life. The statutory eligibility and benefits themselves are dealt with in the disability certification and benefits section of this chapter.

MNEMONIC

PREVENT

Prepare before conception; **R**educe maternal, toxic and nutritional risks; **E**valuate antenatal and newborn screens; **V**erify a positive result; **E**ngage family support; **N**otice comorbidity; **T**arget function through habilitation.

The mature answer is neither fatalistic nor triumphalist. It recognises preventable pathways, acts early when an actionable condition is found, and continues to prevent additional disability through support and treatment. It also respects the person with intellectual disability as more than the outcome of a risk factor. Prevention should enlarge future choice, not become a language for blaming parents, narrowing reproductive autonomy or measuring a life only by what might have been avoided.

- Ask which preventable exposure or remediable condition is relevant at the present point in the person's life course.
- Make sure a positive screen has a confirmation, treatment and follow-up pathway.
- After diagnosis, look for treatable illness and avoidable barriers to participation rather than assuming that decline is inevitable.

For intellectual disability, prevention is a continuum: reduce avoidable risks before disability arises, detect and treat remediable conditions early, and use habilitation to prevent avoidable loss of function after diagnosis.

17 · Disability certification and benefits for intellectual disability in India (IDEAS, National Trust Act)

Certification is a clinical document with legal consequences. For a person with intellectual disability, it can convert an assessment into access to education, work, social protection and supported decision-making. The psychiatrist's task is therefore not merely to write a diagnosis. It is to distinguish clinical formulation from statutory quantification, obtain defensible evidence of functioning, explain what the certificate does and does not establish, and help the family navigate a system that can otherwise feel opaque.

The contemporary legal frame is the **Rights of Persons with Disabilities Act, 2016**, notified on **28 December 2016**. It replaced the **Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995**. Intellectual disability is a specified disability under this framework, alongside other conditions relevant to psychiatric practice. This section concerns the certification route for intellectual disability, its practical consequences, the limited role of IDEAS, and the National Trust framework for adulthood and guardianship.

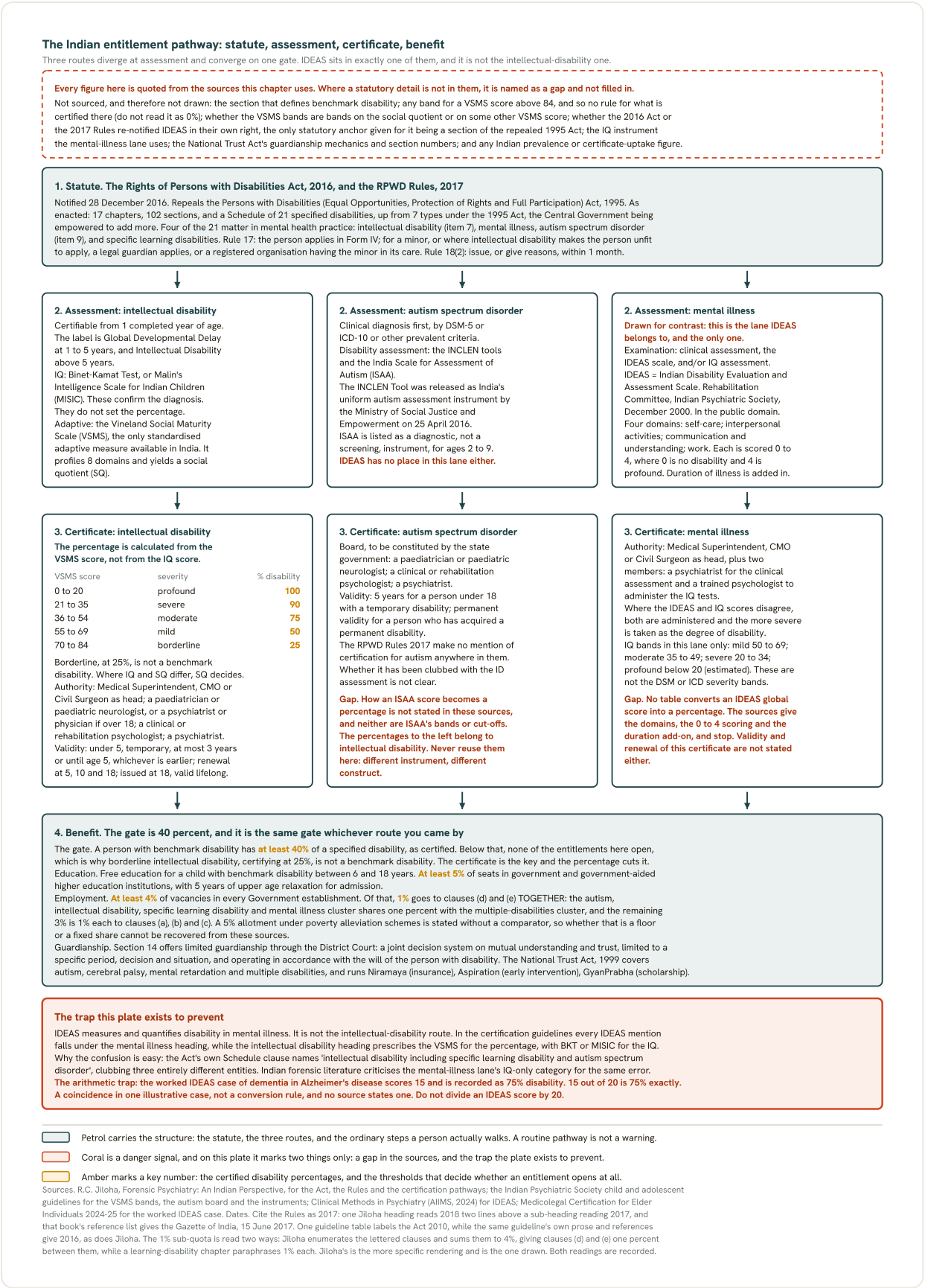


Fig 21.13 The Indian entitlement pathway: statute, assessment, certificate, benefit. One statute, three routes that diverge only at assessment, and one gate at 40 percent that all three converge on. The distinction the chapter turns on: IDEAS is the mental-illness disability instrument, not the intellectual-disability route, whose certified percentage comes from the VSMS score.

17.1 The legal frame: from diagnosis to enforceable participation

The Act is not a diagnostic manual. Its purpose is to translate disability into rights, duties and institutional remedies. It has 17 chapters and 102 sections; its Schedule names 21 specified disabilities, compared with 7 disability types in the earlier law. Within the Schedule, intellectual disability appears at serial 7 and autism spectrum disorder at serial 9. The nomenclature matters: the Act replaces **"mental retardation" with "intellectual disability"**. In clinical records and communication, use the current term consistently.

The statutory definition recognises limitation in intellectual functioning together with adaptive behaviour in everyday social and practical skills. That overlap with clinical assessment is important, but the questions asked are different. A clinical assessment asks what the person can do, what has changed, which supports work and whether there are treatable coexisting problems. A certificate establishes disability in the form required for rights and entitlements. It should never flatten the person into a percentage or be allowed to substitute for an individualised care plan.

RULE **Clinical severity and certified disability are related, but they are not interchangeable labels.** Clinical formulation guides care; statutory quantification establishes eligibility under a legal scheme.

For intellectual disability, the statutory schedule describes significant limitation in intellectual functioning together with limitation in adaptive behaviour. It does not legislate an IQ number, and a candidate should resist the temptation to supply one: the percentage on the certificate is derived from adaptive functioning, not from the IQ score. This is an easily missed distinction. A numerical cognitive test can corroborate intellectual impairment, but it does not itself produce the statutory percentage. Candidates who equate the two have confused an assessment construct with a legal outcome, and quoting a legal IQ cut-off that the statute never states is the sharpest form of that error.

- Use the diagnosis to organise clinical understanding and intervention.
- Use the certificate to document statutory disability and enable access to rights.
- Explain to caregivers that the certificate records function for a stated purpose, not the person's potential or worth.

17.2 The intellectual-disability certification assessment

Start with the correct question. The assessment must establish intellectual disability and then quantify disability in the prescribed manner. Careful administration and a credible developmental history are especially important; a rushed score, divorced from the person's actual opportunities and supports, is a poor foundation for a legal document.

IN INDIA

The Indian guideline identifies the VSMS as the currently available standardised adaptive-behaviour measure. The prescribed adaptive-functioning instrument is the **Vineland Social Maturity Scale (VSMS)**; it yields a **social quotient (SQ)** and an adaptive profile. Intellectual functioning is assessed using the **Binet-Kamat Test** or **Malin's Intelligence Scale for Indian Children**.

Cognitive testing in this pathway provides diagnostic confirmation, not percentage derivation. Where IQ and SQ suggest different grades, the SQ should guide the decision, because social maturity more closely reflects the ability to meet culture-appropriate demands of daily life.

GOOD TO REMEMBER

An implausible or discordant result should prompt review of the history, test conditions, language, sensory or motor barriers, educational opportunity, behaviour during testing and the informant's understanding of the items.

A statutory assessment should be clinically thorough even when its output is concise. Establish the developmental course and current adaptive abilities from an informant who knows the person across settings. Consider whether communication difficulty, behavioural disturbance, sensory impairment, physical illness or an untreated psychiatric disorder has distorted apparent function. Record observed abilities as well as deficits. The certificate process should protect against both overestimation, which deprives a person of support, and underestimation, which may unnecessarily restrict autonomy.

TRAP **Do not use an IQ score to calculate the intellectual-disability percentage.** In this certification pathway, the percentage follows the VSMS-based adaptive-functioning assessment; IQ testing confirms the intellectual impairment.

The categories below are statutory bands, not a substitute for the clinical severity discussion elsewhere in this chapter. They answer the specific legal question of what disability percentage is certified. The row should be read as a mapping: identify the applicable VSMS band, then document the corresponding percentage without improvising a conversion.

CERTIFICATION CATEGORY	VSMS SCORE BAND	CERTIFIED DISABILITY	PRACTICAL INTERPRETATION
Profound	0-20	100%	Highest statutory disability band
Severe	21-35	90%	Benchmark-disability threshold is met
Moderate	36-54	75%	Benchmark-disability threshold is met
Mild	55-69	50%	Benchmark-disability threshold is met
Borderline disability	70-84	25%	Does not meet benchmark-disability status

The borderline-disability row is clinically useful because it makes the eligibility boundary explicit. It is not a reason to dismiss need. A person may still need educational, vocational, family or mental-health support even when the statutory benchmark threshold is not met. Conversely, a benchmark certificate creates a legal entitlement pathway but does not tell the clinician which supports will be effective. Keep these two conversations separate and honest.

17.3 Application, medical authority and validity

The route should be explained before the family is sent from counter to counter. An application for a disability certificate is made in **Form IV**. When a person with intellectual disability cannot apply, a legal guardian may apply; an organisation registered under the Act may also apply where it has a minor in its care. This provision is practical rather than merely administrative: it avoids making access to certification contingent on an ability that is itself affected by the disability.

The medical authority is headed by the Medical Superintendent, Chief Medical Officer, Civil Surgeon or an equivalent state-notified authority. Its clinical membership includes a paediatrician or paediatric neurologist where available, with age-appropriate alternatives specified for adults, a clinical or rehabilitation psychologist, and a psychiatrist. The psychiatrist's contribution is more than signing a completed form. It includes diagnostic coherence, review of developmental and behavioural information, recognition of coexisting psychiatric illness, communication with the family and protection of the person's dignity during examination.

Certification can be issued after at least **1 completed year of age**. The label is age-sensitive: the guidance uses Global Developmental Delay from ages 1 to 5 years and Intellectual Disability after age 5 years. This distinction avoids premature certainty while preserving access to assessment and support. Do not delay a needed certificate simply because the child's development is still being clarified; use the appropriate certification label and plan review.

WHEN THE CERTIFICATE IS ISSUED	VALIDITY APPROACH	CLINICAL IMPLICATION
Before age 5 years	Temporary; it ends at the earlier of age 5 or 3 years.	Plan reassessment rather than treating the early certificate as final.
Between ages 5 and 17 years	Review is scheduled at ages 5, 10 and 18 years.	Make renewal part of transition planning, not a crisis near a deadline.
At age 18 years	Lifelong validity	Use the adult review to address future support and decision-making.

The medical authority must issue the certificate or communicate the reason for rejection within at most **1 month from receipt of the application**. In practice, clinicians can reduce avoidable delay by ensuring that reports identify the tool used, the functional basis of the percentage, the diagnosis appropriate to age and any need for follow-up. Keep a copy of the assessment record: it is clinically useful at renewal and can clarify an apparent discrepancy without making the family repeat an entire evaluation.

17.4 Benchmark disability and the rights that certification can activate

A **person with benchmark disability** has certified disability of at least **40%**. This is an eligibility threshold, not a clinical threshold. It determines access to several statutory provisions, whereas care should respond to need at every level of disability. Explain this plainly. Families often hear "eligible" as "severely disabled" or "ineligible" as "no help is possible"; both inferences are wrong.

40%	5%	4%	1%
BENCHMARK THRESHOLD	HIGHER-EDUCATION SEATS	GOVERNMENT VACANCIES	SHARED JOB-RESERVATION CLUSTER

A child with benchmark disability has a right to free education between 6 and 18 years. Government and government-aided higher-education institutions reserve at least 5% of seats for persons with benchmark disabilities, with an upper-age relaxation of 5 years for admission. In every Government establishment, at least 4% of vacancies are reserved. These provisions should not be presented as a promise of a particular educational placement or job. The clinician should document function accurately and direct the family toward the relevant institutional process rather than make an outcome guarantee.

The employment reservation has a subtle but examinable structure. Autism, intellectual disability, specific learning disability and mental illness form one listed cluster. That cluster does not receive a separate one-percent allocation by itself: it shares exactly 1% of vacancies with the multiple-disabilities cluster. This clarification prevents the common answer that incorrectly assigns the whole sub-quota to intellectual disability or to the listed cluster alone.

- Discuss educational entitlement early enough for the family to use it meaningfully.

- Frame reservation as an access mechanism, alongside realistic skill-building and accommodation.
- Check the current administrative pathway locally before advising on an application or placement.

17.5 IDEAS: important scale, wrong shortcut for ID certification

The acronym is a frequent source of error. **IDEAS** means Indian Disability Evaluation and Assessment Scale. It was developed by the Rehabilitation Committee of the Indian Psychiatric Society in December 2000. IDEAS is designed for disability due to mental disorders and is recommended for disability associated with mental illness. It is publicly available and remains important for psychiatric disability work.

IDEAS rates four functional domains: self-care, interpersonal activities, communication and understanding, and work. Each domain is scored from 0 to 4, from no disability to profound disability, and duration of illness is incorporated into the global score. These features explain why IDEAS may look superficially attractive in an adult with longstanding functional impairment. They do not make it the intellectual-disability certification instrument.

TRAP **IDEAS must not be substituted for the ID certification route.** Its place is the mental-illness pathway, whereas intellectual-disability certification follows its own prescribed assessment route.

This distinction is more than a technicality. Intellectual disability is a neurodevelopmental condition, and its certification requires an account of adaptive functioning. IDEAS includes illness duration, which answers a different question. Importing it into an ID certificate can create a legally vulnerable assessment and obscure the actual statutory basis of the percentage. Where intellectual disability and mental illness coexist, formulate and treat both conditions, but do not let the presence of psychiatric symptoms alter the prescribed ID percentage route.

17.6 Supported decision-making and the National Trust framework

Certification often brings families to the question they had postponed: who will help the person make decisions in adult life? Begin with the person's own preferences, abilities and participation. The **limited guardianship** model under the Act is offered by the District Court. It is a joint decision-making arrangement based on mutual understanding and trust, confined to a specified period and decision or situation, and intended to operate according to the person's will. This is conceptually different from taking over a person's life because support is convenient for others.

Clinicians should avoid treating guardianship as an automatic consequence of diagnosis or a certificate. Assess the decision at hand, the person's capacity to participate with support, the risks of coercion and the least restrictive way to enable a meaningful choice. Documentation should describe function and support needs rather than make sweeping declarations of incapacity. This approach also keeps the consultation aligned with rights, not merely family anxiety.

The **National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999** covers four conditions: autism, cerebral

palsy, mental retardation and multiple disabilities. It creates a national body intended to support independent, community-close living and meaningful participation, rather than segregation or passive care. With an adult who has intellectual disability, the clinician must provide information about guardianship and National Trust provisions.

MNEMONIC

SUPPORT before substitution

Start with the person's wishes, identify the decision and the support required, protect against undue influence, and use the least restrictive lawful arrangement.

- Raise future decision-making before an emergency forces the issue.
- Include the adult with intellectual disability in the discussion in a communication-accessible manner.
- Separate financial or property concerns from a global assumption that the person cannot decide anything.

17.7 Documentation, advocacy and protection from procedural harm

Good certification is disciplined advocacy. The final document should make its reasoning auditable: diagnostic conclusion, adaptive assessment, IQ assessment where used, the statutory basis of the percentage, validity and the need for review. Avoid pejorative wording, casual estimates and unexplained contradictions between narrative and score. Discuss the result with the person and family in plain language. A certificate can open doors, but careless language can also follow a person into school, employment and adult services.

Rights under the Act have enforcement mechanisms. A first contravention of the Act or its rules attracts a **fine which may extend to Rs 10,000**, and a subsequent contravention a **fine of not less than Rs 50,000 and up to Rs 5 lakh**. Neither tier carries imprisonment, and the first-tier figure is a ceiling rather than a flat penalty. Fraudulently availing a benefit meant for persons with benchmark disabilities is a separate and graver offence, punishable with imprisonment which may extend to 2 years, or fine which may extend to Rs 1 lakh, or both. A separate group of offences of atrocities carries imprisonment of not less than 6 months and up to 5 years, and with fine, and their elements are examinable precisely because dropping them broadens the offence. Insult or intimidation qualifies when it is intentional, done with intent to humiliate, and in a place within public view. The sexual-exploitation limb requires the offender to be in a position to dominate the will of a woman or child with disability and to use that position to exploit her. The section runs to several further limbs, each with its own elements, and they are worth reading in the Act itself rather than in summary: a paraphrase that drops an element is precisely how these offences get overstated. Special Courts are designated in each district to handle violations.

The psychiatrist is not expected to become the family's lawyer. The clinical role is to recognise when rights may be at stake, document the relevant functional facts clearly, avoid false reassurance and direct the family toward appropriate legal or administrative assistance. For

broader assessment, service planning and protection issues, consult the Child psychiatry: assessment, treatment, services and protection notes. The practical aim is simple: certification should increase access, participation and safety without becoming a mechanism for unnecessary exclusion.

Must remember: In intellectual-disability certification, diagnose clinically, confirm intellectual functioning with the Binet-Kamat Test or Malin's Intelligence Scale for Indian Children, and calculate the statutory percentage from VSMS-based adaptive functioning - not from IDEAS, and not from the IQ score, which does not enter the percentage at all.

Autism: concept, causes and criteria

18 · Historical evolution (Kanner, Asperger, DSM-IV subtypes to spectrum)

Why this history matters. Autism did not move from obscurity to its current spectrum formulation simply by acquiring a new name. Each classificatory change reflected a different answer to a clinical question: is the presentation a distinct childhood syndrome, a developmental disorder with several recognisable patterns, or a dimensional condition whose boundaries cannot be reliably divided into neat subtypes? For the clinician, this history explains why older notes use unfamiliar terms, why families may still identify with a former label, and why current assessment must not be constrained by obsolete diagnostic partitions.

The examinable spine is therefore not a recital of dates. It is the movement from carefully described clinical prototypes, through a broad pervasive-developmental-disorder framework, to a single spectrum diagnosis. That movement also records an important correction in psychiatric thinking: explanatory models have to be accountable to observation and evidence, particularly when they risk locating blame in parents.

1943	11	1944	2013
FIRST PAPER	CHILDREN DESCRIBED	PARALLEL ACCOUNT	SPECTRUM SHIFT

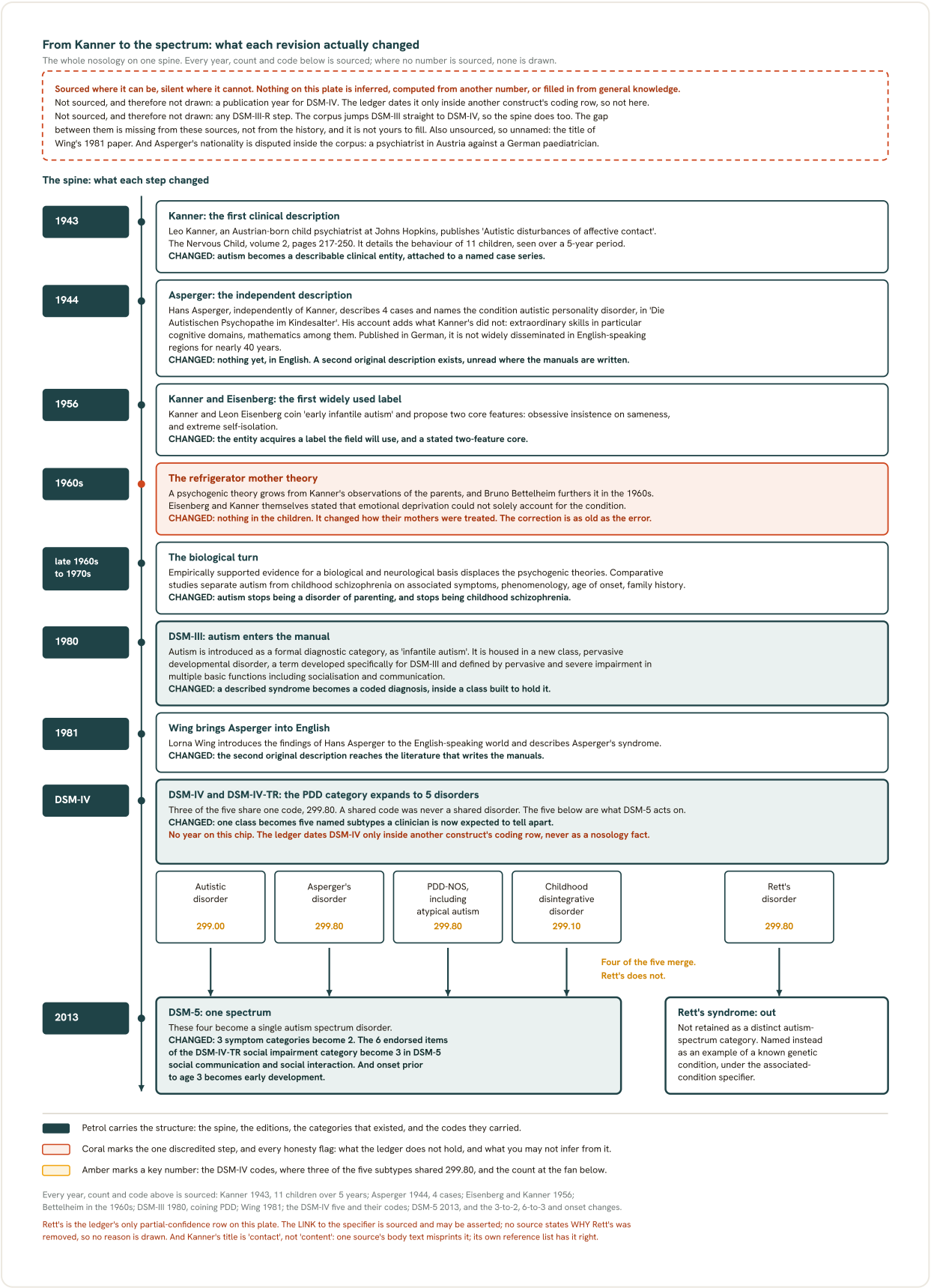


Fig 21.14 From Kanner to the spectrum: the nosological timeline and what each revision changed. The fan at the foot answers the examined question: four of the five DSM-IV subtypes merged into autism spectrum disorder and Rett's did not, surviving instead as an example of a known genetic condition under the associated-condition specifier. No year is drawn for DSM-IV and no DSM-III-R step is shown, because the sources cited hold neither.

18.1 From descriptive observation to a clinical syndrome

The starting point is the clinical description associated with **Leo Kanner, an Austrian-born child psychiatrist working at Johns Hopkins University**. He is credited with the first clinical portrayal of autism in the scientific literature. The importance of that contribution lies in the act of delineation: a set of children who might otherwise have been subsumed under broad and unhelpful psychiatric categories were described as sharing a distinctive developmental pattern. Good historical reading is not hero worship. It is an appreciation that a diagnostic entity begins when clinicians can show, with enough precision, what belongs together and what does not.

The paper, ***Autistic disturbances of affective contact***, concerned a series of **11 children** accrued over 5 years. It appeared in *The Nervous Child*, volume 2, pages 217-250. The title itself is instructive. Its language belongs to its period, but it directs attention to a disturbance in the child's way of relating rather than merely to disruptive conduct or low measured ability. That emphasis helped establish autism as a problem of developmental organisation and social relatedness, rather than a label for any child who was withdrawn, unusual, or difficult to manage.

A later follow-up is a useful corrective to retrospective romanticising of early accounts. Kanner's 1971 follow-up traced 9 of the original 11 children into adulthood; only two were eventually employed, and they remained single and lived with their parents. These observations should not be converted into a modern prognostic rule. They arose from a small historical cohort and a very different service context. Their value is conceptual: a diagnostic history should remain connected to the life course, participation, support, and family circumstances of the people being described.

RULE **Read the early descriptions as clinical prototypes, not as a checklist that limits whom autism can include.** A prototype establishes a recognisable pattern; later classification must test whether its boundaries remain valid in wider clinical populations.

18.2 Asperger's parallel account and its later influence

Independently of Kanner's work, **Hans Asperger** published an account based on **4 cases**. In his 1944 paper, *Die "Autistischen Psychopathen" im Kindesalter*, he used the term “autistic personality disorder”. The parallel descriptions matter because they prevent an overly simple origin story. Autism was not manufactured by a later committee out of a single author's observations. Different clinicians, working separately, identified related developmental phenomena, while giving different weight to their most striking features.

The feature that especially distinguished that account was attention to **extraordinary skills in particular cognitive domains**. This is often simplified into a stereotype of universal talent, which is clinically unhelpful. The historical point is narrower: ability can be strikingly uneven, and the presence of a particular strength does not erase social-developmental difficulty or establish a separate disease entity. Conversely, the absence of a striking skill never argues against autism. A mature formulation should describe the person's actual profile rather than infer ability from a historical label.

The work was published in German and was not widely disseminated in English-speaking settings until nearly 40 years later. **Lorna Wing**, in 1981, introduced these findings to the

English-language literature and described Asperger's syndrome. This delay helps explain why the label became prominent after many clinicians had already learned the original account of autism. It also explains why the label acquired cultural and personal significance for some patients and families. Respecting that significance does not require preserving a classification that later evidence found difficult to delimit consistently.

- Historical labels may illuminate how a person and family first understood a developmental profile.
- They should not be treated as a shortcut to current assessment or assumptions about cognition, language, education, or independence.
- When reviewing an old record, translate the label into a current description of developmental history, functioning, and support needs.

18.3 Early labels, aetiological error, and scientific correction

An influential early label emerged when **Kanner and Leon Eisenberg, in 1956, used "early infantile autism" and emphasised obsessive insistence on sameness and extreme self-isolation**. The label concentrated attention on early developmental presentation and on behavioural patterns that clinicians continue to recognise. Yet it also shows why diagnostic terminology should not be mistaken for a complete explanation. A name can draw attention to a pattern while still carrying assumptions about timing, causation, or typical presentation that later evidence will revise.

One of the most damaging examples was the **"refrigerator mother" theory, furthered in the 1960s by Bruno Bettelheim**. It interpreted autism through a psychogenic account of parenting and emotional deprivation. Its clinical legacy is not merely historical embarrassment. It can lead to guilt, adversarial relationships with caregivers, and neglect of the child's developmental and practical needs. The lesson for a psychiatrist is to separate careful inquiry about family relationships, which remains clinically relevant for every child, from unsupported causal attribution. Families require collaborative assessment, not retrospective blame.

Empirical work displaced this theory by providing **evidence for biological and neurological foundations, while comparative studies distinguished autism from childhood schizophrenia through associated symptoms, phenomenology, age of onset, and family history**. This was a methodological advance as much as an aetiological one. It required investigators to compare syndromes rather than rely on surface impressions, and to ask whether apparently similar social withdrawal had the same developmental meaning. The distinction remains clinically valuable: resemblance in a single symptom is not enough to establish diagnostic equivalence.

TRAP **Examination trap:** do not present the refrigerator-mother account as an historical "cause" that later became less important. It was a discredited psychogenic theory, not a competing aetiology to be balanced against contemporary evidence.

For present practice, history supports a disciplined stance. A developmental diagnosis does not make family context irrelevant, nor does it justify reducing the child to biology. It means that causal claims should match evidence, while formulation still attends to caregiver stress, communication, schooling, access to services, stigma, and the child's strengths. The causes of autism and the clinical features used for diagnosis are addressed elsewhere in this chapter; history here teaches why those domains must not be confused.

18.4 DSM-III and the pervasive developmental disorder framework

Autism entered a formal diagnostic manual in **1980**, when DSM-III used the label “infantile autism”. Formal recognition mattered because it placed the presentation within a reproducible diagnostic framework rather than leaving it dependent on individual clinical tradition. It also created the possibility that criteria could be studied, criticised, revised, and compared across settings.

The broader home created for it was **pervasive developmental disorder (PDD)**, a term developed specifically for DSM-III. It denoted pervasive and severe impairment across basic functions, including socialisation and communication. The word “pervasive” captured an attempt to distinguish a broad developmental organisation from an isolated symptom. Its limitation became clearer over time: a useful umbrella can inadvertently suggest that the conditions beneath it are naturally separate, even when the boundaries between them prove unstable.

The PDD framework nevertheless performed an important transitional task. It organised clinical observation around developmental patterns and made room for presentations that did not resemble a narrow prototype. It also created a common language for research and services. Candidates should understand this as a stage in nosology, not as a rival to the current diagnosis. The historical PDD term is still encountered in case records, educational reports, and older research, so it must be recognised and translated rather than dismissed as meaningless.

There is a broader lesson in this transitional category. Classification is most useful when it makes a clinician ask better questions, not when it supplies a prematurely final answer. The PDD framework encouraged clinicians to look across domains of development, but its named divisions could tempt them to treat a label as a complete account of the person. The later spectrum formulation retained the need for careful description while moving the centre of gravity from deciding which box fits best to explaining the individual's pattern. That is a more demanding task: it requires longitudinal history, direct observation, collateral information, and attention to functioning in ordinary settings.

> The key historical transition is from separately named pervasive developmental disorders to one autism spectrum diagnosis: the clinical task moved from choosing a former subtype to applying a common framework precisely.

18.5 DSM-IV: expansion into named subtypes

The DSM-IV and DSM-IV-TR PDD category contained exactly 5 disorders: autistic disorder, Asperger's syndrome, Rett's syndrome, childhood disintegrative disorder, and PDD-NOS. This

scheme is worth knowing because it shaped generations of clinical records and examination questions. It was also an attempt to represent heterogeneity, especially differences in developmental course and the degree to which an individual resembled the original prototypes. The weakness was not that heterogeneity was unreal; it was that named categories did not reliably carve that heterogeneity at its natural joints.

DSM-IV / DSM-IV-TR SUBTYPE	DIAGNOSTIC CODE
Autistic disorder	299.00
Asperger's disorder	299.80
PDD-NOS, including atypical autism	299.80
Rett's disorder	299.80
Childhood disintegrative disorder	299.10

Do not let the table mislead you into seeing the former codes as a clinical hierarchy. Codes record a classification decision; they do not tell you how a person communicates, what repetitive patterns are present, how development unfolded, or which supports are needed. The full diagnostic criteria, severity framework, and specifiers of current ASD are addressed elsewhere in this chapter. Here, the important point is that a subtype name in an older file is historical data to be interpreted, not a final formulation.

- Do not infer that former subtypes represented neatly separated biological entities.
- Do not convert a former subtype automatically into a contemporary severity statement.
- Do preserve the original developmental account, because it may contain useful information that a code alone cannot carry.

18.6 DSM-5: from subtype boundaries to a spectrum

The decisive revision came with **DSM-5 in 2013. Autistic disorder, childhood disintegrative disorder, Asperger's syndrome, and PDD-NOS were reconceptualised as a single autism spectrum disorder**. This was not a claim that all autistic people are alike. It was a claim that the prior labels did not consistently identify separate disorders, whereas variation could be described more meaningfully within a shared diagnostic framework.

The change also altered the architecture of symptoms: the 3 DSM-IV-TR symptom categories became 2 DSM-5 categories, and the item architecture beneath them was rebuilt. DSM-IV-TR required a total of 6 or more items across its 3 categories, with at least 2 drawn from the social-interaction category, which itself listed 4; DSM-5 carries 3 items in the single social-communication and social-interaction category. The threshold rule is worth reading twice, because it is widely misquoted as though the six were six social items: the six was the total across all three categories, and the social category alone never contained six. These are historical contrasts, not a substitute for learning current criteria. The critical conceptual shift was to bring social communication and social interaction together, while retaining restricted and repetitive

patterns as the other major domain. The diagnostic-criteria discussion should be used for the present rule set; history explains why it was reorganised.

The onset wording changed as well. DSM-IV-TR required onset before age 3, whereas DSM-5 specifies early development. This prevents an arbitrary historical cut-off from overriding a careful developmental history. It does not mean that onset history has become unimportant. Rather, the clinician has to establish whether the overall developmental pattern is compatible with ASD and whether later recognition reflects changing social demands, masking, missing early history, or another explanation.

RULE **Spectrum does not mean vague.** It replaces unstable subtype labels with a common diagnostic framework while requiring a more precise individual description of developmental history and current functioning.

18.7 Rett syndrome, coding legacies, and reading old records safely

The spectrum consolidation had an explicit exception. **Rett syndrome was not retained as a distinct autism-spectrum category; it is cited under the associated-condition specifier as an example of a known genetic condition.** This is a useful guard against a common historical error: assuming that every condition previously housed within PDD was simply renamed ASD. The detailed clinical account of Rett syndrome and childhood disintegrative disorder belongs with their dedicated discussion; the classification point here is that historical placement and present diagnostic status are not the same thing.

The manual pairs that reclassification with a differential instruction, set out where each of those syndromes is discussed in full. The classification principle is what belongs here, and it generalises: a symptom that appears during a particular phase of another condition must not be treated as sufficient evidence for a lifelong co-occurring diagnosis. Diagnostic overlap calls for full criteria, developmental context, and longitudinal reasoning.

Older ICD-10 documentation may use the following labels. The list is useful for record translation, but it must not be read as a DSM-IV row-by-row conversion.

ICD-10 CODE	LABEL PRINTED IN THE HISTORICAL PDD LISTING
F84.0	childhood autism
F84.1	atypical autism
F84.2	Rett's syndrome
F84.3	childhood disintegrative disorder
F84.4	overactive disorder associated with mental retardation and stereotyped movements
F84.5	Asperger syndrome
F84.8	other pervasive developmental disorders
F84.9	pervasive developmental disorders, unspecified

For the ICD-11 ASD stem, the back-mapping permits F84.0 childhood autism, F84.1 atypical autism, or F84.5 Asperger syndrome; use F84.1 when onset before age 3 is unclear, and use F84.5 regardless of onset when there is no general impairment in intellectual functioning or functional language. This is a coding bridge, not a licence to reintroduce obsolete diagnostic distinctions into the clinical formulation.

Finally, modern ASD encompasses historical terms that will appear in legacy material:

- early infantile autism, childhood autism, and Kanner's autism
- high-functioning autism, atypical autism, and PDD-NOS
- childhood disintegrative disorder and Asperger's disorder

GOOD TO REMEMBER

When encountering a historical label, first establish which classification system was used, then recover the descriptive evidence behind it, and finally apply the current framework without erasing the person's history. Taxonomy should improve clinical understanding, not replace it.

19 · Diagnostic criteria of ASD (DSM-5 dyad, ICD-11)

The diagnostic task is to recognise a pattern, not to count isolated oddities. Autism spectrum disorder is formulated from a persistent developmental pattern that is organised around **two** core domains. The value of the formal criteria is that they force the clinician to establish both the social-communication disturbance and the restricted or repetitive pattern, then to ask whether the pattern began developmentally and matters in the person's present life. This protects against diagnosing autism from one striking mannerism, a narrow interest, or social discomfort alone.

The criteria are best understood as a clinical argument. Symptoms must be described in their developmental context, linked to real-world functioning, and weighed against the person's general developmental level. The classification language is concise; the clinical work is not. A good answer therefore states the diagnostic structure first and then explains why each element is necessary. This section addresses the criteria in DSM-5-TR and ICD-11, before showing how their different formats lead to the same disciplined diagnostic reasoning.

2	3	at least 2	6A02
DSM CORE DOMAINS	CRITERION A ELEMENTS REQUIRED	CRITERION B ELEMENTS REQUIRED	ICD-11 PARENT STEM

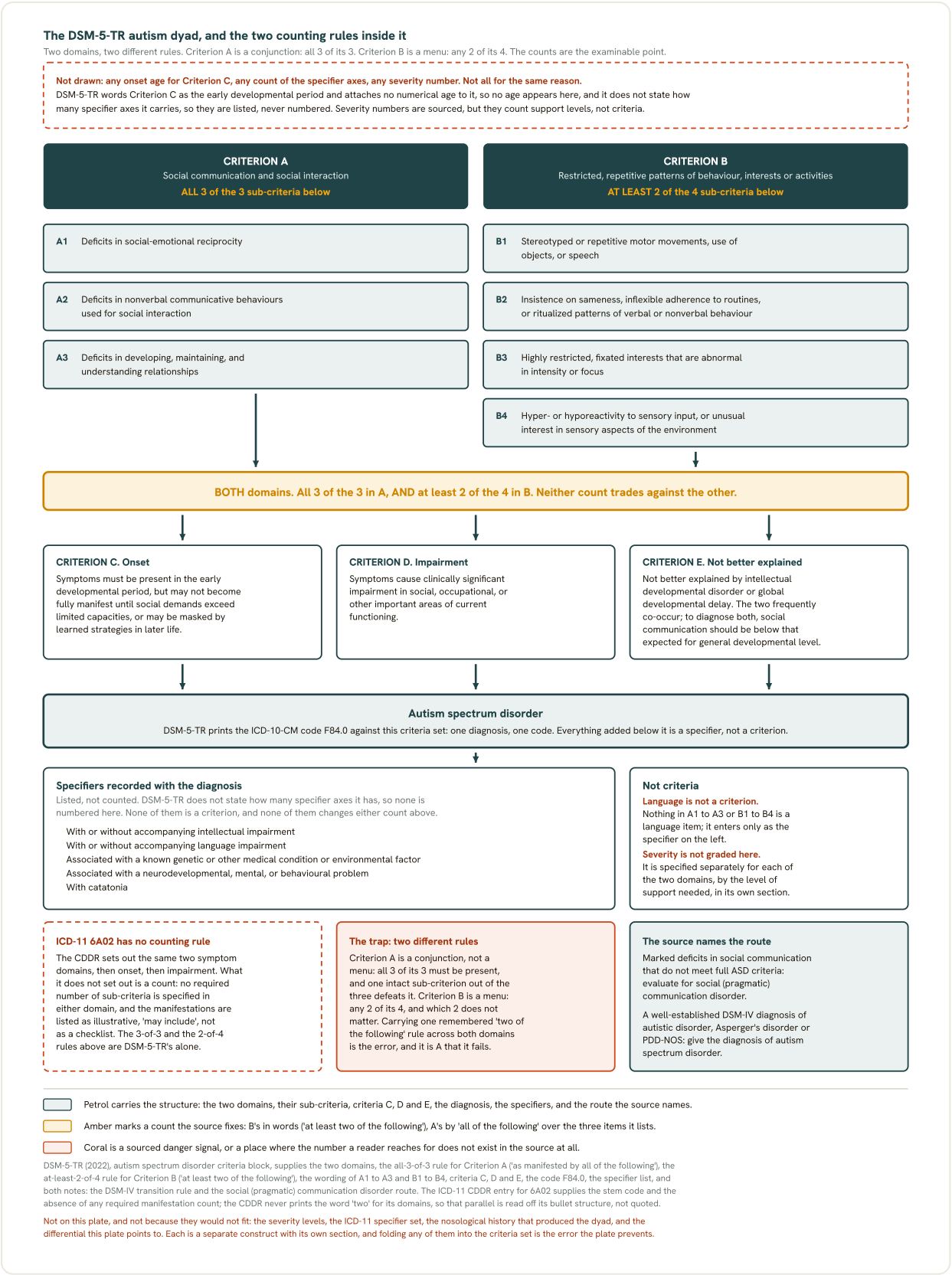


Fig 21.15 The DSM-5-TR autism dyad, and the two counting rules inside it. Two symptom domains, two different rules. Criterion A needs all 3 of its 3 sub-criteria, so one intact sub-criterion defeats it; Criterion B needs any 2 of its 4, and which 2 does not matter. Criteria C, D and E add onset, impairment and the not-better-explained rule against intellectual developmental disorder. Specifiers hang off the diagnosis, not the counts, where language and severity sit, outside the criteria set. ICD-11 6A02 has the same two domains and no counting rule, so these counts are DSM-5-TR's alone. No onset age is drawn: DSM-5-TR attaches none to the early developmental period, and the specifier axes are listed, never numbered, because it does not state how many there are.

19.1 The diagnostic architecture: a dyad with developmental and functional anchors

The DSM-5-TR dyad has one domain concerning social communication and social interaction, and another concerning restricted, repetitive patterns of behaviour, interests, or activities. The dyad is not merely a shorter checklist. It requires the examiner to decide whether social difficulty is part of a broader reciprocal-interaction disturbance and whether the behavioural pattern has the characteristic quality of repetition, inflexibility, restriction, or unusual sensory engagement.

A useful way to read the criteria is vertically as well as horizontally. Vertically, the clinician first establishes the core phenotype, then asks about developmental onset, present impairment, and competing explanations. Horizontally, each core domain must be examined across ordinary contexts rather than inferred from a single consultation. A person may use rehearsed social behaviours in a structured setting and still have difficulty when reciprocity, flexibility, or contextual understanding are demanded. Conversely, a single unusual habit without the wider pattern does not establish the diagnosis.

This structure also explains why a symptom inventory is insufficient. Checklists are useful prompts for enquiry, but their items are not interchangeable. An affirmative response about a repetitive act does not repair missing evidence from the social domain, and a history of social discomfort does not establish the repetitive domain. The clinician must decide whether each observation belongs to the required construct, whether it is persistent, and whether the observations form one developmental syndrome. That is the safeguard against both overinclusive diagnosis and the dismissal of a coherent but subtle presentation.

RULE **Diagnostic rule:** establish the complete pattern across both core domains before using onset, impairment, and exclusion criteria to confirm that it is autism spectrum disorder.

The printed DSM diagnosis carries the code F84.0. In an examination answer, however, the code is less important than showing the logic of the dyad. The examiner should be able to see that the candidate understands why a social-communication presentation without the required restricted or repetitive pattern is not simply labelled autism by default.

19.2 Criterion A: social communication and social interaction

Criterion A concerns deficits that are persistent and span the social-communication field. DSM-5-TR requires **all three** listed components. This matters because conversational difficulty, poor eye contact, or social isolation in isolation can arise for many reasons. The criterion asks for a coherent disturbance in reciprocity, in the use of nonverbal communication for social purposes, and in relationships.

- **Deficits in social-emotional reciprocity** concern the give-and-take of social exchange. The clinical question is whether the person can initiate, respond to, and sustain a reciprocal interaction in a manner appropriate to the context.
- **Deficits in nonverbal communicative behaviours used for social interaction** concern how nonverbal signals are used to regulate and share interaction, rather than a superficial judgement about one gesture or one gaze behaviour.

- **Deficits in developing, maintaining, and understanding relationships** require attention to the person's grasp of social expectations, adjustment of behaviour to context, and capacity to participate in relationships.

The phrase “social communication” should not be reduced to spoken language. A fluent speaker can have marked difficulty with reciprocity, social interpretation, or relationships, while a person with limited speech may show a clear wish to engage and share. The diagnostic question is how social communication functions between people. **Language impairment is not itself a core DSM-5-TR criterion**; its specifier framework is addressed in the severity-level and specifier discussion in this chapter. Detailed language phenomenology belongs with the clinical features of ASD.

Clinical interpretation. Criterion A is often easiest to misread when an observer relies on a socially compelling moment during an interview. The purpose is not to decide whether a person can make contact at all; it is to understand the consistency, flexibility, reciprocity, and context-sensitivity of social communication over development. A single competent performance, particularly in a familiar or highly structured interaction, is not by itself a substitute for that broader account.

For the same reason, Criterion A should not be phrased as a personality judgement. Reserve descriptive language for observable interaction and its functional meaning. Ask how the person shares attention, responds when another person changes the topic, reads the interpersonal situation, and adapts communication to the relationship. Such questions convert a loose impression of being “socially awkward” into evidence that can be placed, or not placed, within the criterion. They also make it easier to explain the reasoning to the person and family without reducing the assessment to a label.

19.3 Criterion B: restricted and repetitive patterns

Criterion B captures a style of behaviour and interest that is repetitive, circumscribed, inflexible, or unusually related to sensory experience. DSM-5-TR requires **at least two** of the listed manifestations. The threshold deliberately prevents a single preference, hobby, or repetitive action from carrying the diagnosis. What counts is the pattern's persistence, context, intensity, and relationship to the rest of the clinical picture.

The manifestations include stereotyped or repetitive motor movements, use of objects, or speech. The point is not simply that behaviour is repeated. Repetition must be interpreted as part of the characteristic pattern, rather than as an isolated self-soothing act, play preference, or response to a transient stressor.

A further manifestation is insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behaviour. Here, the clinical task is to ask what happens when an expected sequence changes. The diagnostic relevance lies in the rigidity and the way the need for predictability shapes functioning, not in whether a household happens to have routines.

The domain also includes highly restricted, fixated interests that are abnormal in intensity or focus. A strong interest should be evaluated for its quality and consequences, not judged by whether its topic seems unusual to the clinician. An ordinary subject can become diagnostically relevant when engagement is unusually narrow or dominant; an unusual subject can be entirely non-pathological when it is flexible and proportionate.

Finally, DSM-5-TR includes **hyper- or hyporeactivity to sensory input, or unusual interest in sensory aspects of the environment**. This places sensory experience within the restricted and repetitive domain. It does not mean that sensory sensitivity alone is diagnostic. Its value is greatest when it helps explain a broader pattern of behaviour, distress, avoidance, fascination, or difficulty adapting to ordinary environments.

MNEMONIC

Memory spine: A is all, B is a selected set

Establish every social-communication element in A, then establish the required threshold within B. Use this as a recall aid only after understanding what the observations mean clinically.

TRAP **Examination trap:** do not diagnose ASD from social-communication deficits alone. The restricted and repetitive domain is required, and it must be demonstrated rather than assumed.

19.4 Criteria C to E: timing, impact, and developmental explanation

The core phenotype is necessary but not sufficient. Criterion C requires that symptoms are present in the **early developmental period**. Recognition may occur much later because demands become more complex or because a person has learned strategies that conceal difficulty. The criterion is therefore about developmental presence, not the age at which a family, school, or clinician first names the concern. A late recognition narrative should prompt careful developmental reconstruction, not an automatic rejection of ASD.

Criterion D requires **clinically significant impairment** in social, occupational, or other important areas of current functioning. Impairment is the bridge from descriptive traits to a disorder. It should be considered in the person's actual environment, including the effort needed to maintain functioning and the consequences when familiar supports are absent. The clinician should avoid both extremes: treating every difference as disorder, or dismissing substantial hidden burden because outward performance appears adequate.

Criterion E says that the presentation must not be better explained by intellectual developmental disorder or global developmental delay. It also permits co-occurring diagnoses when **social communication is below that expected for general developmental level**. This is a comparative judgement, not a shortcut based on an intelligence score. The issue is whether the social-communication profile is disproportionately affected relative to the person's overall developmental functioning. Intellectual disability and its assessment are covered in the relevant sections of this chapter.

- **Timing:** establish a developmental history that can account for the current pattern, including why it became visible when it did.
- **Impact:** describe what the pattern changes in daily participation, relationships, education, work, or other important roles.
- **Explanation:** decide whether the social-communication disturbance exceeds what would be expected from the person's general developmental level.

The transition note is clinically important: an individual with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or PDD-NOS should receive the diagnosis of autism spectrum disorder. This is a diagnostic transition rule, not an invitation to recreate older subgroup boundaries in current formulation. For a person with marked social-communication deficits who does not meet the full ASD criteria, the DSM directs that they should be evaluated for social (pragmatic) communication disorder. The full differential is considered elsewhere in this chapter.

19.5 ICD-11: essential features and a clinically judged threshold

ICD-11 places ASD under the parent stem 6A02. Its essential features have two required symptom domains, structurally paralleling the DSM dyad. The practical message is the same: social-communication disturbance and restricted or repetitive patterns are both indispensable to the syndrome.

The important structural contrast is that ICD-11 does not set a numerical sub-criterion threshold within either domain. Instead, manifestations are illustrative rather than a required count. This calls for disciplined clinical judgement, not diagnostic laxity. The clinician must still establish that the required domains are convincingly represented and persistent. A list of examples is not a licence to infer a domain from a vague or isolated concern.

When working from ICD-11, document the evidence that makes each domain essential rather than simply reproducing several examples. This keeps the record auditable: another clinician should be able to see why the pattern was judged to meet the domain, how it has persisted developmentally, and how it affects functioning. The same discipline is useful when DSM criteria are used. Counting is a decision aid, not a replacement for a coherent account of the person's development and current life.

The ICD onset requirement is that onset occurs during the developmental period, usually becoming apparent early, although characteristic symptoms may become fully manifest only when social demands exceed the person's capacities. Its functional requirement is significant impairment in important areas of functioning; diagnosis remains appropriate when adequate functioning is achieved only through exceptional effort. This wording is especially useful for presentations in which compensation can obscure the burden of the condition.

ICD-11 also notes that a true regression pattern may typically begin between **1 to 2 years of age**, while loss of previously acquired skills is rarely observed above **3 years of age**. This is a narrow

classification observation, not a substitute for the clinical assessment of regression or its differential diagnosis.

19.6 DSM-5-TR and ICD-11: compare the logic, not merely the wording

DIAGNOSTIC AXIS	DSM-5-TR	ICD-11	CLINICAL CONSEQUENCE
Core structure	Two core domains	Two essential symptom domains	Both require a dyadic phenotype rather than a single-domain formulation.
Within-domain threshold	Every Criterion A component is required; Criterion B requires its stated minimum.	No required sub-criterion count is specified.	DSM is more operationally counted; ICD relies more explicitly on judgement about the essential pattern.
Developmental timing	Symptoms are present in the early developmental period.	Onset occurs during the developmental period.	Recognition can be delayed without converting a developmental condition into an adult-onset one.
Functional significance	Clinically significant current impairment is required.	Significant impairment remains relevant despite exceptional compensatory effort.	Assess current consequences and effort, not symptoms in abstraction.

The classifications should therefore not be treated as rival definitions. They are two formats for the same central clinical problem: determining whether a developmental social-communication pattern is accompanied by the required restricted or repetitive pattern and causes meaningful difficulty. DSM makes the internal threshold more visible. ICD makes the need for judgement in a variable phenotype more visible. In either system, the best formulation is evidence-based, developmental, and functionally anchored.

19.7 A disciplined way to write and defend the diagnosis

GOOD TO REMEMBER

In practice, begin by naming evidence under each core domain. Then state the developmental course, the present functional impact, and the developmental comparison required when intellectual disability or global developmental delay is relevant. This sequencing prevents the common error of beginning with a favourite label and searching selectively for confirming behaviours.

A concise formulation can therefore be written as a chain of reasoning: the person has evidence for the social-communication domain; evidence for the restricted or repetitive domain; a developmental history compatible with the condition; current functional consequences; and no more complete developmental explanation for the social-communication profile. If any link is weak, the right response is to clarify that link rather than to stretch another criterion. This

approach is especially valuable when the presentation is compensated, when history is incomplete, or when more than one developmental difficulty is present.

Do not turn the criteria into a proxy severity scale. Severity levels and accompanying intellectual or language impairment are specifiers, not replacements for the core diagnostic argument. Likewise, screening and diagnostic instruments may organise information, but they do not remove the need to establish the criteria. Their selection and use are addressed in the assessment section of this chapter.

> ASD requires the dyad, developmental presence, clinically meaningful impact, and a developmental explanation that does not account for the social-communication profile more fully.

The final formulation should make its reasoning transparent. It should show why the observed pattern belongs together, why it is developmental, why it matters now, and why the chosen diagnosis is more accurate than a partial description. That is the difference between reproducing a checklist and using a diagnostic classification responsibly.

20 · Epidemiology and changing prevalence of ASD

Epidemiology is more than a prevalence figure. In autism spectrum disorder, the number reported by a survey depends on whom it reaches, how cases are found, which diagnostic concept is used, and whether a record, a service register, or direct assessment establishes the diagnosis. The examination task is therefore not to recite one figure as though it were universal. It is to state the population and method to which a figure applies, distinguish occurrence from detection, and explain why apparently conflicting estimates may all be credible within their own settings.

Autism is diagnosed across the life course, but ascertainment is shaped by developmental surveillance, referral pathways, educational provision, clinical expertise, and families' ability to reach assessment. These influences make epidemiology clinically relevant. They determine which children come to attention, which adults remain unidentified, and how a service should interpret a rising caseload. Prevalence describes the burden recorded in a defined population; it should not casually be converted into a claim about causation or a proof that the underlying incidence has changed.

20.1 Reading an ASD prevalence estimate

Prevalence is the proportion of a defined population meeting a case definition at a stated time or over a stated period. For ASD, it is an output of both the condition in the population and the process used to recognise it. A direct, structured assessment can identify people who have never entered services, whereas an administrative dataset captures only those who have acquired a diagnostic label. Neither approach is automatically superior in every setting: each answers a somewhat different question.

A useful distinction is between a population survey, a clinical series, and a service count. A clinic denominator is strongly influenced by referral, affordability, and local diagnostic practice. A

school or disability register may be especially sensitive to eligibility rules. A population study can reduce some of these effects, but still depends on participation and on the screening and diagnostic pathway. Thus, when comparing papers, the candidate should ask: who was sampled, what constituted a case, and how was that case established?

Case definition is equally important. Research that asks whether a person meets a current diagnostic formulation is not directly equivalent to a historical study that used a narrower formulation. Nor is a parent-reported label equivalent to an assessment made after direct observation and developmental history. The point is not to rank methods in the abstract. It is to understand the direction in which each method may shape a result and to avoid comparing unlike estimates as though they measured precisely the same construct.

For clinical readers, this also explains why a service's experience can diverge from published population data. A tertiary service may receive people with complex presentations, delayed recognition, or accompanying needs that make referral more likely. A community survey may capture people whose needs have not brought them to a specialist. Both can be valuable sources of information, but neither should be used to invalidate the other without considering its sampling frame. Epidemiology becomes clinically useful when it trains that habit of interpretation.

RULE **Never quote an ASD frequency without naming its population, period, and ascertainment pathway.** The same label can yield different observed frequencies when the pathway into the numerator changes.

Ascertainment means the process by which potential cases are found and verified. It is not a minor methodological footnote. A wider net may identify people whose presentations were previously overlooked; an altered threshold may change who qualifies; and better access to assessment may turn an unmet need into a recorded diagnosis. These processes can change measured prevalence even when the underlying population risk has not changed.

- State whether the estimate is local, national, or multinational.
- Identify whether it is a survey estimate, a diagnosed-rate estimate, or a service-derived estimate.
- Describe a temporal increase as a change in **measured prevalence** unless the evidence separately establishes an increase in incidence.

20.2 Contemporary frequency: use the denominator carefully

Published figures support a broad conclusion: ASD is not rare in contemporary clinical and public-health practice. They do not support treating one jurisdiction's figure as the world's figure. The DSM-5-TR describes a reported frequency in the United States of **between 1% and 2%**. In the same source, the median global prevalence is **0.62%**, while prevalence across non-United States countries has approached 1%. These are estimates from differently assembled evidence, not interchangeable constants.

1-2%	0.62%	approaching 1%	3:1
UNITED STATES REPORTED FREQUENCY	MEDIAN GLOBAL PREVALENCE	NON-UNITED STATES REPORTS	WELL-ASCERTAINED EPIDEMIOLOGICAL SEX RATIO

The Kaplan & Sadock's Comprehensive Textbook of Psychiatry gives a current estimate of about 69 per 10,000, or about 1 in 145 children. Lewis's Child and Adolescent Psychiatry describes 6.6 per 1,000 as a reasonable overall estimate. The immediate lesson is not to calculate a false reconciliation between these reports. Rather, each estimate needs its source and denominator attached when it is quoted.

IN INDIA

An international or United States surveillance number may be useful as context, but it must not be relabelled as an Indian prevalence estimate. The Indian Psychiatric Society guideline cites a United States surveillance estimate of 1 in 68; its provenance must travel with the number. A responsible answer acknowledges the need for locally representative ascertainment rather than importing a denominator from another health and education system.

20.3 Sex and gender: distinguish epidemiology from diagnosis

Sex ratio is often quoted as a compact epidemiological fact, but it carries an important methodological warning. In well-ascertained epidemiological samples, the global male:female ratio is 3:1. That figure should not be conflated with the ratio among people who receive a diagnosis. The DSM-5-TR states that ASD is diagnosed between three and four times more often in males, while the ICD-11 Clinical Descriptions and Diagnostic Requirements describes males as diagnosed at a 4:1 male:female ratio.

The difference between a diagnostic ratio and an epidemiological ratio matters because diagnosis is a social and clinical event. Referral expectations, recognition of less stereotyped presentations, language and cognitive profile, and co-occurring difficulties can all shape who crosses the threshold into a dataset. Therefore, a male predominance in a clinical register must not be interpreted automatically as a direct measure of the sex distribution of autistic traits in the wider population.

Other textbook summaries similarly report a male excess, but their scope should be retained. Kaplan & Sadock's Comprehensive Textbook of Psychiatry reports on the order of three to five boys for every girl in clinical and epidemiological samples, and notes that the predominance is greater among those with higher cognitive ability. Lewis's Child and Adolescent Psychiatry reports that boys are affected between three and four times more often. These formulations should be presented as source-specific descriptions, not as permission to under-recognise ASD in girls or women.

TRAP **Examination trap:** a diagnosed male:female ratio is not automatically a population prevalence ratio. Name the numerator before interpreting the ratio.

20.4 Why recorded prevalence has risen

The historical contrast is striking, but the correct inference is nuanced. Early epidemiological studies described autism as roughly 1 per 2,000, whereas current estimates are much higher. This temporal pattern establishes that the recorded frequency has changed. It does not, by itself, identify why it changed. Trends are especially difficult to interpret when the diagnostic category, awareness, service incentives, and methods of finding cases evolve together.

REPORT	FIGURE AND INTENDED USE	INTERPRETIVE BOUNDARY
Early studies	Roughly 1 per 2,000	Historical baseline, not a current estimate.
Kaplan & Sadock	About 69 per 10,000, or about 1 in 145 children	Contemporary textbook estimate.
Lewis	6.6 per 1,000	Reasonable overall estimate in that text.
Indian Psychiatric Society guideline	1 in 500 historically, compared with 1 in 68	Both figures are historical comparison and United States surveillance context, not Indian population prevalence.

Secular increase refers to an apparent change across time. It may reflect a real change in occurrence, an altered measurement process, or both. Lewis interprets the **apparent rise** through evolving diagnostic concepts, broader recognition of the spectrum, and access to relevant services, rather than as proof that population occurrence has increased. This is a disciplined reading of time trends: the conclusion should remain proportionate to what the underlying studies can establish.

The evidence base has expanded substantially. Kaplan and Sadock refers to over 60 epidemiological studies. More studies improve the visibility of variation and methodological limitations; they do not erase those limitations. An increased research base should make the clinician more careful about denominators, not more casual about generalisation.

20.5 Mechanisms that inflate or alter measured frequency

Diagnostic broadening or change in diagnostic practice can alter measured frequency. When a category is conceptualised differently, people previously placed outside it, or given another developmental label, may now meet the contemporary definition. Awareness also matters: families, teachers, and clinicians who recognise a broader range of presentations are more likely to refer and document concerns. Service availability can have a similar effect, because visible assessment and educational support make diagnosis more feasible and more relevant to a family.

Diagnostic substitution is a related, but more specific, phenomenon. In the United States in particular, a single diagnostic label is commonly used to identify students for service eligibility. As awareness rose, schools and parents became more likely to use the autism label; estimates can consequently be inflated when service records, rather than direct assessment of children, establish caseness. This is not a claim that every increase is artificial, nor should this United States-specific mechanism be exported uncritically to all countries.

Kaplan and Sadock likewise regards **the measured rise** as partly shaped by evolving diagnosis, professional practice, educational policy, and public recognition; higher rates often occur where awareness and services are more available. It leaves the possibility of a true incidence increase unresolved. That restraint is the correct clinical posture. A service observing more diagnosed children may be seeing a mixture of changing need, changing recognition, and changing access.

MNEMONIC

FRAME the rising count

Find out how cases were found; **R**eview the diagnostic rule; **A**sk about awareness and access; **M**ap service and educational incentives; **E**xpress uncertainty about true incidence.

- Do not call a rise an epidemic merely because a surveillance figure rose.
- Do not dismiss all increase as artefact merely because ascertainment has improved.
- State which mechanisms are supported by the source and which remain unresolved.

20.6 Ethnoracial, social, and cultural interpretation

Within United States child data reported in the DSM-5-TR, prevalence is lower in African American children at 1.1% and Latinx children at 0.8% than in White children at 1.3%, even after socioeconomic resources are taken into account. This is an observed comparison in that source. It should not be rewritten as established proof that the difference is wholly caused by underdiagnosis or differential ascertainment. The same source says reported prevalence may be affected by misdiagnosis, delayed diagnosis, or underdiagnosis, which is a cautious possibility rather than a completed causal explanation.

Ascertainment bias is the distortion introduced when some people are more likely than others to be identified, referred, or recorded. It is a useful hypothesis when interpreting group differences, but it is not a substitute for evidence. A good answer separates the observed distribution from proposed explanations and avoids converting a plausible clinical concern into a settled epidemiological conclusion.

Social-class arguments require the same historical discipline. **Kanner's original observation** involved highly achieving, high-social-status parents, but Kaplan and Sadock regards the sample as likely biased by case ascertainment and notes that epidemiological studies have generally not found such an association. The lesson extends beyond ASD: impressions formed from a selective clinic population should never be mistaken for a population association.

20.7 Applying epidemiology in clinical and service work

What the clinician should do with a rate. Epidemiology should improve case-finding and service planning, not replace individual assessment. A family does not become more or less likely to need a careful developmental evaluation because the clinician has memorised a national estimate. Conversely, a service cannot plan workforce, assessment capacity, or educational liaison responsibly if it assumes that a historical clinic count captures all people who may need support.

GOOD TO REMEMBER

Treat an apparent rise in caseload as an audit question, not a reflex conclusion. Check referral, assessment pathways, education or disability processes, age groups, and the catchment population. This helps distinguish increased recognition from a changed denominator, so planning is based on demand visible to the service.

At the level of a research appraisal, ask whether the study has separated screening from confirmation and whether non-participants might differ from participants. Ask whether a diagnostic record had to pre-exist for inclusion, and whether the study would identify people with a subtle or previously unrecognised presentation. Such questions are transferable across settings. They also keep the clinician from treating an attractive headline figure as more precise than the study design permits.

When counselling families, use population data with humility. Explain that frequency figures vary across settings and methods, and that an epidemiological association cannot determine the cause of one person's ASD. Avoid implying blame from parental characteristics, social position, or the fact that a diagnosis became visible after a change in school or service access. The aetiology of ASD, including genetic and environmental architecture, belongs in the etiological discussion of this chapter; epidemiology here explains how cases are distributed and counted.

For a written answer, a compact but high-quality structure is: define prevalence and ascertainment; quote a source-qualified contemporary estimate; state the male predominance while distinguishing diagnosed from epidemiological ratios; then explain the rise through diagnostic concepts, awareness, practice, educational policy, and service access. End with the unresolved point: changing measured prevalence alone cannot settle whether underlying incidence has changed.

The rise in recorded ASD prevalence is real as a measurement trend; its causes are multiple, and it must not be equated automatically with a proven rise in true incidence.

20.8 High-yield synthesis

The epidemiology of ASD is best understood as a conversation between population occurrence and the systems that recognise it. Contemporary estimates demonstrate substantial need, while their variation demonstrates why source, denominator, geography, and ascertainment must be stated. Sex ratios have the same requirement: a well-ascertained epidemiological ratio and a diagnosed-rate ratio answer different questions. Historical increases should prompt examination of diagnostic change, awareness, education, services, and record-based case definition before claims are made about causation.

This approach protects against opposite errors. Minimisation assumes that ASD is uncommon because an older estimate was lower. Overstatement treats every rise in a recorded rate as proof of a new environmental cause. The clinician's role is to recognise the public-health burden, assess

the individual in front of them, and communicate uncertainty precisely. That combination is more useful than a detached list of figures and more defensible than a single dramatic number.

21 · Etiology of ASD (genetic, neurobiological, environmental)

Aetiology is plural, not a single cause. Autism spectrum disorder arises through developmental pathways in which inherited liability, rare genetic events, brain development and environmental exposures may intersect. The clinical task is therefore not to offer families a simplistic cause, but to explain that association is not destiny, that aetiological formulation can identify relevant medical conditions, and that a cause is not required before support can begin. The examination task is similar: distinguish evidence for familial aggregation from proof of an individual mechanism, and distinguish a risk factor from a cause.

The evidence is strongest for a substantial genetic contribution, but ASD is genetically heterogeneous. Its neurobiology is likewise a set of converging developmental observations rather than a diagnostic test. Environmental findings need particularly careful reading because many exposures are correlated with parental characteristics, obstetric events and ascertainment. A good answer therefore moves from genetic architecture to neurodevelopmental correlates, then appraises environmental association and vaccine misinformation without conflating any of these levels of explanation.

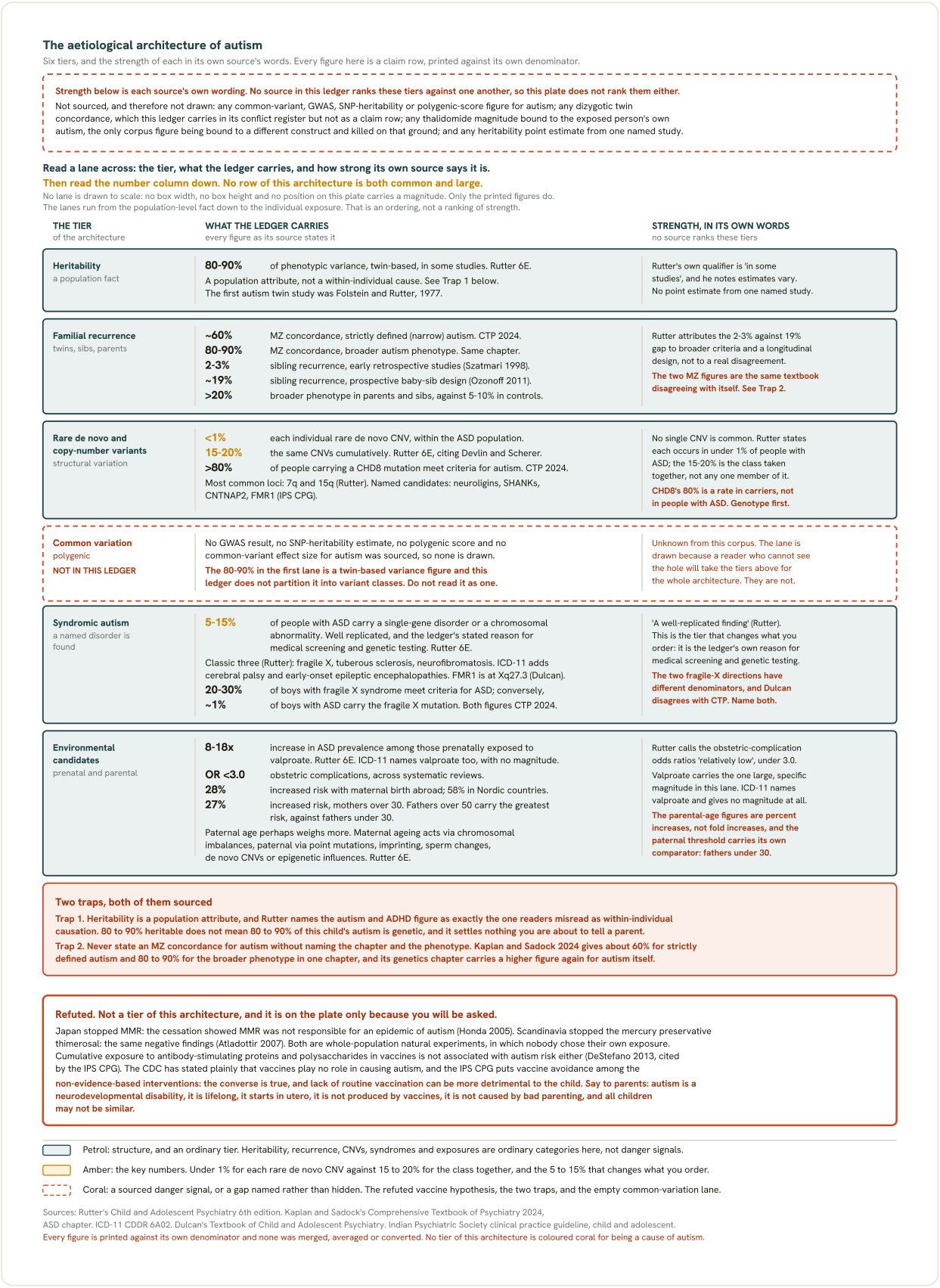


Fig 21.16 **The aetiological architecture of autism.** Six tiers, each printed with the strength its own source claims for it and against its own denominator. The plate teaches one shape: no row beneath twin-based heritability is both common and large, and the one row the ledger ties to a clinical action is syndromic autism. The common-variation lane is drawn empty because no such figure was sourced, and a hole in the map is not a hole in the world. The two traps and the refuted vaccine hypothesis are marked on the plate itself.

21.1 What an aetiological formulation means in ASD

Aetiological heterogeneity means that similar clinical phenotypes can arise through different causal routes. In practice, this prevents the error of treating all ASD as one disease with one lesion. Some presentations occur alongside a recognisable medical or genetic disorder; others reflect the combined effect of many inherited and developmental influences.

> **GOOD TO REMEMBER**
>
> Use the formulation to connect a person's developmental history, physical examination and family pattern to an appropriate medical work-up; choice of ASD genetic tests belongs to the ASD medical workup section.

RULE **Read causation at the right level:** a population estimate of genetic influence does not tell us what caused ASD in one child.

Heritability is a population statistic: it describes the share of variation in a population that is associated with genetic differences under the conditions studied. In some studies, twin-based estimates for autism lie **between 80-90** percent of phenotypic variance. This is compelling evidence that genetic factors matter, but it does not mean that this proportion of any individual's ASD was "caused by genes," nor does it make environmental influences irrelevant. Heritability can change when a population or its exposures change.

Historical twin work made the importance of genetic factors visible after **Folstein and Rutter, 1977**. Twin and family designs are complementary. Twin concordance asks whether co-twins share the phenotype; family studies ask whether traits cluster among relatives. Neither design, on its own, identifies a gene or predicts the outcome for an individual pregnancy. A careful answer also states whether it is discussing narrowly defined autism or the broader phenotype.

approximately 60%	80-90%	approximately 19%	5-15%
MZ CONCORDANCE: NARROWLY DEFINED AUTISM	MZ CONCORDANCE: BROADER AUTISM PHENOTYPE	PROSPECTIVELY FOLLOWED INFANT SIBLINGS	SINGLE-GENE DISORDER OR CHROMOSOMAL ABNORMALITY

21.2 Familial aggregation and the broader phenotype

For strictly defined autism, monozygotic twin concordance is approximately 60%. When the outcome includes the **broader autism phenotype**, concordance is between 80-90%. The broader phenotype refers to subthreshold autistic-like traits in relatives, not to an assertion that every relative has ASD. This contrast is clinically instructive: genetic liability may be expressed as traits rather than as the full diagnostic phenotype, and the phenotype being measured changes the estimate.

Older retrospective family studies reported sibling recurrence between 2-3%. In prospectively followed infant siblings, the estimate is approximately 19%. These figures should not be presented as a contradiction. The later design observes siblings from birth and works with broader contemporary diagnostic ascertainment; both features can increase detection. For

counselling, it is more honest to explain that familial recurrence is elevated and that an individual family needs a personalised assessment rather than a memorised population figure.

Subthreshold autistic-like traits occur in above 20% of parents and siblings of ASD probands, compared with between 5-10% in control families. Such aggregation supports a dimensional account of inherited liability. It must not be turned into blame: a parent's communication style, temperament or isolated trait is not evidence that parenting caused ASD.

TRAP **Examination trap:** do not quote the broader-phenotype twin figure as the concordance for narrowly defined autism, and do not use an early retrospective sibling estimate as though it came from a prospective infant-sibling design.

21.3 Genetic architecture: common liability, rare variants and syndromic ASD

Genetic architecture describes the kinds of genetic contribution found across a condition, rather than seeking one "autism gene." ASD includes polygenic liability, rare inherited or de novo variation, copy-number variation and recognised syndromic disorders. These categories can overlap in a person, and the presence of a genetic finding should be interpreted alongside the phenotype. A result may clarify associated medical surveillance and family discussion, but it does not reduce the child to a laboratory label.

ARCHITECTURE	WHAT IT CONVEYS CLINICALLY	IMPORTANT DISTINCTION
Familial liability	Traits and diagnoses may aggregate in relatives.	Aggregation is not a single-gene explanation.
Rare de novo copy-number variation	A rare genomic event may contribute substantially in an affected individual.	Each individual rare event is below 1% of the ASD population, yet such variants cumulatively account for between 15-20%.
Chromosomal abnormality	May place ASD in a broader medical and developmental formulation.	Reported abnormalities involve many loci; 7q and 15q are described as common sites.
Syndromic association	Prompts attention to syndrome-specific physical and neurological features.	Association does not imply that every person with ASD has a syndrome.

Recognisable syndromic associations include fragile X, tuberous sclerosis, and neurofibromatosis. ICD-11 additionally lists cerebral palsy and early-onset epileptic encephalopathies among medical disorders associated with ASD, alongside chromosomal abnormalities and neurocutaneous disorders. These are associations that enrich clinical assessment; syndrome-specific genetics, phenotype and recurrence belong to their respective disorder sections.

Copy-number variation refers to a genomic deletion or duplication. The useful clinical contrast is frequency against collective contribution: any one rare de novo CNV occurs in **below 1%** of the ASD population, but the group taken together may account for between 15-20%. This is why a negative search for one famous variant never excludes a genetic contribution, and why genetic architecture cannot be understood by memorising a short gene list.

- Candidate genes named in the Indian guideline include neuroligins, SHANKs, CNTNAP2 and FMR1.
- FMR1 is the fragile X gene, and it is the single commonest monogenic contributor a candidate is asked to name here; its locus, repeat mechanism and phenotype are taught with the syndrome itself.
- CHD8 mutations illustrate a genotype-first association: above 80% of carriers meet diagnostic criteria for autism spectrum conditions.

Direction of a proportion is a frequent exam trap. Between 20-30% of boys with fragile X syndrome meet criteria for ASD, whereas approximately 1% of boys with ASD carry the fragile X mutation. These are different denominators and neither can be inverted. This distinction is also why a syndrome association supports targeted clinical consideration, not indiscriminate causal certainty.

21.4 Neurobiological findings: correlates, pathways and limits

Neurobiology informs models; it does not diagnose ASD. Studies of neurotransmitters, brain growth, imaging and postmortem tissue have identified group-level differences. They are heterogeneous, often developmentally timed, and may be affected by sampling, clinical variation and methodology. The appropriate conclusion is that ASD involves altered neurodevelopmental processes, not that any one scan, blood measure or neuropathological feature establishes the diagnosis.

Peripheral hyperserotonaemia is the most consistently replicated biochemical observation: elevated serotonin in blood and platelets is reported in between 25-50% of children and adolescents with autism. It is peripheral, not a direct measure of cerebrospinal fluid or brain serotonin. A candidate should therefore resist the tempting but invalid inference that it specifies a universal central neurotransmitter abnormality or tells the clinician how to treat an individual child.

Structural findings have focused on development and timing. In the first MRI study, total brain tissue volume in ASD was approximately 6% larger than in controls. **Megalocephaly** may be observable as young as 2 years of age, but was not present at birth in the cited observation. The teaching point is not that all autistic children have enlarged heads. It is that a developmental trajectory may differ after birth, and a cross-sectional image cannot be read as a universal sequence.

Postmortem studies describe increased neural packing, reduced cell size in the limbic system, reduced cerebellar Purkinje-cell number and altered cortical minicolumn organisation, as well as macroencephaly and altered brain-growth trajectories. Such work is constrained by small samples and tissue quality. It must be kept separate from in-vivo imaging. In a voxel-based meta-analysis, grey matter reduction was reported in the bilateral amygdala-hippocampus complex and bilateral precuneus, with a small increase in the middle-inferior frontal gyrus. These are group findings, not a radiological signature for clinical diagnosis.

21.5 Synaptic pruning as a mechanistic example

Synaptic pruning is a useful model for linking cellular findings with developmental circuitry. In the cited postmortem study, typically developing controls lost approximately 40% of dendritic spines across the age span, while individuals with ASD lost half as much as controls. The observation supports a hypothesis of less efficient pruning in at least some ASD tissue. It does not establish that deficient pruning is the sole pathway to ASD, nor that it is measurable in routine practice.

In the linked mechanistic work, **mTOR hyperactivity** was associated with impaired autophagy and disrupted synaptic pruning. In mice, rapamycin, an mTOR inhibitor, corrected pruning deficits and ASD-like behaviours. This is an important translational distinction: a correction in an animal model is not a recommendation for standard ASD treatment. The pathway is being examined in the tuberous-sclerosis subgroup, but the same source cautions that rapamycin is unlikely to become standard treatment for ASD. Mechanism-guided research is valuable precisely because it identifies testable subgroup hypotheses, not because it offers a universal cure.

MNEMONIC

Formulate, do not flatten

family pattern, genomic architecture, developmental brain evidence and exposure history belong in one formulation, but none should be promoted alone into “the cause.”

21.6 Environmental and perinatal associations: how to appraise them

Risk factor means an exposure or characteristic associated with a higher probability of outcome; it is not automatically a necessary or sufficient cause. Obstetric complications have some consistency across reviews, but associated odds ratios tend to be **below 3.0**. This magnitude and the possibility of confounding demand restraint. Complications may be on a causal pathway, may mark an earlier developmental difference, or may share determinants with ASD risk. The clinician should neither dismiss a careful obstetric history nor use it to assign parental blame.

Prenatal valproate exposure is a clinically important exception because it is recognised as a teratogenic exposure. ASD prevalence among those exposed prenatally is between 8-18 times that of the general population. ICD-11 also recognises prenatal valproate as an ASD risk factor. This is a risk statement about prenatal exposure, not permission to alter an individual’s medication without specialist review. In clinical practice, risk communication must balance maternal illness, treatment alternatives and reproductive planning.

Parental age and migration findings illustrate why context matters. Maternal birth abroad is associated with a risk increase of exactly 28% in the general estimate, while the association in immigrant mothers in Nordic countries is a risk increase of exactly 58%. These findings may reflect a complex mixture of migration-related exposures, access to care, social context and ascertainment; they must never be used to stigmatise migrant families.

- The greatest paternal-age risk is reported for fathers over the age of 50, compared with fathers below 30 years.

- For mothers over the age of 30 years, the estimated increased risk is exactly 27%.
- Evidence supports advanced parental age as a risk factor, with a possibly greater paternal contribution. Proposed pathways differ: maternal ageing is linked with chromosomal imbalance, while paternal ageing is linked with point mutation, imprinting, sperm-cell changes, de novo CNVs and epigenetic influences.

The professional response to these associations is prevention-oriented but non-punitive: obtain a sound exposure history, coordinate medication decisions before conception where possible, and avoid retrospective certainty. Most importantly, do not imply that ordinary parental conduct produced the child's ASD.

21.7 Vaccines, parenting and the duty to correct misinformation

This is a safety conversation, not an optional controversy. Claims that vaccines cause autism can lead to delayed or absent vaccination and can damage trust at the point when families need clear guidance. The evidence should be explained calmly, directly and without amplifying the myth through excessive repetition. The same principle applies to blaming parenting: it is inaccurate, harmful and clinically obstructive.

Natural experiment evidence is particularly useful when an exposure changes across a whole population. The Japanese cessation of MMR showed that MMR was not responsible for an epidemic of autism. Separately, Scandinavian cessation of the mercury preservative thimerosal gave the same negative finding. These are distinct questions and should not be blurred: MMR and thimerosal are not interchangeable exposures.

TRAP **Examination trap:** do not write "vaccines are controversial causes." The supported conclusion is that vaccines do not cause autism; withholding routine vaccination can harm the child.

IN INDIA

The Indian guideline, citing the CDC, rejects vaccine causation of autism and cautions that missing routine vaccination can harm the child. It also cites evidence that increasing exposure to vaccine antibody-stimulating proteins and polysaccharides was not associated with autism risk. These statements permit an unambiguous clinical recommendation while still making room for parents' fear to be heard respectfully.

When communicating a diagnosis, frame ASD as a lifelong neurodevelopmental disability with prenatal origins. Explain clearly that neither vaccination nor poor parenting produces it, and that children need not look alike clinically. This framing validates uncertainty without inventing a culprit. It also redirects attention toward assessment of strengths, support needs, associated medical conditions and intervention planning.

21.8 Clinical synthesis and examination answer

A complete aetiology answer begins with multifactorial neurodevelopmental causation and then separates evidence streams. Describe strong familial and twin evidence without treating heritability as individual causation. Explain the range from polygenic liability to rare CNVs,

chromosomal abnormalities and syndromic ASD, while referring genetic-test selection to the ASD medical workup. Use neurobiological observations as developmental correlates, state their limitations, and appraise environmental findings by study design, effect magnitude and confounding. End by explicitly correcting vaccine and parenting myths, because they are clinically consequential errors rather than harmless opinions.

For families, the formulation should be usable. It should say what is known, what remains uncertain, and what can be acted upon now. A syndrome-associated presentation may change surveillance and counselling; a prenatal exposure may affect future reproductive planning; neither changes the need for developmental support. Avoid giving a long list of alleged causes, which often leaves parents with blame rather than understanding.

ASD aetiology is best understood as heterogeneous neurodevelopmental causation: genes and developmental biology predominate, environmental associations require cautious causal inference, and vaccines and parenting do not cause autism.

The clinical picture of autism and how it is recognised

22 · Clinical features and core domains of ASD

The clinical task is to recognise a pattern, not to count isolated oddities. Autism spectrum disorder becomes visible when differences in social communication are understood alongside restricted, repetitive or inflexible patterns of behaviour and experience. A child may be quiet, highly verbal, bright, anxious, disruptive, apparently aloof, or warmly attached to familiar people. None of those impressions settles the question. The useful clinical formulation asks how the person shares attention, uses communication with another mind in view, manages reciprocity, and responds when routine, expectation or sensory input changes.

Recognition matters because the presentation is developmental and contextual. The same behaviour can have different meanings at different developmental levels, and a behaviour that looks unusual in a brief consultation may be an adaptive response to uncertainty. History, direct observation and reports from the settings in which the person lives should therefore be brought together. The diagnostic criteria are addressed separately; this section concerns the clinical phenotype that makes those criteria intelligible at the bedside.

approximately 20%	12-24 months	12-24 months	10-50%
REPORTED REGRESSION OR DEVELOPMENTAL STAGNATION	USUAL RECOGNITION WINDOW	USUAL WINDOW FOR SKILL LOSS, WHEN PRESENT	ESTIMATED RANGE FOR SAVANT OR SPLINTER SKILLS

22.1 Recognising a developmental social-communication difference

Autism is usually recognised through a qualitative difference in how social information is noticed, interpreted and used. The central issue is not whether the person wants company in an abstract sense. It is whether interaction is organised as a reciprocal exchange in which another person's

attention, knowledge, feeling and response alter one's own communication. A person may seek proximity, enjoy affection, or initiate contact for a need, yet still have difficulty sustaining the back-and-forth adjustments that make interaction feel shared.

Social reciprocity includes initiating interaction, responding contingently, sharing interests and affect, and allowing the partner's response to shape the next move. In young children this may be seen as limited showing, bringing, pointing out or checking back after an event. In older children and adults it may appear as a one-sided conversation, a tendency to return rapidly to a preferred topic, or difficulty recognising when the listener is confused, bored or trying to change direction. These are descriptions of the quality of exchange, not moral judgements about empathy, attachment or motivation.

A careful history separates capacity from performance. Some people communicate much less when overloaded, unfamiliar with the examiner, tired, frightened or expected to respond rapidly. Others have learned scripts that make initial interaction appear fluent but that do not readily flex when the conversation departs from the script. The clinician should look for developmental continuity and for the effort required to maintain apparently typical social behaviour. A socially successful encounter does not erase a pervasive developmental difficulty, just as an awkward encounter does not establish one.

RULE **Interpret the social behaviour in its communicative context: the question is how the person shares a mind with another person, not whether eye contact or sociability is simply present or absent.**

GOOD TO REMEMBER

At the bedside, ask the caregiver for ordinary examples of sharing an achievement, reacting to another person's distress, joining group play, managing a misunderstanding or telling a story to a listener who does not already know it. Then observe the response to an unexpected but benign shift in topic or activity: does the person repair communication, seek clarification, withdraw, perseverate or become distressed? This helps distinguish a stable developmental pattern from a situational reaction.

CLINICAL DOMAIN	WHAT TO EXPLORE	HOW IT MAY PRESENT IN CONSULTATION	INTERPRETIVE CAUTION
Reciprocal exchange	Initiation, response, turn-taking and sharing	Conversation may be asymmetrical, unusually passive, or driven by an immediate need	Shyness and anxiety can reduce performance without creating the developmental pattern
Non-verbal integration	Gesture, facial expression, gaze and timing	Signals may be limited, atypical, poorly coordinated with speech, or difficult to read	Do not convert one gaze style into a diagnosis
Relationships	Peer interest, social imagination and adaptation to roles	Rules of friendship may be understood literally; group interaction may be hard to enter or sustain	Solitude may be a preference, a coping strategy, or both
Repetition and inflexibility	Patterns, routines, focused interests and sensory responses	Distress, persistence or repetitive action becomes prominent when expectations shift	Determine function and impairment before labelling a preference pathological

22.2 Non-verbal communication and shared attention

Non-verbal communication is not a decorative adjunct to speech. Gesture, posture, facial expression, gaze, distance, timing and prosody carry much of the meaning of social exchange. In autism, the difficulty may lie in producing these signals, coordinating them with words, noticing those used by others, or inferring the unstated message they convey. The pattern is variable. Some individuals use abundant gesture but in an idiosyncratic or poorly integrated way; others have a relatively neutral facial style yet understand familiar relationships well.

Joint attention is especially useful clinically because it captures the difference between requesting and sharing. A person can point to obtain an object while finding it harder to point simply to make another person notice something interesting. Similarly, a child may follow a hand because it predicts access to a desired item but not because the other person's focus is meaningful in itself. The history should ask about following another's attention and actively directing it. Direct observation can then assess whether the person shifts attention between an object and a partner, checks the partner's reaction, or incorporates the partner into the experience.

Do not reduce this to an eye-contact test. Gaze is influenced by culture, anxiety, visual ability, temperament and the demands of the interaction. Sustained eye contact may be uncomfortable, distracting or consciously performed. Conversely, apparently good eye contact may coexist with marked difficulty using its social meaning. A better formulation is that visual social signals can be used differently, sometimes with little coordination between gaze, gesture and spoken language.

- Explore whether gestures are used to share as well as to request.
- Observe whether facial expression and voice match the intended message.
- Ask how misunderstandings are repaired when the listener does not follow.

- Consider whether social signals are missed, over-read or interpreted literally.

TRAP **Examination trap: neither reduced eye contact nor a preference for solitude is a sufficient clinical shortcut. The developmental pattern across reciprocal communication, non-verbal integration and flexibility is what carries meaning.**

22.3 Language phenomenology: form, use and reciprocity

Language in autism must be described at the level of use, not merely the presence or absence of words. The language phenomenology of autism includes differences in developmental progress, conversational reciprocity, prosody, literal interpretation and the ability to adjust communication for another person's perspective. Language ability is heterogeneous. Some people have very limited spoken language; others have extensive vocabulary and grammatically complex speech while finding the social use of language persistently difficult. Language impairment is considered separately as a specifier and should not be confused with the social-communication phenotype itself.

Pragmatic language concerns what speech does between people. It includes selecting relevant information, recognising implied meaning, taking turns, maintaining an appropriate topic, judging what the listener knows, and repairing breakdowns. A child may answer factual questions accurately but not volunteer information that would make the account coherent for someone else. An adult may speak fluently at length about a preferred interest yet have trouble sensing the reciprocal rhythm of conversation. These patterns are often most evident in unstructured conversation rather than in direct question-and-answer exchanges.

Echolalia refers to repetition of heard language. It may be immediate or delayed, but the clinician should not assume that it is meaningless. Repeated phrases can request, protest, regulate emotion, preserve a familiar sequence, or communicate an association that is not obvious to the listener. The clinical task is to determine the communicative function and the degree to which repetition substitutes for flexible, generative language. Similarly, pronouns may be used in an unusual perspective, and speech may have an atypical rhythm, volume or melody. Such features are useful only when understood as part of the wider developmental pattern.

History taking should locate the change in ordinary life. Ask how the person tells a story, joins a conversation already in progress, copes with jokes and indirect requests, or reacts when someone asks an ambiguous question. A family may report that the person is articulate but seems not to "read the room". That everyday observation can be more clinically revealing than a formal vocabulary performance. Equally, a bilingual environment should not be mistaken for a cause of autism or used to excuse a pervasive social-communication concern. The relevant question is whether the pattern is present across the languages and relationships available to the person.

For the intervention plan, speech and language therapy belongs with the broader support approach described in the relevant section of this chapter. At assessment, the immediate responsibility is more basic: document what communication achieves, what breaks down, and what support makes the person's intention understandable.

22.4 Restricted patterns, insistence on sameness and sensory experience

Restricted and repetitive behaviour is clinically broader than obvious motor stereotypy. It includes repetitive movements or speech, a marked need for predictability, unusually intense or narrowly focused interests, and atypical responses to sensory input. Its common thread is a reduced ease with variation or a distinctive way of regulating attention, arousal and meaning through repetition. The behaviour may be quietly internalised and therefore missed in an articulate adolescent or adult whose outward presentation appears composed.

Insistence on sameness is often best recognised through the consequences of disruption. The person may rely on a fixed route, sequence, object arrangement, conversational script or rule. A change may produce distress, anger, shutdown or prolonged preoccupation, not because the preference is trivial but because predictability is serving an organising function. Obtain concrete examples from home, school, workplace and travel. Then ask whether the routine can be modified with preparation, whether the response is proportionate, and whether the restriction limits participation or causes conflict.

Sensory reactivity may involve unusually strong, weak or seeking responses to sound, touch, light, smell, taste, movement or visual detail. It should be elicited as lived experience rather than treated as a box to tick. A child who covers their ears may be in pain, anticipating noise, avoiding a social demand, or doing more than one of these. An adult who avoids crowded places may be managing sensory overload, social uncertainty, panic, or a combination. The formulation must link trigger, response, function and consequence.

- Ask what the person repeatedly does, says, collects, watches or arranges.
- Ask what must happen in a particular order and what follows if it does not.
- Explore focused interests for intensity, flexibility and impact, rather than judging the topic itself.
- Map sensory triggers, protective strategies and the effect on ordinary participation.

Focused interests can be a route to competence, pleasure, identity and connection. They become clinically relevant when their intensity or inflexibility constrains functioning, blocks reciprocal engagement, or makes transition difficult. This distinction protects against pathologising expertise or temperament. It also enables the clinician to use an interest respectfully as a bridge during assessment rather than treating it only as a symptom.

MNEMONIC

Clinical spine - SHARE

Explore **S**ocial reciprocity, **H**ow communication is used, **A**daptation to change, **R**epetitive or focused patterns, and **E**xperience of sensory input. It is an enquiry sequence, not a diagnostic shortcut.

22.5 Developmental regression and developmental stagnation

Developmental regression means loss of abilities that were previously acquired and used, whereas developmental stagnation refers to a plateau in expected gains. Both deserve a careful timeline. A report may be imprecise because a skill was inconsistent, context-bound or only recently emerging. The clinician should therefore ask for examples of the earlier ability, its ordinary use, the sequence of change, and what else changed around the same period. In autism, regression or stagnation is reported in approximately **20%** of cases.

Autism symptoms are typically recognised between **12 and 24 months**. Where previously acquired social or language skills are lost, the loss itself also typically occurs between **12 and 24 months**. These statements describe distinct clinical questions: recognition concerns when the pattern comes to notice, while regression concerns the timing of actual skill loss. Keeping that distinction prevents a history of late recognition from being incorrectly recorded as regression.

Loss of previously acquired skills is usually described during the second year of life and is rarely observed after **3 years of age**. When it occurs, the loss most often concerns language use and social responsiveness. If the reported course is later or broader, document it precisely rather than forcing it into an autism narrative. If a loss occurs after 3 years of age, it is more likely to include changes in cognitive and adaptive functioning, continence, sleep, language, social ability, emotion and behaviour. Such a presentation needs separate evaluation; the differential diagnosis of regression is addressed elsewhere in this chapter.

Regression is emotionally potent for families. They often remember a before-and-after story, and it is important neither to dismiss that account nor to turn it prematurely into an aetiological explanation. Clarify whether the child lost a functional word, stopped responding to name, ceased sharing interest, became less socially responsive, or simply failed to add new skills. Review contextual changes and establish whether the apparent loss was global or selective. The record should preserve the caregiver's observations in concrete behavioural language, because that is more useful than the label alone.

> A plateau and a loss are not interchangeable: establish the prior skill, its functional use and the sequence of change before calling a course regressive.

22.6 Cognitive style, uneven ability and exceptional islands of skill

There is no single cognitive profile that defines autism. What is clinically common is an **uneven profile of abilities**, including in people whose general intellectual ability is average or high. A person may have striking factual knowledge, rapid pattern recognition or strong rote learning alongside difficulty applying ability flexibly in everyday social and practical contexts. The gap between demonstrated intellectual skill and adaptive functioning can be conspicuous. This is why a superficially impressive verbal or factual performance should not end the assessment of support needs.

Several cognitive accounts have helped clinicians describe aspects of the phenotype: **theory of mind**, weak central coherence, and executive dysfunction. Difficulty representing another

person's perspective can illuminate social misunderstandings. A detail-focused processing style can illuminate difficulty deriving the broader context. Problems with planning, shifting set, organising and inhibiting a habitual response can illuminate inflexibility. None should be used as a universal explanatory key. The cognitive theories do not establish a unitary cognitive origin for all manifestations of autism.

Savant or splinter skills describe competencies that stand out above the individual's general level of ability or above population expectation. Estimates vary with how such skills are defined, ranging between **10% and 50%** of people with autism. Their presence does not negate disability in another domain, and their absence has no diagnostic implication. Clinically, ask what the skill enables, whether it is enjoyable or burdensome, and whether it can be incorporated into education, work, self-advocacy or engagement.

Mental-state, contextual-integration, executive and motor features often discussed in autism are descriptive aids, not a substitute for developmental assessment. They can explain why an individual may know a rule yet fail to use it in a fast-moving social situation, or complete a complex task yet struggle with the unstructured demands around it. The practical lesson is to look for discrepancies: between knowledge and use, verbal expression and reciprocal conversation, performance in a preferred task and performance under change, or stated independence and actual day-to-day functioning.

22.7 A disciplined clinical formulation

A high-quality formulation is developmental, functional and contextual. It anchors current observations to the early pattern, describes what the person can do independently and what becomes difficult, and identifies environmental adjustments that alter performance. Home, educational, occupational and peer settings may reveal different aspects of the same difference. This framing matters when a person camouflages difficulties or when family routines have hidden impairment in consultation.

Use examples rather than labels wherever possible. "Talks at length about one topic and does not notice attempts to change it" is more clinically useful than "poor reciprocity" alone. "Becomes unable to continue when the usual route changes" is more useful than "rigid". Concrete descriptions allow later review, enable communication across disciplines and protect against diagnostic overshadowing. They also help the person and family identify accommodations without requiring the clinician to infer motives from a behaviour.

Changes from the person's usual baseline need particular care. Do not attribute new distress, marked withdrawal, loss of function, self-injury, agitation, sleep change or altered eating automatically to autism. Medical and psychiatric comorbidity, including catatonia, is considered in the medical comorbidities and workup section of this chapter. The clinician's immediate job is to recognise a baseline change and investigate it as a change, rather than accepting it as an inevitable expression of the developmental condition.

The assessment must also leave room for the person's strengths, preferences and account of their own experience. A formulation that records only deficits will miss the conditions in which

communication works, the interests through which rapport can be built, and the strategies that already reduce overload. The aim is not to make every distinctive preference disappear. It is to understand the pattern well enough to distinguish difference from impairment and to identify where support can make participation more possible.

23 · Severity levels and specifiers (with or without ID, language impairment)

Severity is a statement about current help, not a shorthand for ability. In autism spectrum disorder (ASD), a useful formulation has to keep several descriptions in view at once: the intensity of core autistic difficulties, intellectual functioning, language functioning, associated conditions and the person's changing circumstances. Collapsing these into one label makes the record look tidy but makes clinical planning less accurate. The diagnostic formulation should therefore preserve distinctions that matter to the person, family and team.

The immediate examination value is equally practical. A severity level describes the support needed for the core autistic presentation. It does not quantify intelligence, does not replace a language description, and does not exhaust the associated clinical picture. Specifiers make those separations visible. They turn a broad diagnostic name into a clinically communicable account of the individual sitting in front of the clinician.

3	2	3
DSM-5-TR SUPPORT LEVELS	DOMAINS RATED SEPARATELY	ICD-11 FUNCTIONAL-LANGUAGE LEVELS

23.1 What an ASD severity level is intended to convey

Start with the question behind the label. The DSM-5-TR severity framework is a description of **support need in the core autistic domains**. It asks how much assistance is currently required because of social-communication difficulty and because of restricted, repetitive patterns of behaviour. It is thus a functional clinical description, not a global ranking of the person.

There are **three** named support levels: **Level 1, requiring support**; **Level 2, requiring substantial support**; and **Level 3, requiring very substantial support**. The wording is deliberately about the assistance needed. A level should prompt the clinician to ask what supports permit participation, communication, flexibility and safety, rather than being treated as a fixed essence of the person.

RULE **Rule:** Record ASD severity as support need in the core domains, and record intellectual and language impairment separately.

That distinction matters because observed difficulty can be shaped by context. A familiar, predictable setting with effective communication supports may reveal capacities that are obscured in an unfamiliar assessment room. Conversely, a change in demands, sensory load, illness, distress or available support may expose need that was not apparent previously. The severity description must therefore be anchored in current functioning and meaningful participation, not in a superficial impression formed from a brief encounter.

The phrase “severity” can mislead candidates because the same word is used elsewhere in developmental psychiatry. Intellectual disability has its own severity classification, which is dealt with in the severity classification of intellectual disability section. The ASD framework answers a different question. It does not establish the presence of intellectual impairment and it does not substitute for an assessment of adaptive functioning. Keeping the questions separate prevents a common category error.

23.2 Rate the domains separately, not the person globally

DSM-5-TR asks that the level of support be recorded separately for **two** domains. One rating concerns social communication; the other concerns restricted, repetitive behaviour. This is not clerical fussiness. These domains can create quite different practical barriers, and their support requirements may not move together.

A person may need intensive help to manage inflexibility, transitions and repetitive behaviour while communicating more effectively in a structured interaction. Another may have relatively less conspicuous repetitive behaviour in a short consultation yet need extensive support to sustain reciprocal communication across daily settings. A single global level would conceal that pattern and can lead the receiving team to organise support around the wrong problem.

The social-communication rating asks how much support is needed for reciprocal communication. The restricted and repetitive behaviour rating asks how much support is needed for rigidity, repetitive behaviour and related interference. The intellectual-impairment specifier asks whether intellectual impairment accompanies ASD, while the language-impairment specifier asks whether language impairment accompanies it and, if so, what current verbal functioning is like. None of these questions can be answered by simply borrowing the answer to another.

GOOD TO REMEMBER

In a clinical note, record the two domain ratings with the observed barriers and the supports that alter them. A later change in level may reflect a change in support need, setting or the effect of effective intervention; it is not a prognosis.

TRAP **Classic trap:** Do not derive the ASD level from an IQ score. Intellectual impairment is carried by a separate specifier, not by the ASD severity level.

Equally, do not infer the support level merely from speech quantity. Language impairment and social-pragmatic difficulty overlap in everyday presentation but are not interchangeable descriptions. The language phenomenology of ASD belongs with the clinical features of ASD section; here the task is to show how language is captured in the diagnostic formulation without converting it into a core-severity score.

23.3 DSM-5-TR specifiers: add the clinically relevant dimensions

Specifiers prevent the broad ASD diagnosis from becoming clinically empty. They should be stated positively where present and negatively where absent, after assessment rather than by assumption. The first pair addresses accompanying intellectual and language impairment: **with**

or without accompanying intellectual impairment, and **with or without accompanying language impairment**.

The intellectual specifier is not an invitation to re-grade intellectual disability within the ASD note. It flags a co-occurring dimension that changes communication, assessment interpretation, educational planning and the kind of support likely to be required. The underlying assessment and severity classification of intellectual disability should be documented using their own standards. In particular, an autistic person's social difficulty should not be mechanically treated as evidence of global adaptive limitation.

The language specifier is similarly an addition, not a restatement of ASD itself. When language impairment is present, the clinician describes the current level of verbal functioning. This avoids the unhelpful shorthand of treating all language difficulty as equivalent. It also guards against the opposite error: assuming that fluent speech rules out significant social-communication disability. The diagnostic criteria section explains why language impairment is not itself a DSM-5 core criterion; the present specifier tells the reader whether it accompanies the syndrome.

Other specifiers place ASD in its wider clinical setting. The formulation may state that it is associated with a known genetic or other medical condition or environmental factor. This wording records an association or context; it must not be casually converted into a causal conclusion. It may also state that ASD is associated with a neurodevelopmental, mental, or behavioural problem. The full map of co-occurring conditions and how to detect them belongs in the medical comorbidities and workup in ASD section.

- Use the intellectual-impairment specifier to make accompanying intellectual impairment explicit, not to estimate it from presentation.
- Use the language-impairment specifier to record an accompanying language problem and current verbal functioning.
- Use the known-condition wording to state context accurately without claiming causation that the evidence has not established.
- Use the associated-problem wording to ensure that important co-occurring neurodevelopmental, mental or behavioural difficulties do not disappear behind the ASD label.

For the candidate, this is a disciplined form of diagnostic writing. "ASD" alone describes the syndrome but not the clinically relevant modifiers. A complete formulation makes visible which parts of the presentation are core, which are accompanying impairments, and which require parallel assessment or treatment. That distinction also protects against diagnostic overshadowing, where all distress or disability is wrongly attributed to autism.

23.4 Catatonia: a specifier that requires active clinical attention

Do not let a specifier become a footnote. DSM-5-TR permits the specification **with catatonia**. This should prompt careful assessment of a change from the individual's usual state, including

motor behaviour, responsiveness, activity and functional capacity. A diagnostic label should never replace a longitudinal account of what has altered and what the family or carers have observed.

When catatonia accompanies ASD, DSM-5-TR directs use of the additional code **F06.1**. It is a separate diagnostic code, not an ASD severity modifier and not a reason to raise a support level by default. The distinction is clinically important: support-level language describes core autistic support needs, whereas catatonia identifies an associated syndrome that requires its own recognition and management pathway.

The period of greatest risk described in DSM-5-TR is the adolescent years. That fact should sharpen clinical vigilance without turning ordinary developmental change into a diagnosis. When there is concern, document baseline, timing and trajectory, seek collateral from people who know the individual well, and evaluate the wider clinical context. Recognition belongs with the ASD comorbidity assessment; treatment is addressed in the pharmacotherapy in ASD section.

> A support level is not a catch-all label: ASD severity, accompanying intellectual impairment, accompanying language impairment and catatonia each answer different clinical questions.

23.5 ICD-11: characterisation through intellectual development, language and loss of skills

ICD-11 takes a differently structured approach. It does not supply DSM-style support-need severity levels. Instead, ASD is characterised through specifiers relating to **intellectual development, functional language and loss of previously acquired skills**. This is not a minor terminological difference. A clinician transferring information between systems must not invent a support level from an ICD-11 code, nor assume that an ICD-11 language category is a DSM support rating.

The intellectual-development axis is expressed as **with or without disorder of intellectual development**. In ICD-11, a co-occurring disorder of intellectual development is diagnosed separately rather than folded into the ASD diagnosis as an inline descriptor. When assessing this co-occurrence in ASD, greater weight should be given to the intellectual, conceptual and practical aspects of adaptive functioning than to social skills. This protects against mistaking social difficulties intrinsic to autism for evidence of a broader adaptive disorder.

The **functional-language axis** has **three** levels. It distinguishes mild or no functional-language impairment, impaired functional language, and complete or almost complete absence of functional language. The middle category concerns a person unable to use more than very short spoken expressions. These categories primarily describe functional expressive language, including nonverbal expression where relevant; they do not replace assessment of the pragmatic communication difficulty that is central to ASD.

FRAMEWORK	WHAT IT RECORDS	CLINICAL READING
DSM-5-TR ASD severity framework	Current support need in each core domain	Use to communicate the assistance required for core autistic difficulties
DSM-5-TR intellectual specifier	Presence or absence of accompanying intellectual impairment	Keep intellectual impairment distinct from ASD support level
DSM-5-TR language specifier	Presence or absence of accompanying language impairment	Describe current verbal functioning when impairment is present
ICD-11 ASD characterisation	Intellectual-development, functional-language and loss-of-skills specifiers	Do not translate this structure into a support-level rating

ICD-11 also records whether there has been loss of previously acquired skills. The suffixes 6A02.x0 and 6A02.x1 distinguish absence from presence of such loss. This coding distinction should not be used to teach the phenomenology or differential diagnosis of regression, which are considered elsewhere in the chapter. Its value here is to show that ICD-11 preserves a clinically salient developmental course feature within the diagnostic characterisation.

23.6 ICD-11 coding: use the matrix, do not guess it

The ICD-11 code reflects the combination of intellectual-development and functional-language descriptors. It is safer to determine the descriptors first, then select the matching code, rather than attempting to recall a code from an impression of severity. The following are selected, explicitly stated combinations. They are examples for accurate use, not a substitute for the full coding matrix.

DOCUMENTED COMBINATION	ICD-11 CODE	POINT TO RETAIN
Without disorder of intellectual development, with mild or no functional-language impairment	**6A02.0**	This is a coding combination, not a DSM support level.
Without disorder of intellectual development, with impaired functional language	6A02.2	Language description and intellectual-development status are both needed.
With disorder of intellectual development, with mild or no functional-language impairment	6A02.1	Co-occurring intellectual-development disorder is represented in the code.
With disorder of intellectual development, with impaired functional language	6A02.3	Do not infer support need from this code.
With disorder of intellectual development, with complete or almost complete absence of functional language	6A02.5	Use the language descriptor that is actually documented.

ICD-11 provides 6A02.Y for other specified ASD when the parameters do not apply, and 6A02.Z for unspecified ASD when the parameters are unknown. These are not interchangeable expressions of uncertainty. Good documentation reduces unnecessary use of the unspecified category while respecting genuine limits of available information.

23.7 A practical method for writing the formulation

Write the formulation in layers. First establish the diagnosis using the diagnostic criteria. Then describe the current ASD support need in each core domain when using DSM-5-TR. Next state the intellectual and language specifiers, followed by relevant associated-condition and associated-problem specifiers. Finally, record catatonia when present and use the appropriate additional code. This order mirrors clinical reasoning: syndrome, core impact, accompanying impairments, then associated context.

- State the diagnostic system being used so that the reader knows whether a support-level or coding-matrix framework applies.
- For DSM-5-TR, record the two core-domain support ratings separately and add a short functional explanation of each.
- State whether accompanying intellectual impairment and accompanying language impairment are present, without converting either into an ASD level.
- Record associated conditions and associated problems as clinical context, and keep association distinct from causal attribution.
- For ICD-11, establish intellectual-development status and functional-language status before selecting the code and any loss-of-skills suffix.

This layered method also improves communication across disciplines. It tells a speech and language clinician that a language issue is recognised without pretending that language alone explains the autistic presentation. It tells an educational or disability team that intellectual impairment requires its own assessment. It tells the medical team that an associated condition needs parallel attention. Above all, it avoids turning a diagnostic label into a description that is too vague to guide care.

When information is incomplete, state what has and has not been assessed rather than filling the gap with an assumed level. Diagnostic precision is not achieved by false certainty. A provisional formulation can still be useful if it clearly separates observed support needs from unassessed intellectual functioning, language status or associated conditions. The next assessment question then becomes obvious.

23.8 High-yield discriminations

The strongest answers distinguish neighbouring ideas before they list them. ASD severity is a support-need description for the core autistic domains. Intellectual impairment and language impairment are accompanying specifiers. ICD-11 uses a different characterisation system, based on intellectual development, functional language and loss of previously acquired skills rather

than DSM-style support levels. These are complementary ways of making heterogeneity visible, not rival measures of a single latent "severity".

In practice, the formulation should remain revisable. Support needs can change with environment, development, communication access, co-occurring clinical problems and the fit between the person and available services. Revision is not inconsistency when it reflects a better account of current functioning. What should remain stable is the discipline of recording each dimension for what it means, rather than allowing a memorable label to do the work of assessment.

24 · Screening and diagnostic tools (M-CHAT, ADOS, ADI-R, CARS, ISAA, INCLEN)

Tools organise evidence; they do not substitute for clinical judgment. Autism assessment is often difficult not because there is a shortage of instruments, but because instruments answer different questions. A brief parent questionnaire can identify a child who needs closer attention; an observed interaction can make social communication and restricted behaviour more visible; a developmental history can establish whether the pattern has been present across time; and a disability assessment can document functional impact for statutory purposes. Treating all of these as interchangeable produces familiar errors: diagnosing from a screen, or mistaking an administrative score for the diagnostic formulation.

For the candidate and the clinician, the useful organising question is therefore not, "Which scale proves autism?" It is, "What decision is this instrument designed to support?" A positive screen changes the urgency of assessment. A clinician-administered diagnostic measure can sharpen an already careful formulation. An Indian disability instrument serves a further, legally important function after diagnosis. This sequence protects children from delayed support while preserving the clinician's responsibility to weigh developmental history, direct observation, informant accounts, context, and alternatives.

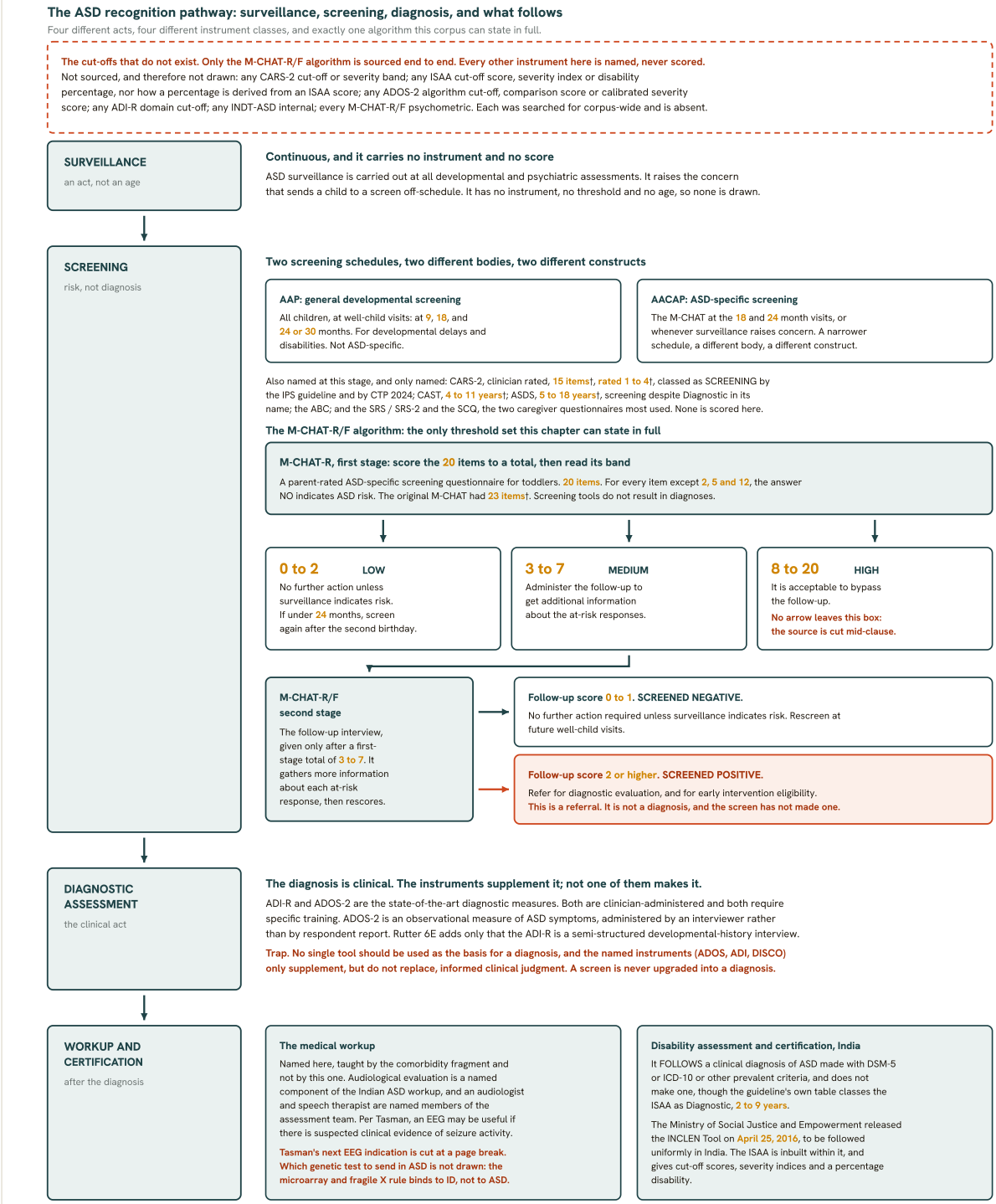


Fig 21.17 **The ASD recognition pathway.** Surveillance raises the concern, screening estimates the risk, the diagnosis is clinical, and both the workup and the Indian certification route follow it. Only the M-CHAT-R/F algorithm is sourced end to end; every CARS-2, ISAA, ADOS-2 and ADI-R cut-off is named on the plate and left undrawn.

24.1 A functional taxonomy of autism instruments

Screening is a process for finding children whose developmental profile warrants further assessment. Its purpose is sensitivity to concern, not a final statement about diagnosis. A screen can be negative when concerns remain clinically persuasive, and it can be positive because another developmental or behavioural difficulty needs assessment. Conversely, the absence of a score should never close a history that is concerning to parents or a clinician. **The M-CHAT-R/F** is a parent-rated, autism-specific toddler screen with a second-stage follow-up interview; it is not a diagnostic instrument.

RULE **Rule:** Match the instrument to its decision, then return the result to a clinical formulation rather than allowing the score to become the formulation.

CLINICAL QUESTION	USEFUL INSTRUMENT CLASS	WHAT THE RESULT SHOULD DO
Is there sufficient concern to escalate assessment?	Parent-rated autism-specific screen	Trigger follow-up questioning, surveillance, or referral according to the algorithm.
Can autism-related behaviour be sampled directly?	Observational assessment	Add direct clinical observations to the history and examination.
What was the developmental course?	Developmental-history interview	Clarify onset, change over time, and examples across settings.
Does a scale indicate concern or quantify observed features?	Clinician-rated screening scale	Support communication and follow-up, without becoming the diagnosis.
What is required for disability documentation in India?	Post-diagnostic disability assessment	Quantify disability and support access to certification-related entitlements.

The distinction is clinically productive. A questionnaire brings the caregiver's longitudinal experience into the consultation. An observation samples what happens under clinical conditions, but cannot by itself reproduce every home, school, or peer context. A history interview may expose a meaningful developmental trajectory, but its interpretation depends on the quality of the informant account and the clinician's questions. Each contributes a different kind of evidence. Diagnostic confidence comes from their convergence with informed judgment, not from collecting the largest possible pile of forms.

Informed clinical judgment remains central: diagnostic instruments supplement it and no single tool should provide the sole basis for diagnosis. This is not a vague appeal to intuition. It means the clinician must decide whether reported and observed features form a coherent autism pattern, whether they are developmentally meaningful, and whether another explanation better accounts for the presentation. The full assessment framework belongs with the Child psychiatry: assessment, treatment, services and protection notes; the present task is to understand what each autism-specific tool can and cannot add.

24.2 M-CHAT-R/F: using a screening algorithm safely

A screen is an invitation to think again. The M-CHAT-R/F is designed for toddlers and is parent rated. The revised checklist contains **20 items**. Its follow-up interview matters because an initial answer may reflect misunderstanding of the question, an unusual circumstance, or a concern that becomes clearer when a clinician asks for examples. In practical terms, the first stage identifies responses needing clarification; the follow-up turns a crude count into a more clinically usable account of risk responses.

0-2	3-7	2 or higher	8-20
LOW FIRST-STAGE BAND	FOLLOW-UP REQUIRED	POSITIVE AFTER FOLLOW-UP	FOLLOW-UP MAY BE BYPASSED

At a first-stage total of **0-2**, the result falls in the low-risk band. No further algorithmic action is required unless surveillance itself indicates risk. For a child younger than 24 months, with repeat screening after the second birthday, the guidance is to screen again. This is a useful reminder that a reassuring questionnaire is not permission to ignore a parent's developing concern, a developmental history, or a change in social engagement.

> **GOOD TO REMEMBER**
>
> A first-stage total of **3-7** is the medium-risk band and calls for the follow-up interview. Do not call this initial score the diagnostic threshold. It is a decision point for gathering better information about at-risk answers. After follow-up, a score of **at least 2** is screen positive and should lead to referral for diagnostic evaluation and consideration of early-intervention eligibility. A follow-up total of 0-1 is screen negative; ongoing surveillance and rescreening at future well-child visits remain appropriate when concerns arise.

At a first-stage total of 8-20, out of a possible **20**, it is acceptable to bypass the follow-up stage. The important interpretive point is that bypassing an interview is a rule within a screening algorithm, not a licence to pronounce a diagnosis from the questionnaire. In any referral, record the informant's examples, what was observed in clinic, and why the referral is being made. This makes the result clinically portable rather than a detached number.

Scoring direction is an easily missed technical trap. On most items, a response indicating risk is “no”; the exceptions are items 2, 5 and 12, where “yes” indicates risk. A clinician should not attempt to reconstruct the scoring from recollection while interpreting a parent form. Use the approved scoring algorithm, check that the correct revised version is being used, and document whether the score is before or after follow-up. That last distinction prevents a medium-risk first-stage score from being misreported as a positive screen.

TRAP **Examination trap:** A positive follow-up screen warrants diagnostic evaluation; it is not itself a diagnostic threshold.

Autism-specific screening is recommended at 18 and 24 months and whenever surveillance raises concern, alongside surveillance at developmental and psychiatric assessments. This differs from the schedule for general developmental screening, which is recommended at 9, 18, and 24 or 30

months during regular well-child visits. The distinction matters because a general screen and an autism-specific screen answer overlapping but not identical questions. The normal developmental context and milestones that make a particular response concerning are developed in the Normal child development and milestones notes.

24.3 Diagnostic instruments: observation, history, and trained use

Diagnostic measures are not simply longer screening scales. The ADI-R and ADOS-2 are described as state-of-the-art diagnostic measures and require specific training for clinician administration. Training is not ceremonial. It is needed to standardise how prompts are given, how behaviours are recognised and coded, and how the resulting information is used without overriding the clinical context. An untrained, improvised administration can create an appearance of precision while reducing the value of the observation.

ADOS-2 is an interviewer-administered observational measure of autism-spectrum symptoms. Its contribution is direct sampling: the assessor sees how communication, reciprocity, play, flexibility, and other relevant behaviours emerge in interaction. That is valuable when caregiver descriptions and clinic impressions diverge, when the child presents differently across contexts, or when the clinician needs well-described behavioural examples for a multidisciplinary discussion. It remains a sample, however. A calm consultation, a familiar caregiver, fatigue, anxiety, unfamiliar language, or the child's strategy for coping with novelty can all influence what is observed.

ADI-R is a semi-structured instrument for obtaining a developmental history. It is particularly useful conceptually because autism is not diagnosed from a single cross-sectional interaction. The interviewer asks the caregiver to move from labels such as “he does not mix” to concrete examples: what the child did, in what situation, whether the pattern was sustained, and how it changed. A good developmental history distinguishes a stable developmental style from a recent change and makes it possible to test whether apparently isolated symptoms belong together. This also protects against treating a questionnaire response as though it were already a clinical observation.

These instruments should be read as complementary rather than competitive. One asks what behaviour can be observed now; the other helps establish developmental meaning through a knowledgeable informant. Neither removes the need to consider communication ability, sensory or physical factors, environmental demands, and alternative developmental formulations. Nor should their absence be used to deny care where an experienced clinician can make a sound diagnosis. Their special value lies in disciplined, reproducible evidence when the assessment is complex, contested, or requires detailed communication across services.

MNEMONIC

H-O-L-D the hierarchy

History, **O**bservation, **L**inkage across contexts, then **D**iagnostic judgment. It is a sequence for thinking, not a substitute scoring rule.

24.4 Rating scales and caregiver questionnaires: useful, but bounded

Rating scales create a compact record of behaviours and can support screening, communication, and longitudinal review. Their apparent simplicity is also their risk. A numerical total can look more authoritative than a detailed narrative, yet a rating depends on who observed the behaviour, what comparison they used, and what setting was captured. The score should lead back to examples. If a scale and the clinical account disagree, investigate the discrepancy rather than automatically privileging either source.

INSTRUMENT	CLASSIFICATION AND RESPONDENT	STRUCTURE STATED IN THE GUIDELINE
CARS-2	Screening, clinician rated	15 items rated 1-4
CAST	Screening, parent rated, ages 4-11 years	37 yes/no items
ASDS	Screening, parent rated, ages 5-18 years	50 yes/no items
Autism Behavior Checklist	Screening, parent rated	57 items rated 1-4

CARS-2 is classified as a screening measure, even though it is clinician rated. That distinction is worth making explicitly because clinician administration alone does not convert a scale into a diagnostic instrument. Likewise, the word "Diagnostic" in the Asperger Syndrome Diagnostic Scale can mislead: the guideline classifies it as screening. Candidates should classify an instrument by its validated clinical role, not by the confidence suggested by its name.

Caregiver questionnaires are especially helpful when clinic behaviour is unrepresentative of home or school. The commonly used instruments include the Social Responsiveness Scale, including SRS-2, and the Social Communication Questionnaire. They can focus the interview and identify domains requiring examples. They do not turn the caregiver into the diagnostician. The clinician's task is to determine the meaning of an endorsed difficulty, its developmental context, its consistency across settings, and the effect of communication level or situational stress.

24.5 ISAA, INCLEN, and the Indian certification pathway

Diagnosis and certification answer different questions. The **Indian Scale for Assessment of Autism** is listed as a diagnostic instrument for children aged 2-9 years. Its stated format is a parent interview with 40 items rated 1-5. It produces cutoff scores, severity indices, and percentage-disability output that can assist certification. These capabilities make it important in Indian practice, but they should not be allowed to collapse the distinction between a clinical diagnosis and the later task of documenting disability for statutory purposes.

The ISAA is inbuilt within the INCLEN Tool; this is a containment relationship, not a claim that the two names are interchangeable. The **INCLEN Diagnostic Tool for Autism Spectrum Disorder** was released for uniform autism assessment in India by the Ministry of Social Justice and Empowerment, Department of Empowerment of Persons with Disabilities on April 25, 2016. In an examination answer, this is best presented as an Indian assessment and certification framework rather than as an alternative to clinical reasoning.

IN INDIA

Clinical diagnosis precedes disability assessment. After an established clinical diagnosis using recognised diagnostic criteria, the INCLEN tools and ISAA are used for disability assessment. It is therefore incorrect to write that a child "has autism because the ISAA is positive." A scale result may support certification-related documentation, but the diagnosis must already rest on a clinical assessment. Conversely, an appropriate clinical diagnosis should not be withheld simply because certification has not yet been completed.

Certification quantifies disability and can facilitate scheme benefits and insurance eligibility. It therefore has material consequences for a family, and careful documentation is part of good clinical care. The required board comprises a paediatrician or paediatric neurologist, a clinical or rehabilitation psychologist, and a psychiatrist. This multidisciplinary composition reinforces the point that administrative assessment should be clinically anchored rather than reduced to a form-filling exercise.

Certificate validity depends on the nature of the disability. For an individual under 18 years of age with temporary disability, validity is 5 years; where a permanent disability has been acquired, the certificate has permanent validity. When discussing this with families, distinguish clearly between the diagnosis, the disability assessment, and the certificate. They are connected steps but not synonymous labels. The statutory context is the Rights of Persons with Disability Act, and the instrument's output should be explained as serving this practical pathway.

TRAP **Examination trap:** Do not use an ISAA or INCLEN disability assessment as though it replaces the clinical diagnosis of autism.

24.6 Integrating results in the consultation

A robust assessment is transparent about the status of each piece of evidence. State whether a result came from a parent screen, a caregiver questionnaire, clinician rating, direct observation, developmental-history interview, or disability assessment. Then state what it adds and what remains uncertain. This simple discipline prevents a referring clinician from reading a "positive" score as definitive and prevents a receiving clinician from discarding valuable information because it is not itself diagnostic.

- When a screen is positive, explain that it identifies a need for thorough diagnostic assessment and does not apply a diagnostic label.
- When a score is negative but surveillance remains concerning, return to the history, settings, and direct observation rather than treating the score as a veto.
- When trained diagnostic measures are used, document that their findings were integrated with clinical judgment rather than reported as a free-standing conclusion.
- When disability documentation is needed, establish the clinical diagnosis first and then proceed through the appropriate Indian assessment pathway.

The practical consequence is a more humane and accurate conversation with caregivers. Rather than saying “the test says autism” or “the test is normal,” the clinician can say what was observed, what the caregiver described, what the instrument contributes, and why further assessment or follow-up is appropriate. This approach also makes room for uncertainty without inaction. Where developmental concerns are real, referral and support planning need not wait for a family to understand every technical distinction among questionnaires, interviews, observation schedules, and certificates.

> A positive autism screen changes the next clinical action; it does not, by itself, make the diagnosis.

25 · Medical comorbidities and workup in ASD (epilepsy, sleep, GI, genetics)

Autism does not protect a person from ordinary illness, and it can make illness harder to detect. A change in behaviour, communication, participation or self-care may be the presenting language of pain, sleep disruption, seizures, anxiety or another co-occurring condition. The assessment therefore has two linked tasks: recognise the developmental autism phenotype and ask what else may be contributing to current impairment. This is especially important when the person has limited spoken language, difficulty describing internal states, or a history in which distress has repeatedly been attributed to autism itself.

Co-occurring conditions are not a miscellaneous appendix to diagnosis. They alter risk, family burden, educational participation and the interpretation of behaviour. A useful formulation begins with the person's usual baseline and asks what has changed, in which setting, with what bodily or emotional correlates, and what reliably relieves or worsens it. The clinician should bring together caregiver observations, the person's own account where possible, developmental history, medication exposure, sleep and elimination history, dietary pattern, and a focused physical and neurological examination. The aim is not indiscriminate testing. It is a hypothesis-led medical workup that can explain a new problem and identify needs that autism alone cannot explain.

10-15%	up to 53%	7-24%	more than 50%
ESTIMATED EPILEPSY IN CHILDREN WITH ASD	WITH A FREQUENT SLEEP PROBLEM	WITH SIGNIFICANT CHRONIC GASTROINTESTINAL COMPLAINTS	ESTIMATED TO MEET ADHD CRITERIA IN SOME SAMPLES

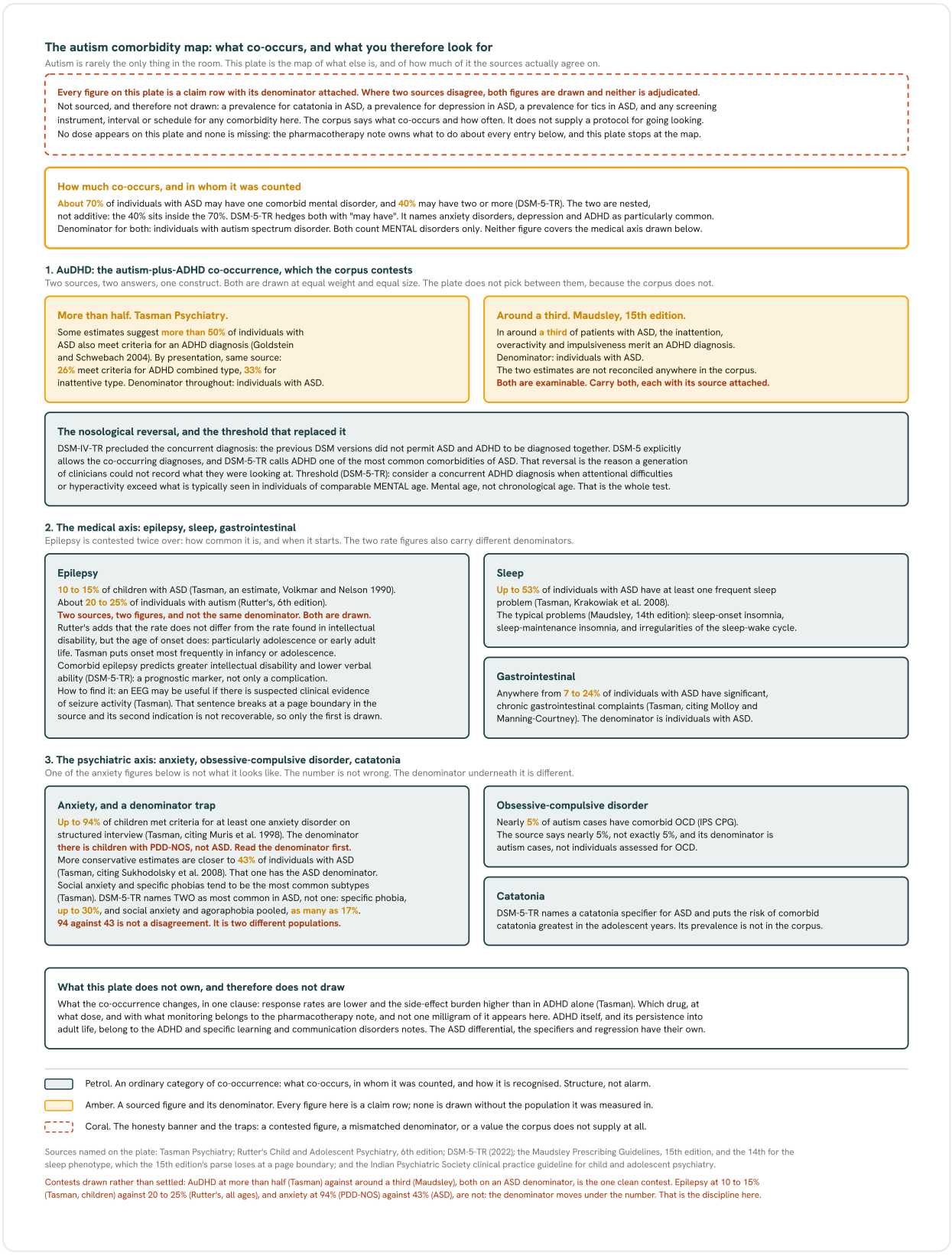


Fig 21.18 **The autism comorbidity map.** What co-occurs with autism, medical and psychiatric, with every figure carried alongside the population it was counted in. AuDHD leads the plate because the sources contest it: more than half of individuals with ASD (Tasman) against around a third (Maudsley), drawn side by side at equal weight rather than reconciled, with the DSM-IV exclusion that DSM-5 reversed and the comparable-mental-age threshold that replaced it. Epilepsy is contested in rate and in age of onset, though its two rate figures also differ in denominator, children against all ages. Anxiety at 94% against 43% only looks contested: the denominators are PDD-NOS and ASD respectively, and telling the two cases apart is the point. Prevalences for catatonia, depression and tics in ASD are not in the sources, so none is drawn.

25.1 A clinical method for finding comorbidity

Start with the referral question, but do not let it narrow the enquiry prematurely. A child described as "more autistic" may in fact be sleeping poorly, constipated, frightened, in pain, having unrecognised seizures, depressed, overwhelmed by a new demand, or experiencing an adverse effect of treatment. An adult who has always required support may develop a new loss of function that deserves the same respect as new loss of function in any other patient. Baseline is therefore a clinical instrument: establish usual communication, mobility, eating, sleep, continence, interests, activity level, self-injury, emotional expression and ability to tolerate ordinary transitions before interpreting change.

Behavioural equivalent is a practical term for a bodily or emotional problem expressed through observable behaviour when direct reporting is limited. It should prompt enquiry, not provide a conclusion. Agitation may reflect discomfort, fear, overstimulation, an interpersonal conflict, a seizure-related event or an emerging psychiatric syndrome. Similarly, apparent non-compliance can be a communication about an inaccessible demand or an aversive physical state. Ask caregivers for a sequence rather than a global adjective: what happens first, what follows, how long it lasts, whether awareness changes, and what restores the person to baseline.

CLINICAL SIGNAL	QUESTIONS THAT SHARPEN THE HISTORY	WHY IT MATTERS	IMMEDIATE ROUTE
New episodic change	Was there altered awareness, a motor event, a fall, a period of confusion, or a return to usual functioning?	Distinguishes a possible neurological event from a behavioural description alone	Document the event carefully and consider neurological assessment
New irritability or self-injury	What has changed in sleep, bowels, eating, activity, medication, demands or sensory load?	Physical discomfort and environmental strain are common explanatory possibilities	Examine, identify urgency, and investigate the leading hypothesis
Functional decline	Which specific skill has changed, how abrupt was the change, and is it present across settings?	Prevents a serious change being absorbed into a static developmental label	Assess medical, neurological and psychiatric contributors in parallel
Internalising distress	What situations are avoided, feared, anticipated or endured with marked distress?	Anxiety may be obscured by shutdown, rigidity, anger or somatic complaint	Make a symptom formulation before assigning a label

RULE **Any marked change from baseline deserves a fresh medical and psychiatric formulation; do not accept autism as its explanation until competing explanations have been considered.**

25.2 Epilepsy: recognise events, assess risk and use EEG selectively

Epilepsy is an important ASD comorbidity, but its clinical relevance lies in more than its frequency. Estimates in children with ASD place comorbid epilepsy between **10% and 15%**.

Another estimate for individuals with autism is about **20% to 25%**. These figures should not be treated as a prediction for an individual patient. They do, however, justify a low threshold for taking a paroxysmal history seriously, particularly when family descriptions include abrupt episodes that differ clearly from the person's usual repetitive behaviour, sensory response or emotional dysregulation.

The age pattern has clinical value. Onset is reported most often in infancy or adolescence, while onset in adolescence or early adult life is particularly distinctive when autism is compared with intellectual disability. The overall epilepsy rate in autism does not differ from that found in intellectual disability; the timing of onset is the more useful discriminating observation. A routine visit should therefore include a longitudinal question about events across development, rather than only asking whether seizures are occurring now.

Paroxysmal event is preferable to the word seizure until the history supports a conclusion. Ask whether the event occurs from sleep, during illness, after a particular trigger, or in a stereotyped sequence. Repetitive movements, staring, withdrawal, panic, dissociation and behavioural shutdown can all be misread if the sequence is not reconstructed.

Explain to families who expect a single investigation to explain autism or every behavioural difficulty that the question for the test is narrow: whether the event pattern raises a neurological concern that the EEG can help clarify. When events are recurrent or the account is unclear, contemporaneous documentation and neurological collaboration are often more informative than retrospective labels.

GOOD TO REMEMBER

When a new event is reported, reconstruct it with a witness before naming it a seizure: onset, behaviour, awareness, responsiveness, colour change, injury, duration, recovery and return to baseline. A caregiver-recorded video can improve phenomenology. An EEG may be useful when there is clinical evidence suggesting seizure activity; it does not replace a careful event history and must be interpreted in its clinical context.

Comorbid epilepsy is associated with greater intellectual disability and lower verbal ability. This association should guide anticipatory support, not deterministic counselling. It signals that communication access, safety planning and caregiver education may need particular attention. It does not mean that every person with epilepsy will follow the same developmental course, nor does it license therapeutic pessimism. Seizure management itself should be coordinated with the relevant neurological service; syndrome-specific seizure teaching belongs to the relevant syndrome sections rather than to a general ASD workup.

TRAP **Examination trap: do not request an EEG merely because a person has ASD. Request it for a clinically credible paroxysmal history, and document the event phenomenology that created that suspicion.**

25.3 Sleep disturbance: make the phenotype visible before treating it

Sleep problems are common enough to merit routine enquiry rather than waiting for a complaint. Up to **53%** of individuals with ASD have at least one frequent sleep problem. The common clinical patterns are **sleep-onset insomnia**, **sleep-maintenance insomnia** and **sleep-wake cycle irregularity**. Naming the pattern matters because a family report of "not sleeping" may refer to a prolonged settling period, repeated waking, a shifted schedule, an early waking pattern, or a combination.

Ask for the sequence around sleep rather than an estimate of total sleep alone. Establish the evening routine, time of attempted sleep, latency, night waking, nocturnal activities, waking time, naps, weekend variation, bedroom conditions, caregiver responses, daytime sleepiness and change from baseline. Ask directly about pain, bowel discomfort, breathing concerns, seizures, itching, medication timing, caffeine exposure, activity, screen use and anxiety. This identifies reversible drivers and clarifies whether the intervention must change the environment, the daytime rhythm, an associated condition, caregiver contingency, or a biological sleep signal.

Melatonin has shown benefit in **17 studies** in children with ASD. The dosing figures come from a narrower base and should be quoted as such: a meta-analysis of five of those studies is what reports good efficacy across doses of **1 and 10 mg**.

IN INDIA

For sleep disturbance in ASD, Indian guidance states a melatonin range between 1 and 10 mg at night.

Treatment periods in the cited evidence ranged from 14 days to over 4 years, which shows that use has not been confined to a single brief interval, not that every patient should receive long-term treatment.

Where epilepsy is also present, the guidance describes melatonin as carrying a low risk of seizure precipitation. This is reassuring but does not remove the need to document the seizure history, current neurological treatment and temporal relation between any new symptom and a medication change. The broader pharmacological management of target symptoms is addressed separately. Here the principle is to treat sleep as a clinical syndrome with contributors, not as an inevitable feature of autism.

For sleep, identify the pattern and its maintaining conditions before adding a treatment. A precise sleep history often prevents both under-treatment of discomfort and over-treatment of behaviour.

25.4 Gastrointestinal symptoms and bodily distress

Gastrointestinal complaint may present as a direct report, altered food intake, agitation around meals, a new sleep problem, avoidance of the toilet, or self-injury. Significant chronic gastrointestinal complaints are reported in between **7% and 24%** of individuals with ASD. It

should encourage active enquiry, not a presumption that every distress behaviour is gastrointestinal.

The clinical history should make eating and elimination discussable without embarrassment. Ask about appetite, food selectivity, texture or smell sensitivity, pain behaviour, swallowing concerns, nausea, vomiting, stool pattern, toileting avoidance, soiling, bleeding, weight change and the relation of symptoms to medication or routine disruption. In a person who cannot describe pain conventionally, a caregiver's recognition of a distinct grimace, posture, guarding, meal-related distress or night waking may be the most useful starting point. Examination and referral should be guided by the symptom pattern and urgency, as in any patient.

It is useful to separate a sensory preference from a medical symptom without making them adversaries. A narrow diet may be a stable sensory accommodation, a consequence of pain, an anxiety-driven avoidance, a learned family adaptation, or several of these together. The same is true of toileting refusal. The formulation becomes clinically useful only when it identifies function, discomfort, nutritional impact and the practical barriers to change. Abrupt dietary restriction, apparent pain, dehydration, bleeding, persistent vomiting or a significant decline in functioning should not be normalised as autism.

- Ask directly about bowel, bladder, appetite and pain at each meaningful change in behaviour.
- Use familiar caregiver observations as data, then test them against a focused history and examination.
- Distinguish a long-standing preference from a new restriction or a new distress signal.

25.5 Genetic and general medical workup: phenotype-led, not reflexive

Phenotype-led genetic evaluation means that genetic assessment is anchored to the individual rather than to a generic autism label. The history should include developmental course, medical events, neurological symptoms, family history and any pattern suggesting a broader developmental condition. The examination should attend to growth, physical features, skin, neurological signs and other findings that may make a syndromic explanation more likely. This approach improves the quality of the referral question and helps the family understand why genetic assessment is being considered.

Genetic testing is part of the ASD medical workup, but its value is not exhausted by producing a laboratory result. A result may refine an aetiological formulation, prompt surveillance for associated medical issues, inform reproductive discussion through an appropriate genetics service, and connect a family with relevant supports. Conversely, an uninformative result does not invalidate the person's autism diagnosis or their need for support. Consent should cover what the investigation can and cannot answer, the possibility of uncertain findings, and the implications of receiving information that concerns relatives.

The psychiatrist's role is to recognise when a broad medical formulation is needed, obtain a careful developmental and family history, coordinate referrals and translate results into a person-

centred plan. It is not to assign a syndrome from a single physical feature or to promise that testing will identify a cause in every case.

- Record the phenotype and the family question that prompted referral.
- Explain what a result may clarify and what it may leave uncertain.
- Coordinate interpretation with genetics and other relevant services.

Hearing and vision concerns, nutritional status, sleep, bowel function, medication effects and neurological symptoms should be considered alongside genetic assessment. This prevents the common error of pursuing an etiological explanation while missing a treatable contributor to day-to-day distress. A medical workup is successful when it makes the clinical picture more intelligible and improves care coordination, even when no single cause is established.

25.6 AuDHD: distinguish co-occurrence from diagnostic substitution

AuDHD refers to the co-occurrence of autism and ADHD. ADHD is one of the most common comorbidities in ASD, and some estimates suggest that **more than 50%** of individuals with ASD also meet criteria for an ADHD diagnosis. The clinical task is not to decide which label "explains everything". It is to establish whether attentional difficulties, impulsivity or hyperactivity represent an additional, impairing syndrome rather than an understandable consequence of overload, anxiety, poor sleep, learning demands or the social environment.

This is a major nosological correction for candidates to understand. DSM-IV-TR did not permit concurrent ASD and ADHD diagnoses; DSM-5 permits co-occurring diagnoses. The earlier exclusion still shapes clinical habits. In one direction, marked activity or distractibility is dismissed as part of autism. In the other, social difficulty is assumed to follow from ADHD alone. Both shortcuts can delay a formulation that makes sense of the person's whole pattern.

Assess attention and activity across settings and against the person's developmental level. A concurrent ADHD diagnosis should be considered when attentional difficulties or hyperactivity exceed what is typical for individuals of comparable mental age. Ask what happens in a low-demand preferred activity, in an unstructured group setting, during a task that is understood but not preferred, and after a poor night of sleep. Gather collateral from the settings where demands differ. This separates sustained regulation difficulty from a problem that appears only under a particular sensory, social or academic load.

The co-occurrence changes management planning because sleep, anxiety, communication demands and environmental predictability can all alter attention and activity. Establish the target impairment, its baseline, the family's priorities and the measures by which benefit and adverse effects would be judged. Pharmacological treatment selection for target symptoms is addressed in the pharmacotherapy section; ADHD itself, including adult persistence, is addressed in the ADHD and specific learning/communication disorders notes. The key point here is that dual diagnosis is clinically permissible and often clinically clarifying.

MNEMONIC

Clinical spine - CHANGE

When behaviour worsens, check **C**ourse from baseline, **H**ealth and pain, **A**rousal and sleep, **N**eurological events, **G**astrointestinal and other bodily symptoms, and **E**motional or attentional comorbidity. It is a sequence for broadening the formulation, not a substitute for assessment.

25.7 Anxiety, obsessive-compulsive phenomena and catatonia

Anxiety disorder is common in ASD, with a more conservative estimate of **43%** in individuals with ASD. Social anxiety and specific phobias tend to be the most common subtypes. The assessment must not mistake all avoidance for autism-related social difference or all insistence on sameness for anxiety. Ask what the person fears will happen, what they anticipate, whether distress appears before the event, what safety behaviours are used, and whether the pattern is new, pervasive or situation-bound.

Obsessive-compulsive symptoms demand a similarly functional distinction. Repetitive acts in autism may be enjoyable, regulating or linked to predictability, whereas compulsions are more often driven by distress and an attempt to reduce a feared outcome. The distinction can blur, particularly when the person cannot easily report intrusive thoughts. Explore the emotional state before and after the act, the consequences of interruption, the degree of choice, and whether the behaviour has acquired a feared meaning. Nearly 5% of autism cases have comorbid OCD, so the possibility should be actively considered rather than hidden within a description of repetitive behaviour.

Catatonia requires recognition because new marked slowing, reduced initiation, mutism, posturing, agitation, loss of previously established function or other conspicuous motor-behavioural change may be misattributed to autism. The core safeguard is temporal: a substantial change from the person's own baseline is a clinical event. Obtain a careful timeline, assess medical and neurological contributors, seek collateral, and involve appropriate specialist services where concern is significant. Do not wait for a person to fit a stereotyped image of catatonia before taking severe change seriously.

TRAP **Examination trap: repetitive behaviour is not automatically OCD, and withdrawal is not automatically autism. Establish the preceding emotion, perceived purpose, degree of distress and change from baseline.**

25.8 Integrating findings into a safe, useful formulation

The completed assessment should answer practical questions: what is longstanding, what is new, what is impairing, what needs urgent medical attention, and which professional needs to act next? Document observations in behavioural language, preserve uncertainty where it remains, and specify the evidence supporting each concern. A formulation such as "new nocturnal waking with apparent abdominal discomfort and daytime irritability" is more actionable than "behavioural problem in ASD". It allows the family, psychiatrist, paediatric or medical colleague, school and therapist to work from the same clinical picture.

Finally, explain the formulation to the person and family without implying blame. Families often arrive after being told either that every problem is autism or that autism explains nothing. Both positions are unhelpful. Autism provides a developmental context. It does not erase the need to recognise pain, epilepsy, sleep difficulty, gastrointestinal symptoms, genetic questions, ADHD, anxiety, OCD or catatonia. Care improves when the clinician can hold both truths at once: the person's baseline neurodevelopmental profile matters, and a real change from that baseline always deserves to be understood.

Managing autism and its outcome

26 · Differential diagnosis of ASD

Differential diagnosis is a longitudinal task. Autism spectrum disorder (ASD) is not established by an isolated socially atypical behaviour, a language delay, or a repetitive act observed in clinic. The clinician asks whether the social-communication pattern is pervasive, whether restricted or repetitive behaviour is present across development, what the child could do before the concern emerged, and whether the proposed alternative explains the whole presentation more parsimoniously. The same exercise determines whether an apparent alternative is instead a co-occurring condition that deserves its own diagnosis and treatment plan.

For examination answers, organise the differential around the **developmental trajectory**: an early and pervasive neurodevelopmental pattern supports ASD; a setting-bound difficulty, a later change after relatively typical development, or a symptom driven by fear, psychosis, sensory loss, neurological illness, or adverse care conditions should redirect assessment. Collateral developmental history, direct observation across settings, and attention to communication without spoken language are often more informative than a checklist answer. The task is not to make every unusual behaviour autistic, nor to deny ASD when another condition is also present.

RULE **Core rule.** Diagnose ASD when its characteristic social-communication and restricted or repetitive pattern is the best account of the developmental presentation; add another diagnosis when that condition independently meets its threshold or requires separate clinical attention.

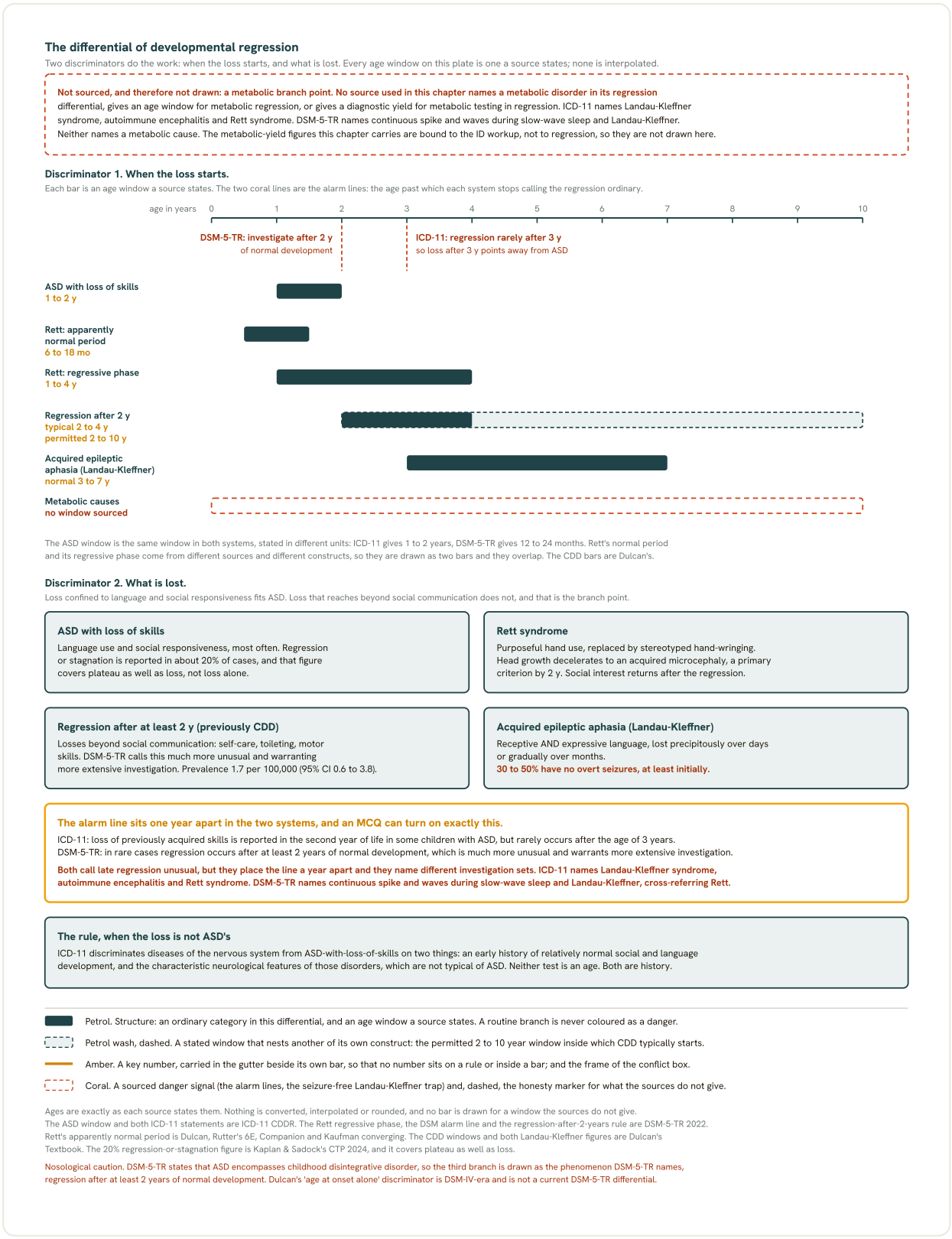


Fig 21.19 **The differential of developmental regression.** The branch points that separate autism with loss of skills, Rett syndrome, regression after at least two years (previously childhood disintegrative disorder) and acquired epileptic aphasia, drawn on the two discriminators that actually do the work: the age at which the loss starts, and what is lost. The ruler carries only age windows a source states, and the alarm lines show ICD-11 and DSM-5-TR placing the boundary of the ordinary a full year apart. A metabolic branch point is named on the banner and left undrawn: no source used here supplies one, and the metabolic yields this chapter carries are bound to the intellectual-disability workup rather than to regression.

26.1 A practical frame for the differential

Start by examining social communication, restricted or repetitive behaviour, pervasiveness across settings, and any loss of acquired capacity. Was early social communication qualitatively atypical, or merely delayed in proportion to overall development? Are repetitive behaviours, unusual interests, inflexibility, or sensory-linked patterns truly present, including historically? Is the pattern evident across relationships and environments? Does the time course suggest ASD or a neurological, psychiatric, or environmental cause? This frame prevents the common error of treating an isolated surface feature as diagnostic.

Use function, not appearance alone. Repetition may be self-organising, enjoyable, anxiety-reducing, an attempt to avoid an aversive demand, or a response to an intrusive thought. Social withdrawal may reflect a pervasive social-communication difference, fear of scrutiny, low mood, psychosis, or an attachment-related adaptation. The meaning of the behaviour, its developmental onset, and what changes it are more discriminating than the behaviour's name.

- Obtain a timeline of social reciprocity, communication, play, interests, daily routines, and any losses of skill.
- Ask about the same behaviour at home, school, and with familiar and unfamiliar people.
- Separate a core ASD feature from a secondary reaction to anxiety, frustration, communication failure, or environmental change.
- Look for independent evidence that an alternative disorder is present, rather than using it as a label for a difficult symptom.

TRAP **Examination trap.** A child who does not speak in a particular setting does not automatically have ASD. Pervasiveness of the social-communication difficulty and the presence or absence of restricted or repetitive behaviour decide the direction of enquiry.

26.2 ADHD and intellectual developmental disorder

ADHD and ASD can be difficult to discriminate. Interrupting, intruding into personal space, excessive volume, impatience, and poorly modulated interaction can create social difficulty in ADHD. These behaviours should not be mistaken for the qualitative reciprocity and communication pattern of ASD. The discriminating history is the developmental course, together with whether restricted or repetitive behaviours and unusual interests are absent. When they are absent and the social difficulty tracks inattention, impulsivity, or hyperactivity, ADHD is the better explanation.

These disorders may also coexist. In a person with ASD, a concurrent ADHD diagnosis should be considered when attentional difficulty or hyperactivity exceeds what is expected at a comparable mental age. This is a clinical comparison against developmental capacity, not a shortcut based on chronological age. Do not use the presence of ASD to explain away disabling inattention, and do not use the presence of ADHD to dismiss a developmental history of restricted interests and pervasive social-communication difference. ADHD itself is covered in the ADHD and specific learning/communication disorders notes.

The boundary with intellectual developmental disorder demands the same developmental comparison. In intellectual developmental disorder without ASD, social-communicative skills generally do not show an apparent discrepancy from other intellectual skills. ASD is justified when social communication and interaction are substantially more impaired than the developmental level indicated by nonverbal abilities. Observe how the child uses gaze, gesture, affect, shared attention, and nonverbal problem solving, rather than equating sparse speech with autism. This distinction is especially difficult before symbolic communication has emerged and when repetitive behaviour occurs in the context of developmental disability.

ICD guidance makes the same point operationally: assign both diagnoses, with the relevant specifier, when social-communication deficits are greater than would be expected from intellectual functioning. In this setting, adaptive assessment should not let ASD-related social difficulty artificially inflate the apparent global developmental impairment. The conceptual and practical evidence, the developmental record, and repeated assessment matter greatly. The full differentiation of intellectual disability, global developmental delay, and borderline intellectual functioning is addressed elsewhere in this chapter.

26.3 Language, pragmatic communication, and selective mutism

A **developmental language disorder** can produce frustration, reduced participation, and secondary social difficulty. It is not usually accompanied by abnormal nonverbal communication or restricted and repetitive patterns. A child with language disorder may therefore show a strong wish to engage, communicative use of gesture and facial expression, and reciprocal response despite impaired spoken language. The assessment should be designed so that social intent can be seen without demanding verbal fluency.

Social (pragmatic) communication disorder is the nearer diagnostic neighbour because social use of communication is impaired. The separator is the absence of restricted or repetitive behaviour and interests. Before making this diagnosis, enquire carefully about such behaviour in both the past and the present. If ASD criteria are met, ASD takes diagnostic precedence; it is not appropriate to divide an ASD presentation into separate social-communication and repetitive-behaviour diagnoses. Conversely, pragmatic language impairment alone does not justify adding developmental language disorder to ASD. Individuals with a primarily pragmatic language disorder may still initiate and respond appropriately to social and emotional cues and share interests, while lacking the typical restricted or repetitive pattern seen in ASD.

Selective mutism is a disorder of context, not a global absence of communication. Early development is not typically disturbed; communication can be appropriate in some settings; and even where the child is mute, reciprocity is not impaired and restricted or repetitive patterns are not present in the way expected in ASD. Ask what the child does at home, with familiar relatives, and in school. Selective mutism shows normal language and social communication in specific environments but not others, whereas ASD-related social-communication deficits and restricted or repetitive patterns are evident across situations and contexts. Anxiety and ASD can coexist, so a clear setting effect should prompt assessment for both rather than a hurried either-or decision.

PRESENTATION	QUESTION THAT RESOLVES IT	PATTERN FAVOURING THE ALTERNATIVE
Developmental language disorder	Can social intent be demonstrated nonverbally?	Reciprocal nonverbal communication without the restricted or repetitive ASD pattern.
Social pragmatic communication disorder	Has restricted or repetitive behaviour ever been present?	Social-communication impairment without that behavioural pattern.
Selective mutism	Does communication become normal in a safe, familiar setting?	Context-specific mutism with preserved reciprocity.

26.4 Attachment-related presentations, deprivation, and disruptive behaviour

Severe social deprivation can produce **quasi-autism**, an autism-like presentation that must not be assumed to establish a lifelong neurodevelopmental diagnosis without careful history. A key discriminating observation is substantial improvement after movement to a more nurturing environment. Where there is no reliable account of earlier social and communicative development, the distinction may remain difficult. Longitudinal observation is then clinically more honest than premature certainty.

Reactive attachment disorder and ASD share social withdrawal and low reciprocity, but their organising patterns differ. ASD shows atypical language development, whereas delayed language in reactive attachment disorder is not stereotyped or otherwise deviant; restricted or repetitive behaviour is not a feature of reactive attachment disorder; and children with ASD can show attachment behaviour with caregivers at least some of the time despite their social-communication difficulty. A history of severe neglect or maltreatment is required for reactive attachment disorder and is very unusual in ASD. The diagnosis should therefore rest on both the caregiving history and the behavioural phenotype, not on either alone.

Disinhibited social engagement disorder may also enter the differential when a child approaches unfamiliar adults indiscriminately. That feature is not decisive, because some children with ASD may also show it. Restricted, repetitive, and inflexible patterns are not typical of disinhibited social engagement disorder, and a marked reduction in symptoms after a nurturing environment is provided supports that diagnosis. The clinical task is to avoid a false split between adversity and neurodevelopment: adversity may be clinically crucial whether or not ASD is ultimately present.

Oppositional behaviour needs a functional formulation. In oppositional defiant disorder, the social-communication and restricted or repetitive pattern characteristic of ASD is absent. Explosive rages in ASD are often linked to a specific trigger - a disruption of routine, aversive sensory input, anxiety, or interruption of a rigid sequence - rather than a wish to be provocative or spiteful as required for an oppositional account. Ask what occurred immediately before the outburst and what the child was trying to preserve, escape, or communicate. Demand avoidance

may be prominent in ASD, but it should not be mistaken automatically for a separate disruptive disorder.

26.5 Repetitive behaviours: OCD, stereotypies, and tics

The same act can look repetitive while serving very different psychological functions. In **obsessive-compulsive disorder**, compulsions are performed in response to intrusive thoughts, commonly to relieve anxiety. In ASD, repetitive motor acts, insistence on sameness, or ordering behaviour may be experienced as pleasurable and reinforcing. Ask the person, in developmentally appropriate language, what happens if the behaviour is interrupted: is there fear of a feared consequence, a drive for relief or completeness, sensory regulation, enjoyment, or distress at change? The answer is informative but not self-sufficient, because insight and the ability to report internal experience vary.

Resistance is another useful but imperfect axis. People with OCD more often consciously resist compulsive urges, whereas the characteristic social-communication deficits of ASD are not features of OCD even when repetitive behaviour is prominent. Adolescents and adults with ASD may nevertheless attempt to suppress behaviour they know is socially unwelcome. Therefore, neither resistance nor lack of resistance should be converted into an isolated diagnostic test. Evaluate the cognitive antecedent, emotional consequence, developmental context, and the rest of the ASD phenotype.

Stereotypic movement disorder is not added merely because repetitive movements are visible in someone with ASD. A separate diagnosis is not made when the movement is better explained by ASD; it can be appropriate when stereotypy causes self-injury and becomes a specific treatment focus. The practical point is to describe the movement carefully, assess injury and impairment, and decide whether it needs additional clinical attention rather than multiplying labels.

Differentiate stereotypies from **tic disorders** by phenomenology. Tics tend to be less stereotyped, briefer, later in emergence, and associated with premonitory sensory urges; unlike ASD repetitive behaviours, they are not generally experienced as soothing. Direct questioning about an urge, temporary suppression, fluctuation, and relief is useful when language permits. Co-occurrence remains possible, so the aim is accurate description and not forced diagnostic exclusivity.

MNEMONIC

Meaning before movement

For any repetitive act, ask: what precedes it, what does it achieve, what happens if it is blocked, and does the broader social-developmental pattern support ASD? This is a reasoning sequence, not a diagnostic acronym.

26.6 Anxiety, psychosis, and personality pathology

Anxiety disorders overlap with ASD because social withdrawal and repetitive behaviours can be core ASD features but can also express anxiety in either presentation. The central question is

whether social functioning becomes broadly intact when anxiety is low and the context is familiar. In **social anxiety disorder**, interaction with familiar people or in non-anxiety-provoking situations does not show the pervasive impairment expected in ASD; persistent restricted, repetitive, or inflexible patterns are also not features of social anxiety alone. A patient may have both conditions, and avoidant behaviour should then be formulated in terms of both developmental style and fear.

Childhood-onset **schizophrenia** is usually preceded by normal or near-normal development, and hallucinations and delusions are defining features that do not belong to ASD. Its prodrome can nonetheless resemble ASD through social impairment, unusual interests, or odd beliefs. Questions about psychotic symptoms require concrete follow-up: an affirmative literal answer may refer to ordinary media rather than a perceptual experience. Establish the source, location, controllability, conviction, and functional consequence of the reported experience. If ASD and schizophrenia each meet criteria, diagnose both rather than making one erase the other.

In adults without major language or intellectual impairment, personality disorder can resemble ASD through detachment, eccentricity, unusual preoccupations, or restricted affect. The most helpful discriminator is the early developmental course: lack of imaginative play, restricted or repetitive behaviour, and sensory sensitivity in childhood point toward ASD rather than a personality-based explanation. Adult social style alone is an unreliable retrospective diagnostic shortcut. Seek informant history and records where available, and distinguish a lifelong developmental pattern from interpersonal adaptations that emerged later.

26.7 Regression and neurological red flags

Regression changes the diagnostic posture. Loss of skills can occur in ASD. The syndrome-specific accounts belong with their dedicated discussion.

> **GOOD TO REMEMBER**
>
> In ASD, loss of skills is reported in the **second year of life** in some children and rarely occurs after the age of **3 years**. A later loss, especially after a relatively normal early social and language history, should trigger a differential that includes acquired epileptic aphasia, autoimmune encephalitis, Rett syndrome, and other neurological causes.

Medical causes are distinguished from ASD with loss of skills through the history of relatively normal development and the neurological features that are not typical of ASD on their own. Look beyond social communication. Loss of self-care, toileting, motor ability, or other acquired competence makes an encephalopathic process more concerning and warrants more extensive medical investigation than an uncomplicated ASD assessment. Where autistic features are attributable to a medical condition, ICD guidance allows a secondary neurodevelopmental syndrome diagnosis rather than ASD. The distinction matters because immediate management and prognosis can change.

Landau-Kleffner syndrome is an important mimic when apparent autism follows loss of receptive and expressive language after a period of normal development. That period may be **3 to**

7 years. An absent seizure history does not exclude it: **30 to 50%** of affected children may initially have no overt seizures. A careful neurological history and appropriately directed investigation are therefore essential in acquired language regression.

30 to 50%
LANDAU-KLEFFNER SYNDROME MAY INITIALLY LACK OVERT SEIZURES

26.8 Sensory impairment and closing clinical synthesis

Severe hearing impairment, severe visual impairment, maltreatment, developmental coordination disorder, epileptic encephalopathy, mood disorder, conduct disorder, and other behavioural conditions belong in a broad ASD differential when the presentation requires it. Their presence should slow diagnosis rather than become a reason to abandon developmental assessment. Hearing assessment is a named component of ASD workup, and audiology with speech and language expertise belongs in the multidisciplinary team for this reason. The technical differentiation of hearing impairment from developmental language disorder should not be imported uncritically as an ASD rule.

End with a positive formulation: which features establish ASD, which features point to a differential, which conditions may coexist, and what further observation or investigation is required before certainty is justified. This separates a thoughtful assessment from a list of labels. It also protects families from both diagnostic delay and diagnostic overreach. The full child psychiatric assessment battery, services and protection are covered in the Child psychiatry: assessment, treatment, services and protection notes.

> In ASD differential diagnosis, developmental course, pervasiveness across settings, the function of repetitive behaviour, and evidence of neurological regression are more useful than any isolated symptom.

27 · Rett syndrome and childhood disintegrative disorder

Why these conditions matter. Both **Rett syndrome** and childhood disintegrative disorder can present to the psychiatrist as a child who has lost development and now appears autistic. That surface resemblance is clinically consequential but diagnostically incomplete. Rett syndrome is a distinctive genetic and neurological condition with a characteristic course and physical phenotype. Childhood disintegrative disorder is a historical diagnostic construct describing unusually marked regression after a prolonged period of apparently typical development. A careful longitudinal history prevents the error of treating every regression as simply another presentation of autism.

The exam task is not merely to recall labels. It is to identify the pattern of loss, look for the accompanying neurological signs, understand what has changed in current classification, and arrange a proportionate medical assessment. The broader differential diagnosis of developmental regression is addressed in the differential diagnosis of ASD section; here the emphasis is on the two named entities and on the clinical reasoning that separates them from ASD.

99%	about 1 per 10,000	four	1.7 per 100,000
RETT CASES DUE TO SPORADIC MUTATION	REPORTED PREVALENCE IN GIRLS	CLASSIC RETT COURSE PHASES	CDD PREVALENCE ESTIMATE

27.1 Rett syndrome: identity, genetics and diagnostic stance

Rett syndrome was first described by Andreas Rett, an Austrian paediatrician, in Austria in 1966. It is an X-linked dominant condition caused by pathogenic change in MECP2, located at Xq28. MeCP2 binds methylated DNA and participates in the regulation of gene expression and chromatin structure. Its loss disrupts neuronal maturation and synaptogenesis. This mechanistic framing is useful because it explains why the syndrome is not just a behavioural regression syndrome: its evolution includes motor, autonomic, skeletal and epileptic manifestations.

Most cases arise anew rather than being inherited. The proportion attributed to a **99%** sporadic mutation is a memorable genetic fact, while the wider clinical point is that family history may be unrevealing. The syndrome is reported chiefly in females. A hemizygous mutation has been described as incompatible with life in a male fetus, but this should not be recited as an unqualified explanation for the sex distribution because the literature contains a contrary account of that mechanism. The clinically safer formulation is that rare affected males may have severe neonatal encephalopathy, and rare male cases have been reported with a concomitant XXY abnormality.

The syndrome is a major cause of intellectual disability in girls, described as the second most important cause after Down syndrome. Frequency figures require care because sources use different denominators and epidemiological constructs. A reported prevalence is **about 1 per 10,000 girls**; an incidence estimate is approximately 1 per 10,000 female live births. These should never be swapped in an answer. In practice, their shared message is rarity combined with high clinical importance.

RULE **Rett syndrome remains a clinical diagnosis.** Consensus clinical criteria establish the syndrome; genetic testing supports the diagnosis but does not establish it in isolation.

This principle avoids two errors. First, a compatible molecular result does not replace phenotype and developmental trajectory. Secondly, a negative or non-diagnostic result must not cause a clinician to abandon a convincing clinical syndrome. Variant forms exist, including a very rare preserved speech variant in which mutation carriers may communicate well and have mild intellectual disability; asymptomatic carriers have also been reported. Such variation makes clinical synthesis more important, not less.

27.2 The Rett developmental trajectory

The diagnostic spine is a period of apparently ordinary early development followed by loss of acquired skills and a changing neurological phenotype. The early apparently normal period is reported as **6-18 months**. Delays may become apparent around 6 months, but this is not a substitute for listening closely to the parents' account of the developmental sequence. In the

regressive phase, typically between ages 1 and 4 years, a child may look strikingly autistic. The key question is what happens next, and what accompanies the loss.

The course is conventionally understood as **four** classic phases. Rather than forcing stage labels onto a history, describe the sequence: an early apparently normal period, a short plateau, rapid deterioration of motor and speech abilities, a later plateau that can last for years, and subsequent deterioration of the motor system. This sequence is more clinically useful than a list of labels because it connects the family narrative to examination findings and anticipates changing care needs.

Loss of **purposeful hand use** is particularly discriminating. It is replaced by stereotyped hand-wringing, hand-washing, hair-pulling, clapping, flapping or twisting movements. These movements are not an incidental repetitive behaviour. They represent the substitution of a stereotypy for previously functional manual activity, and therefore should be elicited with a before-and-after history. Hand stereotypies first appear at about 18 months. Bruxism, mouthing and body twisting can accompany the hand movements.

Head growth is also informative. Head circumference can be normal at birth, then head growth decelerates, producing **acquired microcephaly**. The adjective matters: it distinguishes a postnatal deceleration from a head that was already small at birth. Significant microcephaly has been stated to emerge by 2 years of age, although head-growth slowing is not universal. A normal head-growth record therefore does not by itself dispose of the diagnosis; it makes the whole pattern, rather than one sign, more important.

TRAP **Examination trap.** Do not call a child autistic solely because she has social withdrawal, language loss and stereotypies during Rett regression. Ask specifically about loss of purposeful hand use, slowing of head growth, gait change and the later social course.

There is a further reason this distinction matters. Social interest often diminishes during the regressive period but later improves; many affected individuals develop an intense eye gaze or staring. Thus, an early autistic appearance need not remain the dominant social phenotype. In the current manual, ASD should be considered in Rett syndrome only when all ASD diagnostic criteria are independently met. This is a disciplined use of co-diagnosis, not a reflexive relabelling of the syndrome.

27.3 Neurological, autonomic and systemic phenotype

The neurological examination should deliberately seek a pattern, rather than recording isolated abnormalities. Gait dyspraxia or apraxia, truncal ataxia, gait and trunk movement apraxias, muscle wasting and dystonia are described in Rett syndrome. These features change the clinical question from “is this autism?” to “what neurological disorder is producing regression and autistic-appearing behaviour?” A child who can no longer use her hands purposefully and develops an abnormal gait demands this broader formulation.

Breathing abnormalities are another helpful clue. Episodes of hyperventilation and breath-holding can alternate. Their importance is practical as well as diagnostic: they should not be

assumed to be wilful behaviour or anxiety without a careful clinical account. Reflux and swallowing problems may reflect autonomic pathology. Acrocyanosis and trophic skin changes of the feet add to the autonomic and vascular phenotype. These physical features often explain why a narrowly psychiatric interview is insufficient.

Epilepsy is a frequent complication, but numerical statements in this area differ between sources. One source reports over 90% of girls with Rett syndrome having epilepsy, with seizures usually beginning around 4 years; another reports a lower range beginning at a different age. The defensible clinical learning point is that seizure history must be actively sought and that later changes in behaviour, alertness or function should not automatically be attributed to the developmental disorder. The Rett-specific seizure burden belongs in the medical formulation, not as a generic ASD comorbidity statistic.

Scoliosis is common over the course of the syndrome, reported in about 87% of females by 25 years of age. Sleep disturbance also deserves direct inquiry: 85% of preschool children have been reported to have disturbed sleep with night waking and paroxysmal or continuous laughter. These are not peripheral details. Sleep disruption, immobility, seizures, feeding difficulty and spinal deformity can each alter daily function, caregiver strain and the safety of medication choices.

Cardiac risk requires particular prescribing attention. There is an increased risk of arrhythmias associated with a **prolonged QT interval**. In Rett syndrome, avoid prokinetic agents, antipsychotics, tricyclic antidepressants, certain antiarrhythmics, anaesthetic agents and certain antibiotics where this risk is relevant. This is not an instruction to leave distressing symptoms untreated. It is a reminder that a psychiatric prescription belongs within a medical plan that considers cardiac conduction and concurrent treatment.

Despite the apparent downhill trajectory, Rett syndrome is **not a neurodegenerative disorder**. The neuropathological account is one of developmental arrest in infancy rather than progressive inflammatory, demyelinating or degenerative destruction. That distinction protects against a common conceptual mistake: later motor deterioration is real, but it does not prove a conventional neurodegenerative process.

27.4 Classification and the autism boundary

Rett syndrome is no longer included as an ASD or pervasive developmental disorder subtype in DSM-5. This differs sharply from childhood disintegrative disorder, which was absorbed into ASD. The historical placement of Rett beside autistic disorders should therefore be taught as classification history, not current nosology. The separation has validating evidence: MeCP2 mutation is not found in other autism spectrum disorders, making Rett a distinct genetic and neurological entity rather than simply a severe ASD subtype.

The current ASD diagnosis nevertheless contains a useful documentation route. The specifier **associated with a known genetic or other medical condition or environmental factor** can be applied when the individual has a known genetic condition, with Rett syndrome named as an example. The specifier does not itself claim that every aspect of the autistic presentation is

caused by the genetic condition. It documents clinically relevant context while preserving the requirement to establish ASD on its own criteria.

In ICD-11, Rett is named as a boundary or differential condition rather than as an ASD category. Diseases of the nervous system with regression are distinguished from ASD with loss of skills by an early history of relatively normal social and language development and by characteristic neurological features. This is exactly the clinical distinction the psychiatrist should make at the bedside. The legacy codes are F84.2 in ICD-10 and 299.80 in DSM-IV or DSM-IV-TR; do not use them as current ASD subtype labels.

> A child with regression and autistic-appearing behaviour needs a syndromic neurological formulation: in Rett syndrome, social interest may later improve, whereas the hand, head-growth, motor and autonomic phenotype remains diagnostically central.

27.5 Childhood disintegrative disorder: the historical construct

Childhood disintegrative disorder is also known as Heller syndrome or Heller's disease and was originally termed dementia infantilis. It described a child with a substantial period of apparently normal development followed by marked loss of skills and the emergence of an autistic clinical picture. The eponym is worth recognising because older examinations, case records and ICD-10 terminology may use it, but current clinical reasoning should not mistake a legacy label for a separate contemporary ASD category.

The historical criteria required at least **2 years** of apparently normal development before regression. Regression begins no earlier than 2 years and no later than 10 years; the most typical onset is between 2 and 4 years. These constructs are easy to confuse. The first specifies the preceding normal developmental interval, the second the permitted boundaries for regression, and the third the modal onset. In a vignette, establish the timing before deciding that the term fits.

Under the legacy DSM-IV-TR criteria, loss had to occur in two or more domains. The domains were expressive or receptive language; social skills or adaptive behaviour; bowel or bladder control; play; and motor skills. This breadth of loss is clinically important. A history that includes toileting and motor loss cannot be reduced to a narrow social-communication account. It should trigger medical evaluation alongside developmental and psychiatric assessment.

- Ask what the child could actually do before decline, using concrete examples rather than global parental labels.
- Establish whether language, social or adaptive abilities, continence, play and motor skills were all affected, and in what sequence.
- Seek neurological and systemic symptoms alongside the behavioural change, then pursue the regression differential described in the differential diagnosis of ASD section.

Following the regression, **autistic symptomatology** emerges, with impairments in socialisation and communication together with restricted, repetitive patterns of behaviour. The clinical

features are otherwise quite similar to autistic disorder, and age at onset is the principal distinguishing feature. This is why a prolonged normal developmental period makes the distinction easier, while a shorter apparently normal period makes it less secure.

27.6 Rett syndrome and childhood disintegrative disorder compared

CLINICAL AXIS	RETT SYNDROME	CHILDHOOD DISINTEGRATIVE DISORDER
Core framing	MECP2-related neurological syndrome	Historical syndrome of regression after apparently normal development
Typical developmental timing	Apparently normal early period of 6-18 months	Regression most typically between 2 and 4 years
High-yield clues	Loss of purposeful hand use with hand stereotypies; acquired microcephaly and motor signs	Loss across language, social or adaptive, continence, play and motor domains
Current DSM position	Not an ASD subtype	Subsumed within ASD
Expected outcome	Long-term neurological disability with changing motor and medical needs	Generally more severe intellectual disability and poorer outcomes than autism

The table should be used as a reasoning aid, not as a substitute for a history. Rett syndrome has a biologically distinctive phenotype, while childhood disintegrative disorder is defined by its temporal pattern of broad regression. In both cases, apparent autism is a clinical presentation that must be interpreted in context. The most hazardous mistake is diagnostic closure after observing social withdrawal or repetitive behaviour.

27.7 Current status, intervention and outcome in childhood disintegrative disorder

Childhood disintegrative disorder is not a separate diagnosis in DSM-5 or DSM-5-TR; it is encompassed within ASD and referred to as a disorder previously described as childhood disintegrative disorder. There is no CDD category in ICD-11 CDDR. Its legacy codes are F84.3 in ICD-10 and 299.10 in DSM-IV or DSM-IV-TR. These codes are useful for interpreting older records, but they should not be presented as current parallel diagnostic categories.

DSM-5 absorption should not make the regression clinically bland. A child with the pattern formerly called CDD requires extensive medical investigation, because regression warrants a search for neurological and medical explanations. The detailed regression differential belongs in the differential diagnosis of ASD section, and the broader ASD medical workup is addressed in the medical comorbidities and workup section. The psychiatrist's immediate contribution is to preserve the chronology, document the breadth of lost skills and ensure that an autistic formulation does not truncate investigation.

Intervention methods for CDD are identical to those used for autism. This statement does not mean the clinical task is identical: marked functional loss often changes the family's practical needs and the level of support required. The named behavioural programmes, speech and

occupational interventions, and family support are dealt with in their respective sections of this chapter. Here, the key point is that a historical CDD label does not exclude access to ASD-focused intervention.

Outcome is generally more severe than in autism. CDD has been described as having a much worse prognosis, with more severe intellectual disability and poorer outcomes than autism. This is why it is important to be honest with families without becoming deterministic: outcome language should describe present support needs, continuing medical assessment and the need to revise the formulation if the course changes. It should never be used to imply that rehabilitation, communication support or family partnership are futile.

27.8 Practical clinical synthesis

GOOD TO REMEMBER

When a child with possible ASD has lost skills, establish the developmental baseline and order of loss. Ask about purposeful hand use, continence, play and motor ability; then examine for acquired microcephaly, stereotypies, gait or trunk abnormalities, breathing changes and other neurological signs. Decide whether this is ASD with loss of skills, a known syndrome such as Rett syndrome, or a regressive disorder requiring a broader medical differential.

- For Rett syndrome, preserve the distinction between a clinical diagnosis and a supportive molecular result.
- For any psychiatric prescription in Rett syndrome, incorporate the arrhythmia and QT-risk context into the medical review.
- For historical CDD, document the prolonged normal period and the domains of loss before applying a legacy label; in either presentation, communicate that regression deserves explanation, not merely classification.

These two conditions are therefore important not because they add obscure eponyms to ASD, but because they teach a general clinical discipline. Developmental regression is a temporal event with neurological and functional meaning. Recognising its pattern protects the child from premature diagnostic closure and gives the family a more coherent account of why assessment, treatment and support must extend beyond a behavioural description.

28 · Behavioural interventions (ABA, TEACCH, PECS, ESDM)

Behavioural intervention is a clinical method, not a branded package. In autism spectrum disorder, the psychiatrist's task is to translate a broad concern - communication, participation, learning, distress around change, or a behaviour that has become difficult to manage - into an observable target and a coherent programme. The useful question is not which acronym is fashionable. It is which learning opportunity, environmental support, communication route and review process are most likely to help this person participate more effectively in ordinary life.

Behavioural intervention means planned alteration of the conditions in which a skill is taught or a behaviour occurs, with observation of whether the planned change helps. It is not

synonymous with making a child compliant, and it must never be framed as a contest of wills. Good work begins with strengths, interests, communication needs and the burden placed on the person and family. It then turns a vague wish such as “behave better” into a target that can be observed, practised and reviewed. This fragment concerns named behavioural and educational programmes; the service model of early intervention belongs in the management of intellectual disability, while speech and occupational therapy and family support are addressed separately.

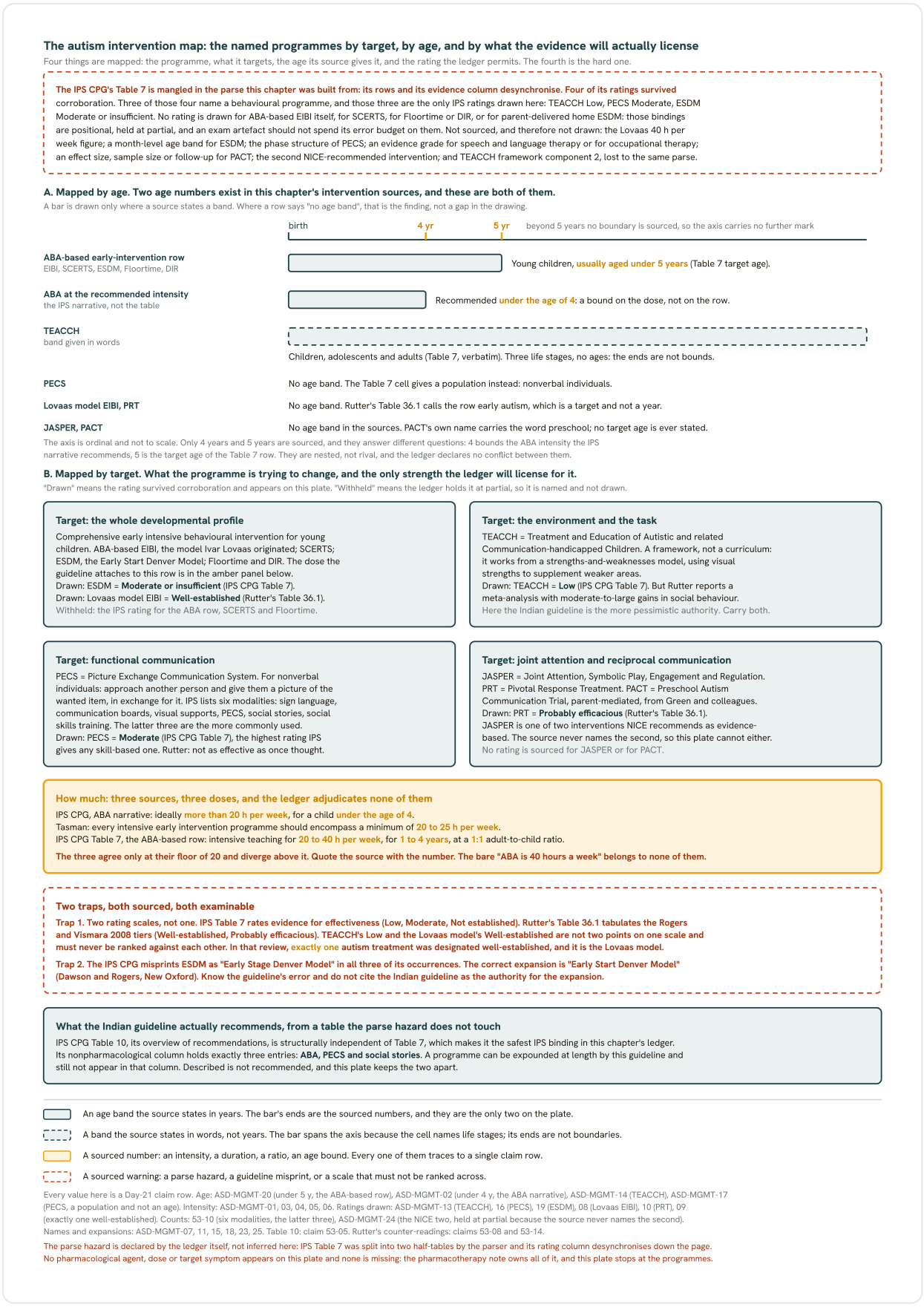


Fig 21.20 **The autism intervention map.** The named behavioural programmes placed by age and by target, carrying only the evidence ratings that survived corroboration: the IPS guideline's Table 7 is mangled in the parse behind this chapter, so TEACCH Low, PECS Moderate and ESDM Moderate-or-insufficient are drawn while the ratings for ABA-based EIBI itself, SCERTS, Floortime and parent-delivered home ESDM are named and withheld.

28.1 Clinical logic before programme selection

A programme label does not replace formulation. The clinician should first establish what is happening, where it happens, what tends to precede it, what follows it, and what the person may be communicating through it. The same outward behaviour can call for quite different changes. This is why copying a technique from another child's plan is poor practice.

Functional formulation links a target behaviour to its context and probable purpose. It makes the intervention humane and testable. Behavioural reasoning should reduce avoidable distress, not explain it away.

> **GOOD TO REMEMBER**
>
> When a child leaves a task, ask what the behaviour may be communicating before choosing a response. It may reflect an incomprehensible demand, a need for a break, an attempt to obtain an item, sensory overload or distress needing medical or psychiatric assessment. The plan may need a communication response, a better-matched task, clearer cues, a smaller step or a predictable way to ask for help.

RULE **Treat the function of a behaviour and the person's communication need, not merely its visible form.**

When the target and its context are explicit, family members, teachers and therapists can work towards the same practical outcome. When they are not explicit, adults often respond inconsistently and the plan becomes a series of reactions rather than treatment.

Targets should be meaningful to the person's daily life. They may concern requesting, tolerating a transition, joining a routine, sharing attention, completing a manageable activity, or reducing a barrier to participation. Progress must be interpreted in context: a newly learned response that occurs only in a training room has not yet become a dependable everyday skill. The clinician should ask where a skill is expected to occur, who can prompt it, what support makes it possible, and how the support will be reduced or adapted when appropriate. This keeps the programme connected to participation rather than to worksheet performance.

- State the target in observable language and identify why it matters in daily life.
- Record the setting, likely antecedents, consequences and communication context.
- Choose a teaching route that matches the person's current access to communication and learning.
- Review benefit, burden, generalisation and acceptability with the family and educational team.

28.2 Applied behavioural analysis and intensive behavioural teaching

Applied behavioural analysis is a framework for using behavioural principles to define targets, arrange teaching opportunities, record response and alter the plan in the light of observed learning. Its strength is not a rigid script. It is disciplined attention to what is being taught, what cues are available, what response is expected, what consequence makes a response worth repeating, and whether the skill transfers outside the teaching situation. A plan can be systematic without being mechanical, and it can be individualised without becoming unmeasurable.

Teaching may be organised into brief, clearly cued learning opportunities or embedded in meaningful activity and routine. The clinical distinction is useful: a more structured format can help when a new discrimination needs clarity, whereas opportunities in ordinary activity are important when a response needs to become useful beyond a formal session. In either case, prompting should help the person succeed rather than repeatedly expose failure. The team should watch for prompt dependence, because an apparently learned response may actually be a response to an adult's familiar cue.

Early intensive behavioural intervention is an ABA-based programme organised around a broad developmental teaching plan rather than an isolated target. The model is associated with **Ivar Lovaas**. A historical evidence review reported that only one autism treatment met its well-established category, namely that EIBI model, classified as well-established. That classification is useful for understanding the evidence history; it should not be turned into a promise about any individual child or into a reason to disregard individual goals and feasibility.

Intensity is often discussed as though it alone determines quality. It does not. The relevant question is whether there is enough repeated, purposeful teaching for a child to learn and use skills, while preserving play, rest, family life, education and responsiveness to distress.

IN INDIA

The IPS guidance recommends, ideally, more than **20** hours per week of ABA for children below 4 years. A broader intensive-programming statement sets a minimum of **20-25** hours per week. These are programme-intensity statements, not a prescription to fill every waking hour with adult-led drills.

20-40	1-4	1:1	<5
ABA-BASED EIBI TEACHING, WEEKLY HOURS	ABA-BASED EIBI PROGRAMME, YEARS	ADULT-TO-CHILD RATIO STATED FOR THE EIBI ROW	USUAL TARGET AGE IN THE EARLY-INTERVENTION ROW, YEARS

More specifically, the ABA-based EIBI row describes teaching between **20-40** hours per week over between **1-4** years, with an exactly 1:1 adult-to-child ratio for that EIBI row. The same early-intervention row is directed at young children, usually below 5 years. These details describe an intensive programme architecture. They do not mean that every component, or every teaching moment, must be delivered in an identical format.

The psychiatrist should make the architecture clinically workable. Ask who delivers each part, how parents understand the aim, whether the educational setting can reinforce the same communication route, and what data will trigger a change in plan. A programme can be intensive on paper but ineffective if targets are poorly chosen, staff turnover is high, the child is distressed, or skills never leave the treatment room. Conversely, a lower-resource setting can still use a disciplined behavioural formulation when it selects priorities carefully and trains the adults who share the person's routine.

TRAP **Examination trap.** Do not equate ABA with a single teaching technique, or assume that a stated adult-to-child ratio applies only to one teaching format. The cited ratio belongs to the ABA-based EIBI row as a whole.

28.3 Structured TEACCHing

TEACCH expands to **Treatment and Education of Autistic and related Communication-handicapped Children**. Its clinical contribution is the deliberate use of structure so that expectations are legible. Rather than assuming that verbal explanation will organise behaviour, the environment, task presentation and sequence are made easier to interpret. This can reduce ambiguity for a person who finds open-ended social or practical demands difficult to process.

Structured TEACCHing is best understood as a way of making the environment do some of the organising work. The framework is described as having exactly four components. In clinical use, the central question is whether the arrangement helps the person see what is happening now, what is expected next, how much is involved, and when an activity is complete. A visual or physical cue is not therapeutic merely because it has been produced; it is useful only if it reduces uncertainty and supports a meaningful response.

Visual structure can be incorporated into home, school or adult settings without reducing the person to a timetable. It may clarify transitions, make materials easier to locate, distinguish work from leisure, or show the endpoint of an activity. The clinician should avoid turning structure into inflexibility. If a plan is imposed without attending to preference and communication, it can become another demand. The better aim is predictable access to activity and choice, with room for the person to signal refusal, need for help, or a wish to change course.

The evidence-for-effectiveness rating listed for TEACCH is low. This should prompt honest discussion rather than dismissal. A low rating does not prove that a structured environment is useless for an individual; it says that confidence in an effect from the cited evidence base is limited. TEACCH is listed for children, adolescents, and adults, which is clinically important because environmental clarity can remain relevant across settings and stages of life. The decision should be based on a specific participation problem, a clearly described support, and observable review.

28.4 PECS and functional communication

PECS means **Picture Exchange Communication System**. It is a communication intervention in which pictures or symbols can provide an accessible route for an individual to initiate an exchange. Its relevance is not that pictures are inherently superior to speech. Its relevance is that a person who cannot reliably use speech may still have a clear reason to communicate, and should have a practical means of doing so.

Functional communication is the clinical aim: a response that changes the person's access to something meaningful in a socially understandable way. When an individual can request, refuse, seek help or indicate a preference, adults need not infer every need from distress or behaviour. This is why communication planning belongs in behavioural formulation. It may reduce conflict

by replacing an ineffective route with a more reliable one, but it should never treat communication as a device for suppressing autonomy.

PECS is listed for nonverbal individuals, with a moderate evidence-for-effectiveness rating. In assessment, establish whether the person notices the visual representation, can physically manage the exchange, understands what will follow, and has communication partners who will respond consistently. The picture, book or display is not the intervention by itself. The intervention is the repeated, successful experience that an intentional act reaches another person and has a meaningful consequence.

Clinical review should include whether the communication route is available where it is needed, not just during planned teaching. A system that stays in a cupboard or depends on one trained adult can produce a misleading appearance of non-response. Equally, the clinician should not make a symbolic system a compulsory endpoint. The right question is whether it expands the person's agency and participation. The separate discussion of speech and language therapy addresses broader communication assessment and therapy; the present focus is the behavioural logic of an accessible communicative exchange.

MNEMONIC

MAP the communication plan

Meaningful need, **A**ccessible response, **P**artner who responds. If any part is missing, the plan risks becoming a display rather than communication.

28.5 ESDM within early behavioural programmes

ESDM is the **Early Start Denver Model**. In a clinical plan it should be named accurately and then linked to a specified developmental and behavioural target, rather than invoked as a generic synonym for good early care. It appears in the same ABA-based early-intervention row as EIBI and other named programmes. That placement helps the candidate remember that programme labels are not competing diagnoses: they are organised approaches whose usefulness depends on the individual's needs, the quality of delivery and the fit with family and educational contexts.

The evidence rating listed for ESDM is **moderate or insufficient**. This wording requires restraint. It should not be simplified into a claim of established benefit for every outcome, nor used to imply absence of any possible benefit. When discussing it with a family, be precise about the proposed targets, the opportunity cost, the support required of caregivers and the plan for reviewing whether the programme is helping. In a fragmented service system, a recognisable model may be less important than a coherent, respectful plan that can actually be delivered and monitored.

The early-intervention row is directed to young children usually below 5 years. This is a description of the target age for that programme row, not a rule that support ceases after that threshold. Across the lifespan, the psychiatrist still identifies barriers to participation and coordinates a plan appropriate to the person's current setting. The form of teaching, the

communication route and the environmental adaptation may change, but the principle of setting meaningful goals and reviewing their effect remains constant.

28.6 Comparing programmes without false equivalence

Named programmes overlap in their concern with learning and participation, but they do not answer precisely the same clinical question. The accompanying table is a way to hold the distinction in mind. It is not a menu from which a family should be asked to choose unaided. The psychiatrist's role is to identify the main barrier, explain what a proposed approach is intended to change, and ensure that claims about evidence are communicated with their stated limits.

APPROACH	CLINICAL ORGANISING IDEA	EVIDENCE OR SCOPE STATED IN THE SOURCE	QUESTION FOR REVIEW
ABA-based EIBI	Planned behavioural teaching across meaningful targets	Between 20-40 hours per week over between 1-4 years	Are skills becoming useful outside teaching?
TEACCH	Environmental and task structure that makes expectations clearer	Low evidence rating; listed for children, adolescents, and adults	Does the support reduce ambiguity and improve participation?
PECS	Accessible symbolic exchange for communication	Moderate evidence rating; listed for nonverbal individuals	Can the person initiate a meaningful exchange in daily settings?
ESDM	Named early behavioural programme linked to individual goals	Moderate or insufficient evidence rating	Are proposed goals, burden and observed benefit explicit?

The comparison also guards against a familiar clinical error: treating an evidence rating as a property of the child. It is not. Ratings describe a body of evidence for an intervention as studied and categorised. The individual question remains whether a carefully specified, feasible intervention is improving a valued outcome. A programme with a stronger evidence classification may still be poorly delivered or poorly matched; a supportive adaptation with limited evidence may be reasonable when it has a clear rationale, low burden and observable benefit. Neither statement licenses therapeutic drift. Every plan needs a target, a responsible team, a way to observe change and a point at which it will be reconsidered.

28.7 Monitoring, ethics and the psychiatrist's coordinating role

Treatment fidelity means that the agreed intervention is actually being delivered in a recognisable and consistent way. It is an ethical as well as a methodological issue. Families are often asked to commit time, effort and money. If the target is vague, adults use incompatible prompts, or records are collected without changing the plan, the family carries the burden while nobody can say what is being tested. Clear documentation protects both the person and the team.

Monitoring should be practical. It can include the frequency or context of a target response, the level of assistance needed, the settings in which it occurs, the person's affect and signs of distress, and the views of family and staff. The record is not an end in itself. It should answer whether the

intervention is helping, whether the goal remains meaningful, and whether a different explanation of the difficulty is now more plausible. A plateau is not a moral failure by the child or caregiver. It is a prompt to re-examine the formulation, access to learning opportunities and competing sources of distress.

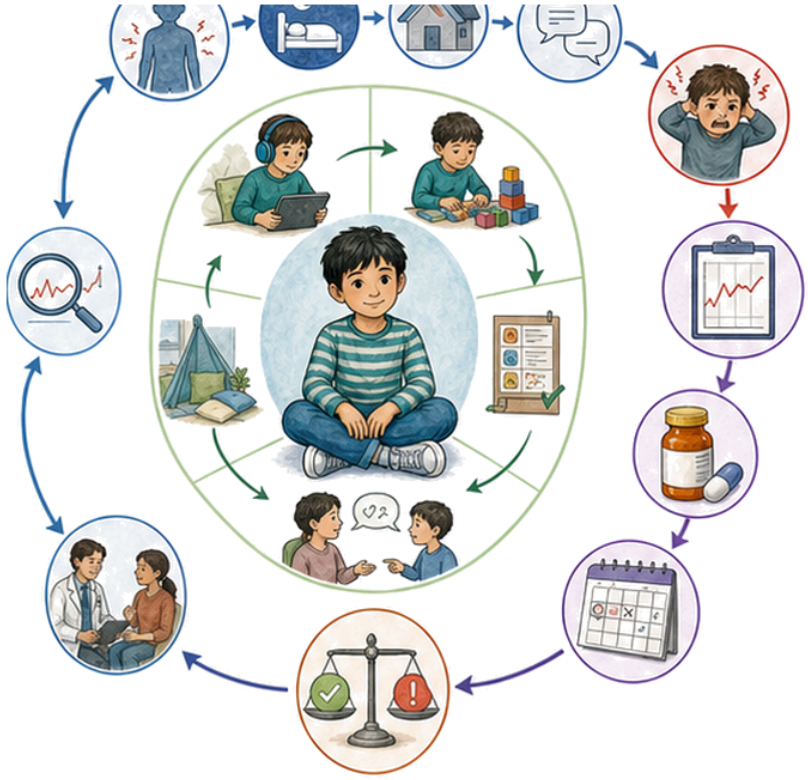
The psychiatrist also has a boundary-setting role. Behavioural work must preserve dignity, assent where it can be expressed, choice, and access to communication. It should not make the suppression of harmless difference its central aim. Concerns about pain, sleep, seizures, anxiety, mood change, trauma, bullying, family stress or adverse effects of medication require appropriate assessment rather than escalation of a behavioural plan. The wider assessment and care system is covered in the Child psychiatry: assessment, treatment, services and protection notes.

What the candidate should be able to defend. A sound answer does more than expand acronyms. It explains why a target was chosen, how the proposed method fits the observed barrier, what the evidence statement does and does not justify, and how progress will be judged in ordinary settings. The best intervention plan is not the most elaborate one. It is the one that gives the autistic person a more understandable environment, a more usable route to communication and participation, and a team capable of learning from the result.

> **Remember:** Select ABA, TEACCH, PECS or ESDM by the clinical problem and delivery context, then judge the programme by meaningful everyday change rather than by its acronym.

29 · Pharmacotherapy in ASD (target symptoms, risperidone, aripiprazole)

Medication in autism is symptom-directed. It is not a treatment for the autistic condition as a whole. No medicine is established to alleviate the **core features of autism spectrum disorder**. This distinction is the conceptual anchor for a safe prescription: the clinician is treating a disabling, observable target and its consequences, not attempting to medicate autistic identity or to substitute a drug for developmental, environmental, or family work.



- Define the target
- Check context
- Measure baseline
- Time-limited trial
- Review benefit and harm
- Never for autism itself

Fig 21.21 Medication in autism is directed at a severe, observable target behaviour and measurable impairment, not at autism itself. Context is assessed first, outcomes are defined before prescribing, and benefit and harm are reviewed as a time-limited clinical trial.

The marks in this area come from clinical precision. A good answer begins by naming the target behaviour, judging its severity and impact, and stating why medication is justified now. It then selects a medicine whose evidence fits that target, starts conservatively, monitors benefit and harm with the same discipline, and plans review from the outset. The prescription is therefore a time-limited clinical experiment with explicit outcomes, rather than an automatic response to a diagnosis.

29.1 The target-symptom framework

Irritability in autism is a clinical cluster, not merely a description of a child who is difficult to manage. In the regulatory construct for risperidone, it includes aggression towards others, deliberate self-injury, tantrums, and rapidly changing moods. These behaviours may cause injury, exclude the person from ordinary settings, exhaust carers, or make education and communication

impossible. They deserve active treatment, but the treatment target must be stated in behavioural language that can later be reviewed.

RULE **Prescribe for a defined target behaviour and measurable impairment, never for autism itself.** A medication trial is defensible when the target is severe, persistent, and associated with meaningful risk or loss of function, after the immediate context has been understood. It is not defensible simply because a person is autistic, has repetitive behaviour, or causes concern to others.

Before calling a presentation psychiatric, reconstruct its function. Consider what precedes the behaviour, what follows it, whether pain, fear, sensory overload, communication failure, a demand that exceeds capacity, or a change in routine is maintaining it, and whether the behaviour has become a reliable route out of an intolerable situation. This is not an argument against medication. It is what prevents a medicine from being used to silence the only available signal of distress. The wider assessment of co-occurring medical and psychiatric conditions belongs with the medical-comorbidity discussion; here the practical point is that an unexplained new target should be assessed before it is medicated.

Agree in advance what improvement would look like: fewer episodes, less intensity, less injury, better participation, or greater ability to use supports. Also agree what would make the trial unsuccessful: no clinically meaningful change, unacceptable adverse effects, or a target that turns out to have been incorrectly formulated. Carer observations are valuable, but must be joined to direct clinical enquiry and the person's own communication wherever possible.

TRAP **Examination trap.** Do not write that antipsychotics treat the social-communication differences or restricted interests of autism. Their established role in this section is management of severe irritability and associated dangerous behaviour.

29.2 Deciding whether medicine is needed

A target-symptom formulation protects against diagnostic overshadowing. The question is not whether the behaviour appears dramatic; it is whether there is a sufficiently clear syndrome of irritability, a serious consequence, and a realistic opportunity to judge change. It also protects the person from prolonged exposure to a drug when its intended benefit was never specified.

- Describe the target in observable terms and identify the harm, distress, or loss of access that makes it clinically important.
- Seek a working explanation for the behaviour, including communication and environmental contributors, before interpreting it as a medication-responsive syndrome.
- Record a baseline and choose a small set of outcomes that matter to the person and carer.
- Discuss the expected trade-off openly: reduction of dangerous behaviour may be valuable, but sedation, appetite change, movement effects, endocrine effects, and weight change may alter quality of life.

This approach also clarifies the place of non-drug intervention. Environmental adaptation, communication support, behavioural work, and carer support remain necessary even when

medication is appropriate. A drug may lower the intensity of a crisis enough for those measures to become usable; it does not replace them. The detailed programmes and therapies are addressed elsewhere in this chapter.

Shared decision-making is particularly important where the observable benefit is reported mainly by adults around the child. Ask what has changed for the person: comfort, participation, sleepiness, appetite, mobility, alertness, and ability to engage. A quiet child is not necessarily a better child. The therapeutic objective is improved safety and access to life, not convenience for a system that has failed to adapt.

29.3 Evidence base and place of risperidone

Risperidone and aripiprazole are the **two FDA-approved atypical antipsychotics** for irritability in children and adolescents with autism. For risperidone, the approved wording is irritability associated with autistic disorder. The listed age range is **5-16 years**. These regulatory facts should not be converted into an indiscriminate rule that every distressed autistic young person requires an antipsychotic. They identify a well-studied target, not a substitute for formulation.

Risperidone has the clearest short-term evidence when severe irritability is the dominant target. In a controlled trial, **69%** of participants receiving risperidone showed substantial reduction in irritability, compared with 12% receiving placebo. Across additional trials, short-term response generally lay between 57% and 72%. The clinical reading is not that response is guaranteed. It is that a clearly observed trial can be worthwhile where the presenting problem is dangerous, severe, and recognisably within this target cluster.

69%	12%	2.7 kg	5.6 kg
SUBSTANTIAL IRRITABILITY REDUCTION WITH RISPERIDONE	CORRESPONDING PLACEBO RESPONSE	MEAN WEIGHT GAIN IN SHORT-TERM LARGE TRIALS	MEAN WEIGHT GAIN AT FOLLOW-UP IN THE CITED STUDY

Evidence must be interpreted alongside burden. In the discontinuation phase of a risperidone study, 62.5% relapsed when switched to placebo. This makes abrupt, reflexive withdrawal after a response unwise. It does not mean that treatment must continue indefinitely. It means that the earlier formulation and the conditions that supported improvement should be revisited before tapering, and that the family needs a plan for recognising recurrence.

A meta-analysis of 46 randomised controlled trials found risperidone and aripiprazole the most effective agents for irritability, with moderate to large effects relative to placebo. This supports their priority over speculative polypharmacy. It also explains why an answer that simply lists psychotropics loses the clinical point: the evidence concerns a particular target, not a general drug treatment of autism.

29.4 Risperidone: practical dosing and titration

Start low and make each change interpretable. Weight-sensitive paediatric dosing is designed to reduce avoidable adverse effects while allowing time to judge the direction of change. The smaller-weight schedule begins at **0.25 mg/day** and then moves to 0.5 mg/day. Subsequent

increases are 0.25 mg at intervals of 2 weeks or more, within a licensed range of 0.5-3 mg/day whose upper end is not a target for a small child: therapeutic benefit plateaus at **1 mg/day**, and only patients over **45** kg may require more. Read the range as the outer bound of the licence and the plateau as the clinical ceiling. That plateau applies to both weight schedules rather than to the lighter one alone; escalation beyond a useful response should therefore not be routine.

For the higher-weight schedule, the initial dose is 0.5 mg/day, followed by 1.0 mg/day. Further increases are 0.5 mg at intervals of 2 weeks or more, with a total range of 1.0-3 mg/day. The 1 mg/day plateau applies to this schedule too. Only those weighing more than **45** kg may require higher doses, and it is in that subgroup alone that the effect plateaus at 3 mg/day. Reading the higher plateau as licence for every child on this schedule is the error the weight bands exist to prevent. Below **15 kg** there is no paediatric dosing data at all, and the source's instruction is caution for that reason rather than caution about data that exist. The distinction is the whole point: an absent evidence base is not a cautious one.

CLINICAL SITUATION	STARTING AND EARLY DOSE	LATER ADJUSTMENT	INTERPRETIVE POINT
Lower body-weight schedule	0.25 mg/day, then 0.5 mg/day	Increase by 0.25 mg at intervals of 2 weeks or more	Licence 0.5-3 mg/day, but benefit plateaus at 1 mg/day: the top of the range is not a target at this weight
Higher body-weight schedule	0.5 mg/day, then 1.0 mg/day	Increase by 0.5 mg at intervals of 2 weeks or more	Licence 1.0-3 mg/day, but benefit plateaus at 1 mg/day: the 3 mg/day ceiling belongs to patients over 45 kg alone, so a lighter child on this schedule is not titrated toward it

GOOD TO REMEMBER

The table is a dosing aid, not permission to chase the top of a range. At each step, ask whether the pre-agreed target has changed enough to justify further exposure. A partial response may be clinically important if it prevents injury or restores access to school and family life. Conversely, an apparently calmer presentation accompanied by marked sedation may represent harm rather than success. Avoid simultaneous medication changes where possible, obtain information from the settings in which the target occurs, and resist adjunctive psychotropics before the initial trial has become interpretable.

29.5 Risperidone: adverse effects, monitoring, and review

Weight gain is the adverse effect that most often changes the risk-benefit balance over time. In the larger short-term trials, mean gain was 2.7 kg. In a follow-up study it was 5.6 kg, an increase of 16.7% from baseline body weight. A paediatric estimate over a year was 7.5 kg, compared with expected annual gain of 3-3.5 kg/year. These figures make routine measurement clinically necessary rather than an administrative formality.

Prolactin elevation is another important adverse effect. Reported rates in paediatric risperidone users range from 49% to 87%, compared with 2% to 7% on placebo. Galactorrhoea has been reported in 0.8%, and gynaecomastia in 2.3%, of paediatric users. These are not simply laboratory concerns: enquire sensitively about symptoms, pubertal concerns, and distress, and interpret any abnormality in the whole clinical context.

Movement effects require active questioning and observation, especially when altered posture, restlessness, or behavioural change might otherwise be attributed to autism. Tardive dyskinesia was reported in 0.1% of paediatric participants in industry-sponsored risperidone trials, while an annual estimate for young people receiving antipsychotics was 0.3% per year. Transient somnolence after initiation had a median duration of 16 days. The numbers are low enough to tempt omission and important enough to make that unsafe: movement phenomena and sedation may be difficult to elicit from a person with limited speech.

Monitoring must therefore connect directly to the indication. At every review, revisit the original behaviour, weight trajectory, appetite, alertness, movement symptoms, endocrine symptoms, and the person's capacity to participate. If benefit is marginal, adverse effects should carry more weight in the decision. If benefit is substantial, monitoring is still not optional, because an initially acceptable trade-off can become unacceptable as exposure continues.

29.6 Aripiprazole: alternative evidence and dosing

Aripiprazole is the other approved antipsychotic for autism-related irritability in children aged 6-17 years; the FDA approval was granted in 2009. It is an alternative when the same target syndrome is present and risperidone is unsuitable, not a drug for core autism. Its initial dose is 2 mg/day. The usual range is 5-15 mg/day, the maximum is 15 mg/day, and titration proceeds by 5 mg/day at intervals of no less than 1 week.

Across the pivotal trials, active-arm responder rates were 52.2% and 55.8%, while placebo rates were 34.7% and 14.2%. The trial-to-value pairing is not reliable and should not be asserted. The defensible conclusion is that the medicine has evidence of benefit for irritability, but the size of individual benefit and the placebo contribution need careful reading rather than slogan-level certainty.

At short-term follow-up, aripiprazole-associated weight gain was 1.3-2 kg, somewhat lower than that reported with risperidone in the cited trials. It was not associated with prolactin elevation. These differences may matter when choosing between agents, especially where weight or endocrine effects have already shaped the discussion. They do not make aripiprazole benign: treatment-emergent extrapyramidal symptoms and vomiting were reported more often than in the risperidone studies. Moreover, aripiprazole may be ineffective for self-injurious behaviours. The target behaviour, rather than an imagined universally preferable drug, should drive selection.

The comparative choice is therefore a conversation about the individual target and anticipated trade-offs. Risperidone offers a strong evidence base with substantial concerns about weight and prolactin. Aripiprazole offers a distinct adverse-effect pattern, including movement effects and vomiting, and may have limitations where self-injury is the central target. Both require the same

disciplined baseline, follow-up, and willingness to stop if the promised benefit does not materialise.

29.7 Restricted and repetitive behaviour and the limits of extrapolation

Restricted and repetitive behaviours and interests are often distressing, but they should not be treated as a single undifferentiated drug target. A Cochrane review found no evidence of effect and emerging evidence of harm for selective serotonin reuptake inhibitors in children with autism. This is an important corrective to the tempting, but unsound, analogy that repetitive behaviour in autism should automatically be treated as though it were an obsessive-compulsive symptom.

The negative citalopram trial illustrates the point: responder rates were 33% with citalopram versus 34% with placebo. Evidence should be allowed to overrule pharmacological intuition. If an SSRI is being considered for another clearly formulated indication, that decision requires its own assessment; it should not be presented as treatment of core repetitive behaviour in a child with autism.

Where fluoxetine is used in the paediatric regimen cited for repetitive behaviours, the starting schedule is 2.5 mg/day for 1 week and the maximum is 0.8 mg/kg/day. These dosing details do not overturn the negative child evidence. In an examination answer, that distinction earns more credit than listing a drug without stating the weakness of its indication.

29.8 Duration, discontinuation, and the longitudinal plan

Planned discontinuation belongs in the initial prescription, not only after adverse effects emerge. For irritability in autism, antipsychotic treatment appears beneficial for **6-12 months**, after which discontinuation should be considered. This is a prompt to review, not a rigid deadline. The clinician should ask whether the original syndrome persists, whether the environment and communication supports have changed, whether adverse effects have accumulated, and whether a carefully observed reduction is now feasible.

> The success of medication in autism is not a quieter person. It is a safer, less distressed person with greater access to ordinary life, at an acceptable cost in adverse effects.

When a person has improved, explain that withdrawal is also a clinical test. A gradual, monitored reduction allows the team to distinguish continuing need from inertia. If the target returns, reconsider the formulation rather than simply restoring medication without thought: relapse may identify a genuine medication-responsive syndrome, an environmental trigger, loss of support, or an insufficiently prepared taper. If the target does not return, the successful outcome is not merely drug cessation but a person spared unnecessary exposure.

For the MD or DNB candidate, the mature answer is consequently structured rather than encyclopaedic: state that core autism is not medicated, define the target, justify either risperidone or aripiprazole for severe irritability, give cautious dosing, name the adverse-effect trade-off, and

make review and discontinuation part of treatment. That sequence shows pharmacological knowledge and, more importantly, clinical judgement.

30 · Speech and occupational therapy and family support in ASD

The practical aim is participation, not performance. Speech and language work, occupational therapy and family support translate an autism formulation into a plan that can be used during ordinary communication, play, self-care, learning and community life. They are not interchangeable therapies, and they should not be presented to families as a menu of equally established options. The useful clinical question is: which barrier is limiting this person's participation now, and what change can the child, family and communication partners realistically carry across settings?

A good plan makes communication more available, adapts demands and environments, and gives carers a role that is sustainable. It also makes uncertainty explicit. This matters especially where an intervention has an appealing explanatory story or a memorable label: plausibility, popularity and individual preference do not by themselves establish effectiveness. The psychiatrist's contribution is to hold the formulation together, protect the family from exaggerated promises, and ensure that therapy goals remain linked to daily function rather than to a fashionable technique.

30.1 Speech and language therapy: from language form to functional communication

Speech and language therapy begins with an account of how the person currently communicates, what communication partners understand, and where breakdown occurs. The assessment is broader than spoken output. It asks what the person can initiate, how they show choice or refusal, whether they can repair a misunderstanding, and which routines make communication easier or harder. The resulting targets should be concrete enough for a caregiver and teacher to recognise in ordinary life. A target that cannot be seen outside the therapy room is difficult to generalise and difficult to judge honestly.

RULE **Treat communication as access to agency.** The person needs a reliable way to request, refuse, share attention and participate, whether or not speech is the route.

This framing prevents a common drift towards making speech itself the sole outcome. Spoken language may be an important goal for some people, but clinical work should not postpone access to communication while waiting for it. The therapist therefore works with the person's existing signals and with the adults who respond to them. The psychiatrist should ask whether the proposed therapy has identified a meaningful communication function, a communication partner, and a setting in which the new skill will be practised.

A **communication partner** is not merely a helper standing nearby. The partner notices an attempt, allows time for a response, interprets it cautiously, and creates repeated opportunities for the person to communicate. This is why family and classroom work cannot be an afterthought to individual sessions. A technically correct target can fail if the adults around the person repeatedly anticipate needs, change the routine without warning, or respond inconsistently.

Conversely, a modest target can become powerful when it is recognised in the home, school and clinic.

Clinical review should distinguish a communication goal from a behavioural label. For example, a difficult moment may represent an unmet need, an inaccessible instruction, an intolerable demand, or an ineffective means of protest. The response is not to assume intent from the behaviour alone, but to test whether a clearer route for communication and a changed interaction pattern reduce the impasse. This keeps speech and language work tied to formulation without turning every difficulty into a speech problem.

- Specify the everyday situations in which communication fails.
- Agree on the response expected from communication partners.
- Choose a visible marker of change that families can recognise without specialist scoring.
- Review whether the skill appears outside the session, not only during prompted practice.

30.2 Augmentative and alternative communication in the therapy plan

Augmentative and alternative communication covers every route that supplements or replaces speech: gesture, signing, objects of reference, picture and symbol systems, and speech-generating devices. The named manualised picture-exchange programme is described with the other manualised interventions in the behavioural-interventions section of this chapter; the question here is the one the speech and language therapist actually answers, which is what the person needs a communicative route *for*, and how that route is chosen, taught and kept available.

The clinical decision is not which system is best in the abstract. It is which communicative acts are currently impossible for this person, and what would make them possible. A route is worth introducing when there is a real need to request, refuse, seek help, comment or indicate a preference; when the person can physically and perceptually manage it; and when the people around them will respond to it consistently. Assessment therefore examines comprehension as carefully as expression, because a system chosen for output alone will be abandoned by a person who cannot follow what it is being used to negotiate.

The practical discipline is to decide what communicative act the route is meant to make possible and whether the family can keep it available in the settings that matter. A picture system that remains in a folder at school is not a functional communication system at home. Equally, the introduction of a symbol system should not lead adults to stop attending to gesture, vocalisation, movement toward an item, or any other communicative attempt. The method should widen the person's options, not narrow adults' attention.

TRAP **Examination trap.** Do not present augmentative communication as a last resort that follows failed speech therapy, and do not describe it as a substitute for therapeutic formulation. It is offered alongside speech and language work from the outset, because an accessible route now does not foreclose speech later; the evidence does not show that a symbol route suppresses talking.

Review asks whether the selected communicative functions have become more available in daily routines, whether the person initiates them with multiple partners, and whether the route itself has become a barrier through poor access, excessive prompting or inconsistent adult response. A system that only works in the therapy room has not yet done its job.

30.3 Occupational therapy: participation, adaptation and sensory questions

Occupational therapy addresses participation in the occupations of ordinary life. Its clinical value lies in observing the fit between a person, a task and an environment, then changing the part of that fit that can be changed. This may involve simplifying a routine, preparing a transition, altering materials, building a practicable self-care sequence, or helping adults recognise what makes an activity inaccessible. The emphasis is not on a universal profile of autism; it is on the particular activity that has become difficult for this person and family.

Sensory integration therapy, associated with Jean Ayres, requires sharper evidence literacy. The IPS narrative frames sensory integration as challenge within a purpose-designed sensory environment, intended to support adaptation in daily activity. It assumes that a child may be receiving too much or too little environmental stimulation. That description explains why the intervention can sound intuitively compelling to families: it connects a visible response to a tangible environment. It is a rationale, however, not an outcome demonstration.

CLINICAL QUESTION	CONSTRUCTIVE RESPONSE	BOUNDARY THAT PROTECTS THE FAMILY
What activity is difficult?	Describe the task, setting, demand and response in functional terms.	Do not infer a single cause from the label “sensory”.
What can change now?	Adapt the routine, materials or adult response and observe participation.	Keep goals visible outside the therapy room.
Is sensory integration proposed?	Discuss its rationale and agree a time-limited, functional review.	Explain the uncertain evidence before commitment.
Are sound-based treatments offered?	Ask what is delivered and what safety safeguards are in place.	Do not treat a sensory rationale as evidence of benefit.

The IPS evidence rating for sensory integration is **Not established, but potentially effective**; its overview also places sensory integration outside the guideline’s recommended nonpharmacological group. This is not a contradiction to be concealed from parents. It is a reason to state the uncertainty plainly, define a functional outcome in advance, and avoid allowing an expensive or time-consuming programme to displace communication, education, family support or medical review.

30.4 Sensory integration and auditory integration: explaining contested evidence safely

A sympathetic explanation is not an endorsement. Sensory distress can be real and can interfere substantially with participation. The clinical response should be respectful observation, environmental problem-solving and a careful search for what the person is communicating

through their response. It should not convert an observation into a certainty that a particular branded intervention will correct an assumed underlying deficit.

Systematic reviews find the evidence base for sensory integration inadequate for recommendation as an evidence-based ASD treatment, with poor study design a central concern. A different textbook account reports **an absence of controlled efficacy studies**. Rather than pretending these summaries are identical, the clinician should communicate their common practical implication: controlled evidence does not establish sensory integration as a treatment for autism. The source-level tension reinforces, rather than weakens, the need for transparent uncertainty.

Auditory integration training needs an even firmer boundary. Reviews do not support a conclusion that it is effective in ASD, and they identify a potential hearing risk from loud sound exposure. The distinction between occupational adaptation and a sound-based treatment matters. A clinician who hears "sensory therapy" should ask what is actually being proposed, what outcome is promised, and whether a potential harm is being minimised in the sales language.

For sensory interventions, validate the difficulty, adapt the environment, define a functional outcome, and state the evidence limit before recommending a programme.

30.5 Family support and parent-mediated work

Family support is clinical work, not a polite adjunct after referral. Families need a coherent formulation, clear goals, practical help in negotiating settings, and space to describe what a proposed programme costs them. A plan that depends on constant availability, specialised materials or flawless delivery may be technically elegant but clinically unsustainable. The psychiatrist should make the burden visible early, especially when multiple services each prescribe home tasks without coordination.

GOOD TO REMEMBER

Before adding a parent-mediated task, ask whether it can be carried across the family's routines. Engaging parents as **co-therapists** can help maintain treatment effects and generalise learned responses across settings, but the same therapeutic tasks can increase parental stress when they become an added burden. Protect capacity: the parent is a partner whose knowledge of routines is indispensable, not an untrained therapist to be judged for poor adherence.

Preschool parent-mediated social-communication interventions teach parents, carers or teachers strategies that increase **joint attention** and reciprocal communication, often through interactive play and action routines. Their evidence should be read with precision. Improvements are usually found in proximal measures closely related to what was trained or in broader developmental measures; autism behaviours are rarely assessed and longer-term outcomes remain unstudied. This does not make the work pointless. It tells the clinician what result may reasonably be expected and what result should not be promised.

JASPER expands to Joint Attention, Symbolic Play, Engagement and Regulation. It is one of **two** evidence-based ASD interventions recommended by NICE in the cited account. The remaining intervention is not named in that source, so it should not be guessed. **PACT** means Preschool Autism Communication Trial and illustrates the same broad clinical principle: the adult-child interaction is a treatment context that needs skilled support, realistic goals and review of burden.

2
NICE-RECOMMENDED EVIDENCE-BASED INTERVENTIONS IN THE CITED ACCOUNT

NICE found too little evidence to recommend a programme for parental stress, mental health or quality of life, and directs practical intervention towards behaviours that challenge. This is a statement about the evidence base, not permission to ignore carers. Clinicians should still listen to strain, coordinate demands, make plans understandable, and reassess whether the family can live with the regimen. Where family distress requires assessment or treatment in its own right, that work belongs within the broader child psychiatric care framework, including the Child psychiatry: assessment, treatment, services and protection notes.

30.6 Matching expectations to developmental stage and setting

RULE **Match the intervention to the functional target.** The target must survive in the setting where it actually matters, not only in the therapy room.

Home, clinic and educational settings each reveal different demands. The point is not to prescribe identical practice everywhere, but to make sure that the adults in those settings understand the same goal and respond in compatible ways. This is particularly important when a child is taught a new communication act in a setting but encounters a different routine, material or response elsewhere.

Social-communication programmes can have a role where social isolation is the therapeutic target. Their evidence does not justify comparable claims for restricted, repetitive behaviours or sensory sensitivities. Candidates should avoid claiming that a communication programme treats every domain of autism. It may improve an interactional pathway while leaving another source of difficulty unchanged. That is not a failure of the child or family; it is an instruction to keep the formulation plural and to revise the plan.

For older school-aged children and young people, the evidence for social-skills and peer-mediated work is methodologically limited. A possible signal in favour of more intensive and longer work is not enough for firm conclusions. In clinical practice, this calls for proportionate claims, collaboratively chosen goals and regular review of whether a group or peer-based format is producing meaningful participation rather than merely attendance.

- Write a shared functional aim in language that family and school can use.
- Identify the adult responses that will support that aim in each setting.
- Ask what new burden the plan creates before adding another home task.
- Review benefit, feasibility and unintended effects together.

30.7 The psychiatrist's synthesis and review

The psychiatrist need not deliver every therapy to lead the treatment plan. The task is to ensure that referrals answer a clinical question, that different professionals are not pursuing incompatible goals, and that the family is not asked to carry an impossible programme. At review, ask what has changed in the specified activity, who has observed the change, where it is seen, and what has become harder. A vague report that therapy is "going well" should be translated into observable participation and weighed against burden.

This approach also guards against false choices. It is not speech therapy versus occupational therapy versus family work. Communication access, environmental fit and caregiver capacity are linked, but each needs a distinct assessment and an honest account of evidence. When an intervention is uncertain, the ethical response is neither contempt nor uncritical referral: explain the rationale, disclose the limitation, agree a meaningful review point and retain interventions with clearer functional value. Document the family's own priorities and the practical barriers that may prevent follow-through. At the next review, revise the plan rather than interpreting an unworkable intervention as a failure of motivation.

31 · Prognosis and outcome in ASD

Prognosis is not a single endpoint. In autism spectrum disorder (ASD), outcome has to be described across the abilities and circumstances that make adult life workable: communication, adaptive functioning, education and employment, relationships, autonomy, mental health, safety, and the fit between a person's needs and the support actually available. A child may make striking developmental gains yet continue to need help in daily life; another may meet fewer diagnostic features over time but remain vulnerable at transitions. The useful clinical question is therefore not whether autism will "go away", but what trajectory is emerging, what risks can be anticipated, and what support will allow the person to participate as fully and safely as possible.

For examination answers, separate the course of autistic features from functional outcome and from service outcome. They overlap but are not interchangeable. A reduction in visible autistic symptoms does not itself prove independence, and a constrained adult outcome may reflect a poor transition environment as much as the person's intrinsic abilities. Prognosis should be communicated as an individual formulation: it recognises uncertainty while identifying practical levers for surveillance, preparation and support.

31.1 The longitudinal frame

Autism is developmental, not a progressive neurological decline. ASD is **not a degenerative disorder**. Learning, adaptation and compensation can continue across the life course, which is why adult outcome cannot be inferred simply from the severity of a child's presentation at one assessment. Development may be uneven: a person can gain language, practical routines or self-awareness while continuing to have substantial difficulty with reciprocity, flexibility, sensory demands or social judgement. Clinical review must therefore look for new demands as well as changes in core features.

At the population level, many people show a **gradual reduction in autistic symptoms** alongside improved adaptive abilities. The most important qualification is the breadth of individual variation. The same diagnostic label includes people whose adult lives are relatively autonomous and people who require continuing intensive support. That variation is not a reason to abandon prognosis. It is a reason to make prognosis descriptive, revisable and grounded in function rather than in a label alone.

RULE **State prognosis as a trajectory of function and support needs, not as a promise of cure or a verdict based on diagnosis alone.**

A minority have a more difficult behavioural course in adolescence, whereas improvement is the more usual direction overall across the long run. This distinction is clinically useful. It prevents the erroneous reassurance that developmental progress eliminates later risk, while avoiding the equally damaging assumption that autism inevitably worsens. Behavioural deterioration requires assessment of change in context, physical health, seizures, psychiatric symptoms, environmental demands and the adequacy of support. It should not be dismissed as an unavoidable feature of ASD.

31.2 Diagnostic stability and its meaning

Diagnostic stability is one strand of outcome research, not a complete outcome measure. A systematic review brought together 23 longitudinal studies of children diagnosed using earlier diagnostic categories. Such work asks whether a later profile still crosses a diagnostic threshold. It does not by itself answer whether the person is communicating well, participating in education, safe from exploitation, or living with a satisfying degree of autonomy. A resident should explicitly make this distinction in a long-answer question.

Within the earlier category of **DSM-IV autistic disorder**, the diagnosis was generally stable. At follow-up, however, approximately **15%** no longer met criteria for that earlier category. This should not be translated into a claim that a corresponding proportion of people with present-day ASD lose the diagnosis. The denominator, diagnostic system and question are different. It is better understood as evidence that developmental profiles can change sufficiently for some individuals to cross a categorical boundary.

Earlier labels of Asperger syndrome and pervasive developmental disorder not otherwise specified showed a **more variable diagnostic course**. Follow-up could move in either direction: some profiles no longer met criteria for a pervasive developmental disorder, whereas others became more consistent with autistic disorder. That finding illustrates a broader teaching point. Categories are useful clinical shorthand, but development is dimensional and context-sensitive. A later reassessment should be based on the current developmental history and functional picture, rather than treated as an administrative confirmation of a childhood label.

TRAP **Do not equate a change in diagnostic threshold with normalisation.** Diagnostic status, symptoms, adaptive functioning and participation must be reported separately.

31.3 What adult outcome studies actually show

Adult outcome studies are difficult to compare because they use different samples, eras of diagnosis, follow-up methods and definitions of a good outcome. Some use a common classification ranging from very good to very poor, while others emphasise schooling, work, living arrangement or social inclusion. These are related outcomes, but they are not synonyms. The evidence base also contains relatively few prospective studies that follow children from early childhood into adult life. That limitation matters when counselling families: precise-sounding estimates may conceal a very particular cohort and a very particular endpoint.

23	approximately 15%	between <5% and 25%
LONGITUDINAL STUDIES IN ONE STABILITY REVIEW	LATER BELOW AN EARLIER AUTISTIC-DISORDER THRESHOLD	VERY-GOOD RATING ACROSS PROSPECTIVE COHORTS

Using that common outcome classification, the proportion rated as having a **very good outcome** lay **between <5% and 25%** across prospective childhood-to-adulthood studies. This is not an employment rate, a school-attendance rate or a prevalence estimate. It is a rating on a particular outcome tool. The correct interpretation is that very favourable adult outcomes occur, but their frequency varies substantially by cohort and definition.

Another older, narrower set of estimates concerns children with **childhood autism**, not the contemporary whole ASD spectrum. Around **10% to 20%** improved from early childhood and subsequently attended an ordinary school and obtained work. A further 10% to 20% could live at home but could not work and required special schooling or a training setting. At least **60%** improved little and could not lead an independent life. These figures are worth knowing only with their boundaries intact: they are historical, category-specific outcome tiers, not a universal prediction for all persons now diagnosed with ASD.

OUTCOME QUESTION	WHAT IT CAPTURES	WHY IT MUST NOT BE SUBSTITUTED FOR ANOTHER OUTCOME
Diagnostic status	Whether current features meet a specified threshold	It does not establish independence or quality of life.
Symptom trajectory	Change in autistic features over time	Improvement can coexist with persistent support needs.
Functional outcome	Communication, practical autonomy, participation and work	It depends on both personal skills and opportunity.
Living arrangement	Where and with what support a person lives	Family resources and service availability influence it greatly.
Outcome classification	A study-defined global rating	It should not be relabelled as a single attainment figure.

Improvement is also not synonymous with the disappearance of autistic traits. People with childhood autism who improve may continue to have language problems, emotionally detached interpersonal style, and unusual behaviour. The clinical implication is respectful realism:

celebrate gains without withdrawing supports prematurely, and assess the person's own goals rather than judging success only against a conventional adult template.

31.4 Predictors: useful, but never deterministic

The strongest recurring predictors are markers, not destiny. Better long-term outcome is associated with **higher intellectual ability** and the presence of useful speech before **5 years of age**. A second account places useful speech at age 5 years. The slight difference in wording should not be forced into a false precision. Both formulations identify the early emergence of functional language as a favourable marker, while preserving the fact that people with similar apparent strengths can have very different adult outcomes.

Why are these predictors clinically plausible? Intellectual ability and functional speech can broaden the routes through which a child learns, signals distress, understands rules, uses education and later negotiates environments. They may also make it easier for carers and teachers to recognise strengths and tailor demands. Yet this is interpretation, not a reason to reduce prognosis to a score or a language milestone. Social understanding, emotional regulation, daily living skills, family circumstances, educational fit, co-occurring conditions and adult services can each alter what those strengths mean in real life.

There is also an **optimal outcome** literature describing a minority whose later presentation no longer meets diagnostic criteria. In observational comparisons, this group had four distinguishing features four:

- milder social impairment at baseline, despite comparable early communication and restricted or repetitive difficulties;
- earlier access to intervention;
- more intensive behavioural intervention services; and
- a greater likelihood of receiving applied behaviour analysis rather than pharmacological intervention.

These observations are important but do not prove that any one service caused the outcome. Baseline social differences may themselves influence both eventual outcome and access to an intervention. Service intensity may also be a proxy for family resources, local provision or a clinician's perception of need. This is the distinction a mature answer should make: observational association can guide hypotheses and service planning, but causal claims require a design able to separate treatment effects from pre-existing differences.

RULE **Use prognostic markers to individualise support and follow-up, never to ration intervention or forecast an individual's ceiling.**

That caution is especially necessary when discussing earlier identification. There has been **no randomised combined screening-and-treatment trial** demonstrating that screening and an earlier age at diagnosis itself lead to better long-term outcome. This does not make timely recognition unimportant. It means that the causal chain should be stated honestly: earlier

recognition may allow access to help sooner, but the long-term benefit of a screening-and-treatment pathway has not been established by that trial design. The detailed approach to early intervention belongs with the management sections of this chapter.

31.5 Adolescence: where trajectories can diverge

Adolescence increases both opportunities and strain. New educational settings, changing social expectations, bodily changes, growing self-management demands and the approach to adult roles can expose a mismatch between a person's coping strategies and their environment. A previously manageable pattern may become more visible when routines change or supports recede. It is therefore good practice to establish a functional baseline and to ask what has changed before assuming a deterioration reflects the autism itself.

Some studies describe a **deterioration in functioning during adolescence** that may coincide with the development of epilepsy or with the onset of psychiatric disorders. The occurrence of epilepsy in ASD, its assessment and medical management are covered in the medical-comorbidity section. In this prognosis section, its relevance is as a warning that a loss of functioning needs active medical review rather than passive observation.

Similarly, the onset of **co-occurring anxiety or mood disorder** may accompany adolescent deterioration. A changed presentation may be behavioural rather than verbal: withdrawal, irritability, sleep change, avoidance, increased rigidity, loss of skills in familiar routines or escalating distress can all be clinically meaningful. Do not presume that every change is a core autistic feature. The map of psychiatric and medical comorbidity, including how to detect it, is addressed in the medical-comorbidity section; pharmacological treatment of target symptoms is addressed separately.

Regression should also be handled carefully in prognostic discussion. A developmental history of regression may shape a family's fear about future loss, but it is not a licence to make a numerical prediction. When there is new loss of function, the clinician must revisit the differential diagnosis and investigate the current change. The differential of regression is considered in the differential-diagnosis section of this chapter.

31.6 Mortality and preventable risk

Mortality in ASD appears **slightly increased** relative to the general population, but the available evidence is limited and no numerical rate should be implied where one has not been established. Prognostic counselling should avoid alarmist language. The clinical value of raising this issue is not to frighten families; it is to focus attention on preventable hazards and on continuity of medical care.

One proposed pathway concerns medical events such as status epilepticus or accidental death associated with epilepsy. This makes seizure monitoring during adolescence a potentially preventable part of risk reduction when seizures emerge or change. The point is not that every deterioration is epileptic, nor that epilepsy explains all excess mortality. It is that a new seizure history, impaired recovery after an event, or a change in functioning deserves prompt clinical attention.

A change in function in an adolescent or adult with ASD is a clinical event: reassess health, mental state, environment and support before attributing it to autism.

31.7 Transition to adulthood is a prognostic intervention point

Services shape outcome. The exit from school can be profoundly stressful and may slow overall progress. The move into adulthood often reveals gaps in adult mental-health care, social care and developmental-disability provision. This is a service problem as well as a developmental challenge. A young person's competence can appear to fall when familiar structures disappear, travel demands increase, family carers become exhausted, or no one coordinates education, work, benefits, healthcare and daily support.

Transition planning should begin with an account of the person's present strengths, communication preferences, sensory and behavioural needs, health risks, decision-making support, family capacity and preferred adult roles. It should identify what the young person can increasingly manage independently and what assistance remains necessary.

GOOD TO REMEMBER

Make the transition plan concrete: who will notice deterioration, who will coordinate appointments, what happens when routine breaks down, and how meaningful daytime activity will be maintained. This protects dignity while avoiding a sudden and unrealistic withdrawal of care.

The evidence for specific transition-planning interventions remains limited, so clinical reasoning matters. Build continuity wherever possible, prepare the receiving service, and make the handover understandable to the person and family. The broader assessment battery, service organisation and safeguarding framework are set out in the Child psychiatry: assessment, treatment, services and protection notes. The detailed discussion of adult ADHD belongs in the ADHD and specific learning/communication disorders notes.

31.8 A practical way to communicate prognosis

A useful prognostic conversation starts with what is already known and names uncertainty without retreating into vagueness. Describe the person's trajectory in domains: communication, adaptive skills, learning, participation, mental health, physical health, safety and support network. Then identify favourable capacities, current barriers and foreseeable transition points. Families often need help distinguishing a realistic plan from a deterministic prediction. The clinician can say that development may continue, that outcomes vary markedly, and that progress is strengthened when demands and support are matched over time.

In a written formulation, avoid a bare phrase such as "poor prognosis". Instead state the active issues and the plan for each. This gives the team a framework for review and gives the family an intelligible account of why monitoring continues even when the person is doing well.

FORMULATION DOMAIN	QUESTION FOR FOLLOW-UP	CLINICAL USE
Developmental trajectory	What has improved, plateaued or changed?	Separates expected variation from a clinically significant loss of function.
Functional participation	What can the person do with the available support?	Prevents symptom counts from standing in for real-world outcome.
Communication and cognition	How are strengths being used in education and daily life?	Uses prognostic markers without turning them into ceilings.
Health and mental state	Has there been a new seizure, distress pattern or behavioural change?	Prompts review of potentially modifiable contributors.
Transition and supports	What will change when current structures end?	Turns a predictable risk point into a planned intervention point.

The final examination-quality conclusion is balanced. ASD usually permits ongoing learning and adaptation, but outcome is highly heterogeneous. Better intellectual ability and early useful speech are favourable markers, not guarantees. Co-occurring epilepsy or psychiatric illness, and failures at major transitions, can worsen functioning and require active review. The best clinical response is sustained, person-centred planning that measures meaningful function and keeps support available as needs change.

Discriminate, apply and consolidate

32 · Differentiation of intellectual disability from autism, GDD and borderline intellectual functioning

The discriminative task. A developmental presentation is not solved by attaching the most visible label to the child. Intellectual disability, autism spectrum disorder, global developmental delay and borderline intellectual functioning may all come to attention through slow learning, school difficulty, communication concerns or behaviour that unsettles adults. They answer different clinical questions. The useful formulation asks what the person can do in everyday life, how development has unfolded, whether social communication is qualitatively atypical for that developmental level, and whether the current assessment is a valid account of ability.

The marks are usually in the reasoning, not in reciting a checklist. Start by separating a broad developmental profile from a distinctive pattern of social-communication and behavioural difference. Then decide whether the profile has reached the threshold for intellectual disability or is better recorded as **borderline intellectual functioning**. This avoids opposite errors: calling every child with delayed language autistic, and using a reassuring test score to overlook everyday limitations that require support.

32.1 Begin with a developmental formulation, not a label

A **developmental formulation** is a map of strengths, difficulties and their context. It is more useful than an early diagnostic label because the same presenting complaint can arise from very different pathways. Slow acquisition of school skills may reflect a generally low level of functioning, a sensory or language barrier, missed learning opportunities, emotional distress, a neurodevelopmental condition, or an assessment that did not capture the child's usual capacity. The clinician therefore compares domains rather than treating a single complaint as the whole phenotype.

History supplies the frame. Establish the tempo of acquisition and whether abilities have continued to accrue, plateaued, or been lost. Ask how the person communicates needs, joins shared activity, copes with ordinary demands, learns from modelling, and manages changes in routine. Observe the same questions in the interview. A score is evidence, but not an explanation. It must be interpreted with language, sensory, motor, educational and behavioural context in view. This is especially important when the interview setting is unfamiliar or the person is anxious, overactive, shut down, oppositional, exhausted, or unable to understand the task demands.

RULE **Rule.** Diagnose the pattern of functioning and its real-world consequences; never let a conspicuous developmental symptom decide the diagnosis by itself.

The comparison must be made against **developmental level**, not merely chronological expectation. This prevents a common false positive for autism. A person with broadly delayed development may use simpler language, play, social approaches and coping strategies than peers. The pivotal question is whether social communication is more impaired, qualitatively different, or oddly uneven even when compared with that person's overall developmental level. Conversely, apparently sociable behaviour does not by itself settle the issue: the clinician asks whether contact is reciprocal, flexible, shared and meaningful, rather than simply frequent.

- Define the referral problem in ordinary functional terms before translating it into a diagnostic question.
- Seek convergent information from the person, family, school and direct observation.
- Describe strengths as carefully as limitations, since unevenness often carries the diagnostic clue.
- Record factors that could have distorted the assessment before treating its result as trait-like ability.

32.2 Comparison at the bedside

The table is a reasoning aid, not a substitute for assessment. Intellectual disability concerns the established diagnostic construct and its functional consequences. Autism spectrum disorder concerns a characteristic social-communication and behavioural pattern. Global developmental delay is a developmental description used when a stable intellectual-disability formulation cannot yet be made with confidence. Borderline intellectual functioning identifies a clinically relevant

zone near the boundary, where careful assessment and context matter more than an automatic diagnostic conclusion.

CLINICAL QUESTION	INTELLECTUAL DISABILITY	AUTISM SPECTRUM DISORDER	GLOBAL DEVELOPMENTAL DELAY	BORDERLINE INTELLECTUAL FUNCTIONING
Central task	Establish the intellectual and adaptive profile	Identify a characteristic social-communication and behavioural pattern	Describe developmental delay while the profile is still evolving	Judge a boundary presentation and its clinical relevance
Pattern of difficulty	Broad functional limitations are central	Qualitative difference may coexist with any intellectual level	Delay is described across development rather than presumed permanent	Difficulties may be real without establishing intellectual disability
Key comparison	Everyday function alongside intellectual assessment	Social reciprocity and behaviour relative to developmental level	Current abilities, opportunities and developmental trajectory	Intellectual and adaptive findings, including their mismatch
Common error	Equating a test result with the whole diagnosis	Calling global delay autism without qualitative evidence	Forcing a permanent label before adequate assessment	Using an obsolete numerical rule as a current diagnosis

Use the table dynamically. A person can occupy several categories in a clinically meaningful sense. Autism can occur with intellectual disability, and developmental delay can be the initial description before the later formulation becomes clearer. The task is not to make the categories mutually exclusive. It is to avoid using a category as an explanation for every feature and to state clearly what each diagnosis contributes to care planning.

> The decisive comparison is qualitative pattern against developmental level, interpreted alongside everyday functioning, not the presence of delay alone.

32.3 Intellectual disability and autism spectrum disorder

When intellectual disability is being considered, autism must be established by a characteristic qualitative pattern beyond the effects of broad developmental limitation, rather than inferred from delayed performance alone.

GOOD TO REMEMBER

Observe how the person uses the abilities they do possess. Do they seek another person for comfort, enjoyment, help or shared attention? Can they respond to a familiar social bid when demands are low? Is there flexibility in the way people and objects are used? Interpret the answers in the context of communication ability and the environment, not as isolated signs.

In autism, the important finding is a disproportionate alteration in **relative social reciprocity** and in the behavioural pattern, rather than delayed performance alone. A person may have very limited speech yet show clear social interest and shared enjoyment that are consistent with their overall developmental level. Another may have fluent speech but persistently atypical reciprocity, difficulty using communication socially, inflexible interests or restricted patterns that cannot be explained by general developmental delay. The latter pattern warrants an autism assessment even when intellectual ability is not clearly impaired.

Do not set up a false contrast in which one diagnosis excludes the other. When autism and intellectual disability coexist, the formulation should state both and then show what observations support the autism diagnosis beyond global delay. That discipline protects against diagnostic overshadowing in either direction. It prevents clinicians from attributing all behaviour to intellectual disability, while also preventing an autism label from obscuring practical support needs, communication limitations or safeguarding concerns associated with intellectual disability.

TRAP **Examination trap.** Delayed language, poor eye contact in an unfamiliar interview, repetitive play at a low developmental level, or behaviour under stress is not by itself evidence of autism. The question is whether the social-communication and behavioural pattern is qualitatively atypical for that person's developmental level.

Clinical interviews should therefore include situations that lower performance pressure. Watch what happens when the examiner follows the person's lead, offers a familiar object, pauses for a response, or involves a caregiver. A narrow clinic observation can overread anxiety, sensory discomfort or communication mismatch as autism, especially when the person has intellectual disability. Equally, a warm greeting or brief eye contact cannot rule autism out. Longitudinal history and reports across settings are what convert an impression into a defensible formulation. Detailed diagnostic criteria and assessment methods for autism belong in the relevant sections of this chapter; here the practical point is to ask whether autism adds a distinctive explanatory pattern beyond general developmental difficulty.

32.4 Intellectual disability and global developmental delay

Global developmental delay is best understood as a developmental description, not as a shortcut to a lifelong conclusion. It communicates that delay is evident across the developmental profile while acknowledging that the available evidence may not yet support a stable intellectual-disability formulation. The distinction matters because a child's observed performance is shaped by opportunity, health, communication access and the feasibility of formal assessment. A label that is too final can close inquiry prematurely; a label that is too vague can fail to communicate support needs.

The key concept is **developmental trajectory**. Ask whether the profile is broadly delayed or strikingly uneven, whether new skills are being acquired, and whether the child's functioning is being assessed under conditions that permit a fair estimate. Repeat assessment may be more informative than forced precision when a child cannot engage with formal tasks, when communication access is poor, or when the environment has substantially limited experience.

The clinician should explain uncertainty plainly: uncertainty is not indecision when it accurately reflects the developmental state of the evidence.

This distinction also changes the conversation with families. The immediate work is to describe present strengths and needs, arrange appropriate developmental and functional assessment, and review change over time. It is not to promise a future intellectual level or to use a temporary descriptive term as a euphemism for a diagnosis that has not been established. The normal developmental framework should be read alongside the *the Normal child development and milestones notes*; assessment, services and protection are addressed in *the Child psychiatry: assessment, treatment, services and protection notes*.

- Use global developmental delay when it accurately describes the current developmental evidence and its limits.
- Do not assume that a broad early delay proves a fixed intellectual-disability formulation.
- Do not assume that later identification of intellectual disability was predictable from one early observation.
- State what must be clarified on follow-up: developmental course, everyday function, communication access and validity of assessment.

The distinction is therefore practical rather than semantic. It determines how confidently the clinician communicates prognosis, how the record represents uncertainty, and why follow-up must revisit the formulation rather than merely repeat a label. It also keeps the assessment open to alternative or coexisting explanations when the profile is not globally uniform.

32.5 Borderline intellectual functioning: category, boundary and limits

Borderline intellectual functioning is not a milder synonym for intellectual disability. In the DSM-5-TR, it is coded **R41.83** and appears in Section II among conditions that may warrant clinical attention. That location is clinically useful: it permits recognition of a relevant cognitive vulnerability without converting every such presentation into a formal mental disorder.

The nosological boundary must be stated accurately. Borderline intellectual functioning is a **condition**, rather than a formal DSM-5 disorder. It should not be treated as a clear-cut disability category or as proof of definite deficits across intellectual and adaptive domains. The category is appropriate when the cognitive profile is itself the focus of clinical attention, or when it materially shapes treatment or prognosis. In practical terms, it can alert the clinician to adjust explanations, consent processes, expectations of independent follow-through, and the format of psychological or pharmacological care, while continuing to assess the actual person rather than acting on a label.

A psychometric zone may be described as **about 70 to 85**, or as one to two standard deviations below the mean, but this is not a current definitional rule. The current DSM-5 approach does not use a numerical IQ criterion to define the category. The older DSM-IV-TR definition explicitly used **IQ 71-84**; importing that band into current diagnostic reasoning is a category error. A

numerical result can prompt a closer look. It cannot replace clinical assessment of function, context and discrepancy.

R41.83	about 70 to 85	71-84	no numerical criterion
CURRENT CODE	DESCRIBED PSYCHOMETRIC ZONE	OLDER DEFINITIONAL BAND	CURRENT DEFINITION

Why this boundary matters. A person can have modest cognitive efficiency yet function capably in familiar, well-supported settings. Another may appear competent until demands increase, language becomes technical, routines change, or treatment requires planning and self-monitoring. Neither observation alone settles whether the person has intellectual disability, borderline intellectual functioning, another condition affecting performance, or a mixture of these. The clinician must avoid both minimisation and overpathologising.

32.6 Separating borderline intellectual functioning from mild intellectual disability

This is the boundary at which disciplined assessment matters most. The current DSM-5 framing expressly compares borderline intellectual functioning with mild intellectual developmental disorder, rather than making a broad contrast with intellectual disability in general. The assessment requires careful appraisal of intellectual and **adaptive functions**, including the **discrepancies** between them. This is not a mechanical exercise. A discrepancy may signal uneven opportunity, a co-occurring disorder, an invalid test session, a skill that is context-bound, or a genuine pattern requiring further understanding.

Work in both directions. If a test result lies near the boundary but everyday functioning is more limited than expected, ask what accounts for the gap before deciding that it demonstrates intellectual disability. Consider communication barriers, educational experience, emotional state, psychiatric symptoms, physical illness, sensory difficulty, family scaffolding and the actual demands of the setting. If everyday functioning appears stronger than a test result, ask whether the person has learned routines exceptionally well, receives extensive unobtrusive support, or had a poor-quality testing experience. The aim is not to rescue a preferred diagnosis. It is to identify the most credible account of the data.

Test validity is central to this judgement. The DSM entry specifically cautions that co-occurring disorders can affect adherence to standardised testing, including schizophrenia and ADHD with severe impulsivity. A low score obtained when attention, motivation, comprehension or behavioural regulation has collapsed is not automatically evidence of stable intellectual ability. Nor should a clinician dismiss all low performance as psychiatric. Reassess the conditions of testing, use collateral evidence, and formulate whether the observed score is likely to represent the person's usual functioning.

The practical record should make the reasoning visible. State the referral question, the data sources, their limitations, the relation between assessed ability and everyday functioning, and what alternative explanation has been considered. Then state why the conclusion is intellectual disability, borderline intellectual functioning, or a provisional formulation. This is kinder to families and more defensible clinically than an unsupported categorical assertion. Intelligence

testing itself and the instruments used for it are addressed in the assessment section of this chapter; do not confuse such testing with a complete functional evaluation.

32.7 Coding, language and the historical trap

The current label has a complicated historical trail, which explains why outdated terminology still appears in records and teaching material. In DSM-II, the 1968 entry used the label "borderline mental retardation" and the code 310. In 1973, the American Association on Mental Deficiency, now AAIDD, eliminated that name in favour of "borderline intellectual functioning".

The coding location also shifted. DSM-III placed it on Axis I with V62.89 in 1980. DSM-III-R moved it to Axis II with V40.00 in 1987; DSM-IV later used Axis II V62.89 in 1994. Axes were removed in DSM-5 in 2013, which used R41.83.

This history should sharpen, not confuse, current practice. It shows why an old numerical band, an old axis placement, or stigmatising terminology is not a substitute for a contemporary formulation. Use language that describes the person's current functioning and support needs. When older records are encountered, translate their meaning cautiously and verify what assessment was actually done before carrying a label forward.

Finally, "borderline" in borderline intellectual functioning has no relationship with borderline personality disorder. Similar wording is not shared aetiology, shared diagnosis or a reason to infer one condition from the other. Keeping this distinction explicit is particularly important when a patient has emotional dysregulation or interpersonal difficulty, because such features can tempt clinicians into semantic rather than phenomenological reasoning.

32.8 A defensible conclusion and its clinical use

Clinical attention is the right frame for borderline intellectual functioning. The category may be recorded when it changes how treatment is delivered or how prognosis is understood, not as a casual descriptor of anyone who struggles academically. Explain information plainly, check comprehension through the person's own account, anticipate difficulties with abstract instructions, and involve supports appropriately while respecting autonomy. These are good clinical practices because they respond to observed needs, not because a code has replaced assessment.

In a written answer, a strong conclusion follows a consistent sequence. Identify whether the central issue is broad functional limitation, a distinctive autism pattern, an evolving developmental profile, or a boundary cognitive presentation. State the observations that support that judgement. Name any coexisting diagnosis separately. Finally, state what must be reassessed and how the formulation changes communication, support and follow-up. This makes the differential useful at the bedside rather than a set of mutually exclusive examination labels.

Diagnostic humility is not vagueness. It means using a provisional developmental description when the evidence is still developing, making an autism diagnosis only when its qualitative pattern is established, recognising intellectual disability through the established formulation rather than a score alone, and using borderline intellectual functioning accurately when it is

clinically relevant without overstating its status. For associated attention and learning questions, use the ADHD and specific learning/communication disorders notes.

33 · Four worked cases

Vignettes test clinical organisation, not label recognition. A short stem rarely gives a complete developmental history, a valid cognitive assessment, an adaptive profile and a collateral account. The candidate's task is to recognise what the available pattern supports, state what remains uncertain, and choose the next discriminating enquiry. The same discipline protects clinical practice from premature labelling.

Use each vignette as a **developmental formulation**: place the person's trajectory, everyday function, social-communication pattern, repetitive or restricted behaviour, medical context and environment alongside each other. A diagnostic label is the conclusion of that process, not a substitute for it.

Trajectory	Function	Pattern	Context
DEVELOPMENTAL COURSE	EVERYDAY INDEPENDENCE	SOCIAL COMMUNICATION AND BEHAVIOUR	MEDICAL, FAMILY AND EDUCATIONAL SETTING

33.1 Read the stem before naming the diagnosis

The useful first question is not “Which disorder is this?” but “What is impaired, in which settings, and since when?” Separate a person's learning and problem-solving capacity from **adaptive functioning**, and separate both from the quality of social reciprocity and the behavioural pattern. School difficulty, delayed language, disruptive behaviour and poor self-care are findings. None is diagnostic in isolation.

RULE **Rule.** Diagnose the pattern of impairment, then test whether the pattern is global, autism-specific, developmental but still evolving, or below expected ability without the pervasive functional deficits required for intellectual disability.

- **Trajectory:** establish whether development has been delayed, uneven, static or marked by loss of previously acquired abilities.
- **Current function:** ask how the person manages communication, self-direction, daily routines, safety and participation in ordinary settings.
- **Pattern and context:** seek social-communication differences, restricted or repetitive behaviour, sensory concerns, physical clues, medical symptoms and the accounts of people who know the person well.

33.2 The central discrimination

Intellectual disability remains an assessment question when a stem describes broad difficulty with learning and everyday function. An autism-spectrum formulation depends on its characteristic social-communication and behavioural pattern. These formulations may coexist. The presence of autism does not answer the question of intellectual functioning, and global learning difficulty does not by itself establish autism.

FINDING IN A STEM	WHAT IT SUGGESTS	WHAT PREVENTS AN OVERCALL
Broad difficulty learning and carrying out everyday tasks	Consider a global impairment formulation	Clarify adaptive functioning and the developmental course
Qualitative difference in reciprocal social communication with a restricted or repetitive pattern	Consider an autism-spectrum formulation	Do not infer intellectual disability from the autism label alone
Developmental concerns in an early developmental presentation without a stable assessment picture	Use **global developmental delay** as a working developmental formulation where appropriate	Plan review as developmental information becomes clearer
Academic or occupational struggle with relative preservation of everyday adaptive competence	Consider **borderline intellectual functioning** and competing explanations	Do not convert a low score, poor scholastic performance or social disadvantage directly into intellectual disability

TRAP **Exam trap.** "Delayed speech" is not a shortcut to autism, and "poor school performance" is not a shortcut to intellectual disability. The discriminating evidence is the whole developmental and functional pattern.

33.3 Vignette: broad developmental difficulty without an autistic pattern

A child is brought because progress across learning, communication and self-care has been slow. The family describes a steady developmental course and needs help across ordinary routines. In the consultation, the child seeks shared engagement in a manner that is proportionate to developmental level, with no clear history of a restricted or repetitive behavioural pattern.

The defensible formulation is that the stem raises concern for intellectual disability or, when developmental assessment remains incomplete, a developmental-delay formulation. The point is not to exclude autism because the child is friendly, nor to diagnose autism because language is delayed. Ask for formal assessment of ability and adaptive behaviour, collateral accounts across settings, developmental history, physical and neurological review, and an aetiological evaluation guided by the wider presentation.

Why the distinction matters. The intervention plan must address the actual pattern of support needs. If autism is added without its defining pattern, families may be diverted from the assessment and supports that explain the person's everyday difficulty.

33.4 Vignette: autism with an uneven profile

An adolescent has intense, narrow interests, inflexible routines and marked difficulty interpreting reciprocal social interaction. Academic achievement is strong in selected areas, while practical independence and social judgement are variable. The stem offers no valid basis to conclude that intellectual functioning is globally impaired.

The appropriate formulation is autism spectrum disorder with a separate assessment of intellectual and adaptive functioning. Uneven strengths do not cancel clinically important disability, but neither do social difficulty and inflexibility prove intellectual disability. Document

the areas of competence as carefully as the areas of difficulty, because support planning follows function rather than assumptions about a diagnostic label.

- Ask which difficulties are intrinsic to social communication and behavioural flexibility.
- Ask whether practical dependence reflects limited capacity, limited opportunity, anxiety, environmental mismatch or a combination.
- Describe co-occurring attention, mood, anxiety, sleep, neurological and medical concerns without attributing all distress to autism.

33.5 Vignette: the apparent boundary case

A young person has struggled academically for years and has been described as "slow." At home and in the community, the person manages familiar routines, relationships and responsibilities with little extra help. An isolated test result is quoted in the referral note, but its validity, context and relation to everyday functioning are not described.

This stem is designed to expose **score determinism**. Consider borderline intellectual functioning, specific learning or communication disorders, attention problems, educational deprivation, sensory impairment, emotional disorder and contextual barriers. For the detailed assessment battery, see the Child psychiatry: assessment, treatment, services and protection notes; for attention and learning differentials, see the ADHD and specific learning/communication disorders notes.

GOOD TO REMEMBER

Do not diagnose from a number or a pejorative description. Interpret formal assessment alongside adaptive function and developmental history.

33.6 Vignette: change after an established developmental course

A caregiver reports that a child who had acquired skills is no longer using them in the same way. The current presentation includes communication difficulty and repetitive behaviour. The temptation is to treat the current surface pattern as sufficient for an autism diagnosis.

Here the clinical priority is a careful account of **regression**, its tempo, the affected skills, associated neurological or medical symptoms, and the possibility of an alternative developmental or neurological condition. Autism may remain part of the formulation, but loss of skills changes the workup and makes a broad differential essential. Do not reassure, diagnose or narrow the enquiry before establishing the trajectory.

MNEMONIC

MAPS

Map the developmental trajectory. **A**ssess everyday adaptive function. **P**attern-match social communication and restricted or repetitive behaviour. **S**earch for syndromic, neurological, psychiatric and contextual signals. This is a retrieval map, not a substitute for assessment.

33.7 Turning a vignette into a clinical answer

A strong answer starts with a provisional formulation, gives the positive findings that support it, then names the information required to distinguish nearby alternatives. It states comorbidities and safety or medical concerns as possibilities to assess, rather than presenting them as conclusions not contained in the stem. A developmental diagnosis does not make new distress, behaviour change or physical symptoms self-explanatory: assess each reported change on its merits.

When asked for management, link recommendations to the person's identified functional needs and family priorities. Do not leap from a label to a named programme, medication or legal entitlement. The relevant chapters provide the detailed intervention, medical-workup, disability-certification and family-support pathways.

> In every developmental vignette, the diagnosis must explain the whole pattern of trajectory, function and behaviour better than its nearest alternative.

34 · Consolidate: the master mnemonic, the retrieval prompts and the synthesis map

Consolidation is a clinical discipline, not a list of labels. Intellectual disability, autism spectrum disorder, developmental delay and borderline intellectual functioning can overlap in a referral, yet each answers a different clinical question. The task is to preserve that distinction while building a single account of the person's abilities, difficulties, context and needs.

A high-quality answer therefore moves from the presenting concern to a **developmental formulation**. It does not let a test result, a screening result, a certificate or a diagnostic label substitute for the history, observation and functional account. The chapter's component sections supply the detail; this closing section shows how to hold them together without flattening them.

MAP	READ	CHECK	PLAN
THE DEVELOPMENTAL COURSE	THE FUNCTIONAL PROFILE	CO-OCCURRENCE AND CONTEXT	MEANINGFUL SUPPORT

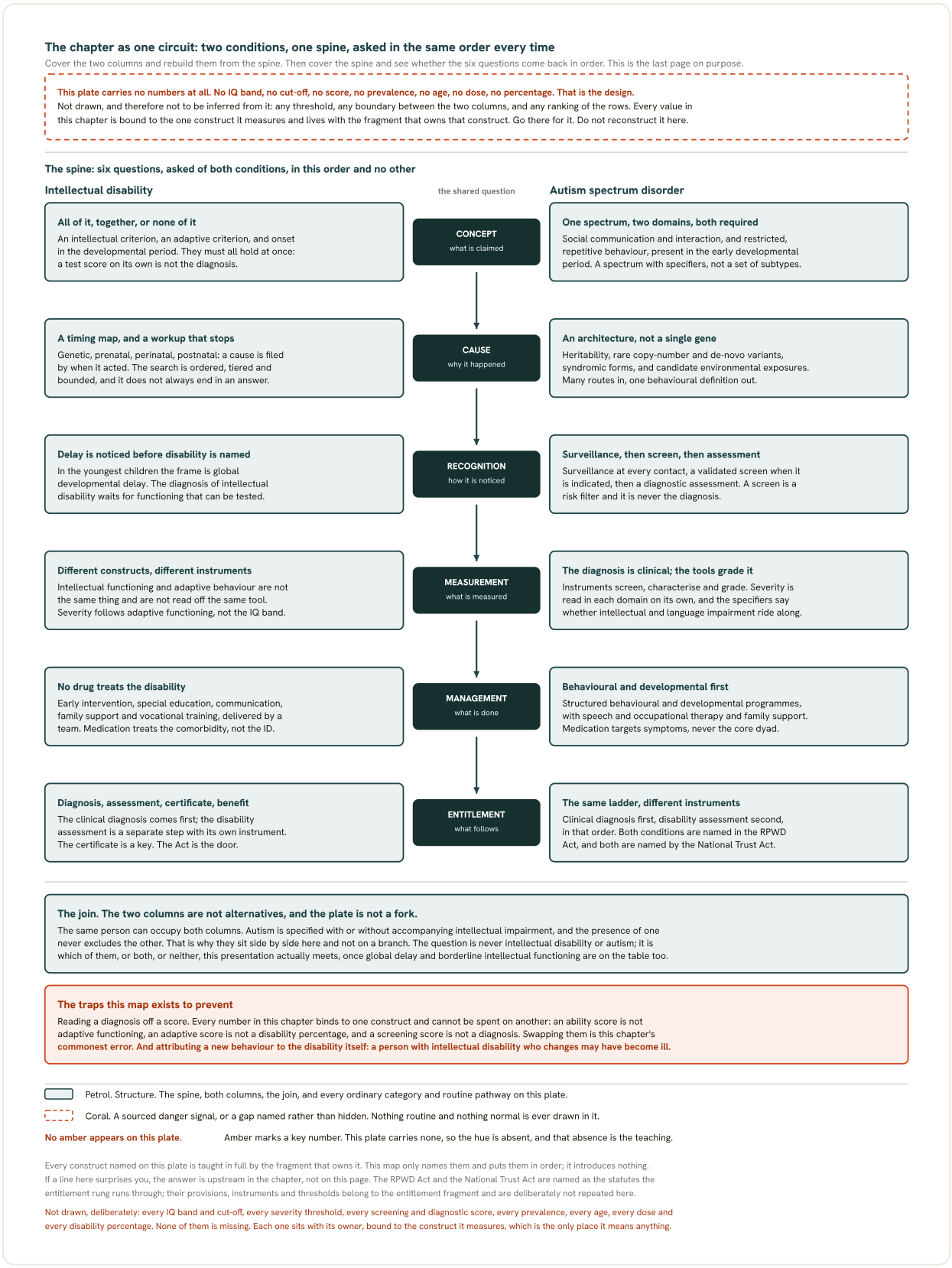


Fig 21.22 **The chapter as one circuit.** Intellectual disability and autism spectrum disorder set side by side across a shared spine of six questions, concept to cause to recognition to measurement to management to entitlement, asked of both conditions in the same order. The plate carries the shape of the chapter and no numbers at all, because every number in this chapter binds to the one construct it measures and lives with the fragment that owns that construct. The join band states the thing the side-by-side layout is there to teach, that the two columns are not alternatives and the same person can occupy both.

34.1 Start with the developmental question

The starting task is to establish the **developmental trajectory**: what was acquired, what is currently difficult, whether skills have been lost, and how the pattern affects everyday life. This makes the assessment developmental rather than merely behavioural. It also keeps current symptoms in relation to the person's communication, cognitive and social capacities.

Developmental history should be interpreted alongside the account in the Normal child development and milestones notes. If the presentation includes regression, unusual episodic events, altered sleep, pain, sensory difficulty or a change from baseline, the formulation must remain open to medical and psychiatric contributors rather than assuming that all change belongs to the neurodevelopmental condition.

RULE **Rule.** Begin with the person's developmental course and present functioning; use diagnostic categories to clarify the pattern, not to replace the formulation.

34.2 Separate constructs before combining them

Intellectual functioning, **adaptive functioning**, developmental level and the autism phenotype are related but not interchangeable. A cognitive assessment addresses an aspect of ability. Adaptive functioning asks what the person manages in ordinary settings. Autism assessment asks whether a characteristic pattern of **social communication** differences and **restricted and repetitive behaviour** is present. Each finding changes the meaning of the others, but none can be inferred from another alone.

CLINICAL TASK	QUESTION TO KEEP SEPARATE	WHERE TO RETURN FOR FULL TEACHING
Describe ability	What can the person understand, learn and do?	Intellectual disability definition, clinical assessment and IQ testing
Describe everyday function	What support is needed in usual environments?	Adaptive behaviour assessment and intellectual disability severity
Describe autism features	Is the social-communication and behavioural pattern characteristic of autism?	Autism diagnostic criteria, clinical features and diagnostic tools
Describe developmental concern	Is the available profile sufficient for a stable diagnostic conclusion?	Global developmental delay and differentiation of intellectual disability from autism, GDD and borderline intellectual functioning
Describe participation	What changes at home, in education, in work and in the community are required?	Management, family support, disability certification and benefits

TRAP **Examination trap.** Do not use an intelligence score as a synonym for adaptive functioning, or use either as proof for or against autism. They are different clinical constructs.

34.3 Read the profile, not only the label

A useful formulation gives a profile of strengths and vulnerabilities. It asks how communication is used, how social reciprocity is experienced, how routines and sensory demands affect participation, and how demands change behaviour. It records what helps the person engage, learn and regulate. This profile is often more useful for care planning than a diagnostic word alone.

- Describe the person's effective means of communication and the situations in which communication breaks down.
- Identify abilities that can be recruited for learning, self-care, relationships and participation.
- Notice environmental triggers, including mismatch between demands and capacity.
- Ask whether behaviour is communicating distress, pain, fear, overload, confusion or an unmet need.

This approach protects against **diagnostic overshadowing**: the error of attributing every new symptom or behaviour to an established developmental diagnosis. A change from baseline still deserves ordinary clinical curiosity. The full child psychiatric assessment battery, services and protection are set out in the Child psychiatry: assessment, treatment, services and protection notes.

34.4 Look actively for co-occurrence

Co-occurrence is clinically important because it can alter presentation, risk, family burden and the practical plan. Medical conditions, sensory problems, sleep disturbance, emotional symptoms, behavioural disturbance and psychiatric syndromes may make a familiar developmental profile look suddenly more difficult. The right response is not diagnostic proliferation; it is a disciplined search for treatable contributors and an account of how they interact.

When autism and intellectual disability coexist, describe each profile explicitly. When attentional symptoms or social difficulties raise the possibility of ADHD, use the ADHD and specific learning/communication disorders notes for the full assessment framework. Do not treat social difficulty as automatically explained by either condition.

MNEMONIC

FIND

is a practical closing mnemonic: **F**unction in daily life; **I**nteraction and communication profile; **N**eurodevelopmental course; **D**rivers of change, including co-occurring conditions and context.

34.5 Convert formulation into support

The endpoint of assessment is a plan that is intelligible to the person and family and usable across settings. State the priority difficulty, the strengths that can be used, the support required, the contributors that need treatment or further assessment, and the follow-up question. A plan framed around **support needs** is more clinically honest than one framed around a label alone.

- Link recommendations to a named functional difficulty rather than to diagnosis alone.

- Make family partnership part of the formulation, not an afterthought.
- Coordinate educational, communication, occupational, behavioural and mental-health input around shared goals.
- Review change over time, especially after a new stressor, treatment or transition.

Intervention models, speech and occupational support, family support, pharmacotherapy and prognosis are considered in their respective sections.

GOOD TO REMEMBER

Keep statutory processes separate from clinical formulation: certification may help access entitlements, but it does not replace an individualised account of function and care.

34.6 The final answer in practice and in examination

For a case discussion, write the problem representation before writing the diagnosis: developmental course, current profile, functional impact, possible co-occurrence, contextual modifiers and priority supports. This structure prevents the common drift from a complex clinical presentation into a label-led answer.

The must-remember synthesis is simple: diagnose carefully, describe function clearly, search for change and co-occurrence, then plan support around the person rather than the label.

Previously asked

Genuine past questions from this chapter's territory, with their board of origin. Only two examination questions in the catalogue fall inside intellectual disability and autism, and both are printed here. No question is reconstructed, paraphrased into a new one, or invented to pad the list.

QUESTION	TYPE	ASKED
Describe the etiology, clinical features and management of Fragile X syndrome	Long essay	MUHS 2013
Asperger's syndrome	Short note	MUHS 2012

TRAP **Asperger's syndrome no longer exists as a diagnosis.** A question asked under the older nomenclature still expects you to know where the construct went and why it was absorbed, not to defend it as a current category. The historical topic in this chapter carries that story.

The quick review

One table, read down the left column, cover the right. Every line is taught in full somewhere above; nothing here is new. Where the sources disagree, the disagreement is the answer.

ASK	HOLD
WHAT MAKES INTELLECTUAL DISABILITY	All three criteria: intellectual deficits, adaptive deficits, onset in the developmental period. Not an IQ score on its own.
WHAT GRADES ITS SEVERITY	Adaptive functioning across the conceptual, social and practical domains. IQ is supporting evidence, not the grade.
WHAT GRADES AUTISM SEVERITY	Support needs, rated separately for the two domains. Never IQ. Grading autism by IQ is the classic error.
GLOBAL DEVELOPMENTAL DELAY	The under-fives placeholder for a child too young or too impaired for a valid standardised assessment. It is a holding position, not a diagnosis to keep.
THE FOUR INSTRUMENTS ROUTINELY CONFUSED	They measure four different constructs: intelligence, development, social maturity, adaptive behaviour. Being asked for adaptive scales and listing all four is the exam error this chapter exists to prevent.
THE STATUTORY INSTRUMENT FOR INTELLECTUAL DISABILITY IN INDIA	Not the mental-illness disability scale. The routes are separate, and the chapter shows which is which.
THE AUTISM DYAD	Social communication, all of its sub-criteria; restricted and repetitive behaviour, the stated minimum of its four. Language is a specifier, not a criterion.
WHERE ASPERGER'S WENT	Absorbed into the spectrum. A past question under the old name still expects you to know why.
THE COMMONEST PSYCHIATRIC CO-OCCURRENCE IN AUTISM	ADHD. DSM-IV forbade the joint diagnosis; DSM-5 permits it. The frequency is contested and the chapter gives both figures.
DIAGNOSTIC OVERSHADOWING	A new behaviour in intellectual disability gets blamed on the disability and the treatable illness is missed. It is a reasoning failure, not a knowledge failure.
WHAT NO DRUG DOES IN AUTISM	Treat the core features. The licensed agents target irritability, and the monitoring burden is the price.
WHAT THE SOURCES REFUSE TO TELL YOU	Several cut-offs, several band tables and several Indian figures are simply not in the literature consulted. The chapter says so where it happens rather than inventing them.

References

Every specific in this chapter is bound to one of the sources below, and the count is the number of claims each carried. Books and guidelines are cited author, title and year in the house convention; no PMID is asserted for a book. Where two sources disagreed, the chapter shows both rather than choosing, and those disagreements are named in the text where they fall.

SOURCE	CLAIMS CARRIED
IPS CPG CAP CHILD	165

SOURCE	CLAIMS CARRIED
Tasman Psychiatry	119
Kaplan & Saddock's CTP 2024	118
Companion to Psychiatric Studies	107
DSM-5-TR-2022	98
New Oxford Textbook of Psychiatry	85
Shorter Oxford Textbook of Psychiatry	69
RC Jiloha - Forensic Psychiatry - An Indian Perspective	59
ICD-11 CDDR	58
Rutters Child and Adolescent Psychiatry 6E	47
Lewis Child and Adolescent Psychiatry	46
Rutter's Child and Adolescent Psychiatry 6E	40
DSM-5-TR (2022)	39
Dulcan's Textbook of Child and Adolescent Psychiatry	33
Maudsley 15th edition	33
Shorter Oxford Textbook of Psychiatry, ch 17	28
Kaplan & Sadock's CTP 2024	26
Kaufman's Clinical Neurology for Psychiatrists	23
61:254-69)	17
Kaplan & Sadock's CTP 2024, intellectual disability chapter	17
Tasman Psychiatry, ch 42	17
Clinical Methods in Psychiatry 1st Ed 2024, AIIMS Publication	16
IPS CPG CAP CHILD - Kishore et al., Indian J Psychiatry 2019	15
Geriatric Psychiatry Study Guide	12
New Oxford Textbook of Psychiatry, Chapter 24	12
IPS CPG CAP CHILD (Kishore et al.)	12
Developmental Psychopathology (Cicchetti)	11
Dulcan's Textbook	11

On what is not here. This chapter declares its gaps rather than filling them. Where a value a reader might expect is absent, the absence is deliberate and stated at the point of use: the source consulted did not carry it, and nothing was

supplied from memory to cover the silence.

PART III

III

ADHD and Specific Learning and Communication Disorders

ADHD and the disorders of learning and communication: recognising them, telling them apart, and treating them.

01 ADHD: the concept, the criteria and the mechanism

02 Recognising ADHD: assessment, scales, comorbidity and differential

03 Treating ADHD

04 ADHD beyond childhood and its outcome

05 Specific learning disorder

06 Communication and motor disorders

07 Discriminate, apply and consolidate

PAPER III

ADHD & specific learning/communication disorders

Six bands . one complete notes document

ADHD: the concept, the criteria and the mechanism

1 · The neurodevelopmental frame

Why this chapter matters clinically. A child described as inattentive, restless, struggling at school, difficult to understand, or unable to keep up may be presenting with a disorder, an environmental mismatch, a response to distress, a developmental difference, or more than one of these at once. The useful question is therefore not simply whether a symptom can be recognised. It is whether a coherent developmental pattern is affecting the child's participation in ordinary life, and what evidence is needed before that pattern is named. This chapter provides the framework for approaching attention-deficit/hyperactivity disorder, specific learning disorder, communication disorders and selected motor disorders without turning a referral complaint into a premature conclusion.

These conditions are grouped because they frequently enter clinical care through the same doors: concern from home, a report from school, conflict around work, behavioural escalation, or a child's growing sense of failure. Their mechanisms, diagnostic boundaries and interventions are not interchangeable. A good clinician holds both truths at once: the presenting difficulties need to be understood together, while each possible disorder must be assessed on its own terms. The chapter therefore moves from recognition to assessment, then to management and longer-term planning, while keeping the child's actual functioning at the centre.

Child	Family	School	Clinic
DEVELOPMENTAL CONTEXT	DAILY FUNCTIONING	PARTICIPATION DEMANDS	INTEGRATED FORMULATION

1.1 A shared neurodevelopmental frame

A **neurodevelopmental frame** asks how a child acquires and uses capacities over time, rather than treating each behaviour as a free-standing symptom. Attention, activity regulation, communication, motor coordination and academic skill are expressed in relation to the tasks a child is expected to manage. The same observable difficulty can have a different meaning when the demand changes, when support is added, or when the child moves from a familiar setting to one that makes the weakness more visible. This is why a chapter on these disorders must begin with development and function, not with a checklist.

The frame also protects against a false split between biology and context. A developmental vulnerability does not make family life, teaching conditions, language exposure, sleep, adversity, peer experience, or emotional state irrelevant. Conversely, the presence of contextual stress does not by itself explain away a persistent developmental difficulty. Clinical work is the disciplined

task of deciding which influences are central, which are amplifiers, and which are consequences of the child's struggle. A child who is repeatedly corrected, excluded, or unable to demonstrate competence may understandably become anxious, angry, avoidant or demoralised. Those reactions deserve care, but they should not obscure the developmental question that brought the child to attention.

A **developmental expectation** is therefore a clinical comparator, not a demand for uniformity. Children develop unevenly. Strength in one area does not cancel a marked problem in another, and a difficulty does not define the whole child. The clinician looks for a pattern that has enough persistence, breadth and consequence to require explanation. The formal diagnostic discussion later in the chapter supplies the criteria for particular disorders. The orientation point is more basic: diagnosis is an act of pattern recognition constrained by evidence, not a label attached to inconvenience.

RULE **Start with development in context, then decide whether a disorder best explains the pattern.** The referral label is a hypothesis. It becomes clinically useful only after the child's capacities, demands, supports and impairment have been considered together.

1.2 From complaint to clinical question

Referral language is usually compressed. "Not listening," "poor concentration," "slow work," "bad handwriting," "talks too much," "does not speak clearly," or "cannot sit" are observations made by an adult under pressure. They are worth taking seriously, but none is a diagnosis. Each must be translated into a clinical question: What exactly happens? In which tasks? What precedes it? What follows it? What can the child do when the task, setting, support or motivation changes? This translation prevents the clinic from inheriting the assumptions already embedded in a referral.

The key distinction is between a behaviour and a **functional impairment**. Behaviour is what another person sees. Impairment concerns what the child cannot reliably do, participate in, learn, communicate, organise, or sustain in the situations that matter. A child may be conspicuous yet functioning adequately, or quiet yet carrying a substantial burden that is visible only in lost learning, exhausted family routines, social withdrawal, or a fragile sense of competence. Asking about function makes assessment fairer to both children: the child whose activity is disruptive and the child whose difficulty is hidden because it causes little trouble for adults.

Clinical questions should also distinguish capacity from performance. A child may understand an instruction but fail to hold it in mind long enough to act on it. Another may remain engaged but lack the academic skill the task assumes. Another may have the skill but become overwhelmed by language, motor demands, anxiety, sensory discomfort, conflict, or fear of error. The chapter's later sections sort these possibilities systematically. At orientation, the discipline is to resist collapsing all failed performance into a single explanatory category.

- Describe the behaviour before interpreting its cause.
- Identify the task and demand in which the difficulty becomes visible.

- Ask what the difficulty costs the child in participation and relationships.

CLINICAL QUESTION	PURPOSE	WHAT MAY CHANGE THE INTERPRETATION
What is the observed difficulty?	Separates description from explanation.	The task, the adult response and the child's own account.
Where does it occur?	Locates the demand on the child.	Structure, language, pace, familiarity and available support.
What is the functional cost?	Establishes why the concern matters clinically.	Participation, learning, relationships and self-concept.
When does performance improve?	Identifies strengths and possible supports.	Interest, reduced load, clearer communication or adapted expectations.

GOOD TO REMEMBER

The stated referral problem and the clinical target are often different. A family may seek help for disruptive evenings, while the most useful formulation concerns an unrecognised learning or communication burden that makes each school-related demand a conflict.

1.3 The logic of cross-setting formulation

A **cross-setting formulation** asks whether a difficulty is present across the child's life and, if it is not, what the pattern of variation means. Home and school are not duplicate testing sites. They make different demands, provide different structure, reward different behaviours and tolerate different levels of support. A child can appear settled in one setting because an adult has quietly adapted the environment, because the task is intrinsically engaging, or because the child has withdrawn from challenge. A difficulty that is most apparent in a particular setting is not thereby unreal. It may tell the clinician where demands and vulnerabilities meet.

This is the reason collateral information is indispensable. The caregiver sees routines, transitions, play, sleep-related strain and the emotional aftermath of demanding days. School staff see sustained group demands, pace, written work, peer comparison and the supports already being improvised. The child can describe effort, embarrassment, boredom, worry, confusion, unfairness and the private strategies used to cope. Each account is partial. The clinician's job is not to award one informant the status of truth, but to integrate accounts into an explanation that can survive contact with the child's everyday life.

An **informant discrepancy** is often data rather than noise. If adults disagree, explore the conditions under which they observe the child. The disagreement may reveal a highly structured classroom, a home routine with little academic load, a language mismatch, different thresholds for concern, or a relational pattern that changes behaviour. It can also reveal that an adult has seen a meaningful change over time while another is describing a longer baseline. Prematurely averaging such accounts destroys the very clinical information that makes formulation possible.

PITFALL

Do not convert a school report into a diagnostic verdict. Educational observations are essential evidence, but they are observations made within a particular curriculum, classroom culture and set of available supports. They need to be placed alongside history, direct clinical work and the child's own account.

1.4 ADHD within the chapter's map

ADHD is approached here as a developmental disorder of regulation whose diagnosis requires more than recognising a lively child or a poor worker. The diagnostic section addresses the formal structure of the diagnosis. The clinical-features section gives the lived expression of its core symptom domains. Epidemiology, sex differences, mechanisms and neurobiology are then considered separately so that the reader does not mistake a statistical association or a mechanistic model for a diagnostic criterion.

This separation is deliberate. In practice, attentional and behavioural complaints commonly travel with other difficulties. A child may have problems with academic acquisition, language, mood, anxiety, sleep, behaviour, tics, family stress or school fit. Sometimes these are concurrent conditions; sometimes they are competing explanations; sometimes they are consequences of repeated failure. The assessment and differential sections show how to sort this without treating every overlap as proof of comorbidity. Management follows only after that work, because an intervention should be matched to the formulation rather than to the loudest symptom.

The reader should keep an **ecological formulation** in view. It links the child's regulatory style to actual environments: an unstructured transition, a long verbal instruction, independent written work, a crowded classroom, an inconsistent routine, or a conflictual homework interaction. This does not reduce ADHD to an environmental problem. It ensures that clinical recommendations alter the conditions in which impairment occurs, instead of relying solely on exhorting the child to try harder. Medication, behavioural support, parent work, school intervention and psychosocial care each have a place only when they address a defined part of the formulation.

TRAP **Do not diagnose ADHD from a complaint of poor attention alone.** Attention can be disrupted by many developmental, emotional, medical, educational and relational processes. The clinical task is to establish the full pattern and then test alternatives, not to rename a common complaint.

1.5 Why learning, communication and motor concerns sit beside ADHD

Academic underperformance can be the consequence of difficulty regulating attention and effort, but it can also arise because a child has not acquired a particular academic skill in the expected way. This distinction matters because a child who repeatedly fails at a task may look inattentive, avoidant or oppositional even when the primary obstacle lies in learning. Conversely, a child with ADHD may underperform inconsistently despite having the relevant skill. The chapter later defines and assesses specific learning disorder, while the discrimination section brings the relevant possibilities into direct comparison. At this stage, the clinician should retain the question rather than force an early choice.

Communication difficulties can similarly alter the apparent meaning of behaviour. A child who cannot efficiently understand, formulate or express language may disengage from verbal teaching, respond slowly, interrupt, rely on action rather than words, or become distressed during rapid social exchanges. Motor coordination difficulties may make written tasks, self-care routines, games or classroom production disproportionately effortful. The communication and motor sections describe these disorders in their own right. In an initial formulation, their importance is that they can shape performance, self-esteem, relationships and behavioural presentation.

This is not an argument for indiscriminate diagnostic multiplication. It is an argument for **diagnostic humility**. A clinician should be able to say what is known, what remains to be clarified, what needs collateral evidence, and what support is justified even before every boundary question is settled. Children do not need to wait for conceptual perfection before adults reduce avoidable strain. At the same time, an accommodation should not be used as a substitute for careful assessment when persistent impairment needs explanation.

- Consider whether the task is exposing a regulation difficulty, a skill deficit, a communication barrier, a motor burden, or a combination.
- Ask whether avoidance is protective behaviour in the face of repeated failure.
- Separate immediate support needs from the longer diagnostic enquiry.

1.6 The child as participant, not a collection of deficits

Good developmental psychiatry does not ask only what is wrong. It asks where the child can participate, who understands the child well, what the child enjoys, what supports already work, and how the current difficulty has affected identity. A **strengths-based formulation** is not a reassuring add-on. It improves diagnostic accuracy because it shows the conditions under which abilities emerge. It also changes management: a plan that ignores interests, relationships and existing competence is unlikely to be sustained.

Listen directly to the child whenever communication and developmental level allow. Adults often report observable disruption more readily than internal experience. The child may describe constant effort to keep up, shame about reading aloud, fear of being called on, exhaustion after school, anger at being misunderstood, or relief when a particular adult gives help without humiliation. Such accounts do not independently establish a diagnosis, but they reveal the burden of impairment and the meaning of interventions. They also protect against plans designed for adult convenience that worsen the child's exclusion.

Family work begins with explanation, not blame. Caregivers may be exhausted, divided about what is happening, worried about labels, or understandably sceptical after receiving conflicting advice. Teachers may feel they have already tried every practical adjustment available to them. The clinician's role is to replace moral language with a shared working model: identify the difficulty, identify the demand, identify the support, and review what changes. This preserves accountability without implying that the child's struggle is wilful or that adults caused it by insufficient effort.

IN INDIA

School information may come from settings that differ markedly in teaching language, class routines, resources, assessment style and access to remedial support. Ask what the child is being asked to do in that particular school before treating academic performance as a stable measure of ability. A useful plan must be intelligible to caregivers and feasible for the educational setting, not merely ideal on paper.

1.7 Working across systems without losing the formulation

These disorders sit at the boundary of home, school and health care. Each system has a legitimate concern, but each also sees a different slice of the problem. The clinic must avoid becoming an isolated site that issues labels without understanding the child's day-to-day ecology. Equally, it must not hand all responsibility back to school or family with vague advice to be more patient. A useful **longitudinal formulation** is revised as the child's demands, supports and difficulties change. It records not simply what diagnosis was considered, but why the current explanation remains the best fit.

Coordination is most helpful when recommendations are concrete and linked to a stated functional problem. "Support attention" is too vague to guide anyone. A better plan identifies the demand that breaks down, the environmental modification or skill support being tried, the adult who can implement it, and the sign that it is helping. Later sections of the chapter give disorder-specific approaches. The orienting principle is that recommendations should be testable in ordinary life. If they cannot be implemented or reviewed, they are not yet a clinical plan.

The same principle applies to referral. Speech and language input, educational assessment, occupational support, paediatric review, psychological intervention or specialist psychiatric management may each be appropriate depending on the formulation. Referral should answer a question, not merely distribute responsibility. The broader assessment battery and service approach are set out in the Child psychiatry: assessment, treatment, services and protection notes. Developmental history should be interpreted alongside the Normal child development and milestones notes, while conditions that lie outside this chapter's main focus are addressed in the Child behavioural, emotional and other disorders notes and the Intellectual disability and autism spectrum disorder notes.

1.8 A practical route through the chapter

Use the chapter in the order a careful assessment unfolds. Begin with the concept and diagnostic boundaries of ADHD, then learn the clinical pattern well enough to recognise it without overcalling it. Move next to comprehensive assessment, rating scales, co-occurring conditions and differential diagnosis. Treatment sections should then be read as components of a formulation-led plan rather than as an isolated drug list or a menu of generic advice. The later discussion of adolescence, adulthood and outcomes keeps the initial consultation connected to the child's future functioning.

The specific learning disorder material follows the same logic: definition before assessment, assessment before remediation, and educational provisions after the clinical basis is clear.

Communication and motor disorders require the same restraint. Learn the boundaries of each disorder, then ask how that disorder changes a child's participation and what intervention is realistic. The closing discrimination and vignette material is intended to consolidate clinical reasoning, not to reward pattern matching based on a few memorable clues.

MNEMONIC

MAP: Meaning, Across settings, Participation

Use **M**eaning to translate a complaint into a clinical question; ask what is seen **A**cross settings and why it varies; then judge the effect on **P**articipation. MAP is a guardrail against both premature diagnosis and dismissing a child whose difficulty is real but quiet.

Formulate the child in context before naming the disorder, and let the diagnosis lead to support that changes participation.

2 · Diagnostic criteria of ADHD (DSM-5 presentations, ICD-11 hyperkinetic disorder)

Why the criteria matter. Attention-deficit/hyperactivity disorder is not diagnosed by recognising a lively child, a poorly organised student, or an adult who reports distractibility. The diagnostic task is to decide whether a developmentally inappropriate pattern has persisted, is evident beyond a single relationship or environment, produces impairment, and is not better accounted for by another condition. The criteria make that judgment reproducible. They also protect against the opposite errors of dismissing clinically important inattention because overt overactivity is absent, and labelling a situational response as a neurodevelopmental disorder.

For the postgraduate candidate, ADHD criteria are best learnt as a sequence rather than as a loose symptom list: establish the relevant symptom pattern, establish persistence, establish developmental onset, establish pervasiveness, establish impairment, and then consider exclusionary explanations. The symptom descriptions themselves are discussed with the core clinical features. This section concerns the diagnostic architecture: what must be shown before the label is applied, how the current **presentation** is specified, and why the older term **hyperkinetic disorder** should not be used as though it were simply a synonym.

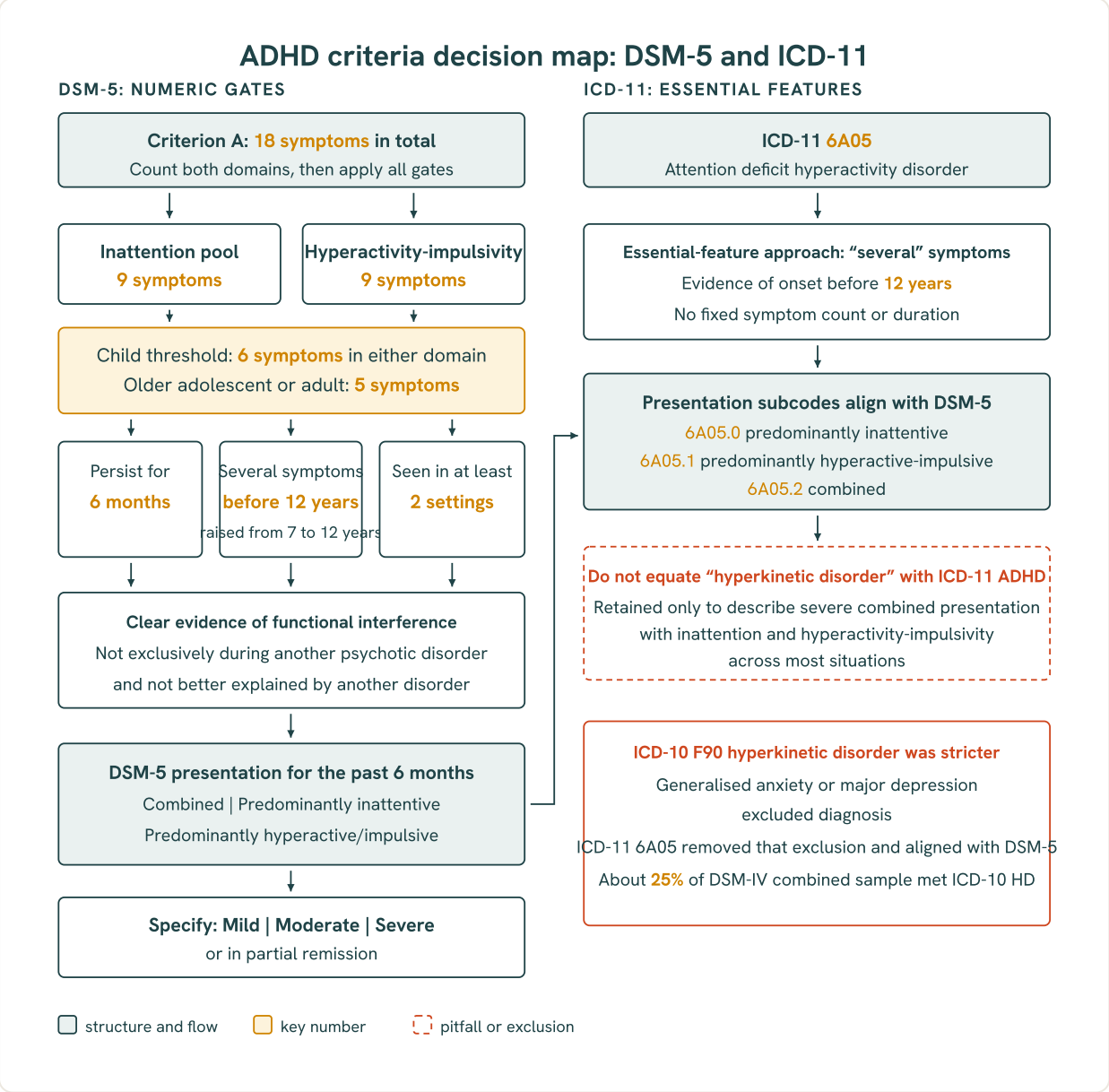


Fig 22.1. DSM-5 ADHD presentation thresholds and gates contrasted with ICD-11 ADHD essential features and the narrower ICD-10 hyperkinetic-disorder legacy.

2.1 The diagnostic task: pattern plus consequence

ADHD diagnosis begins with a pattern of symptoms drawn from the inattention list and the hyperactivity-impulsivity list. Neither list is a personality inventory. Each item has to represent a behaviour that is persistent, clinically meaningful, and incongruent with the person's developmental level. A symptom count without clinical interpretation is therefore insufficient. Conversely, a persuasive clinical narrative cannot substitute for the required structure of the criteria.

The two lists are deliberately balanced in their construction. The inattention list contains 9 symptoms, and the hyperactivity-impulsivity list contains 9 symptoms. Together they make up the full diagnostic set of 18 symptoms. This matters because the clinician should ask separately about each domain rather than use a global impression such as "attention problems" or "overactive behaviour". A person may meet the required pattern through one domain, or through both; the later presentation specifier communicates that distribution.

9	9	6	5
INATTENTION ITEMS	HYPERACTIVITY-IMPULSIVITY ITEMS	CHILDHOOD THRESHOLD	OLDER-AGE THRESHOLD

In children, the threshold is **at least 6 symptoms** from the inattention list when that domain is being met, and at least 6 symptoms from the hyperactivity-impulsivity list when that domain is being met. For older adolescents and adults, the threshold in either relevant domain is at least 5 symptoms. The change acknowledges that the same disorder need not appear as a childhood-level tally of overt behaviours throughout later life. It does not mean that a lower count alone establishes the diagnosis. The other diagnostic requirements retain their force.

RULE **ADHD is diagnosed from a structured pattern of symptoms with demonstrable developmental and functional significance, not from a single striking behaviour.** The count opens the diagnostic question; persistence, onset, setting and impairment determine whether the threshold has clinical meaning.

There is a useful discipline in recording the evidence alongside each domain. State which symptoms are supported, where they occur, who observed them, and how they interfere with the person's responsibilities or relationships. This makes the formulation auditable and prevents an apparently precise number from concealing vague evidence. It also leaves room for a later review if the pattern changes, collateral information changes the picture, or another disorder proves to be the better explanation.

- Separate the evidence for the inattention domain from the evidence for the hyperactivity-impulsivity domain.
- Record concrete examples rather than relying on a global adjective such as "careless" or "restless".
- Identify the settings in which the pattern is evident and the functional consequence in each.
- State any competing explanation that remains clinically plausible and why it is or is not primary.

2.2 Persistence and developmental appropriateness

The symptom pattern must have persisted for **at least 6 months**. This requirement distinguishes an enduring pattern from a transient deterioration during a stressful school term, a disrupted home environment, a medical illness, or an episode of another mental disorder. Duration is not a clerical detail. It asks whether the behaviour has acquired the stability expected of a disorder rather than remaining an understandable response to circumstances.

Persistence must be read together with developmental appropriateness. A behaviour can be inconvenient to adults and still be ordinary for a particular developmental stage. The clinical question is whether the frequency, intensity, and consequences are out of keeping with what is expected for that individual's developmental level. The question is comparative, but it is not a demand for a false precision. The resident should integrate the developmental history with reports from daily settings and avoid treating a single complaint as evidence of pervasive

pathology. The Normal child development and milestones notes provide the wider developmental frame needed for that comparison.

This criterion is also a guard against retrospective simplification. A family may recall a recent escalation more readily than a long-standing, lower-grade pattern. Conversely, a current crisis may make every past act of restlessness seem diagnostic. The appropriate approach is to reconstruct the course carefully, ask for concrete examples from earlier periods, and separate chronic traits from changes in intensity. The criteria require persistence of symptoms, but clinical reasoning must still decide whether the account is coherent and whether the behaviours have the same meaning across contexts.

TRAP **Do not convert a period of poor concentration into ADHD merely because it has lasted for the minimum duration.** The duration criterion confirms persistence; it does not establish developmental inappropriateness, pervasiveness, impairment, or diagnostic primacy.

In practice, this distinction is especially important when school demands have changed or when conflict, sleep disruption, emotional distress, substance use, or illness has altered functioning. Such factors may coexist with ADHD, amplify its expression, or account for the presentation altogether. They should be explored as explanations, not treated as inconvenient exceptions to a symptom tally. The full child psychiatric assessment battery and services are set out in the Child psychiatry: assessment, treatment, services and protection notes.

2.3 Developmental onset

The criteria require that several inattentive or hyperactive-impulsive symptoms were present before **12 years**. The wording is important. It does not require a complete diagnosis before that point, nor does it require that the disorder was recognised at the time. It requires credible evidence that several relevant symptoms had already emerged in the developmental period. This distinction is clinically useful because many people reach assessment only after educational, occupational, or relational demands reveal the functional cost of a long-standing vulnerability.

Developmental onset is a test of continuity, not a demand for perfect recall. Retrospective reports may be incomplete, coloured by current distress, or limited by absent records. A careful clinician therefore looks for convergence: the person's account, family recollection, old school comments where available, and a developmental narrative that makes sense across settings. If the evidence is weak, the uncertainty should be acknowledged rather than covered by a confident label. The criterion is designed to preserve the neurodevelopmental identity of ADHD while allowing the ordinary reality that recognition can be delayed.

The present onset requirement is a broader developmental threshold than the earlier DSM formulation. It should not be misread as permission to dispense with developmental evidence. The criterion still asks whether the history supports symptoms in the developmental period, rather than whether current impairment can be given a retrospective label.

Do not mistake later impairment for later onset. A person may have managed adequately while demands were modest and then struggle when independent organisation, sustained work, or

complex role responsibilities increase. That change in visibility can be real without implying that the underlying symptoms began only then. At the same time, a genuinely new attentional syndrome requires a broader search for psychiatric, medical, sleep-related, substance-related, and situational explanations. The diagnosis should follow the developmental history, not rescue an attractive explanation for a recent decline.

GOOD TO REMEMBER

When evidence from the early developmental period is uncertain, document both the supporting history and its limits. Diagnostic confidence should track the quality of the onset evidence rather than the examiner's wish to make the record look decisive.

2.4 Pervasiveness, impairment and exclusion

Symptoms must be present in **at least 2 settings**. This is the **pervasiveness** requirement. It prevents the diagnosis from being based solely on a conflictual classroom, an unstructured workplace, one difficult relationship, or one setting whose demands are mismatched to the person. The settings need not be identical in their demands or in the exact behaviour they reveal. What matters is that the underlying pattern is evident beyond a single local explanation.

Pervasiveness is not a mechanical search for the same symptom in every place. Different environments expose different demands on attention, activity regulation and impulse control. A quiet child may struggle most when tasks require sustained self-organisation; another may show overt difficulty chiefly where waiting, turn-taking, or behavioural restraint is required. The clinician's task is to identify whether these observations cohere as manifestations of the same pattern, while remaining alert to setting-specific stressors that explain them better.

There must also be clear evidence that symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning. This is the **functional impairment** requirement. The diagnosis is not a reward for endorsing enough familiar behaviours. It is a clinical conclusion that the pattern matters in the person's life. Impairment may involve underachievement, missed responsibilities, relationship strain, unsafe impulsive acts, or a disproportionate effort required to maintain ordinary functioning. The precise form of impairment varies with age, role and environmental support.

Finally, the presentation must not occur exclusively during a psychotic disorder and must not be better explained by another mental disorder. This exclusion requirement obliges the clinician to consider whether the apparent ADHD symptoms belong instead to an alternative syndrome, or whether they are secondary to another disorder. It does not turn differential diagnosis into a ritual list. The central question is explanatory priority: does ADHD best account for the enduring, cross-situational developmental pattern and its impairment? The differential diagnosis of ADHD is addressed in the later differential section of this chapter.

PITFALL

School difficulty alone is not proof of pervasiveness or impairment due to ADHD. The clinical error is to let one setting define the disorder before asking whether the pattern is present elsewhere and whether another explanation better accounts for the difficulty.

2.5 Presentations, severity and course language

DSM uses the term presentation rather than a fixed subtype because the balance of symptoms can change over time. The recognised presentations are **combined, predominantly inattentive, and predominantly hyperactive/impulsive**. The current presentation is determined by which symptom-domain requirements have been met over the recent period. This terminology is clinically preferable to implying that each person has an immutable biological category. It describes the current configuration of the diagnostic evidence, while the underlying developmental history may be broader and more changeable.

The combined presentation is used when the requirements are met in both domains. Predominantly inattentive presentation is used when the inattention requirement is met but the hyperactivity-impulsivity requirement is not, and the converse applies to predominantly hyperactive/impulsive presentation. The labels should not be used to infer personality, intelligence, prognosis, family functioning, or treatment response. They are descriptive specifiers, not complete formulations. The lived phenomenology of the symptom domains belongs to the clinical-features section of this chapter.

Current severity is specified as **mild, moderate, or severe**. Severity should communicate the burden represented by the symptom load, the intensity of symptoms, and the degree of functional impairment. It is not a substitute for a formulation and should never obscure a major environmental stressor, coexisting condition, or protective support. The criteria also permit the course description of partial remission when the full current requirements are no longer met but clinically relevant difficulties remain. Such language helps the record explain the current state without erasing the earlier course.

MNEMONIC

Pattern - Persistence - Past - Places - Performance - Primary explanation

Use this as a recall spine for the criteria: identify the symptom pattern, confirm persistence, establish developmental onset, demonstrate more than one setting, show functional consequence, and consider whether another disorder is the primary explanation.

ADHD requires a developmentally inappropriate, persistent symptom pattern with developmental onset, cross-setting evidence, functional impairment, and no better explanation.

2.6 ICD-11 ADHD and the meaning of hyperkinetic disorder

In ICD-11, attention deficit hyperactivity disorder is coded 6A05 and sits within neurodevelopmental disorders. Its clinical organisation aligns closely with the presentation-based approach: 6A05.0 denotes predominantly inattentive presentation, 6A05.1 predominantly hyperactive-impulsive presentation, and 6A05.2 combined presentation. The shared language helps when records move between classification systems, but the diagnostic descriptions should not be assumed to be word-for-word interchangeable.

CLINICAL QUESTION	DSM APPROACH	ICD-11 APPROACH
Symptom threshold	Uses a specified count from each listed domain.	Uses several symptoms rather than a fixed tally.
Duration	Requires a stated period of persistence.	Describes essential features without a fixed duration rule.
Developmental onset	Uses a stated developmental threshold.	Seeks evidence of significant symptoms before the same developmental threshold.
Presentation language	Specifies the current presentation.	Uses corresponding clinical-presentation specifiers.
Hyperkinetic disorder	Does not use it as the principal category.	Reserves it as a descriptor for a more severe combined pattern.

The important difference is that ICD-11 describes essential features rather than applying the DSM machinery of a fixed symptom count and stated duration. The **essential-features approach** requires clinical judgment rather than arithmetic substitution. Nevertheless, ICD-11 asks for evidence of significant symptoms before 12 years. A clinician should therefore avoid the simplistic claim that one system is merely "strict" and the other merely "loose". They organise the evidence differently, while both require a developmental, impairing and pervasive pattern.

Within ICD-11, hyperkinetic disorder is retained to describe a severe combined presentation, with marked inattention and hyperactivity-impulsivity evident across most situations. It is not the primary name for the whole category. This distinction is clinically and examination-relevant: calling every person with ADHD "hyperkinetic" imports an older and narrower clinical image, particularly when overt motor activity is not the dominant current presentation.

IN INDIA

When preparing a clinical record, referral letter, or certification-related document, state the classification system being used and write the full diagnostic formulation rather than relying on a legacy label alone. This reduces ambiguity when services, schools, and clinicians use different diagnostic vocabularies.

2.7 The older ICD-10 category: why the distinction persists

The historical ICD-10 category of **hyperkinetic disorder**, coded F90, was more restrictive than the current ICD-11 ADHD category. It excluded the diagnosis when generalised anxiety or major depression was present. ICD-11 removed that exclusion and brought its category closer to the

DSM approach. The practical lesson is not that comorbidity should be assumed, but that the presence of another disorder does not automatically settle the question against ADHD. Each syndrome must be evaluated on its own evidence and explanatory value.

The earlier stringency had visible consequences. In a comparison of children meeting the combined ADHD pattern, only **about 25%** also met the ICD-10 hyperkinetic-disorder threshold. This figure should be used as an illustration of diagnostic narrowness, not as a prevalence estimate and not as a shortcut for individual diagnosis. It explains why older literature, older records, and older teaching may appear to describe a more uniformly severe and overtly hyperactive group than current ADHD classifications do.

For a resident, the safe wording is precise: ICD-11 names the overall category attention deficit hyperactivity disorder; hyperkinetic disorder denotes a severe combined pattern within that framework; and the former ICD-10 category was narrower. This protects the reader from treating nomenclature as mere semantics. Classification language changes the threshold for whom a service identifies, the populations represented in older studies, and the continuity of a person's clinical record.

3 · Clinical features and core symptom domains

The clinical task is to recognise a pattern, not to count a collection of irritating behaviours. Attention-deficit/hyperactivity disorder is expressed through **three** interacting symptom domains: **inattention**, **hyperactivity** and **impulsivity**. They are useful clinical lenses rather than labels to be applied to any child who is busy, forgetful, or impatient. The marks lie in recognising how these domains work together in everyday activity. The formal diagnostic framework addresses threshold questions. This section addresses the lived picture: what the domains look like, how they change in their outward form, and why a brief apparently reassuring encounter can mislead.

The domains often travel together, but they should be described separately before they are assembled into a formulation. That discipline prevents a familiar error: calling every difficulty with schoolwork "poor attention", or calling every interruption "hyperactivity". A careful phenomenological account makes the later diagnostic judgement more defensible and gives parents and teachers language for observations that otherwise seem unrelated.

Inattention	Hyperactivity	Impulsivity
ENGAGEMENT AND ORGANISATION	ACTIVITY REGULATION	PAUSE BEFORE ACTION

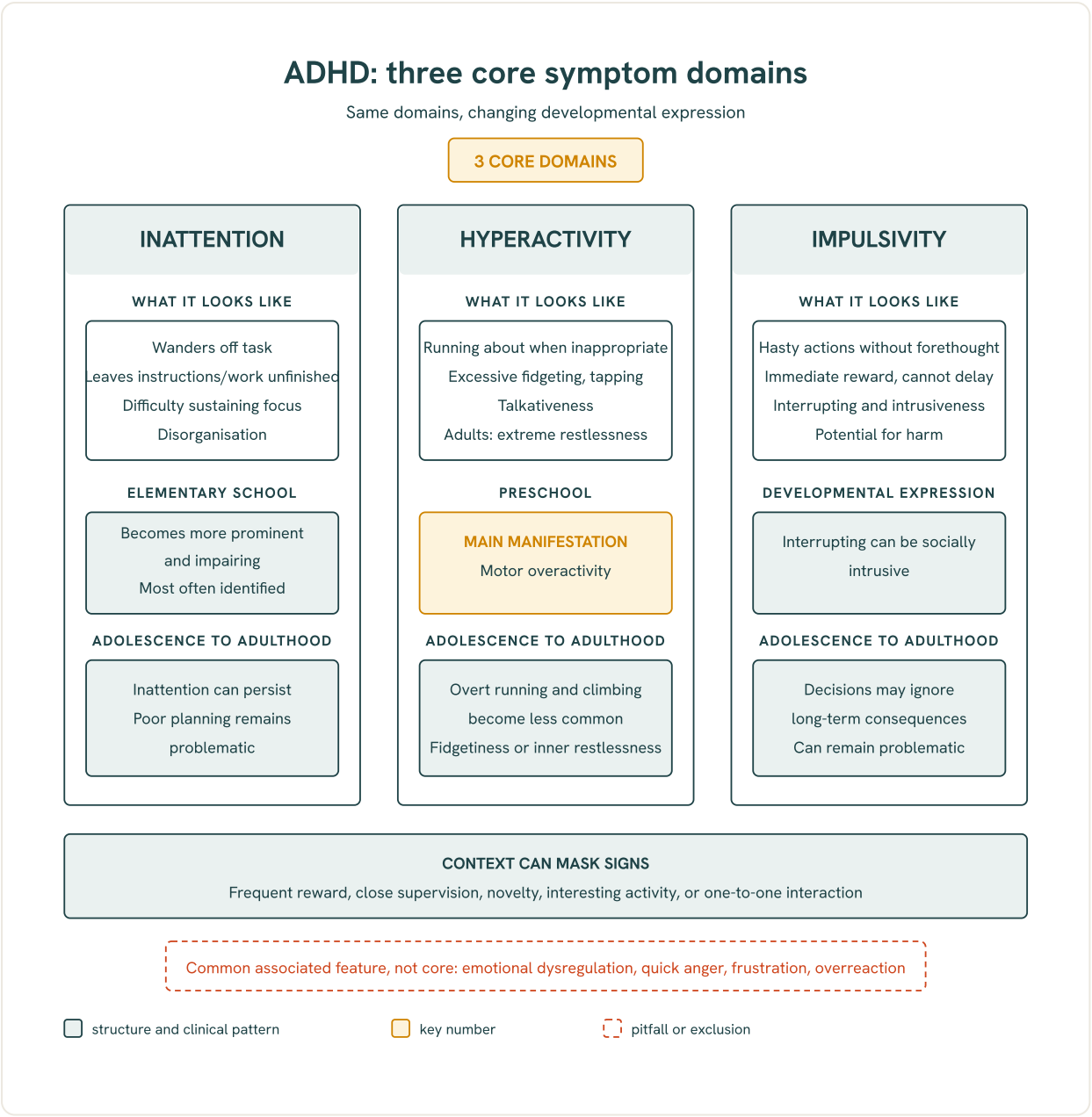


Fig 22.2. ADHD has three core symptom domains whose observable expression changes from preschool through adulthood.

3.1 The clinical architecture of the symptom domains

The domains overlap in ordinary life because a person must sustain attention, regulate activity, and pause before responding during the same task. A child who leaves a written exercise unfinished may have lost the task set, been pulled away by an attractive stimulus, become restless while seated, or answered before reading the instruction. The surface event is one event; the clinical work is to identify the process that repeatedly produces it. This is why a useful history preserves sequence and context instead of accepting an umbrella description such as “does not study”.

Phenomenology means staying close to the observable pattern and to the person's experience of it. It asks what occurs just before the task is abandoned, what happens while demands are sustained, and what follows an interruption or rash response. It does not require a moral explanation. In particular, the central symptoms should not be translated into laziness, poor

upbringing, or deliberate opposition. Such translations close enquiry prematurely and make the informant defend either the child or the family rather than describe the difficulty.

The distinction between activity and impulse is especially useful. Hyperactivity concerns the regulation of movement and verbal output. Impulsivity concerns the failure to insert a sufficient pause between urge and action. A person may be physically restless yet wait appropriately, or may sit quietly while repeatedly blurting, intruding, buying, deciding, or acting before considering the likely result. Clinically, the domains remain separable and can have different consequences and examples.

RULE **Describe the domain first, then infer its effect.** A behaviour becomes clinically informative when it is linked to the attentional, activity-regulation, or response-inhibition process that repeatedly precedes it.

This formulation also protects against circular reasoning. “He cannot complete work because he has ADHD” is not a description. It merely repeats the conclusion in another form. “He begins work, drifts from it, misses parts of the instruction, and has difficulty organising the steps needed to return” is a clinical description. The latter allows competing explanations to be considered later without making this section into a differential-diagnosis exercise.

3.2 Inattention: failure to keep the task online

Inattention is not simply an absence of attention. It is a difficulty in regulating attention in relation to a task, especially when the task demands sustained engagement, orderly follow-through, and retention of its goal. The person may begin with genuine intention and adequate comprehension, yet **wander off task**, lose the thread of what is being done, or shift to a more immediately available stimulus. The result may be mistaken for lack of effort because the work is visibly incomplete, even though the difficulty arose while trying to maintain the task rather than from a decision to refuse it.

The ordinary presentation can include **disorganisation**: misplaced materials, an unclear sequence of work, trouble keeping track of multiple instructions, or a chaotic transition between activities. It can also include a pattern of initiating work but failing to follow through. The important clinical distinction is that the person may understand the instruction and wish to comply, yet not maintain the task sufficiently to complete it. This is different from a strategic refusal, and it is different from not understanding what has been asked.

- Difficulty sustaining focus can leave an otherwise ordinary task only partly processed.
- Following an instruction may break down at the stage of carrying it through, rather than at the stage of hearing it.
- Work may be left unfinished after the person has moved away from the original task.

At the desk, this domain is often visible in the pathway rather than the final product. A notebook with gaps tells little by itself. Ask whether the child loses place while copying, starts before the full instruction is heard, repeatedly requires redirection, abandons one component for another, or cannot reconstruct where the task was left. The same pathway can appear outside academic work:

routine preparation, household responsibilities, conversation, and paperwork all require a goal to remain active while distractions compete.

> **GOOD TO REMEMBER**
> "Can focus on preferred activities" does not by itself negate an inattentive presentation. The useful question is how reliably attention is regulated when a task is repetitive, delayed in reward, or requires self-organisation.

Inattention should therefore be recorded in action language: loses track, does not return, omits a step, needs the task restated, or cannot organise the next move. This makes the account falsifiable. It also avoids collapsing a symptom domain into an academic outcome. Academic difficulty may be the consequence that brings the family to care, but the clinical domain is the repeated difficulty in sustaining and directing attention.

3.3 Hyperactivity: activity out of proportion to the setting

Hyperactivity involves **movement that is excessive for the setting**. Its significance lies in the mismatch between activity and context, not in whether a child is energetic or enjoys play. It may be expressed through running about when remaining nearby is expected, leaving a place repeatedly, conspicuous fidgeting, tapping, or a level of talking that disrupts the shared activity. The clinical description should specify what was expected in that setting and why the observed activity was difficult to regulate.

Movement may be small and continuous rather than dramatic. Feet may move beneath a desk, hands may tap or manipulate objects, and speech may fill pauses that others can tolerate. Such behaviour is easily dismissed as a habit if its cost is not explored. The relevant questions are whether it repeatedly disrupts work, disturbs others, makes waiting difficult, or continues despite a clear environmental cue to settle. The same person may appear calm in a stimulating or closely structured interaction and much less regulated when independent stillness is required.

It is useful to separate the observation from its social interpretation. "Running around" is an observation. "Naughty" is an interpretation. The first can be placed beside other data and tested against setting. The second is often a frustrated adult's shorthand, and it may obscure both the child's difficulty and the demands that provoke it. A respectful account also asks the person what the body state feels like, rather than assuming that outward movement is chosen for attention or disruption.

TRAP **Do not equate high energy with hyperactivity.** The symptom is dysregulated activity in a situation where that degree of movement is inappropriate, not a temperament judgement about an active child.

With development, the external form can become less obvious. The clinician should not require running or climbing in order to recognise the activity domain. In later developmental periods, overt activity may become **fidgetiness** or an internal experience of restlessness and impatience.

The change in form matters because informants often report that the person has "grown out of hyperactivity" when the visible expression has simply become more contained.

3.4 Impulsivity: action before adequate forethought

Impulsivity refers to **acting before enough thought has been given** to the situation. The central problem is not merely speed. It is a reduced capacity to pause long enough to consider information, social boundaries, likely consequences, or the possibility of waiting. The action may be minor and frequent, such as interrupting before another person has finished. It may also carry greater risk when a decision is made without allowing long-term consequences to influence the immediate response.

A useful formulation distinguishes impulse from intention. A child who calls out may genuinely know the answer and genuinely want to participate; the difficulty is waiting for the appropriate turn. A young person who agrees, spends, leaves, or reacts quickly may later recognise the consequence clearly; the difficulty was insufficient delay at the point of decision. This is why retrospective remorse does not exclude impulsivity. It may instead reveal the gap between what the person values after the event and what could be brought to bear in the moment.

- Interrupting can express social intrusiveness rather than simple enthusiasm.
- A strong pull toward immediate reward can make delay difficult to tolerate.
- Actions taken without adequate forethought may create potential for harm.

Why it matters clinically. Impulsivity often creates the most visible interpersonal consequences because it enters other people's space: it cuts across conversation, queues, shared rules, and family routines. Yet it should not be reduced to rudeness. The clinical account asks what the person did, what opportunity there was to pause, what consequence was foreseeable, and whether the same rapid-response pattern appears elsewhere. This preserves accountability without treating the symptom as a character defect.

MNEMONIC

Focus - Activity - Response

Use this simple spine when eliciting the domains: how the person keeps **focus** on a task, regulates **activity** to the setting, and pauses before a **response**.

3.5 Development changes the form, not the need for description

Symptom domains must be read through developmental demands. In the preschool period, the activity domain is usually the most conspicuous feature. This is clinically awkward because active movement is also common in ordinary early development. The task is therefore not to pathologise exuberance, but to notice whether activity is persistently difficult to contain when the setting requires containment and whether it creates a recurring burden for the child or those around the child.

As school demands become more sustained and organised, the inattentive domain comes to the foreground and creates clearer difficulty, and ADHD is often identified during the elementary-

school period. The developmental shift is intelligible: a setting that requires listening through instructions, maintaining place in work, organising materials, and completing sequences exposes failures of task regulation more clearly than a setting built around brief, adult-led activity. The change is not proof that inattention suddenly began. It may be that the demand has made an existing vulnerability visible.

DEVELOPMENTAL CONTEXT	CLINICAL EMPHASIS	HOW TO HEAR THE ACCOUNT
Preschool	Activity is the feature most likely to stand out.	Ask whether movement can be regulated when regulation is expected.
Elementary school	Difficulties in sustaining and organising attention become clearer.	Trace the pathway from instruction to completed work.
Adolescence	The large visible forms of activity recede.	Ask about fidgetiness, restlessness, impatience, and rash responding.

In adolescence, obvious running or climbing becomes less common and activity may be confined to fidgetiness or an **inner feeling of restlessness**. This is a change in presentation, not a licence to stop asking about the activity domain. The clinician should use the informant's developmental language rather than forcing childhood examples onto a person whose difficulty is now experienced more privately.

IN INDIA

In an Indian clinical record, preserve an everyday phrase such as “does not sit”, “forgets instructions”, or “answers without waiting”, then translate it into an observed sequence before attaching a symptom-domain label. This prevents a culturally familiar complaint from being mistaken for a complete clinical formulation.

3.6 Context dependence: why the consultation may look deceptively calm

Context-dependent expression is a central clinical fact. Signs may be minimal or absent when there is frequent reward, close supervision, novelty, an especially interesting activity, or a **one-to-one** interaction. This is not inconsistency in the pejorative sense. It shows that external structure, immediate reinforcement, and intrinsic engagement can temporarily carry regulatory work that the person struggles to sustain alone.

Office observation must therefore be interpreted modestly. A brief interaction is novel, adult-led, and often personally engaging. It may provide rapid feedback and a clear structure. A child who sits appropriately during it has demonstrated that regulation is possible under those conditions; the observation does not settle how regulation functions during ordinary demands. Conversely, a restless encounter should also be understood in its setting, rather than treated as a self-explanatory demonstration of the disorder.

PITFALL

A calm, cooperative consultation can become falsely reassuring when it is allowed to outweigh a consistent history of difficulty in less structured settings. Observation is valuable, but it is one context among several.

The same principle improves clinical conversations with families. Rather than treating apparently good performance during a preferred activity as a contradiction, ask what is different there: who is nearby, how quickly reward arrives, whether the activity is new, how much structure is supplied, and what happens when the task becomes routine. The answer may show why the family has experienced the behaviour as selective or puzzling without implying that the difficulty is fabricated.

3.7 Emotional reactivity as an associated clinical feature

Emotional dysregulation and emotional impulsivity are commonly encountered alongside ADHD. The person may be quick to anger, easily frustrated, and overreactive. These experiences deserve careful description because they can dominate the family's account and shape peer, school, and household consequences. They are not, however, an additional core diagnostic domain. Treating them as one blurs the boundary between the required symptom architecture and a clinically important associated feature.

The link with impulsivity is clinically intuitive: when delay, frustration, or interruption is difficult to tolerate, emotion may be expressed quickly and at high intensity. That explanation should remain a hypothesis in the individual case, not a shortcut that dismisses other contributors to distress. Describe triggers, sequence, recovery, and impact. Then decide whether the emotional pattern is best understood as associated reactivity, as part of another condition, or as both. The assessment and comorbidity sections take up those broader questions.

For bedside practice, the aim is a coherent narrative: the person loses the task, becomes active when stillness is required, responds before sufficient pause, and may react intensely when blocked or frustrated. Such a narrative is more useful than a symptom tally because it tells the clinician where everyday impairment is likely to arise and where apparent exceptions may be generated by context.

ADHD is recognised clinically by the patterned regulation of attention, activity, and response, interpreted in developmental context rather than by any single behaviour.

4 · Epidemiology and sex differences in ADHD

Epidemiology is not a decorative preface to diagnosis. It tells the clinician what a reported frequency can and cannot mean, and it explains why a child who is struggling may be missed when local expectations have been shaped by a narrow stereotype. In attention-deficit/hyperactivity disorder, the useful question is not whether a survey produces a definitive figure. It is whether the population examined, the route by which participants were identified, and the diagnostic method used make that figure applicable to the clinical question at hand.

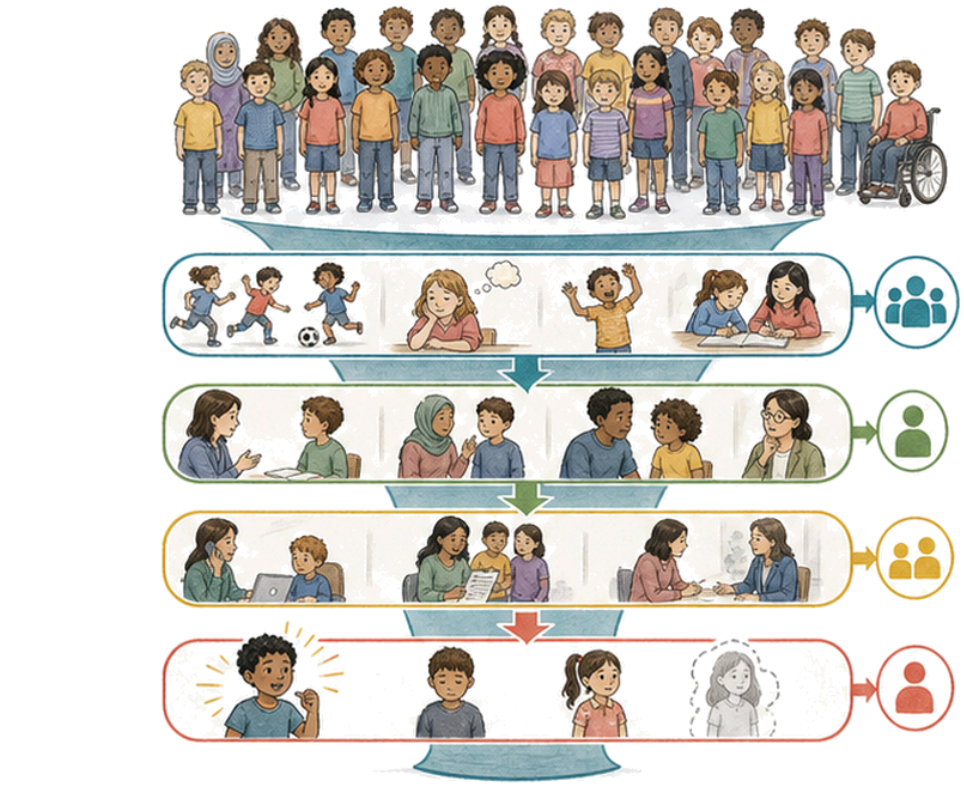


Fig 22.3 Observed ADHD caseloads pass through filters of presentation, recognition, access and referral. Disruptive behaviour is noticed earlier than quieter organisational or attentional difficulty, so clinic sex ratios cannot be read as population prevalence.

The epidemiological account also has a corrective function. ADHD is encountered across cultural settings and across the lifespan, but referral pathways do not select people neutrally. Behaviours that disrupt a classroom usually attract attention sooner than quieter difficulties with organisation or sustained mental effort. Sex differences in the observed caseload must therefore be read alongside sex differences in presentation and recognition. For a postgraduate answer, report the estimate, then explain the method and the clinical implication. That sequence demonstrates epidemiological reasoning rather than recital.

4.1 What prevalence means in ADHD

Population prevalence is the proportion of a defined population that meets the relevant diagnostic standard at the time and in the setting studied. It is not the same as the proportion already attending a clinic, receiving treatment, identified by a school, or labelled in administrative records. Each of those groups has passed through filters of recognition, help-seeking, access,

referral, and assessment. Their frequencies may be clinically useful, but they cannot simply be substituted for a community estimate.

For children worldwide, the current manual reports a frequency of **about 7.2%**. This is best used as an orienting benchmark, not as a shortcut to diagnosis in an individual child. A diagnosis still depends on the clinical assessment described elsewhere in this chapter. Prevalence provides a prior expectation that the condition is common enough to be actively considered when the presentation fits; it never converts an isolated complaint of distractibility or activity into a disorder.

In adults, the corresponding cross-national estimate is **about 2.5%**. This figure establishes that ADHD remains relevant beyond child services, while detailed adult presentation, persistence, and transition are addressed in the adult ADHD section of this chapter. The practical point here is modest but important: an epidemiological estimate should not be misread as either a developmental prognosis for an individual or a statement that every person identified in childhood will have the same clinical course.

7.2%	2.5%	2:1	1.6:1
WORLDWIDE CHILDHOOD ESTIMATE	ADULT ESTIMATE	CHILD MALE:FEMALE RATIO	ADULT MALE:FEMALE RATIO

RULE **Read every ADHD prevalence figure as an estimate produced by a particular method in a particular population.** The number is the beginning of interpretation, not its conclusion.

4.2 Why published estimates differ

A **cross-national range** is expected when studies do not use the same sampling frame or diagnostic process. Across nations, reported childhood and adolescent frequencies range from **0.1% to 10.2%**. A range of this width should prompt scrutiny of method before claims are made about culture, parenting, schools, or biology. The critical issue is comparability: are investigators asking the same question of populations selected in the same way and deciding caseness through an equivalent procedure?

Several features can shift the observed estimate without necessarily altering the underlying occurrence of ADHD. A survey based in schools begins with children who are present and observable in that setting. A community survey must locate families and achieve participation outside it. A clinic sample begins after referral, which is itself shaped by local awareness, resources, and the threshold at which difficulty is considered to require help. The informants available, the extent of collateral information, and the distinction between screening symptoms and a diagnostic assessment also influence who is counted. These are not technical footnotes. They determine whether figures from different studies can be compared at all.

It is also worth distinguishing measurement from service visibility. A community may have few recorded diagnoses because assessment is difficult to obtain, because school concerns do not reach health services, or because families frame the difficulty in non-medical terms. The inverse problem can occur where referral systems are highly responsive to classroom concerns. Neither

pattern can be interpreted without knowing the pathway from difficulty to identification. Epidemiology is strongest when it makes this pathway visible rather than concealing it behind a single headline percentage.

Diagnostic procedure has a particularly large effect. A symptom questionnaire can identify children who warrant fuller assessment, but it is not identical to a clinical diagnosis. Conversely, a restrictive procedure may miss children whose impairment is less visible to the informant or whose difficulties are interpreted through another frame. The examiner should therefore avoid treating a low estimate as proof that a disorder is rare, or a high estimate as proof of overdiagnosis, without first examining how the estimate was generated.

- Ask who was sampled and who was left outside the sampling frame.
- Ask whether the setting selected children before assessment.
- Ask how symptoms, impairment, and alternative explanations were evaluated.
- Ask whether the reported figure is a screening yield, a clinical rate, or a population estimate.

This discipline protects against a familiar error in viva discussion: explaining a numerical difference immediately as a cultural difference. Culture matters to recognition, report, and service access, but a difference between studies may be methodological before it is cultural. The answer should retain that uncertainty rather than inventing a causal story the data have not established.

MNEMONIC

MAP the estimate

Method asks how diagnosis was made; **A**scertainment asks how participants entered the study; **P**opulation asks who the result represents. Use this before comparing figures from different reports.

4.3 Culture, setting, and interpretation

The appropriate inference from the available international evidence is **cross-cultural comparability**: ADHD is seen broadly across cultures, and regional variation in reported prevalence is better understood primarily through diagnostic procedures and study methodology than as evidence of genuine regional differences in occurrence. This matters because the idea that ADHD is restricted to a particular cultural setting can lower diagnostic vigilance and make families feel that a formulation is imported rather than clinically grounded.

At the same time, cross-cultural comparability does not authorise cultural blindness. The clinician still has to establish what a behaviour means within the child's home, school, language, and daily demands. A child's difficulties can be obscured when educational expectations are inconsistent or when a family has had little opportunity to describe concerns in mental-health language. They can also be amplified when the referral is driven by a conflict with a particular environment. Epidemiology supports the possibility of ADHD; it does not replace contextual formulation.

IN INDIA

The **pooled estimate in Indian children** is **about 63.2 per 1000**. This is useful evidence against dismissing ADHD as uncommon in Indian practice. It should not be used as a local clinic target or as a substitute for a full developmental, educational, and psychiatric assessment. Differences between school-based and community-based estimates are especially instructive because they show how the place of recruitment changes the population being counted.

INDIAN STUDY CONTEXT	POOLED ESTIMATE	HOW TO USE THE FINDING
Children overall	About 63.2 per 1000	A broad pooled reference, not an individual diagnostic threshold.
School-based studies	About 75.1 per 1000	Interpret in light of school selection and school visibility of difficulty.
Community-based studies	About 18.6 per 1000	Interpret in light of household sampling and participation outside schools.

The lower community-based pooled estimate than the school-based pooled estimate is a methodological lesson, not a contradiction requiring a single winner. Schools concentrate observation of task demands and may make concerns more visible; community sampling reaches a differently selected population. Neither setting alone captures every child whose needs deserve attention. In clinical work, school information remains essential, but it is part of assessment rather than a population survey in miniature.

PITFALL

Do not compare a school-derived figure with a community-derived figure as though they measure identical populations. The apparent difference may arise before the assessment begins, through the route by which children entered the study.

4.4 Sex ratio is a finding, not a diagnostic rule

In the general child population, the male:female ratio is **about 2:1**. In the general adult population it narrows to about 1.6:1. These ratios describe observed population distributions. They do not mean that ADHD is a male disorder, that a female patient requires a different standard of evidence, or that a ratio can decide the probability of diagnosis for an individual.

The distinction between population and clinic is particularly important here. Referral services are shaped by whether concerns have been noticed, how they have been understood, and whether help has been sought. A clinic ratio can therefore reflect both underlying distribution and the selection pressures that precede referral. It should not be presented as a direct estimate of the frequency in the general population. Similarly, a clinician should not lower suspicion simply because a patient does not resemble the locally familiar referral pattern.

The change in the reported ratio across age groups invites thoughtful interpretation but does not, by itself, tell us why it occurs. A complete explanation could involve differences in recognition,

referral, symptom expression, service contact, or other features of study design. The epidemiological data in this section establish the pattern of ratios; they do not license a simple causal account. In a written answer, separating observation from explanation is a mark of clinical maturity.

TRAP **Do not turn a sex ratio into an exclusion criterion.** The ratio describes groups. Diagnosis concerns the individual's symptoms, impairment, developmental context, and differential diagnosis.

4.5 Female presentation and under-recognition

Females are more likely than males to present chiefly with **inattentive features**. This statement has direct clinical consequences. Difficulties that are less outwardly disruptive can be interpreted as poor motivation, anxiety, low confidence, or a personality style rather than as possible ADHD. The error is not that these alternative formulations never apply. The error is failing to consider ADHD because the presentation does not match an expectation built around conspicuous overactivity or impulsive behaviour.

Under-recognition is not solved by applying a lower threshold to girls and women. It is solved by asking a better question and gathering better evidence. Explore whether the reported concentration, organisation, task completion, and regulation difficulties are persistent, present in relevant settings, impairing, and better explained by another condition or circumstance. Seek collateral wherever feasible, and ask how the demands of school, work, family life, and social roles have exposed or concealed the difficulty. The core symptom domains and the formal diagnostic approach are set out in the relevant sections of this chapter.

Questions should be phrased so that a patient is not required to recognise their experience as ADHD before it can be described. Ask for situations in which work was abandoned despite intention, responsibilities were managed only through elaborate reminders, or attention failed under ordinary demands. Then ask what happened when external structure was removed. Such enquiry is not a symptom checklist in disguise. It is a way to understand function, context, and adaptation before deciding whether the broader diagnostic formulation is supported.

A less disruptive presentation may produce a quiet trajectory of burden. A patient can compensate by overpreparing, avoiding demanding tasks, relying heavily on relatives, or restricting opportunities. Such adaptation can make impairment harder to see in a brief consultation. It should not be mistaken for absence of impairment. The task is to identify the cost of maintaining functioning as well as the visible failures of functioning, while avoiding retrospective certainty where the history is unclear.

Why it matters clinically. Sex-sensitive assessment improves accuracy in both directions. It reduces missed ADHD in patients whose difficulties have been normalised or misattributed, and it guards against premature attribution when another formulation better accounts for the presentation. A careful history should neither presume ADHD from a stereotype nor exclude it because of one.

GOOD TO REMEMBER

When a patient reports a long history of effortful organisation or concentration without a disruptive referral history, ask what supports, avoidance strategies, and role demands have kept the difficulty out of view. The absence of a dramatic school narrative is not, by itself, reassuring.

4.6 From epidemiology to clinical judgement

Epidemiological data should change the clinician's calibration, not replace clinical judgement. A common condition deserves active consideration in an appropriate presentation; it does not deserve automatic attribution. The same discipline applies to sex differences. They should broaden the clinician's recognition of possible presentations, but should not encourage speculative diagnosis without evidence of clinically meaningful difficulty and a careful differential diagnosis.

In practice, keep separate the question of how often ADHD is identified in a population sampled by a given method, the question of who may have been missed or preferentially included before assessment, and the question of whether the individual in front of the clinician meets the required clinical formulation after relevant alternatives have been considered. Conflating these questions creates both overdiagnosis and under-recognition. Keeping them separate makes prevalence genuinely useful.

Documentation benefits from the same clarity. When recording epidemiological information, state whether it is a population benchmark, a school-based finding, a community estimate, or a service figure. When recording sex-related considerations, describe the observed presentation and the assessment undertaken rather than writing a stereotype as though it were an explanation. This produces records that are easier for colleagues, families, and future services to interpret.

For the examination candidate, an epidemiology answer should move from broad frequency to heterogeneity, then to clinical consequence. State the worldwide and Indian evidence where relevant, explain why estimates vary across settings, give the child and adult sex ratios, and finish with the implication that inattentive presentations in females may be under-recognised. Avoid expanding this section into diagnostic criteria, neurobiology, comorbidity, or treatment. Those topics require their own evidence and their own clinical reasoning.

Prevalence describes populations; careful assessment decides diagnosis, and sex differences should widen recognition rather than narrow it.

4.7 A concise examination framework

A high-quality short answer can be organised around interpretation. Begin with the worldwide childhood estimate and the adult estimate, making clear that these are population figures. Next, note the wide cross-national range and state that differing diagnostic procedures and methodology account for much of the apparent regional variation. Then add the Indian pooled figure and the contrast between school-based and community-based studies to show that setting

changes estimates. End with the male:female ratios and the greater likelihood of inattentive presentation among females.

The final sentence should carry the clinical point: prevalence and ratios should guide recognition and service planning, but they do not diagnose an individual. This ending prevents a fact-heavy answer from becoming detached from patient care. It also avoids opposite errors: using epidemiology to minimise ADHD in a setting where it is under-recognised, and using a familiar epidemiological figure as a substitute for careful assessment.

5 · Etiology and neurobiology (genetics, dopamine-noradrenaline, executive dysfunction)

Why it matters clinically. ADHD is best understood as a developmental disorder of regulation, not as a failure of will, parenting, or intelligence. Its aetiology is therefore neither a discrete lesion nor an isolated adverse experience. The useful clinical question is not "what caused this child's ADHD?" but how inherited liability, brain development and context have combined to produce the present pattern of impairment. This formulation gives the clinician a coherent explanation for families while keeping diagnosis anchored in clinical assessment.

The biology is examined because it explains several otherwise puzzling features: clustering within families, variation in the balance of inattentive and hyperactive-impulsive difficulties, inconsistent performance across settings, and the characteristic difficulty in converting intention into organised action. It also prevents common errors: genetic evidence must not be mistaken for genetic determinism, and a brain-based account must not be used to erase the child's environment, strengths, or need for practical support.

about 74%	about 76%	20 to 25%	3 to 5 years
HERITABILITY ESTIMATE	TWIN-STUDY VARIANCE	FIRST-DEGREE RISK	MATURATIONAL DELAY

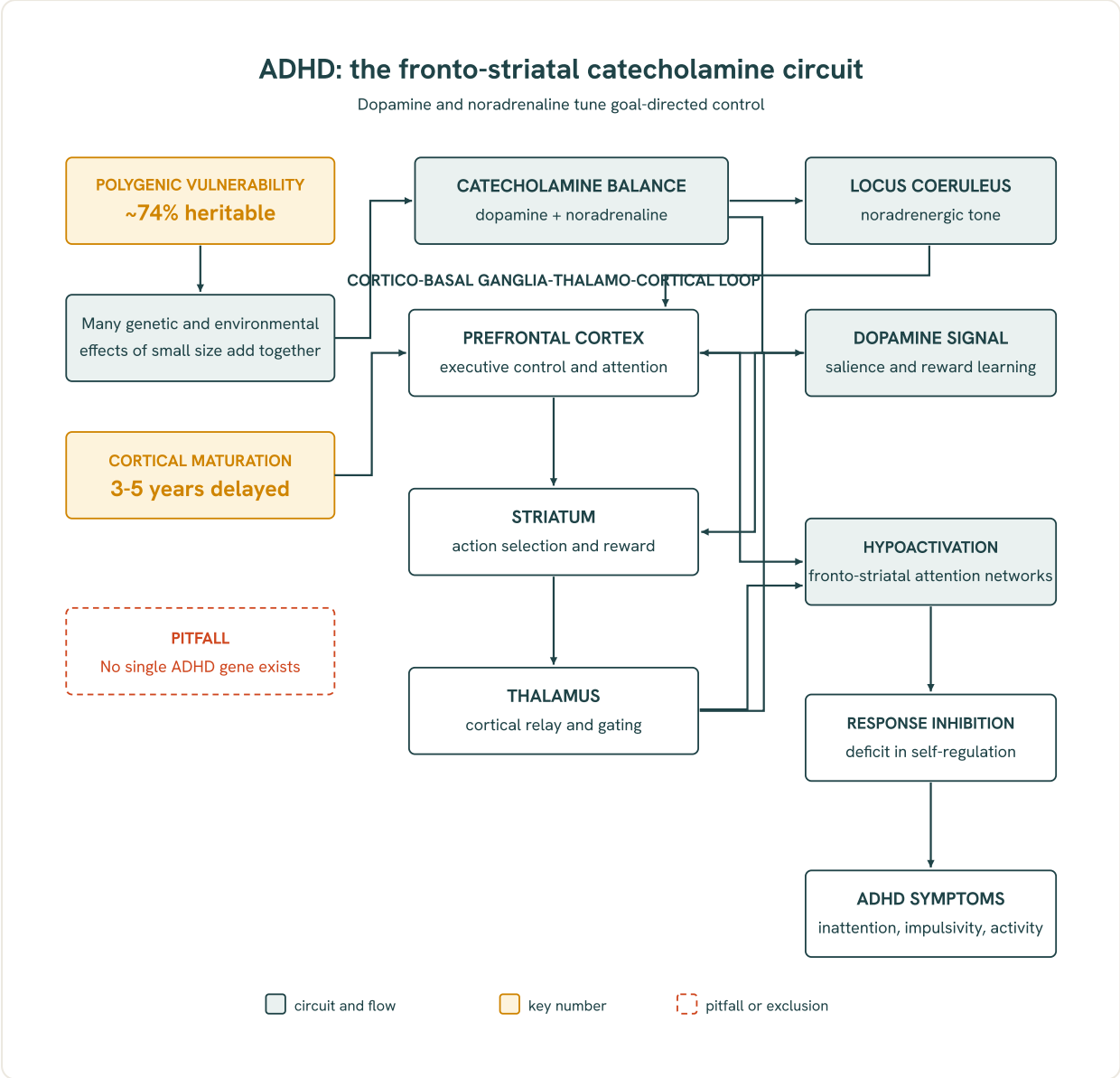


Fig 22.4. Fronto-striatal dopamine and noradrenaline circuit in ADHD.

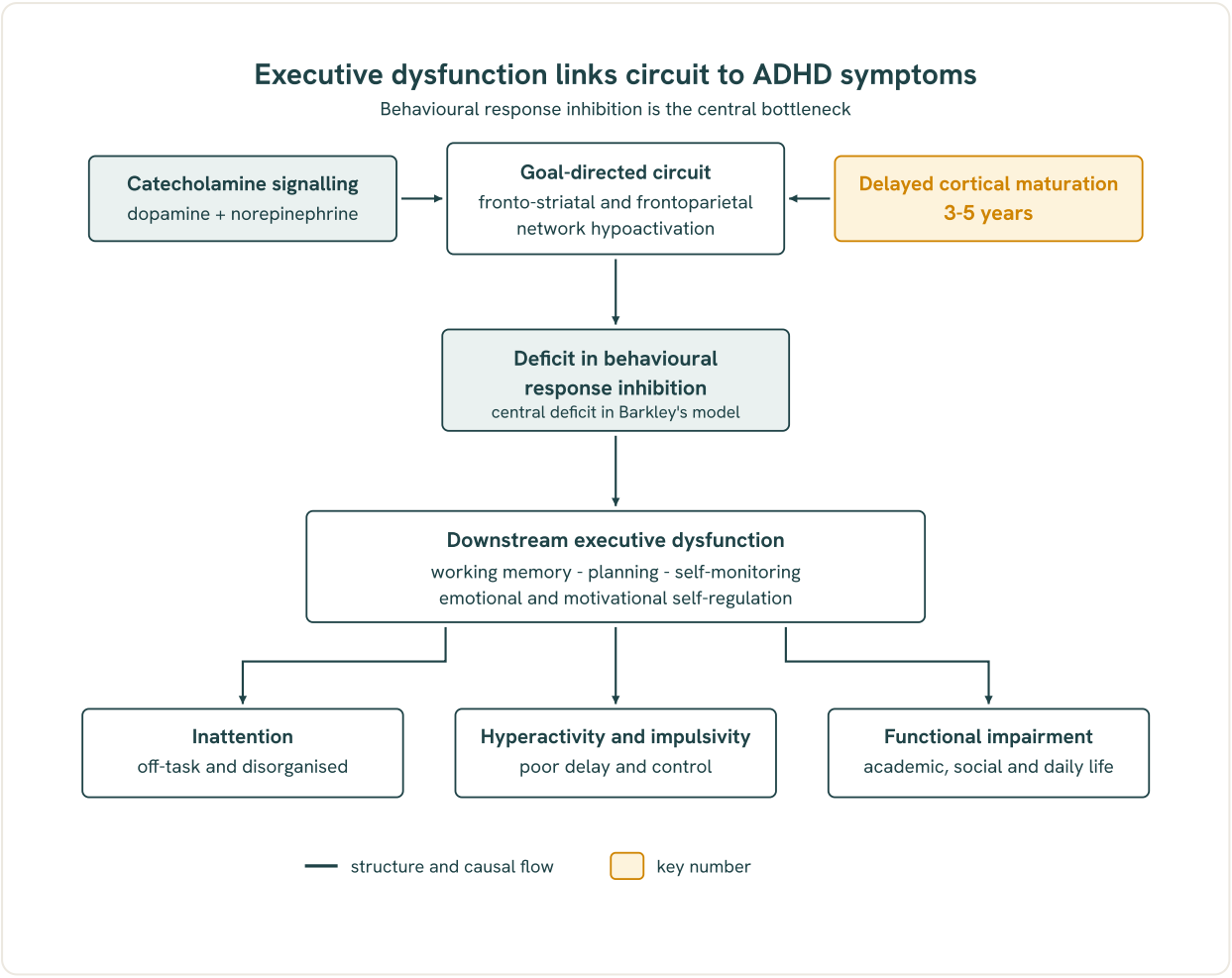


Fig 22.5. Executive dysfunction as the mechanism linking circuit-level dysfunction to core ADHD symptoms.

5.1 A multifactorial model, not a single cause

ADHD is a **multifactorial vulnerability**: multiple inherited and environmental influences of small effect can converge in an individual. This is a more accurate model than searching for a decisive biological abnormality. The causal pathways are heterogeneous. Children may meet the same clinical diagnosis through partly different combinations of familial liability, developmental exposures, neural organisation and compensatory strengths.

This matters for formulation. A family history can make an inherited contribution plausible, while a prenatal or early developmental history can identify circumstances relevant to vulnerability. Neither alone establishes the diagnosis, explains every current difficulty, or tells the clinician what a particular child will become. The phenotype is the clinical end point of development, not a direct read-out of a gene or an exposure.

RULE **Heritability describes variation in a population; it does not measure how inevitable ADHD is for an individual child.** It supports a substantial inherited contribution while leaving room for developmental context, individual differences and change over time.

For the same reason, a high heritability estimate does not license blame directed at a parent. It is compatible with shared family traits, with parents who have developed effective adaptations, and with a child whose support needs are different from those of relatives. The clinician should use

biological explanation to reduce moral judgement, not to convert a complex developmental problem into fatalism.

At the bedside, the formulation can be kept orderly without pretending to be exhaustive:

- identify the developmental pattern and current functional difficulty;
- ask whether familial liability is likely to be relevant;
- consider developmental circumstances that may have added vulnerability; and
- look for the present demands and supports that determine how severely the difficulty is expressed.

This sequence is deliberately formulation-led rather than cause-hunting. It acknowledges uncertainty honestly. It also gives the family a practical narrative: some contributors cannot be changed, but the child's current environment, routines and supports can be altered. A neurobiological explanation earns its place only when it makes this conversation clearer and less blaming.

5.2 What family and twin evidence establishes

Family aggregation and twin research provide the strongest starting point for the genetic account. The DSM estimate is displayed in the evidence strip above. Across family, twin and adoption designs, the reported heritability index ranges from **0.6 to 0.98**. Such estimates indicate that inherited differences make an important contribution to variation in ADHD in the populations studied; they do not identify an individual cause.

The pattern within twin pairs makes the inference intuitively clear. Reported concordance is **MZ 59-92%; DZ 29-42%**, with the more genetically similar pairs showing greater concordance. The twin-study estimate of genetic contribution is displayed in the evidence strip. The residual difference within genetically similar pairs is clinically important. It cautions against treating genes as a complete explanation and directs attention to development and context.

The first-degree relative estimate is displayed in the evidence strip. In practice, this means that the history should be taken broadly. Ask about lifelong distractibility, disorganisation, impulsive decisions, school difficulties and coping styles in close relatives, rather than asking only whether a relative carries a diagnostic label. A parent's account of childhood experience may illuminate the family context, but it must never substitute for an assessment of the child.

Evidence of familiality answers a population question: whether inherited factors contribute meaningfully to variation in the condition. It does not answer the individual question of why one sibling is more impaired than another, why a child has difficulties in one setting but not another, or whether a current school problem is due to ADHD. Those questions require the longitudinal, contextual assessment described elsewhere in the chapter. This distinction protects the clinician from making a statistical association carry more clinical meaning than it can bear.

GOOD TO REMEMBER

Family history has complementary uses: it strengthens the developmental formulation and it helps identify practical supports within the family. It is not a diagnostic shortcut, and it should not be presented as proof that a child cannot improve.

5.3 Polygenic architecture and candidate-gene findings

ADHD is **polygenic**; there is no single ADHD gene. Candidate-gene work has concentrated on systems relevant to catecholamine signalling and synaptic regulation. The **DAT1 (dopamine transporter gene)** has been associated with ADHD, particularly with hyperactive-impulsive or combined clinical presentations. Its biological interest lies in its relation to synaptic dopamine reuptake, which offers a plausible bridge between molecular variation and regulation of neural signalling.

Another repeatedly studied candidate is the **DRD4 seven-repeat allele**, linked in this literature with novelty seeking, impulsivity and the inattentive subtype. Other reported candidates include **DRD5, DBH, COMT, SNAP25, SLC6A2 and ADRA2A**. These names are useful for understanding why dopamine, noradrenaline and synaptic processes recur in mechanistic accounts. They are not a clinically actionable genetic panel for routine diagnosis.

The candidate-gene story also teaches an important scientific lesson. Many early associations have not been consistently reproduced. Known candidate genes account for below **5%** of genetic variation. Broad genomic association work identified **12 independent loci**, reinforcing the conclusion that liability is distributed across many variants of small effect rather than concentrated in one explanatory gene.

For an examination answer, distinguish levels of evidence. Family and twin findings support heritability. Molecular findings ask which biological pathways may carry part of that liability. Neither level reduces ADHD to a Mendelian disorder, and neither makes molecular testing a replacement for phenomenology, developmental history and impairment. This distinction is often more valuable than memorising a long list of gene symbols.

TRAP **Do not answer "DAT1 causes ADHD" or "DRD4 is the ADHD gene."** Candidate associations are part of a distributed liability model. The exam-safe conclusion is polygenic vulnerability, with individual variants contributing limited and sometimes inconsistently replicated effects.

LEVEL OF EXPLANATION	WHAT IT CONTRIBUTES	CLINICAL INFERENCE
Familial liability	Explains aggregation across relatives	Take a developmental family history without assuming destiny
Polygenic variation	Distributes liability across many small effects	Do not seek a diagnostic gene
Neural signalling	Links molecular systems to regulation of behaviour	Use it to explain mechanisms, not to label a child biologically
Developmental context	Shapes vulnerability and adaptation	Build a formulation that remains individualised

5.4 Dopamine, noradrenaline and state regulation

The central neurotransmitter account concerns **dopamine and norepinephrine (noradrenaline), with epinephrine**, within a broader catecholamine imbalance. These systems are relevant because efficient attention and purposeful behaviour require the brain to regulate salience, arousal, effort and response selection according to the demands of the moment. A child may know what should be done yet fail to sustain the regulated state required to do it consistently.

Dopamine is especially helpful as a conceptual link to reinforcement, motivation and the selection of responses; noradrenergic signalling is helpful as a link to alertness and the allocation of attention. These are not separate boxes. They work within connected circuits, so an apparent problem of "motivation" may actually reflect inefficient regulation of attention, timing and response control. This helps the clinician move beyond the simplistic contrast between "can do" and "will not do."

The important idea is state regulation. Effective performance depends on bringing attention and effort to the task, maintaining them despite distraction, and readjusting when the task changes. Catecholamine-linked systems are plausible contributors to these transitions. When they are inefficient, the child's output may fluctuate sharply with task structure, novelty, feedback and competing stimulation. Such fluctuation can look oppositional or careless if the clinician observes only the finished work rather than the regulatory demands imposed by the situation.

This account should not be used to collapse all difficulties of attention into ADHD. Attention can be disrupted by many developmental, emotional, cognitive and environmental conditions. The neurobiological model explains why ADHD is a plausible formulation after diagnostic work has been done; it does not establish the diagnosis before that work.

A proposed noradrenergic mechanism is reduced inhibition of **locus coeruleus neurons**. This could account for inattention, cognitive difficulty and gross motor activity by impairing the regulation of arousal and attention. The wording is deliberately mechanistic rather than deterministic: the finding is a model of how a symptom pattern may arise, not a laboratory test that confirms the disorder in an individual patient.

IN INDIA

When families ask whether ADHD is "chemical" or "because of upbringing," avoid forcing a false choice. Explain that biology and developmental context jointly shape vulnerability, then return to the child's observable impairment and the supports that can be put in place at home and school.

5.5 Circuit-level account and cortical development

The circuit model locates ADHD in **cortico-basal ganglia-thalamo-cortical (fronto-striatal) circuitry**. Hypoactivation has been reported in frontostriatal, frontoparietal and ventral attention networks. These systems support goal-directed executive processes and decision making. The clinical relevance is that regulation requires a coordinated network: maintaining a

goal, filtering competing input, selecting a response, monitoring its consequence and adjusting course are connected operations.

Network language is preferable to a crude "frontal-lobe deficit" formulation. It explains why ADHD can affect the organisation of behaviour across tasks without implying a fixed global intellectual deficit. It also explains why performance may improve markedly when structure, novelty, immediate feedback or external scaffolding reduces the regulatory load. Such variability is not evidence that the difficulty is fabricated; it is often the clinical signature of context-sensitive control.

Developmental imaging work describes the maturational delay displayed in the evidence strip, particularly in frontal and temporal regions. This should be read as a developmental timing account. It does not mean that every child follows one anatomical timetable, nor does it permit prediction of outcome from a scan. The useful inference is that symptoms arise during an evolving developmental process, which is consistent with the importance of developmental history and longitudinal review.

Important safeguards apply when interpreting circuit findings. Group-level differences do not create a diagnostic signature for an individual, and a network description is not an excuse to overlook psychosocial formulation. Neural systems operate in a child who is learning, relating, sleeping, attending school and responding to expectations. A mature formulation holds both levels in view without falsely setting them against each other.

> **PITFALL**
>
> Do not present group-level circuit findings as though they explain an individual child completely. They are useful for formulation, but they do not replace careful clinical reasoning about that child's developmental history, context and impairment.

5.6 Executive dysfunction: the clinical bridge from circuit to behaviour

The most clinically useful bridge from neural systems to daily impairment is **behavioural (response) inhibition**. In the executive-function model, a central weakness in pausing or withholding an immediate response has downstream effects on self-regulation and executive functioning. The point is not that every person with ADHD is constantly disinhibited. Rather, when rapid response, delay, distraction or competing reward increases demand, the person may have less reliable capacity to stop, hold a goal in mind and choose a more adaptive next action.

Executive functions are therefore best conceptualised as control processes that allow behaviour to be organised over time. They include maintaining task goals, monitoring performance, shifting strategy, resisting a dominant response and regulating effort. The accompanying figure can be used to connect the neural network account with this control problem. It should not be confused with the descriptive account of core symptoms, which is covered separately in the clinical-features section of this chapter.

This model makes sense of the everyday paradox of an able child who starts with intention but does not complete work, gives a quick answer before considering alternatives, or needs repeated

external prompts to return to a task. The difficulty is often not lack of knowledge of the rule. It is inefficient use of the internal control processes required to apply that rule at the relevant moment. External organisation can therefore be therapeutic because it temporarily supplies structure that the child cannot yet generate reliably.

Executive dysfunction is a mechanism, not a synonym for the diagnosis. The clinician should not infer it from an isolated messy notebook, an isolated impulsive act or a parent's understandable frustration. Its explanatory value lies in a coherent pattern across contexts and over time: the child repeatedly struggles to regulate action when independent planning, sustained monitoring or delayed response is required. The model then guides a practical question: which external prompts, routines and task structures reduce the control load enough for the child to show existing competence?

MNEMONIC

PAUSE

Pause the response, **A**im at the goal, **U**pdate the plan, **S**can for competing input, **E**xecute deliberately. This is a memory aid for the executive-control sequence, not a diagnostic checklist.

5.7 Environmental contributors and a usable formulation

Environmental associations include **very low birth weight, prematurity, prenatal smoking exposure, in-utero alcohol and lead exposure**. These should be approached as contributors to vulnerability, not as a list of proven causes for every patient. The distinction matters both scientifically and ethically. Retrospective history can identify a relevant developmental context, but it cannot establish that one exposure caused one child's ADHD.

In a clinical history, exposures should be recorded accurately and without accusation. The question is whether they contribute to the developmental formulation, not whether a parent can be assigned responsibility for a disorder that has complex origins. It is equally important not to let an exposure history eclipse evidence of familial liability or current contextual stressors. The biological and environmental strands are most useful when they are integrated rather than made to compete.

A good formulation brings levels together. Start with familial and developmental vulnerability; consider whether attentional arousal, reward sensitivity and response regulation offer a plausible mechanism; then identify current contexts that expose or buffer the executive-control difficulty. This produces practical, non-blaming language: the child has a difficulty regulating behaviour across demands, and the environment can either overload that system or make success more likely.

Mechanism should guide empathy and intervention planning, not become an explanation that eclipses the child. Ask what demands are being placed on self-regulation, what supports already work, and where the mismatch between capacity and expectation is greatest. For the wider assessment framework, see the Child psychiatry: assessment, treatment, services and protection

notes. For developmental context outside ADHD, see the Normal child development and milestones notes.

ADHD is a multifactorial, polygenic developmental disorder in which catecholamine-linked control networks and executive dysfunction help explain the clinical phenotype.

Recognising ADHD: assessment, scales, comorbidity and differential

6 · Comprehensive assessment of ADHD (history, school reports, observation)

Assessment is the diagnostic intervention before treatment is considered. A convincing assessment of ADHD does not arise from a child's behaviour in the consulting room, a single checklist, or an anxious parent's account taken in isolation. It is a deliberate reconstruction of patterns over time, across demands and relationships, followed by an appraisal of their consequences. The task is not to decide whether the child is lively, distractible, or difficult on a particular afternoon. It is to decide whether the reported pattern is developmentally inappropriate, persistent in the child's ordinary life, and sufficiently impairing to require a clinical formulation.

The assessment has a diagnostic purpose and a formulation purpose. It establishes whether ADHD is the best account of the presenting difficulties, and it identifies the factors that will change the meaning of those difficulties for this child and family. A good assessment makes the later management plan more precise because it has already mapped the child's strengths, the settings in which problems emerge, the adults who can observe change, and the obstacles that may be mistaken for the disorder itself.

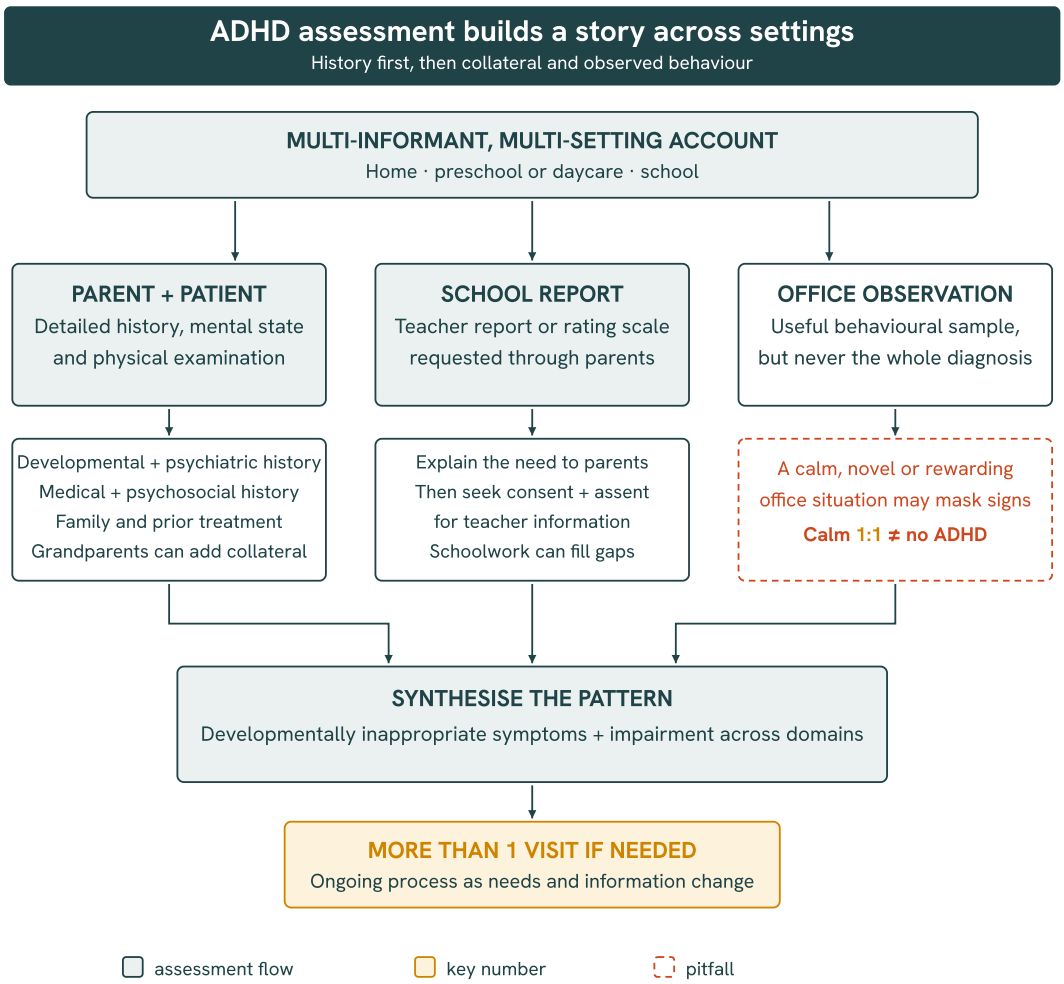


Fig 22.6. ADHD assessment pathway: history-led, multi-informant evidence across settings.

6.1 Architecture of a comprehensive assessment

A **comprehensive ADHD assessment** rests on detailed history, mental state examination, and physical examination. These are not separate bureaucratic stations. Each corrects a limitation in the others: history supplies the longitudinal and contextual picture, the examination tests the immediate clinical impression and alternative explanations, and physical assessment detects medical issues that may alter interpretation or subsequent care.

The **three** pillars should be gathered with a single clinical question in mind: what does the child actually do, where does it occur, what demand exposes it, who is affected, and what follows? This turns global labels such as “not listening” or “very naughty” into observable, comparable information. It also prevents the clinician from treating every report of poor work, conflict, or restlessness as if it carried the same diagnostic weight.

- Describe the behaviour in concrete terms before naming it.
- Place it in the setting and demand in which it occurs.
- Establish the consequence for the child and the people around them.
- Record what remains uncertain and needs corroboration.

History	School	Observation
PATTERN OVER TIME	ORDINARY PERFORMANCE	CLINICAL CONTEXT

RULE **ADHD assessment is a synthesis of converging accounts, not a verdict from a single encounter.** The clinical interview remains the organising method: it decides what needs corroboration, where information is missing, and whether apparent agreement between informants reflects the same behaviour in comparable circumstances.

Use the assessment to construct a formulation rather than merely to fill a diagnostic template. Begin with the presenting concern in the family's own language, then translate it into concrete examples. Ask what has already been tried, what has helped, and what has worsened the problem. This sequence preserves rapport and produces information that can later be shared with parents and school without implying blame. It also reveals whether the referral question is diagnostic uncertainty, functional decline, conflict around expectations, concern about safety, or a request for documentation.

6.2 Multi-informant and multi-setting enquiry

The core strategy is **multi-informant assessment** across settings. Parents or caregivers know the child's routine, transitions, sleep, self-care, conflict, and unstructured time. Teachers witness performance under group instruction, sustained work, peer demands, rules, and academic expectations. The child's own account may clarify internal experience, efforts to compensate, distress, and the meaning attached to repeated criticism. These accounts are complementary rather than competitors in a courtroom.

A **caregiver history** is central because ADHD is diagnosed primarily through history and caregiver report; a brief office sample is rarely adequate to detect the relevant pattern. Ask each informant for examples rather than asking only whether a symptom is present. "What happens when homework begins?" is usually more useful than "Is attention poor?" The first question elicits sequence, triggers, adult responses, and consequences. The second often elicits an interpretation already shaped by frustration or stigma.

Discrepancies deserve curiosity, not premature resolution. A child who appears settled in one environment may be supported by a structure, a relationship, or a task that reduces the relevant demand. Conversely, a report of difficulty in one setting may point to a contextual mismatch, a learning demand, peer difficulty, or a relational strain that needs separate assessment. The clinician should identify what is different about the setting before deciding what the discrepancy means. Agreement is helpful; carefully understood disagreement can be even more informative.

MNEMONIC

Listen, Locate, Link, Look again

Listen for concrete examples; **locate** them in ordinary settings; **link** them to their functional effects; and **look again** when accounts conflict. This is an interviewing spine, not a diagnostic shortcut.

IN INDIA

Collateral need not be restricted to parents. In joint or extended households, **extended-family collateral**, including from grandparents, may add a useful account of routines and behaviour. The clinician should still establish who has regular, direct knowledge of the child rather than treating kinship alone as evidence of reliability.

Interview quality improves when the clinician makes the purpose of collateral explicit. Explain that the aim is to understand the child's functioning in ordinary environments, not to recruit adults to prove that the child is problematic. This framing reduces defensiveness and helps informants offer examples that include strengths, successful situations, and environmental supports. Collateral from other caregivers may be useful when it concerns a setting they know directly, but it should be recorded as an account rather than elevated automatically above the child's or parent's report.

6.3 History: developmental anchoring and clinical context

The history should establish the course of concerns, the situations in which they are most visible, the child's capacities, and the family's explanatory model. **Developmental and psychiatric history** is taken to support differential diagnosis and identify comorbidity. Its value lies in anchoring current concerns in the child's broader developmental trajectory, rather than interpreting behaviour only through the immediate school complaint. For developmental context beyond this focused assessment, consult the Normal child development and milestones notes.

The essential anchor is **developmental appropriateness**. Behaviour must be judged against the child's developmental level, not against an abstract expectation that every child of similar chronological age will behave identically. When intellectual subnormality is suspected, the relevant question is whether the difficulty is inappropriate for the child's mental age; this is why developmental history and a working impression of mental age belong in the assessment. The point is clinical fairness: a behaviour can be challenging for adults yet still be developmentally expected for that particular child.

Build the developmental account around function. Clarify communication, play, self-regulation, adaptive demands, and the child's response to routine changes or increasing expectations, without turning the history into a catalogue. Ask how the current concern differs from the child's usual style and whether it is experienced similarly by the child and adults. A timeline is useful when it links difficulties to transitions in demands or contexts, but it should not be mistaken for proof by itself. The history is an interpretive tool, not a chronology contest.

Medical history searches for comorbidity and identifies issues relevant to medication planning. It should include relevant physical disorders and a focused account of symptoms that may change the safety assessment. When pharmacotherapy may later be considered, obtain family history of ADHD and, specifically, family history of sudden cardiac death **under 40 years**. Baseline sleep and appetite are also worth recording because later change cannot be interpreted well if the starting state was never established.

The wider history includes prior interventions, substance-use history where relevant, psychosocial context, and family experience of the problem. It is tempting to regard family history as a confirmatory box to tick. Instead, treat it as a clue whose meaning is contextual. A history of relatives with ADHD can support the formulation, whereas absent affected relatives in the context of traumatic stress or a family history suggestive of a mimicking condition should prompt renewed diagnostic caution. The detailed differential is addressed elsewhere in this chapter; this is the moment to keep the differential open rather than to settle it too early.

GOOD TO REMEMBER

Baseline sleep, appetite, prior treatment, and family concerns are not "background." They make later follow-up interpretable and help distinguish a new treatment effect from a pre-existing difficulty or a changing environmental demand.

6.4 School reports and the educational record

School is usually the setting in which the gap between capacity and performance becomes most visible, but the school report must be requested and interpreted with care. A **teacher report** may be an unstructured account of observed behaviour or a teacher rating on a structured scale. It is sought through the parents after explaining why information from school is needed and obtaining consent and assent. The explanation matters: parents may fear stigma, blame, or adverse treatment of the child, and a request that feels like surveillance can damage collaboration.

Ask the teacher to describe the learning environment rather than simply to endorse a label. Useful observations concern how the child begins work, sustains it, responds to instruction, handles transitions, completes tasks, interacts with peers, and functions when supervision changes. Ask what appears to help, not only what fails. Schoolwork, notebooks, report cards, and patterns of incomplete or inconsistent work can provide a concrete record of the educational impact, but none is diagnostic in isolation. They need to be read alongside the developmental history and the child's opportunities to learn.

CLINICAL QUESTION	WHAT THE SCHOOL RECORD CAN CONTRIBUTE	HOW TO INTERPRET IT
Where does difficulty arise?	Examples from instruction, independent work, transitions, and peer situations	Locate the difficulty in a real demand rather than in a global judgement
How stable is the pattern?	Observations across routine school tasks and records over time	Compare patterns, not isolated incidents
What supports functioning?	Teacher accounts of structure, prompts, seating, reinforcement, or task format	Identify conditions under which impairment is reduced
What is the impact?	Work completion, classroom participation, relationships, and educational progress	Separate functional consequence from a diagnostic label
What remains uncertain?	Gaps, conflicting accounts, or records that lack context	Return to parent, child, and teacher for clarification

If parents remain reluctant to approach the school, do not convert reluctance into non-cooperation. Elicit the reasons, revisit consent, and make the best assessment possible from parent and child accounts together with schoolwork and report cards. The limitation should be documented honestly. A missing teacher report reduces one source of corroboration; it does not make thoughtful clinical assessment impossible.

Rating scales can help obtain structured teacher information and later monitor response. Their role is supportive; diagnostic judgement rests on clinical assessment. The selection, structure, and interpretation of specific rating scales are covered in the section on rating scales.

6.5 Observation, mental state and physical examination

Direct observation is useful when it is treated as a sample with a known context. The clinician can note engagement, activity level, communication, response to structure, separation from caregiver, frustration tolerance, and the fit between observed behaviour and the history. Observation may also show the child's competencies, which matter when explaining the formulation to family and school. It cannot, however, be allowed to overrule a carefully gathered longitudinal account merely because the interview was calm.

The office is a particularly poor place to infer absence of ADHD from absence of obvious signs. Features may be minimal or absent in **one-to-one** interaction, in a novel setting, under close supervision, with frequent rewards, or during especially engaging activity. These are not loopholes in assessment. They are reminders that behaviour is shaped by the demand and support available at the time it is observed.

TRAP **"The child sat quietly in my room, so the history must be wrong."** A short, structured, novel encounter may be far less demanding than the environments from which the referral arose. Use the observation to refine the formulation, not to dismiss collateral evidence.

The **mental state examination** is especially valuable because it can rule out another mental disorder that better explains the symptoms. It should be developmentally adapted and integrated with the interview rather than reduced to an adult-style checklist. Affect, thought content, anxiety, mood, perception, communication, insight appropriate to development, and risk are considered insofar as they clarify the presenting pattern. This is a screen for explanatory alternatives, not a duplicated teaching of the differential diagnosis.

The **physical examination** and medical history help rule out mimicking disorders and detect comorbid developmental coordination disorder. There are no diagnostic physical signs of ADHD. Abnormal findings therefore require their own clinical interpretation rather than being treated as evidence for ADHD. Examination also establishes a sensible baseline for care and may reveal a reason to broaden the assessment beyond the referral label.

PITFALL

Do not write “normal examination” as if it were a positive diagnostic test for ADHD. A normal examination narrows some concerns; it does not confirm the diagnosis. Equally, an abnormal finding should prompt explanation rather than diagnostic drift.

6.6 Impact, selective tests and the adolescent interview

Symptoms acquire clinical importance through their consequences. Assess **functional impairment** across academic, family, social, interpersonal, peer, and occupational domains as relevant, and ask how the difficulty affects the patient and caregivers. This prevents severity from being equated with how disruptive an adult finds the child. A quietly struggling child may have substantial educational or internal burden, while a highly visible behaviour may have limited impact once the context is understood.

Discuss impact concretely. What activities are avoided? What interactions repeatedly deteriorate? What does the child believe about their own abilities? What is the cost to caregivers in supervision, conflict, time, or distress? The answers guide priorities for follow-up and create a baseline against which meaningful improvement can be judged. They also make it easier to distinguish a symptom count from the lived burden that justifies intervention.

Routine psychological testing and specific physical investigations are not indicated solely to establish ADHD. Cognitive assessment is reserved for suspected intellectual subnormality, and investigations are selected when the history or examination indicates them. This restraint is good clinical method: testing should answer a question generated by the assessment, not substitute for the assessment that should have generated the question.

For older children and adolescents, make space for a **confidential adolescent interview** separate from parents. This acknowledges autonomy and confidentiality and creates an opportunity to elicit mood-related risk, substance use, and high-risk behaviour that may not emerge in a family interview. Explain the limits of confidentiality in language the young person can understand, and then return to shared discussion only to the extent that safety and care require.

6.7 Integrating and revisiting the formulation

End the first assessment by making the reasoning visible. Summarise the reported pattern, the settings represented, the degree and type of impairment, the corroborating evidence, the unresolved discrepancies, and the factors that require further assessment. This is more useful than a bare conclusion because it tells the family why a diagnosis is being considered and tells the clinician exactly what must be clarified at follow-up.

Assessment is not necessarily concluded in a single visit; it may require **at least** a further visit and remains an ongoing, multi-informant process across settings. Follow-up is not an administrative afterthought. New school information, changing demands, treatment response, and family circumstances can sharpen the formulation or reveal that an initial explanation was incomplete. The clinician should preserve uncertainty where the evidence is incomplete, rather than forcing a premature categorical answer.

> The diagnosis is made from a developmentally anchored, multi-setting history of impairment, interpreted with school collateral and examination - never from a quiet consulting-room encounter alone.

7 · Rating scales (Conners, Vanderbilt, SNAP-IV)

Rating scales make behaviour discussable across settings. They convert an informant's observations into a structured record, but they do not convert a questionnaire result into a diagnosis. Their proper contribution is to show which concerns are being endorsed, by whom, how much functioning is affected, and whether the pattern merits clinical synthesis with the history, collateral information and examination. A scale is therefore evidence from an informant, not a substitute for clinical judgement.

The marks in this area usually turn on a more precise distinction: the instruments share an ADHD focus but do not share the same raters, age bands, score metric, thresholds or reproduction permissions. Treating them as different versions of one test produces errors in both interpretation and documentation. The accompanying figure separates the instruments by the question each actually answers.

3	6 to 12	26
CONNERS RATER FORMS	VANDERBILT AGE BAND	SNAP-IV ITEMS

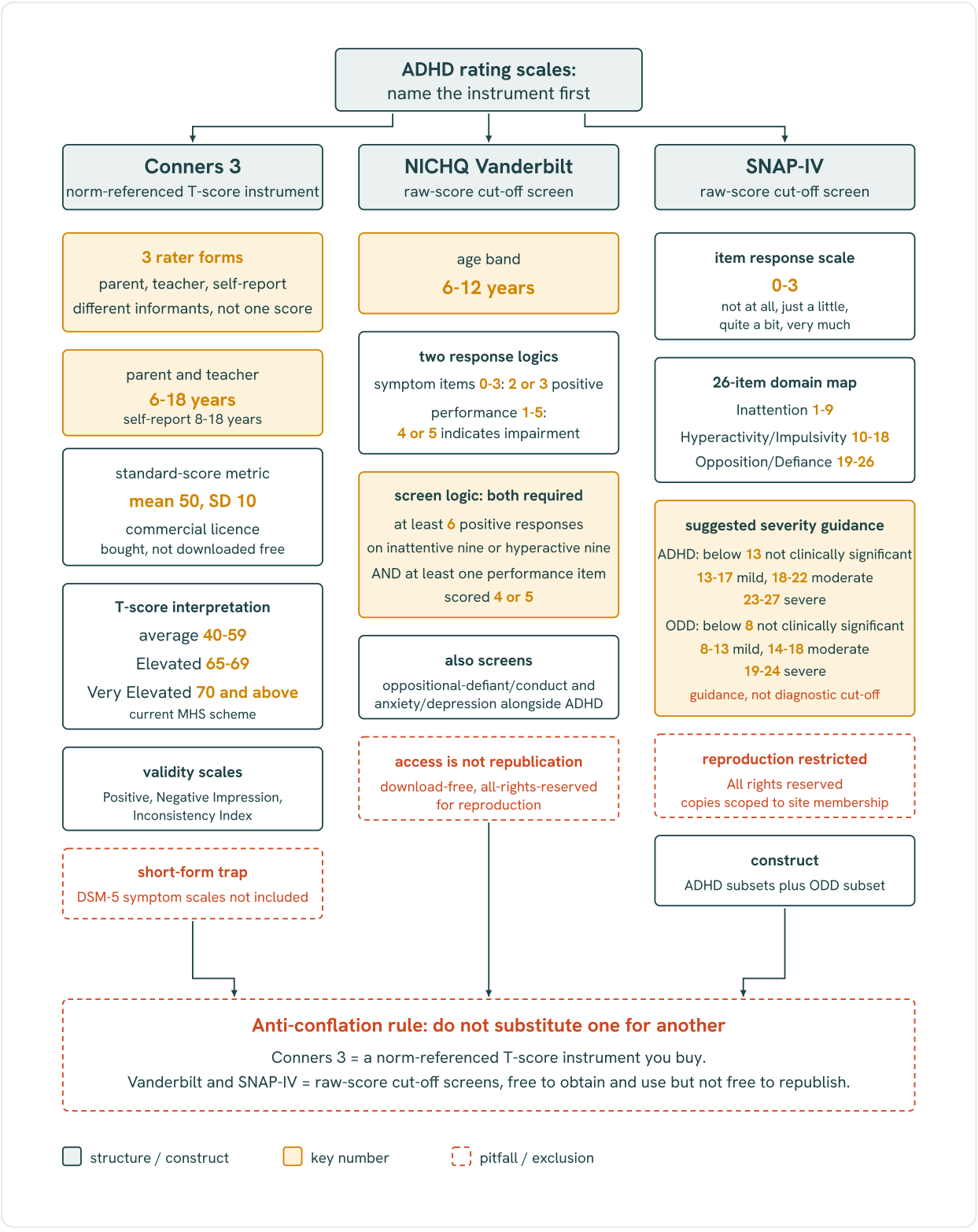


Fig 22.7. ADHD rating-scale split: match the instrument to its rater, age band, scoring construct and cut-off logic before interpreting it.

7.1 What a rating scale adds

A **rating scale** is a structured informant report. It is most useful when the clinician needs a disciplined account of behaviour in the contexts in which it is observed, rather than a retrospective global impression. The form does not observe the child directly. Its value lies in making the informant's frame visible: a teacher may describe demands in a classroom, a parent may describe routines and transitions, and the young person may add an account of internal

experience. Concordance may strengthen confidence in a pervasive difficulty; disagreement is information to explore, not a technical nuisance to average away.

Before choosing any form, decide what is needed from it. A clinician may need an age-appropriate informant report, a profile relative to a reference group, a transparent symptom-and-impairment screen, or a repeatable raw score for monitoring. These are different purposes. A high score may arise from genuine difficulty, context-specific strain, a rater's threshold for concern, misunderstanding of the item, or a response style that needs checking. Conversely, a modest score cannot erase a coherent clinical history. Scale data must be read with the informant's opportunity to observe the behaviour and the demands of that setting in mind.

RULE **Interpret the instrument that was completed, not the instrument you wish it had been.** Its rater, age range, score metric and threshold determine what its result can mean.

This principle also prevents a common shortcut: extracting a number from one scale and applying a cut-off remembered from another. The three named instruments are deliberately **not interchangeable**. Their scores carry meaning only within the rules of their own form and scoring system.

7.2 Conners 3: a norm-referenced profile

Conners 3 provides three rater forms: parent, teacher and self-report. The parent and teacher forms apply from 6 to 18 years; the self-report form applies from 8 to 18 years. This is clinically useful because different raters have access to different parts of the child's life. It does not license a mechanical vote-count. A discrepancy should lead to questions about setting demands, support, structure, relationships and the informant's actual observation window.

The important technical distinction is that it is a **norm-referenced T-score instrument**, supplied under a commercial licence rather than as a freely downloadable form. The score describes the respondent's report relative to the instrument's reference framework. It is not a raw symptom total that can be transferred into another scale's rules. The T-score metric has a mean of 50 and a standard deviation of 10. On the current interpretive scheme, 40 to 59 is the average band, 65 to 69 is Elevated, and 70 and above is Very Elevated.

These bands describe the position of a scale score, not a diagnostic verdict. An elevated profile should focus the interview: which reported behaviours are impairing, are they developmentally unexpected in that context, do they occur across relevant settings, and what alternative explanation might account for them? The result is most helpful when it sharpens questions rather than ends them. Equally, an average score should prompt review of who rated, what period they had in mind, and whether protective structure is masking difficulty in that setting.

Conners 3 also has **validity scales**: Positive Impression, Negative Impression and the Inconsistency Index. These are not accusations of dishonesty. They are prompts to consider whether the response pattern may be unusually favourable, unusually unfavourable or internally inconsistent. The correct response is clinical clarification, including a careful discussion with the informant, rather than discarding the person or treating the profile as self-explanatory.

The choice of form matters. In particular, the **short form** does not include the DSM-5 symptom scales. A short form may be appropriate for the limited question it was designed to answer, but it cannot be read as though it supplied information that it omits. This is a small technical detail with disproportionate consequences in a written answer and in a clinic note.

PITFALL

Do not call a Conners 3 result a "positive screen" and then apply a raw-score rule. Its clinical language is a norm-referenced profile and interpretive band. A high T-score signals a report that needs synthesis; it does not dispense with the rest of the assessment.

7.3 Vanderbilt: symptom screen with impairment built in

The **NICHQ Vanderbilt** scales are intended for children aged 6 to 12 years. Their practical attraction is transparency: the clinician can see the endorsed symptom responses, the associated performance ratings and the additional screening sections. Unlike a norm-referenced profile, this is a **raw-score cut-off screen**. It is free to obtain and use, but reproduction remains rights-protected; free access is not permission to republish the form in a handout, case sheet or digital product.

Its symptom items are **scored from 0 to 3, with 2 or 3 treated as positive responses**. Performance items are scored from 1 to 5, with 4 or 5 indicating impairment. This design teaches a useful clinical discipline: symptom endorsement and functional impact must be considered together. A behaviour may be frequent yet not show the impairment pattern required by the form's screening logic; impairment without the relevant symptom pattern requires a broader explanation.

For its ADHD screen, Vanderbilt requires **at least 6 positive responses in the inattentive nine or the hyperactive nine, or both, plus at least one performance item scored 4 or 5**. This is a form-specific decision rule, not a universal conversion key for other questionnaires. The phrase "or both" is important: a clinician should not force a report into a single neat category when the form records concerns in both symptom groupings.

The form also **screens oppositional-defiant/conduct and anxiety/depression concerns alongside ADHD**. These sections are an invitation to widen the interview, not a replacement for assessment of those conditions. They protect against the narrow habit of treating every difficulty in a child with attentional complaints as merely another expression of ADHD. A screen can identify a direction of inquiry; diagnosis requires the clinical work that follows.

GOOD TO REMEMBER

When using Vanderbilt results, document both sides of the screen: the symptom pattern and the performance information. This makes the reasoning visible and avoids the misleading shorthand of reporting only a symptom total.

7.4 SNAP-IV: transparent raw-score monitoring

SNAP-IV is another raw-score screen. Each item is **scored from 0 to 3: not at all, just a little, quite a bit or very much**. The response anchors are clinically helpful because they make the informant's judgement of frequency or intensity explicit. They do not establish a diagnosis by themselves, and a change in raw score should be interpreted alongside what has changed in the setting, the informant and everyday functioning.

The common form has 26 items, organised as items 1 to 9 for inattention, 10 to 18 for hyperactivity/impulsivity, and 19 to 26 for opposition/defiance. The domain labels can guide scoring and interpretation without reproducing protected item wording. In an answer, state the domains and the scoring structure rather than attempting to recite questionnaire items from memory. That approach is both safer and clinically more useful.

Suggested guidance for each ADHD subscale is **below 13 not clinically significant, 13 to 17 mild, 18 to 22 moderate and 23 to 27 severe**, from a possible total of 27. These are suggested severity bands, not a validated diagnostic cut-off. That distinction matters: a severity label may help describe a rating pattern or monitor it over time, but it should not be presented as proof that a diagnostic threshold has been met.

For the opposition/defiance subset, suggested guidance is **below 8 not clinically significant, 8 to 13 mild, 14 to 18 moderate and 19 to 24 severe**, from a possible total of 24. This section can bring disruptive interaction patterns to attention, but it does not establish a disorder in its own right. Where this screen is clinically salient, the relevant differential and comorbidity assessment belongs in the wider child psychiatric formulation and in the Child behavioural, emotional and other disorders notes.

SNAP-IV is a **raw-score screen with reproduction rights reserved**. It may be available for use, but copying it into an unapproved clinic template, online portal or teaching booklet is a separate permission question. The same distinction applies to Vanderbilt: availability to obtain is not a blanket republication licence.

7.5 The examination contrast: metric, logic and permissions

INSTRUMENT	WHAT THE SCORE REPRESENTS	INTERPRETIVE LOGIC	ACCESS AND REPRODUCTION
Conners 3	Norm-referenced T-score instrument	Interpret the profile and its T-score band in clinical context.	Commercially licensed and purchased
NICHQ Vanderbilt	Raw-score cut-off screen	Read symptom responses together with impairment.	Free to obtain and use, but not free to republish
SNAP-IV	Raw-score cut-off screen	Use its stated scoring guidance without converting it into a diagnostic proof.	Free to obtain and use, but not free to republish

The table captures the distinction worth writing before any detail. Conners 3 is the norm-referenced T-score instrument that is bought; Vanderbilt and SNAP-IV are raw-score screens that may be obtained and used without charge but may not be freely reproduced. This is not mere administration. The metric tells the clinician whether the output is a standard-score profile or a form-specific raw-score screen. The licence tells the clinician whether a familiar form may lawfully be copied into routine materials.

A norm-referenced score and a raw score answer different descriptive questions. A T-score locates a scale result on the instrument's standard-score metric; it is especially useful when the profile and its interpretive band are the clinical focus. A raw score preserves the form's own endorsed responses and scoring rule; it is especially useful when the clinician wants to see exactly how the rule was met and whether the form also requires evidence of impairment. Neither metric is intrinsically more diagnostic. The error is to pretend that they have the same denominator, the same reference frame or the same implication for clinical formulation.

For the same reason, do not compare a numerical change on one scale with a numerical change on another as though the amounts were equivalent. A change has meaning only against the metric, rater, context and scoring method that generated it. In follow-up, the most defensible comparison is usually within the same instrument and informant, with a narrative account of what changed in the child's daily functioning. If a different form is required, record the transition clearly rather than constructing a false trend line.

MNEMONIC

SCALE

Source of report, **C**onstruct measured, **A**ge range, **L**ogic of the score, **E**xceptions and permissions. Use this spine before interpreting any named scale.

TRAP **"All ADHD scales are screening tools, so their cut-offs are interchangeable" is wrong.** Similar subject matter does not make scores comparable. The instrument's own metric and decision logic must be retained.

7.6 Reading rater differences clinically

Rater difference is often where a scale becomes most valuable. The question is not which respondent is "correct" in the abstract, but what each report reveals about the interaction between the child and an environment. A child may appear settled in a highly structured setting and struggle where organisation is self-directed. Another may show difficulties mainly when tasks are boring, socially threatening, confusing or beyond current academic capacity. Such patterns should trigger contextual questions rather than an attempt to manufacture agreement.

- Check whether each rater has enough opportunity to observe the behaviour in the relevant context.
- Clarify the situations the rater used as a reference when responding to the form.
- Ask what supports, supervision or environmental adaptations were already in place.

- Explore whether a discrepancy reflects different demands rather than unreliable reporting.

This interpretive stance protects against two opposite errors. One is to dismiss a school report because the parent does not see the same pattern at home. The other is to accept a concordant report uncritically without asking whether the same developmental, emotional, academic, sensory or relational burden is producing the behaviour. Rating scales help organise the question. They cannot answer it in isolation.

The same caution applies to self-report. It can add a perspective that an adult observer cannot supply, particularly when effort, distress or internal distraction shape the reported problem. Yet self-report too is an informant account, affected by insight, language, current mood and the meaning the young person assigns to the questions. A mature interpretation neither privileges one respondent automatically nor averages away a clinically meaningful discrepancy. It places each response beside the context from which it came.

7.7 Documentation, repeat measurement and Indian practice

When a scale contributes to the record, document the instrument, informant, version used, date, scoring method, salient result and the clinical interpretation. Record whether the result was consistent with the rest of the assessment and what uncertainty remains. This is preferable to writing "ADHD scale positive", a phrase that erases the difference between a T-score profile, a symptom-and-impairment screen and a raw-score severity guide.

Repeat measurement can be useful when the same instrument, rater and scoring method are retained, because it makes change easier to follow. But it should not be mistaken for a simple outcome score. A shift may reflect a changed school context, a different respondent, altered expectations, a new stressor or better understanding of the questions. Clinical improvement must therefore be anchored in functioning and the account of the child and family, not only in a numerical movement.

IN INDIA

Clinic teams often build reusable parent and teacher packs. Keep the scoring sheet, consent process and clinical interpretation separate from the copyrighted instrument itself. Conners 3 requires commercial licensing; Vanderbilt and SNAP-IV may be obtained for use but their reproduction is rights-protected. This small administrative discipline prevents a routine template from becoming an unauthorised republication.

Name the scale, then state its rater, age range, score metric and decision logic before interpreting the result.

8 · Comorbidities of ADHD (ODD, learning disorder, anxiety, tics)

Comorbidity is the rule, not a footnote. In ADHD, the presenting complaint may be distractibility, restlessness, poor homework completion, temper outbursts, school refusal, or an apparently simple behavioural problem. The clinical task is to decide which difficulties belong to

ADHD, which represent a co-occurring disorder, and which arise from the interaction between the two. **Comorbidity** is common, and a child may have multiple additional disorders. That fact changes formulation, the sequence of intervention, and the way the family understands apparent treatment failure.

A diagnostic formulation that stops after identifying ADHD often explains only part of the impairment. Co-occurring externalising symptoms may make conflict the most visible problem; anxiety may make inattention look situation-bound; a learning difficulty may turn ordinary classroom demand into daily demoralisation; and tics may complicate the history of movements and medication concerns. The point is not to turn every difficulty into another label. It is to test whether the additional pattern has its own persistence, context, developmental meaning, and functional consequence.

Common	Externalising	Learning	Anxiety
COMORBIDITY BURDEN	MAY DOMINATE REFERRAL	MAY AMPLIFY IMPAIRMENT	MAY ALTER PRESENTATION

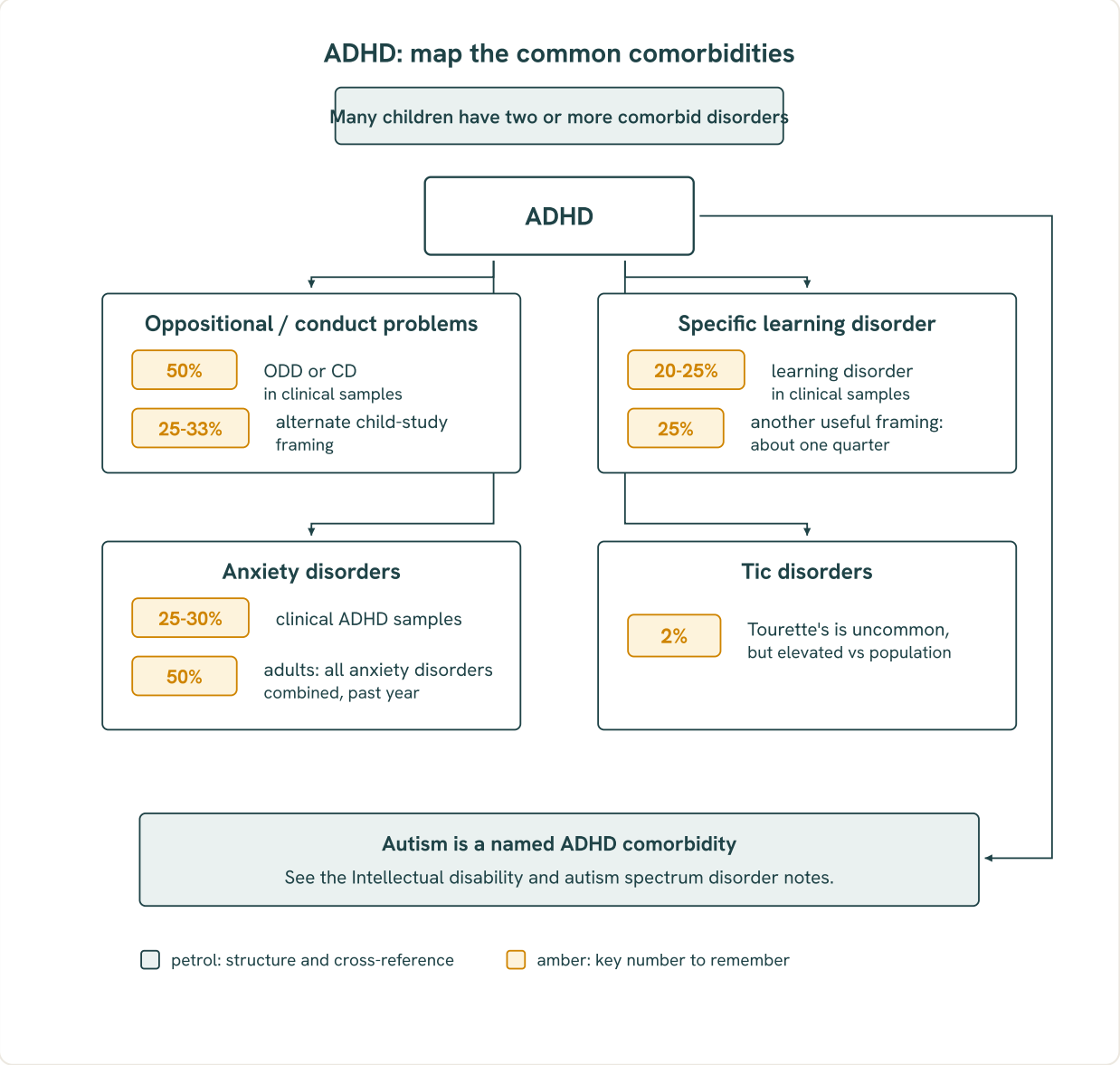


Fig 22.8. ADHD comorbidity map: high-yield associations and the autism cross-reference.

8.1 The comorbidity formulation

Think of the assessment as an effort to separate a *shared consequence* from a *second syndrome*. Poor concentration can follow worry, boredom, repeated academic failure, conflict at home, inadequate sleep, or a primary attention disorder. Irritability can be a reaction to repeated correction, an externalising pattern, an affective symptom, or a child's depleted response to chronic demand. The clinician therefore asks not only, "Is this symptom present?" but also, "When does it occur, what reliably evokes it, and what remains when the immediate trigger is absent?"

This is especially important because impairment is cumulative. A child with ADHD may be able to compensate in a supportive environment, yet become markedly dysregulated when faced with a reading task, peer conflict, fear of failure, or a prolonged bedtime struggle. Conversely, a symptom that appears to be a comorbidity may recede when the core ADHD-related demands are understood and the environment is adjusted. The formulation should preserve this uncertainty rather than prematurely converting every association into a separate diagnosis.

RULE **Diagnose a comorbidity when it adds a coherent pattern of symptoms and impairment, not merely because ADHD is severe.** Ask what the additional formulation explains that ADHD alone does not explain, and whether it persists across the situations in which it would be expected to appear.

For practical work, make a problem list before making a diagnostic list. Record the child's attention and activity difficulties, then separately map academic functioning, oppositional interactions, mood and worry, motor or vocal phenomena, sleep, peer functioning, and the family response. A problem list prevents a familiar error: allowing the loudest complaint to erase quieter but clinically decisive difficulties. It also gives a sensible way to revisit the formulation after intervention, when the relative contribution of each difficulty may become clearer.

- Identify the complaint that brought the family or school to attention.
- Ask which setting makes the difficulty most obvious and which setting protects against it.
- Clarify the sequence between demand, emotion, behaviour, and consequence.
- Determine whether the additional symptoms have a pattern independent of immediate frustration.
- Link each problem to a concrete domain of impairment rather than to diagnostic language alone.

8.2 Externalising comorbidity: opposition, conduct problems, and the referral trap

Oppositional defiant disorder and conduct disorder are frequent companions of ADHD in clinical practice. In clinical ADHD samples, oppositional defiant disorder or conduct disorder together occur in **about 50%**. This estimate is sample-dependent and should never substitute for an assessment: referral pathways and the way disorders are grouped both influence what a clinic reports.

The central clinical distinction is between *reactive non-compliance* and a broader oppositional pattern. A child with ADHD may refuse when a task is lengthy, poorly structured, humiliating, or delivered after a chain of reprimands. That behaviour calls for analysis of antecedents, expectations, and support. A co-occurring oppositional disorder is considered when the pattern extends beyond isolated task frustration and contributes its own recurring interpersonal impairment. Conduct problems require similarly careful separation from impulsive acts, developmental immaturity, and behaviour that is primarily retaliatory or peer-mediated.

ADHD can increase the speed with which an interaction escalates. The child acts before considering consequences; adults become more directive; correction becomes frequent; and both parties can enter a coercive loop. That mechanism does not by itself establish a disruptive-behaviour disorder. Equally, it must not be used to minimise persistent aggression, deceitful behaviour, serious rule violation, or marked hostility. These have their own clinical and safeguarding implications and should be assessed directly.

CLINICAL QUESTION	ADHD-LINKED DIFFICULTY	POSSIBLE ADDITIONAL EXTERNALISING FORMULATION	WHY THE DISTINCTION MATTERS
What precedes refusal?	Demand, boredom, delay, or disorganisation may be prominent.	The pattern may continue beyond task demands and occur within many relationships.	It directs attention toward structure and relational context, not labels alone.
What is the emotional tone?	Frustration may follow repeated failure or correction.	Persistent angry, defiant, or hostile interactions may require their own formulation.	It avoids mistaking understandable distress for wilful misconduct.
What is the behavioural pattern?	Acts may be rapid, poorly considered, and followed by regret.	More organised or recurrent conduct concerns need a fuller risk assessment.	It affects the urgency and breadth of intervention.
Where is the impact?	Impairment may centre on task completion and classroom regulation.	Conflict may be pervasive across home, school, and community settings.	It clarifies whose report and which settings need close scrutiny.

PITFALL

Calling every angry refusal "opposition" hides the function of the behaviour. Before naming an externalising comorbidity, ask whether the child is escaping an impossible task, responding to shame, protecting against anticipated failure, or reacting to an interaction that has already become adversarial. This does not excuse harmful behaviour; it makes the intervention more accurate.

The disorders themselves, their diagnostic boundaries, and their management are covered in the *Child behavioural, emotional and other disorders notes*. Here, the practical message is narrower: ADHD plus an externalising pattern often creates more impairment than either presentation

appears to create in isolation, so the clinical formulation must include both the child's self-regulation difficulty and the interpersonal system in which it repeatedly unfolds.

8.3 Specific learning disorder: when academic failure is more than inattention

Specific learning disorder is a clinically important comorbidity in ADHD. Clinical ADHD samples report it in the **20-25%** range, while another source describes learning and language disorders in **about 25%** of children with ADHD. The educational impact is often disproportionate because the child must manage both the task-specific difficulty and the organisational demands of schoolwork.

Do not infer a learning disorder solely from poor marks, unfinished work, careless mistakes, avoidance of homework, or a parent's report that the child "does not study." These can arise from ADHD, an unsuitable learning environment, emotional distress, inconsistent attendance, or an unrecognised language-related difficulty. Equally, do not assume that ADHD accounts for all academic underachievement. A child who performs poorly despite interest, support, and adequate attention to a particular academic task may need a focused learning assessment.

The useful question in an ADHD clinic is not "ADHD or learning disorder?" but "What is the contribution of each?" Attention problems can reduce the quantity and consistency of practice. A specific learning difficulty can make effort inefficient, expose the child to repeated failure, and generate avoidance that resembles inattention. Once a task becomes associated with humiliation, the child may appear restless, oppositional, anxious, or disengaged only in that context. The formulation should therefore connect symptom pattern to the actual work the child is asked to do.

Obtain examples of the child's work, identify whether the difficulty clusters around particular academic demands, and compare performance under ordinary classroom conditions with performance when the task is broken down and attention is supported. Reports from school are most useful when they describe the task, the error pattern, the help offered, and the child's response to help. A global judgement such as "weak student" provides little clinical information and often imports stigma into the case formulation.

IN INDIA

School records, notebooks, examination history, and teacher observations can be exceptionally informative, but they must be read in context. Medium of instruction, changes in schooling, access to remedial support, family resources, and the child's opportunity to practise may all shape the record. Treat school labels as prompts for inquiry rather than as diagnostic conclusions. The definition, formal assessment, and educational route for specific learning disorder are addressed in the learning disorder sections of this chapter.

The full ADHD-versus-learning-disorder discrimination belongs in the chapter's dedicated comparative section. At this point, preserve both possibilities in the formulation and avoid a false either-or conclusion. That protects the child from being described as simply inattentive when

remedial needs are missed, and from being described as simply learning-disabled when support for ADHD-related regulation is also required.

8.4 Anxiety: quiet suffering behind apparent inattention

Anxiety disorders are also common in ADHD. Clinical samples report any anxiety disorder in the **25-30%** range. Anxiety may be conspicuous through avoidance, reassurance seeking, somatic complaints, tearfulness, or distress around separation and performance. It may also be quiet: the child sits still, appears to daydream, postpones tasks, and is interpreted as inattentive when the active mental process is worry.

The phenomenology matters. ADHD-related inattention is often variable with interest, novelty, structure, and competing stimulation. Anxiety-related concentration difficulty may be most evident when the child is preoccupied by threat, anticipated criticism, uncertainty, or a feared task. These patterns can coexist in the same child, and their interaction can be self-reinforcing. Disorganisation creates missed deadlines or negative feedback; these experiences increase apprehension; apprehension consumes working attention; and the child then performs even less effectively.

Ask what the child is thinking during the period described as "not concentrating." A report of worry, dread, fear of error, or mental rehearsal points the assessment toward anxiety. Ask also about avoidance, bodily sensations, sleep-related fears, and the meaning of school or social situations. Do not rely on the child's direct denial of anxiety alone. Children may have limited language for internal states, may fear disappointing adults, or may describe their experience through behaviour rather than words.

> **GOOD TO REMEMBER**
> An anxious child with ADHD may look less overtly hyperactive in a formal consultation than in daily life. Quietness in the room is not evidence that the attention disorder has disappeared, and activity at home is not evidence that all school avoidance is ADHD. Reconcile reports by examining the emotional demands of each setting.

Clinical priorities follow impairment, risk, and the child's capacity to engage. When anxiety is driving avoidance, a plan that only demands better organisation can feel punitive and may fail. When ADHD-related disorganisation is feeding anxiety, practical scaffolding may reduce anticipatory distress. Families benefit from hearing that both processes can be real at once. This explanation shifts the conversation away from blame and toward a shared map of the child's difficulties.

8.5 Tics, sleep, developmental coordination, and autism: name the association, assess the child

Tourette's disorder is uncommon but clinically relevant in ADHD, occurring in **about 2%** of affected children. The practical issue is not to make an assumption from a single observed movement or sound. Clarify the phenomenology with the child and family, the temporal pattern, the settings in which it occurs, and the degree of distress or interference. The assessment should

also distinguish tics from restlessness, habitual movements, medication concerns, anxiety-linked behaviours, and other repetitive phenomena.

Tics and Tourette's disorder as disorders in their own right are covered in the *Child behavioural, emotional and other disorders notes*. In an ADHD formulation, document the movement or vocal history carefully enough that later change can be interpreted meaningfully. A family may attribute every fluctuation to ADHD treatment, while a clinician who does not establish the baseline may be unable to decide whether a reported change reflects the natural course, heightened observation, stress, or an intervention-related concern.

Sleep disorders have a high prevalence in children with ADHD. Sleep can be both a co-occurring problem and a source of symptoms that resemble ADHD, so it deserves a direct history rather than a perfunctory question about bedtime. Establish the family's account of sleep opportunity, sleep routine, nocturnal disturbance, waking, daytime sleepiness, and the relationship between sleep quality and daytime regulation. The differential diagnosis of sleep-related attentional symptoms is addressed in the ADHD differential diagnosis section.

Developmental coordination disorder is a common ADHD comorbidity. Notice when the child's functional difficulties include everyday motor demands, handwriting burden, sports participation, self-care tasks, or avoidance of activities that expose clumsiness. The purpose at this stage is to recognise that these difficulties may not be explained by inattention alone. The disorder's definition and assessment belong in the communication and motor disorders section.

Autism spectrum disorder may also be named in an ADHD formulation. Do not use this brief comorbidity note to collapse the two developmental histories into one or to make assumptions about prevalence, diagnostic rules, or treatment response. For that discussion, see *the Intellectual disability and autism spectrum disorder notes*.

TRAP **Do not let a recognised comorbidity become a diagnostic shortcut.** A tic does not explain every movement, a learning concern does not explain every unfinished task, and anxiety does not automatically replace ADHD. Each requires its own history, observed impact, and place in the overall formulation.

8.6 Mood symptoms and the longitudinal formulation

Children with ADHD have an increased risk of mood disorders, which may emerge later. In practice, this calls for a longitudinal rather than purely cross-sectional formulation. A child's irritability today may be tied to conflict, anxiety, sleep disruption, demoralisation, environmental stress, or a mood disorder. The clinician should avoid treating the word "mood" as an explanation in itself. Describe the emotional state, its triggers, the change from the child's usual functioning, its relationship to activity and sleep, and the consequences for safety and functioning.

This part of assessment is often more useful when conducted across contacts. Families may initially prioritise disruptive behaviour and disclose hopelessness, withdrawal, or self-critical thinking only after they feel understood. Teachers may notice a decline in engagement rather than verbal sadness. The child may frame the experience as anger, boredom, or physical

discomfort. A careful formulation welcomes these different descriptions and asks whether they fit one process or several.

Where significant mood symptoms are present, assess immediate risk and the supports available to the child. Do not attribute serious distress to ADHD merely because ADHD is already established. At the same time, do not assume that every tearful or irritable period establishes a mood disorder. The useful clinical stance is active curiosity: identify the pattern, obtain collateral, review change over time, and decide what needs attention now while diagnostic certainty develops.

8.7 Turning recognition into a workable plan

The plan follows the formulation, not the order in which diagnoses were noticed. Begin by stating, in plain clinical language, the contribution of ADHD and each suspected or established comorbidity to the child's current impairment. This makes priorities visible. A family can then understand why academic support, emotional work, sleep assessment, behavioural intervention, school liaison, or risk management may be needed alongside ADHD treatment.

MNEMONIC

PAUSE

Problem list, **A**ntecedents, **U**nique pattern, **S**ettings, **E**xtra impairment. Use it to slow down before deciding that a difficult behaviour is either "just ADHD" or automatically a new disorder.

Prioritisation is clinical rather than ideological. Address urgent risk, severe suffering, major barriers to participation, and the factors most likely to prevent the child from benefiting from care. Revisit the formulation after support is introduced. Improvement in one domain can reveal another more clearly: a child whose attention becomes easier to support may then show a specific academic need; a child whose anxiety reduces may provide a more reliable account of attention; a child whose home conflict diminishes may show that apparent defiance was closely tied to coercive interactions.

- Share a formulation that separates symptoms, settings, triggers, and impairment.
- Agree which problem needs action now and which needs observation or further collateral.
- Coordinate with caregivers and school around functional goals rather than labels alone.
- Review whether the working formulation still explains the child's difficulties after intervention.

Comorbidity is therefore not an add-on to an ADHD assessment. It is the reason the clinician must remain both structured and humble: structured enough to look beyond the core syndrome, and humble enough to revise an early explanation when the child's developmental, emotional, academic, and relational pattern says more is happening.

In ADHD, identify the additional pattern of impairment before deciding the additional diagnosis, then let the combined formulation determine what must be addressed first.

9 · Differential diagnosis of ADHD

The diagnostic task is explanatory, not merely descriptive. Inattention, activity and impulsive behaviour are common final presentations in child psychiatry. ADHD is diagnosed only when its core pattern is the best account of the child's difficulties, rather than a label applied to any restless, poorly performing or hard-to-manage child. Differential diagnosis therefore asks what the behaviour means in its developmental, emotional, social and medical context.

The practical stakes are substantial. A false ADHD diagnosis can obscure distress, a communication difficulty, a sleep problem or a treatable medical contributor. The converse error is **diagnostic overshadowing**: dismissing developmentally inappropriate ADHD symptoms as inevitable within another disorder. Good differential work protects against both errors and leaves room for more than one diagnosis when the evidence supports it.

Developmental	Psychiatric	Medical
CAPACITY AND PHENOTYPE	COURSE AND EXPERIENCE	CONTRIBUTORS AND MIMICS

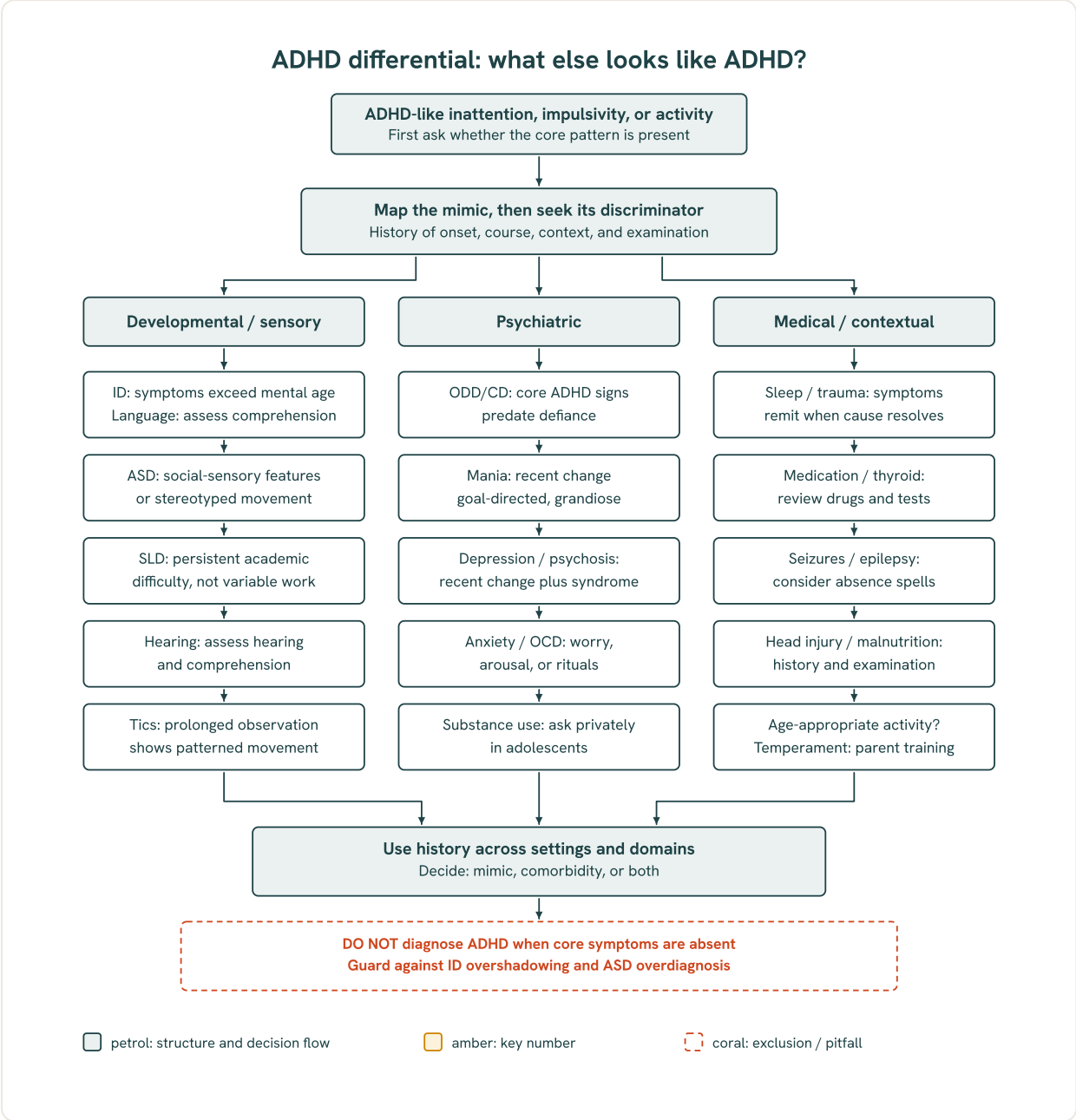


Fig 22.9. ADHD differential tree: common mimics and the short clinical clues that exclude them.

9.1 A structured way to think about the differential

Begin with a broad **developmental, psychiatric and medical differential**, rather than moving immediately from a parent's description to a syndrome label. The **three** groupings organise the possibilities: developmental presentations include intellectual disability, speech and language disorders, learning disorders, motor coordination disorders, autism spectrum disorder and tic disorders; psychiatric presentations include oppositional defiant disorder, conduct disorder, mood and anxiety disorders, psychotic disorders and substance use; medical presentations include epilepsy, tics, seizures, malnutrition and thyroid abnormalities. They are a map for enquiry, not a claim that every child requires every investigation.

At each branch, ask a small set of linked clinical questions.

- Has the behaviour always been characteristic, or does it represent a change from the child's usual state?

- Does the apparent failure to attend arise because the child cannot understand, is preoccupied, is exhausted, or is responding to an internal experience?
- Is movement purposeless and diffuse, patterned and repetitive, or directed toward a particular aim?
- Is the pattern best explained by one condition, by coexisting conditions, or by a contextual stressor?

These questions translate a parent's accurate observation into clinically usable data. They prevent the common mistake of treating a symptom word as though it were a diagnosis. They also make contradictory reports useful: a child who is distractible only in one kind of demand may be telling the clinician more about task capacity or context than about a pervasive attentional problem. The aim is analytic economy: each proposed explanation should account for the observed pattern without making the remainder of the history unintelligible, and should remain compatible with all available collateral. This discipline keeps the formulation honest.

Developmental history, school observations and the mental-state examination supply different parts of this answer. The assessment process itself belongs in the Child psychiatry: assessment, treatment, services and protection notes. Here, the central interpretive discipline is to compare the observed behaviour with the child's developmental capacities and with its temporal course.

RULE **Diagnose ADHD only when its core pattern explains the presentation better than a mimic or contributor.** A symptom such as poor concentration has little diagnostic value until its developmental meaning, onset, context and accompanying features have been established.

9.2 Developmental and educational presentations

Intellectual disability may look like ADHD when a child fails to follow instructions, abandons tasks or appears inattentive. The decisive question is whether the child understood what was asked. In intellectual disability, apparent inattention may be better accounted for by limited comprehension; ADHD should be added only when the symptoms are clearly **developmentally inappropriate for the mental age**. This is not a semantic nicety. It distinguishes failure at a task beyond the child's capacity from a regulatory difficulty at a task the child can perform.

Do not allow a global developmental diagnosis to end the enquiry. Establish the child's usual level of understanding, then examine behaviour in tasks matched to that level. A child who remains markedly distractible or impulsive despite clear, comprehensible demands may have ADHD in addition to intellectual disability. Conversely, repeated demands that exceed comprehension can create frustration, escape behaviour and apparent non-compliance without demonstrating ADHD. For the wider framework, see the Intellectual disability and autism spectrum disorder notes.

Speech and language disorders, hearing impairment and specific learning disorder may also surface through classroom inattention or failure to follow instructions. Undetected hearing impairment deserves active consideration when this is the presentation. Specific learning disorder should be named as a differential. Its academic difficulty tends to be persistent, whereas

ADHD performance can be strikingly variable. See Differentiating SLD from intellectual disability, ADHD and slow learner for the complete comparison.

High activity in a young child is not, by itself, pathology. In preschoolers, supposed symptoms may reflect normal development or temperament; in that circumstance, refrain from an ADHD diagnosis and offer parent training rather than converting an ordinary developmental challenge into a disorder. The developmental and temperament framework is set out in the Normal child development and milestones notes.

IN INDIA

The IPS clinical guidance supports a deliberately broad developmental, psychiatric and medical differential. In busy school-referral practice, "does not listen" is often a presenting complaint rather than a diagnosis. Clarify whether the instruction was heard, understood and developmentally achievable before interpreting the behaviour as inattentiveness.

9.3 Autism, motor phenomena and the form of activity

Autism spectrum disorder can produce behaviours that resemble ADHD, but their form and context matter. In autism, increased motor activity may be **repetitive and stereotyped**, unlike the broader hyperactivity of ADHD. Some apparently ADHD-like behaviours are better understood through sensory difficulties or atypical socio-emotional reciprocity. The question is not whether the child is active, inattentive or difficult to engage; it is what precipitates the behaviour, what function it serves, and whether it is embedded in the autism phenotype.

There are errors in both directions. It is wrong to call sensory-driven avoidance, a difficulty reading a social demand, or repetitive movement "hyperactivity" without further analysis. It is equally wrong to assume that a child with autism cannot also have ADHD. The task is to decide whether developmentally inappropriate ADHD symptoms are present beyond what autism explains. The wider autism framework and the co-occurrence discussion are in the Intellectual disability and autism spectrum disorder notes.

Tic disorders require observation over time rather than a snapshot at one interview. Prolonged observation helps separate complex motor tics in Tourette's disorder from ADHD-associated fidgetiness and increased activity. This is especially useful when the movement is intermittent, complex or embarrassing, because the child may suppress it briefly in a clinic. The phenomenology and management of tics belong in the Child behavioural, emotional and other disorders notes.

TRAP **Do not equate every visible movement with hyperactivity.** Repetitive movement, a tic, sensory-related distress and diffuse ADHD overactivity may all look "restless" from a distance, but they imply different questions and different formulations.

9.4 Disruptive behaviour and emotional disorders

Oppositional or conduct symptoms can dominate the consultation and tempt the clinician to infer ADHD from poor behaviour alone. **Chronology** is the useful discriminator: ADHD symptoms usually predate defiant or conduct symptoms. Defiance without the core ADHD

pattern is not a basis for diagnosing ADHD. In very severe ADHD, oppositional behaviour may arise soon after the attentional and activity difficulties begin, so chronology must be interpreted carefully rather than applied mechanically.

With mood disorders, ask whether the child has changed from their usual state. **Mania** has a relatively recent onset and a definite change from premorbid functioning; its activity is goal-directed, and inflated self-esteem or grandiosity points away from uncomplicated ADHD. The contrast is particularly important when a previously manageable child becomes overactive. Chronic activity alone does not establish mania, and episodic change alone should not be mistaken for a lifelong neurodevelopmental pattern.

Depression can be masked by irritability, agitation and poor concentration. It too is marked by relatively recent onset and a change from the prior state, with features such as decreased interest in pleasurable activities that exceed simple irritability. The clinician should not treat concentration as an isolated cognitive symptom. It belongs to an affective pattern, and the timing of that pattern is often more informative than the intensity of the classroom complaint.

Anxiety commonly brings poor concentration, distractibility and generalized hyperarousal. Worry and autonomic arousal support anxiety as the explanation. Explore the child's thoughts as well as their behaviour: the child whose attention is repeatedly captured by threat or worry may appear inattentive, yet the mechanism is preoccupation rather than the core ADHD pattern. Severe anxiety, including post-traumatic stress disorder, and distress after life events can mimic ADHD; when symptoms remit after the stressor is removed, that course weighs against true ADHD.

PITFALL

Calling a distressed child "ADHD" because the behaviour is disruptive can delay recognition of a new affective or anxiety state. The discriminating work lies in establishing change from baseline, accompanying experience and the relationship of symptoms to stressors.

9.5 Psychosis, compulsions and substance use

Psychosis can include behavioural disorganisation and apparent distractibility, but it generally represents a relatively recent change from premorbid functioning and is accompanied by delusions or hallucinations. The interview should make room for the child or adolescent to describe unusual perceptions and beliefs in language they can use. Such enquiry should be calm and direct; it is not made unnecessary by an existing ADHD diagnosis.

Obsessive-compulsive disorder may also be mistaken for overactivity when the child repeatedly performs acts, cannot move on from routines, or seems slow to begin work. The behaviour in obsessive-compulsive disorder is goal-directed and ritualistic, and concurrent obsessions may be present, unlike the non-goal-directed overactivity of ADHD. Ask what the child fears would happen if the act were not completed. That question clarifies the function of repetition without requiring the clinician to infer it from appearance alone.

Substance use belongs in the psychiatric differential, particularly among older children and adolescents, and must be discussed with privacy. The practical aim is not a moral interrogation but a credible account of when symptoms occur and what may be contributing to them. A private, developmentally appropriate conversation gives the young person a better chance of disclosing use or related risk. It also prevents the clinician from attributing a change in concentration or behaviour automatically to ADHD.

9.6 Sleep, physical illness and medication effects

Sleep disorders can present with inattention, poor impulse control, mood change and daytime sleepiness that resemble ADHD. Sleep-disordered breathing deserves particular attention because suspicion of it warrants sleep evaluation. The value of sleep enquiry is not confined to excluding a mimic: a sleep problem may coexist with ADHD and amplify the functional presentation. Establish the pattern of sleep and daytime alertness before deciding that poor classroom concentration is purely attentional.

Medical history should actively seek acquired and physiological contributors. ADHD-like problems may follow head injury and may be secondary to thyroid disorders or absence seizures; genetic syndromes such as fragile X are rare possibilities. The history should be directed by the presentation rather than reduced to a routine list. A new or fluctuating pattern, altered awareness, physical symptoms or a temporal link to illness makes a medical explanation more plausible and requires appropriate evaluation.

Medication review is equally part of differential diagnosis. Bronchodilators, thyroxine, neuroleptics through akathisia, and isoniazid can be associated with ADHD-like symptoms. Map the timing of behavioural change against medication exposure and distinguish a drug-related restlessness from the child's baseline pattern. This is especially important when a family reports that a previously settled child became restless after treatment began.

> **GOOD TO REMEMBER**
>
> When a child has ADHD-like behaviour plus sleepiness, altered awareness, physical symptoms or a clear medication temporal association, pause before escalating an ADHD formulation. These clues redirect the clinical interview toward a potentially remediable contributor.

9.7 Resolving uncertainty without premature closure

Many referrals contain both a genuine ADHD pattern and another source of impairment. Differential diagnosis should not be treated as a contest in which one label must eliminate every other possibility. The better formulation identifies which phenomena are explained by ADHD, which are explained by another condition, and which require observation over time. This preserves diagnostic precision without denying comorbidity.

When the history is incomplete, resist the pressure to convert uncertainty into certainty. Reconstruct the child's baseline, the sequence in which concerns emerged, and the circumstances in which they improve or worsen. Repeated reports across home and school are useful because they test whether a proposed explanation has coherent reach. A stress-related presentation, for

example, is less convincing as ADHD when it lifts after the stressor is removed; a developmental explanation is weaker when behaviour is plainly disproportionate to the child's capacity.

The overdiagnosis error is particularly instructive: labelling autism-related social or sensory features as ADHD. Its mirror image is diagnostic overshadowing in intellectual disability. These **two** failure modes are corrected by detailed interviewing and by collecting information across situations and domains. The goal is not maximal diagnostic complexity. It is the smallest adequate explanation that remains open to revision when new information appears.

Use the table as a prompt for hypothesis testing, not as a shortcut to diagnosis. No row is intended to work in isolation. A recent change, for example, gains meaning when it is linked to the quality of activity, the child's account of inner experience, and corroboration from those who know the child well. Conversely, the absence of a conspicuous alternative does not by itself prove ADHD. A coherent longitudinal account remains more useful than a checklist of isolated signs.

CLINICAL SIGNAL	INTERPRETATION THAT SHOULD BE TESTED	REASONING CONSEQUENCE
Recent change from usual functioning	mania, depression or psychosis	Seek the new syndrome rather than assume a longstanding neurodevelopmental pattern.
Failure to follow directions	lack of comprehension or hearing impairment	Match the demand to capacity and establish whether it was heard.
Repetitive or intermittent movement	repetitive, stereotyped movement or complex motor tics	Describe form, trigger and persistence before calling it hyperactivity.
Worry, fear or bodily arousal	Anxiety	Explore the cognitive and physiological context of poor concentration.
Sleepiness or altered awareness	Sleep disorder or absence seizures	Redirect the history toward sleep and medical causes.
Clear relation to treatment exposure	Medication effect	Map symptom timing against medication use before changing the psychiatric formulation.

MNEMONIC

Course, Capacity, Context, Character of movement

Use this as a compact differential spine. Ask whether the course is longstanding or changed, whether the demand matches the child's capacity, whether context supplies worry, stress, sleep loss or exposure, and what kind of movement is actually being described.

The differential diagnosis of ADHD is settled by developmental appropriateness, course, context and accompanying phenomena - not by the mere presence of inattention or restlessness.

Treating ADHD

10 · Stimulant pharmacotherapy (methylphenidate, amphetamines, mechanism, dosing)

Stimulants are a prescribing exercise in precision, not a generic trial of "ADHD medicine". Their value lies in matching a clearly defined target problem to a preparation whose exposure pattern fits the child's day, then adjusting from observed benefit and tolerability. The examination answer should therefore distinguish mechanism, formulation, starting regimen, titration and ceiling. A dose without its formulation and population is not a safe answer.

Within pharmacotherapy, a stimulant is best understood as one component of an individual treatment plan. Medication can make attention and behavioural regulation more available to the child; it does not substitute for the assessment of learning, family context, classroom demands or coexisting difficulties. Those elements determine what a meaningful improvement looks like. Adverse effects, physical monitoring and the wider multimodal plan are considered in their respective sections.

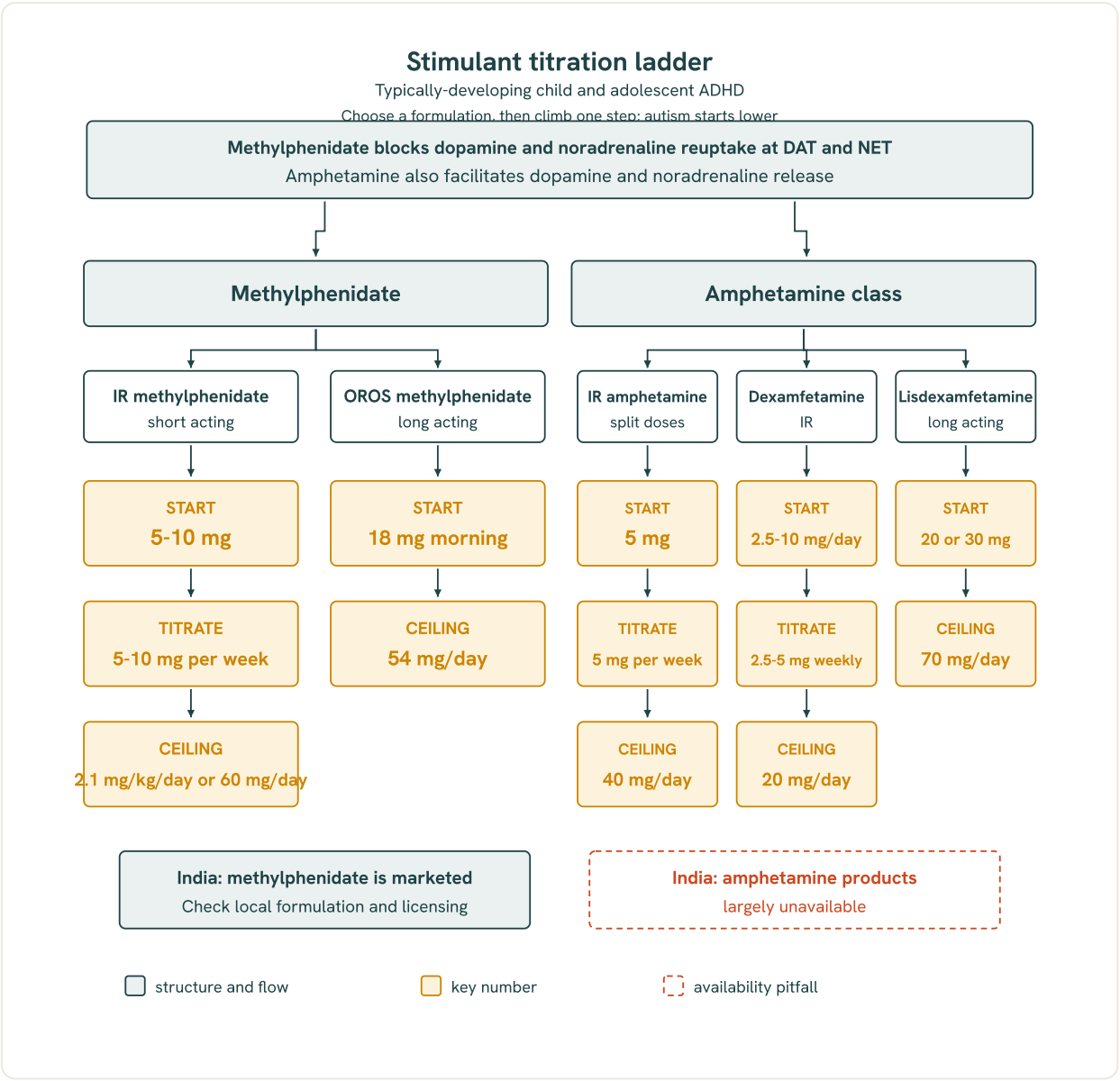


Fig 22.10. Stimulant formulation and titration ladder for ADHD.

10.1 Pharmacological logic of stimulant treatment

Methylphenidate works by reducing reuptake of dopamine and noradrenaline through the relevant transporters. The clinical inference is not that it simply "activates" a child. Rather, it changes catecholamine signalling in circuits that support the allocation and maintenance of attention, response selection and behavioural control. The desired outcome is more usable self-regulation in ordinary settings, not a sedated or compliant appearance.

The pharmacological contrast with **amphetamine** is worth stating precisely. Amphetamine both impedes reuptake and facilitates release of noradrenaline and, particularly, dopamine. Thus the classes overlap in their transporter-level targets but are not mechanistically interchangeable. This distinction helps the candidate explain why a child's response to one preparation cannot be assumed to settle the question of response to every stimulant preparation.

RULE **Prescribe the formulation, not merely the molecule.** The molecular mechanism explains the class effect; the release pattern determines when that effect is available in the child's real daily life.

The prescriber first defines the functional window that needs help. A short-acting preparation is useful when a brief, observable period is needed to establish the relation between dose and effect, or when different parts of the day require different exposure. A long-acting preparation may better suit a continuous school and home routine and can reduce the practical burden of dosing away from home. Neither formulation is intrinsically "stronger"; they solve different timing problems.

It is equally important to decide in advance what will count as benefit. Descriptions such as "more settled" are too vague to direct a dose change. A useful target is concrete and shared with caregivers and school: sustaining a task, completing work, following an instruction, reducing impulsive interruption, or participating without repeated redirection. The target must be observable across the settings in which impairment was established. If the target has not been specified, apparent non-response may actually be a failure of measurement or a mismatch between the chosen exposure window and the relevant demand.

Mechanism should therefore be used to reason, not to over-promise. Transporter actions describe a plausible pharmacological route to clinical change, but they do not tell the clinician which domain will improve most for a particular child or whether a chosen delivery pattern will fit the family's routine. The prescription remains a testable clinical decision. Its interpretation depends on the target behaviour, the setting, the timing of administration and collateral observation, rather than on a theoretical account of catecholamines alone.

GOOD TO REMEMBER

A calm child is not automatically a well-treated child. Ask whether attention, impulse control and participation have become more available in the setting that mattered to the family and school.

10.2 Methylphenidate preparations: translating mechanism into a regimen

Immediate-release methylphenidate is a practical formulation when the clinician needs a clear and adjustable relation between administration and the period of clinical benefit. It requires the family to understand that the formulation and the child population define the instruction. An immediate-release schedule should never be copied mechanically into a modified-release product, even though the active molecule is the same.

For a typically developing child with ADHD, the cited immediate-release starting regimen is **5-10 mg** orally each day, with subsequent divided administration as clinically indicated. This is a start point, not a target achieved by a calendar. It creates room to see whether the intended functional change appears during the desired period before moving further. The child's context matters: a preparation that seems ineffective may simply have its useful interval outside the school or home situation being judged.

In the same population and formulation, titration proceeds in increments of **5-10 mg per week**. Weekly adjustment gives enough clinical space to distinguish an emerging benefit from a transient impression, while preserving the principle that the regimen is adjusted purposefully. The instruction is formulation-specific and should be documented as such. Recording only

"methylphenidate increased" obscures the information needed for a later clinician to understand what has actually been tried.

The ceiling has two dimensions. For immediate-release methylphenidate in a typically developing child with ADHD, keep the weight-based total **below 2.1 mg/kg/day** in divided doses, and the licensed total **below 60 mg/day**. These are boundaries, not goals. A child who has not shown worthwhile functional benefit should not be pushed towards a numerical ceiling merely because that ceiling exists. Conversely, a partial response should prompt a disciplined question about timing, target and formulation before it is labelled a failure of the drug class.

Immediate-release prescribing is also a useful teaching model for the general principle of dose interpretation. A change in daily total, a change in the timing of administration and a change in release profile are different interventions. If they are all altered together, the subsequent response is hard to interpret. Where possible, make one purposeful alteration and record why it was made. This preserves a coherent treatment history and prevents the next decision from being based on recollection rather than clinical evidence.

The family's account should be sought in language that separates effect from expectation. Ask what the child can now do with less prompting, whether the benefit appears during the intended functional period and whether the demand itself changed. A report that the child is "fine at home" may not answer a school-time question; a school report may not answer an evening homework question. This is not a reason to demand perfect measurement. It is a reason to match the question to the formulation being assessed.

5-10 mg	5-10 mg per week	below 2.1 mg/kg/day	below 60 mg/day
IR START	IR TITRATION	IR WEIGHT CEILING	IR LICENSED CEILING

TRAP **Do not quote a methylphenidate dose without saying immediate-release or modified-release.** The molecule alone does not identify the regimen, its timing or its ceiling.

10.3 Modified-release methylphenidate and the school routine

OROS modified-release methylphenidate is designed to provide a morning-administered exposure pattern rather than a simple repetition of an immediate-release dose. Its clinical attraction is organisational as much as pharmacological: it can align medication delivery with a longer functional period while avoiding a school-time administration decision. The practical question is whether this exposure pattern fits the child's own demands, not whether a longer preparation is automatically preferable.

For child ADHD, the cited OROS starting dose is **about 18 mg** in the morning, titrated upward at weekly intervals. It should be communicated as an OROS-specific regimen. "Modified release" is not a licence to infer equivalence across products; the release design is clinically material. When a family reports that a medicine works at one point in the day and not another, the prescriber should think first about the relation between the preparation's delivery pattern and the child's functional timetable.

The licensed ceiling for this OROS preparation in child ADHD is below 54 mg/day. The word licensed matters in a textbook answer because it distinguishes an established product limit from an informal dose escalation. It also reinforces the basic discipline of identifying the exact product before discussing a maximum. A treatment review is then about whether the selected formulation has created a meaningful and durable improvement, not about chasing a number.

QUESTION	IMMEDIATE-RELEASE METHYLPHENIDATE	OROS MODIFIED-RELEASE METHYLPHENIDATE
Prescribing aim	Flexible, observable exposure periods	Morning-administered exposure across a longer functional period
How to write the order	Name the immediate-release formulation and divided administration plan	Name the OROS product and morning administration plan
Interpretation of response	Relate benefit to each intended period	Relate benefit to the child's day-long demand pattern
Common error	Treating a daily total as if timing did not matter	Assuming it is dose-for-dose interchangeable with immediate-release treatment

This formulation distinction has a wider teaching value. Medication decisions should be reversible hypotheses: "this release profile may cover this part of the child's day." A good review can confirm, refine or reject that hypothesis using collateral observations. It does not turn an imprecise prescription into a better one by attaching a diagnostic label to it.

A request for a long-acting preparation may arise from a genuine access problem, a wish to avoid medicine administration during the school routine, or a belief that a longer formulation is inherently superior. These possibilities are clinically different. The prescriber should identify the actual problem first, because the answer may be a different release profile, a clearer administration plan, or recognition that the target period itself has been defined too broadly. Formulation choice is therefore part of case formulation, not a purely administrative afterthought.

10.4 Amphetamine preparations: related class, distinct pharmacology

Amphetamine preparations require the same formulation discipline. Their additional release-facilitating action means that one should not describe them as merely another brand of methylphenidate. Clinically, the useful comparison is between a child's target window, the preparation's delivery pattern and the observed outcome, rather than an abstract hierarchy of "mild" and "strong" stimulants.

For immediate-release mixed amphetamine salts in child ADHD, the cited starting regimen is about 5 mg, given once or twice daily. The associated titration is about 5 mg per week, with a total kept below 40 mg/day in split doses. These statements belong together: drug, immediate-release formulation, child ADHD population, regimen and ceiling. Separating the number from that tuple is how a technically correct figure becomes an unsafe instruction.

Dexamfetamine immediate-release is another amphetamine-class option. In child ADHD, the cited regimen is to start 2.5-10 mg/day, increase by 2.5-5 mg weekly, and use a usual maximum of 20 mg/day in divided doses. The source permits occasional use up to 40 mg/day, but this should never be presented as the routine maximum. The key teaching point is that a regimen belongs to a named preparation, not to "amphetamine" in the abstract.

Lisdexamfetamine is a long-acting prodrug of dexamfetamine. For child ADHD, its cited regimen is 20 or 30 mg in the morning, titrated at weekly intervals, with a maximum below 70 mg/day. The distinction between this prodrug and immediate-release dexamfetamine should be explicit in an answer. The molecule ultimately delivered does not erase the different formulation design, dosing instruction or clinical timing.

PITFALL

Do not convert between methylphenidate and amphetamine products by a remembered "equivalent dose". The supplied evidence establishes formulation-specific regimens, not a universal conversion rule.

10.5 Indian prescribing context

Methylphenidate is marketed in India, making it the stimulant whose local prescribing details deserve particular familiarity. A commonly cited Indian paediatric methylphenidate approach starts at 0.25 mg/kg/day and may be increased in weekly steps up to 1 mg/kg/day, with morning and afternoon administration. This is not the same numerical ceiling as the cited immediate-release framework for a typically developing child with ADHD. The discrepancy must be acknowledged, not silently harmonised.

IN INDIA

State the source framework when documenting a weight-based methylphenidate regimen. The Indian paediatric approach and the cited immediate-release ceiling are not interchangeable. Non-stimulant pharmacotherapy is considered separately.

Local availability changes what can be prescribed, but it should not collapse pharmacological distinctions. Where a cited amphetamine preparation is not locally available, it may still be examined as an international pharmacotherapy option. The answer should say what preparation is being discussed and avoid implying that a regimen can be implemented locally without confirming the product and regulatory setting. Brand names are especially poor substitutes for this discipline because they can obscure formulation and release profile.

The Indian clinical task also includes making the prescription intelligible to the family. Explain the medicine by its purpose and its timing rather than by promising a personality change. Give caregivers a concrete target to observe and a clear instruction not to improvise a different formulation or schedule. When treatment is reviewed, place caregiver and school observations alongside the stated target. This keeps the medication decision connected to function rather than to a vague global judgement that the child is "better" or "worse".

In an examination, this local context is best handled with restraint. State the preparation and regimen that the source supports, then state the population and source framework. Do not imply availability from a foreign dosing table, and do not turn a locally marketed medicine into an assertion that every release form is available in every setting. Precision here is clinically respectful: it prevents an answer from sounding comprehensive while leaving the actual prescriber with an unusable instruction.

10.6 A disciplined sequence for choosing and adjusting a stimulant

Stimulant prescribing becomes safer when it follows a clinical sequence. First, confirm the target impairment and identify the part of the child's routine in which change is sought. Next, choose a molecule and release pattern that can plausibly address that period. Then begin with the cited formulation-specific starting regimen, explain the intended observation and adjust only against the agreed target. Finally, decide whether apparent non-response represents inadequate exposure at the relevant time, insufficient benefit despite an adequate trial, a practical problem with the regimen, or a need to reconsider the treatment plan.

- Write the drug, formulation and administration plan in full.
- State the population to which the dose schedule applies.
- Define the functional target before changing a dose.
- Use the cited titration interval rather than reacting to a single impression.
- Interpret a ceiling as a safety boundary, not as an efficacy target.

This sequence guards against an easy but consequential error: treating dose adjustment as the main therapeutic act. In fact, dose adjustment is only informative when the target, formulation and timing have been kept stable enough to interpret the result. If school information is unavailable, family observation remains useful, but its question must still be specific. If the family cannot feasibly deliver the intended regimen, that is a prescribing problem rather than a failure of adherence or motivation.

At review, distinguish a poor result from an uninterpretable result. A poor result means that the child received the intended formulation during the relevant demand period and the agreed functional target did not improve sufficiently. An uninterpretable result means that one does not know whether the preparation reached the relevant period, whether the target was observed, or whether a practical obstacle disrupted the regimen. The first finding may support a change in treatment strategy. The second requires clarification before a pharmacological conclusion is drawn.

This distinction prevents both over-treatment and premature abandonment. It also makes communication with families more honest. The clinician can say that a medication plan is being assessed against a shared functional question, not against an expectation that every difficulty will disappear. Such framing keeps the child's abilities, school needs and relationships central while still allowing pharmacotherapy to be used with technical rigour.

MNEMONIC

Target - Formulation - Start - Observe - Titrate

Before every stimulant change, name the functional target, name the release profile, begin with the relevant schedule, observe in the intended setting and titrate only when that observation can be interpreted.

A stimulant dose is safe and meaningful only when the drug, formulation, child population, schedule, titration plan and ceiling are stated together.

11 · Non-stimulant pharmacotherapy (atomoxetine, alpha-2 agonists)

Non-stimulants are not merely substitutes for stimulants. They offer a different pharmacological route to treating ADHD, and therefore require a different conversation with the child, family and school. The important distinctions are mechanism, the pace at which benefit is judged, formulation, and the safety issue that must be made explicit before treatment begins. A sound prescription is not a drug name followed by a dose: it is a deliberately scoped plan that states who the regimen is for, how it will be advanced, what response is being sought, and when the plan will be reconsidered.

Atomoxetine and the adrenergic agonists are the principal non-stimulant options considered here. Their place is clinical rather than ideological. A child may need an alternative route because the treatment plan, co-occurring difficulties, family priorities, prior experience, or practical feasibility make that route more appropriate. The prescriber should avoid presenting non-stimulant treatment as passive or lesser treatment. It is active pharmacotherapy, but its logic is slower, more longitudinal, and especially dependent on a shared expectation of what early treatment can and cannot show.

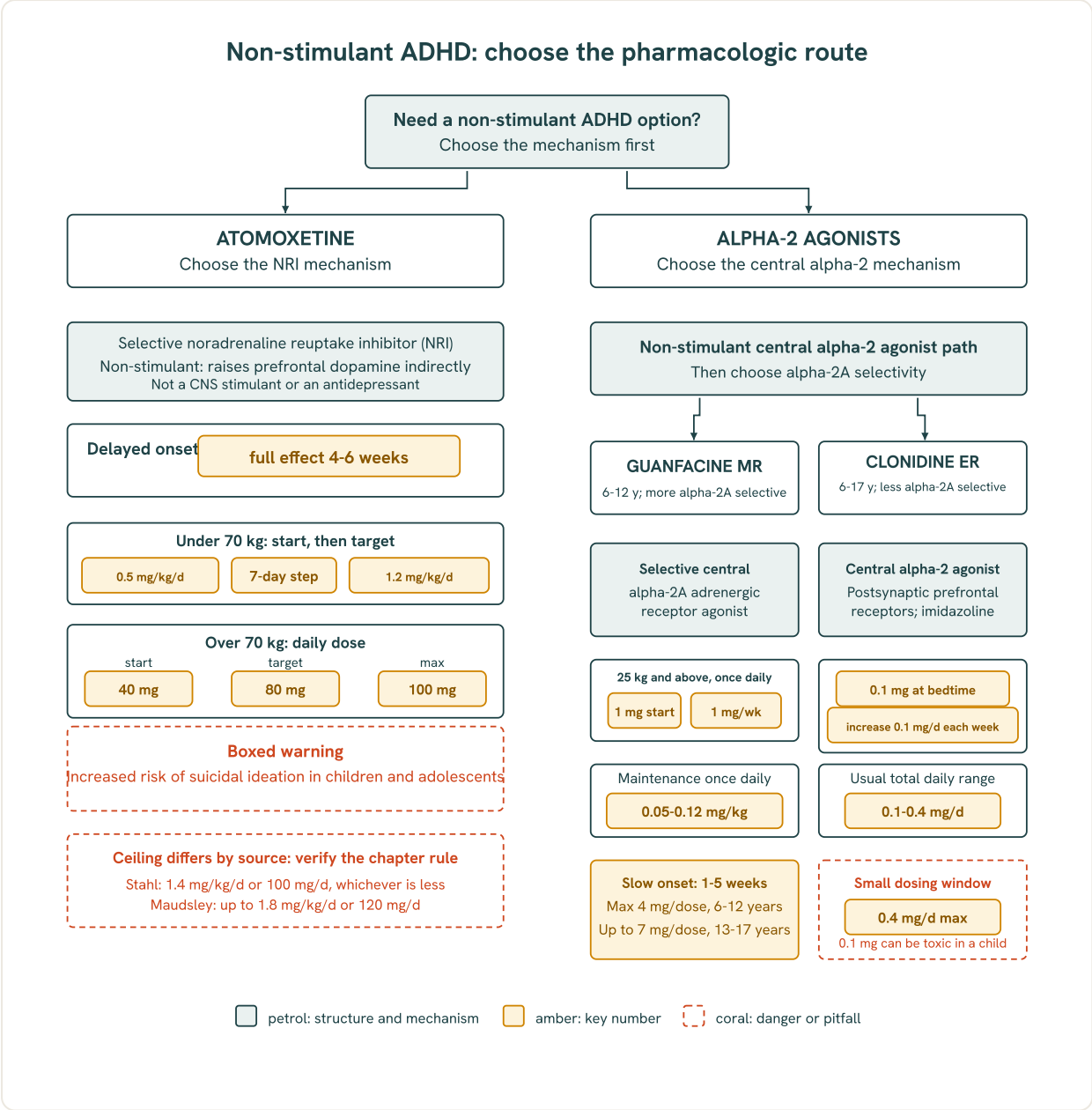


Fig 22.11. Non-stimulant ADHD choice: atomoxetine versus alpha-2 agonists.

11.1 The non-stimulant frame

Atomoxetine is a **selective noradrenaline reuptake inhibitor** and a non-stimulant. This matters because its clinical effect is understood through sustained noradrenergic modulation rather than an immediately perceptible stimulant effect. Its pharmacology also supports attention and behavioural control through prefrontal catecholamine regulation. The practical lesson is not to reduce mechanism to an examination label. Mechanism predicts the tempo of prescribing, the way a family interprets change, and the error made when an early partial response is called failure.

The adrenergic agonists work through a different regulatory pathway. **Guanfacine** is a **selective central alpha-2A adrenergic receptor agonist**. **Clonidine** has **central adrenergic agonist action in the prefrontal cortex**, including postsynaptic receptor activity relevant to ADHD. These descriptions are not interchangeable shorthand. Guanfacine has greater receptor selectivity, whereas clonidine has broader receptor action. That distinction is useful when one

explains why agents grouped together pharmacologically are not automatically interchangeable in formulation, schedule, or dose.

ATX	GUA	CLO
NON-STIMULANT OPTION	NON-STIMULANT OPTION	NON-STIMULANT OPTION

RULE **Choose and prescribe a non-stimulant as a complete treatment strategy, not as an afterthought.** Its mechanism, onset, formulation and review plan must be explained before a family can judge it fairly.

The distinction is also pedagogically useful. When asked to discuss non-stimulants, a high-quality answer starts with this pharmacological map and then moves to the individual agent. It does not collapse atomoxetine and adrenergic agonists into one undifferentiated list. Nor should it drift into the full assessment of ADHD, behavioural management, school intervention, or stimulant prescribing, each of which is addressed elsewhere in this chapter.

11.2 Atomoxetine: planning treatment around delayed benefit

Atomoxetine has a **delayed onset**; full therapeutic benefit may take **approximately 4-6 weeks**. This is the central counselling point. Families often judge medicines by what can be observed soon after a dose is started. With atomoxetine, early impressions should instead be organised around tolerability, adherence, and whether the intended course has had sufficient time to declare itself. A clinician who does not set that expectation creates an avoidable cycle of premature stopping, hurried switching, and loss of confidence in treatment.

The slower tempo also changes follow-up questions. Rather than asking only whether the child was “better” on a given morning, ask whether the medicine has been taken consistently, whether home and school can describe the same target difficulties, and whether observations are being compared with the pre-treatment baseline. The relevant outcome is functional improvement across the child’s everyday settings, not a dramatic subjective effect. This makes collateral information valuable, while detailed rating-scale selection and use remain the subject of the rating-scales section of this chapter.

MNEMONIC

SLOW

Scope the population, **L**ay out the titration, **O**wn the onset expectation, and **W**atch the agreed clinical targets. It is a prescribing spine rather than a claim that one drug suits every child.

When changing a plan, do not allow the phrase “non-response” to conceal several different possibilities. The treatment may not yet have been exposed adequately; the dose may not yet have reached its intended therapeutic range; adherence may be inconsistent; the outcome selected by adults may be too vague; or the underlying difficulty may demand parallel behavioural, educational, or family work. These are clinical questions, not reasons to multiply drugs reflexively. The wider multimodal plan is discussed in the multimodal treatment section of this chapter.

TRAP **Expecting atomoxetine to behave like an immediately acting medicine is a category error.** If delayed benefit was not explained at the outset, an early discontinuation may be recorded as drug failure when it actually reflects an inadequate therapeutic trial.

11.3 Atomoxetine dosing: state the whole tuple

For the lower-weight child, atomoxetine may be started at **about 0.5 mg/kg/day for the first 7 days** and then advanced towards **about 1.2 mg/kg/day**. The population qualification is essential: this is the regimen for a child **under 70 kg**, not an unlabelled paediatric formula to be transferred to every patient. The schedule may be given once daily or in divided doses. In teaching and in the case record, write the formulation and the population beside the number. A dose without its denominator and population is a trap awaiting a prescribing error.

There is a source divergence at the upper end of this regimen. Stahl gives a ceiling **below 1.4 mg/kg/day or 100 mg/day, whichever is less**, whereas Maudsley permits an increase **up to 1.8 mg/kg/day or 120 mg/day** when necessary. This is not a licence to blend two ceilings into an invented third schedule. It is a reason to use the local prescribing reference and product information that govern the individual prescription, document the rationale for any higher-dose plan, and seek senior review when the decision is not straightforward. The key examination point is to recognise the divergence rather than memorise an isolated maximum stripped of its source.

For an adult or a child over **70 kg**, begin at **40 mg/day** for the first week and then work towards **80 mg/day**, with benefit judged over the subsequent weeks; do not exceed **100 mg/day**. This separate schedule prevents a common error: carrying a weight-based paediatric instruction into a patient for whom the fixed-dose regimen is intended. The word “target” is clinically more useful than “destination”. It asks the clinician to assess response and tolerability at a planned dose, rather than treating dose escalation as an automatic ritual.

CLINICAL SCOPE	STARTING AND TARGET PLAN	UPPER LIMIT AND INTERPRETATION
Lower-weight child	Use the weight-based starting and target plan.	Use the ceiling from the prescribing authority being followed; Stahl and Maudsley differ at the upper end.
Adult or higher-weight child	Use the fixed-dose starting and target plan.	Use the maximum attached to that fixed-dose schedule.
Any atomoxetine plan	Record formulation, population and dosing schedule.	Interpret efficacy only after allowing for delayed onset.

PITFALL

Writing “atomoxetine at the usual dose” is clinically unsafe documentation. The correct prescription language makes the patient group, weight logic, formulation, schedule, target and source-specific ceiling visible to the next clinician.

11.4 Atomoxetine safety conversation

Atomoxetine carries a **boxed warning** for increased risk of **suicidal ideation in children and adolescents**. This requires a real conversation, not a hurried consent formula. Explain to the family what emerging concerning thoughts or behavioural change might look like in their child, who will be informed, and how they should obtain help if concern arises. A warning is not a prediction that the child will develop suicidality. It is an obligation to make risk visible and to ensure that the family does not feel abandoned between appointments.

Risk communication is best done in plain clinical language. Invite the young person, as developmentally appropriate, to describe distress directly rather than relying solely on adult report. Ask parents or caregivers to report abrupt changes rather than waiting for a routine review. The prescriber must distinguish a medicine-specific safety concern from the broader psychiatric assessment of mood, self-harm risk and family stress. Those domains should be evaluated clinically, but the full adverse-effect and monitoring framework for ADHD medicines belongs to the medication monitoring section of this chapter.

> **GOOD TO REMEMBER**
>
> Before atomoxetine is started, agree on a safety contact pathway. This transforms a boxed warning from an alarming sentence into a practical plan shared by clinician, young person and caregivers.

Documentation matters here. Record that the warning was discussed, the caregiver's understanding, the young person's account where available, and the plan for contact if risk emerges. Such notes improve continuity when care is shared and protect the therapeutic alliance by showing that safety was anticipated rather than raised only after a crisis. Do not make a family carry the burden of pharmacovigilance alone: the treatment plan must state how the clinical team will remain reachable and responsive.

11.5 Guanfacine modified-release

Guanfacine modified-release is a formulation-specific treatment. The words "modified-release" should remain attached to the dose whenever it is discussed, because pharmacological family membership does not make formulations interchangeable. For a child in the specified school-age and weight group, the starting dose is **about 1 mg** once daily. The row is scoped to children aged **6-12 years** who weigh at least **25 kg**. This is why copying a dose from a drug class summary without its heading is unsafe.

Titrate guanfacine modified-release in increments of **about 1 mg per week** when needed and tolerated. The usual maintenance range in the same child group is **0.05-0.12 mg/kg** once daily. Its onset is **approximately 1-5 weeks**, so it too requires an expectation of progressive rather than instantaneous benefit. A prescriber should decide before titration what observations will count as meaningful improvement, and should not confuse a calm consultation-room presentation with change in the child's ordinary functioning.

The maximum for children aged **6-12 years** is **below 4 mg per dose**. In those aged **13-17 years**, the maximum is determined by weight band and may rise **up to 7 mg per dose**. A good answer

does not simply quote the highest figure. It says that the adolescent ceiling is weight-band dependent, because that is the safeguard which prevents an age label from being mistaken for complete dosing guidance.

- Confirm that the intended product is guanfacine modified-release.
- State the age and weight scope before calculating or documenting a dose.
- Advance the dose only through the specified weekly steps and review the agreed clinical targets.
- Keep the delayed-onset expectation explicit for caregivers and school.

IN INDIA

Do not assume that a class name guarantees the same formulation, availability, or labelling across settings. Verify the product actually available to the family and prescribe from the locally applicable information rather than importing a regimen from an unfamiliar brand or market.

11.6 Clonidine extended-release

Clonidine should be approached with the same formulation discipline. The regimen here is for **clonidine extended-release** in children with ADHD aged **6-17**. Start at **about 0.1 mg** at bedtime. The small numerical scale is itself an important safety cue: it should make the prescriber pause before transferring an unrelated adrenergic agonist dose, a non-ADHD regimen, or a non-extended-release schedule into this context.

The extended-release regimen is advanced by **about 0.1 mg per week**. Doses are divided, with the larger portion at bedtime. The usual upper limit is **below 0.4 mg/day** in divided doses. Every element belongs together: drug, extended-release formulation, paediatric ADHD population, bedtime start, weekly advance, divided administration and ceiling. Separating the number from this tuple is the way correct-source information becomes incorrect prescribing.

Mechanistically, clonidine's prefrontal receptor action offers a coherent reason for its place among non-stimulants. Clinically, however, mechanism does not absolve the prescriber from precise instructions. Caregivers need a written plan that matches the product dispensed, uses plain wording for when doses are given, and tells them which member of the clinical team to contact when the plan cannot be followed. The medication monitoring section of this chapter addresses the wider safety checks required for ADHD pharmacotherapy.

11.7 Choosing, reviewing and integrating a non-stimulant plan

Choice between these agents begins with a clinical formulation, not a preference for a fashionable molecule. Consider the treatment goals, the symptom pattern that is impairing daily functioning, prior treatment experience, practical feasibility, family understanding, and the capacity for follow-up. The aim is to select a plan whose expected course can be observed honestly. If the family cannot state what change would matter at home and school, the next task is to define targets rather than to change the prescription.

Targets should be concrete enough to be recognisable but broad enough to matter. They may concern the child's capacity to remain with a task, to participate in class, to complete routine work with less conflict, or to recover a more manageable rhythm at home. The prescriber should ask each informant what would count as meaningful change and should note disagreement rather than forcing a false consensus. A medicine can be helping in one setting while a separate unmet need remains prominent in another. That pattern calls for formulation and coordination, not a simplistic verdict that the treatment either worked or failed.

At review, proceed in a sequence. Has the prescribed medicine actually been taken in the intended formulation and schedule? Has sufficient time passed for the agent's expected onset? Has the child's function changed in the domains that prompted treatment? This order protects against both therapeutic inertia and impulsive switching. It also makes room for the possibility that medication is a component of the plan rather than its entirety. Parent-focused work, behavioural intervention, educational support and school collaboration should proceed according to the child's needs, rather than being postponed until medication has solved every difficulty.

QUESTION AT REVIEW	REASONING TASK	USEFUL ACTION
Is the prescription being implemented as written?	Separate adherence or formulation problems from lack of efficacy.	Reconcile the medicine in hand with the documented regimen.
Has the expected onset been allowed for?	Prevent premature attribution of non-response.	Revisit the time course discussed at initiation.
What has changed in ordinary life?	Judge function rather than a vague global impression.	Obtain collateral from the settings where impairment occurs.
What remains unmet?	Identify needs that medication alone cannot address.	Integrate behavioural, family and school interventions.

For candidates, the mature answer is therefore structured and conditional. Name the mechanism, give a fully scoped regimen, state the onset expectation, identify atomoxetine's specific warning, and show how review is tied to function. For clinicians, that same structure prevents dangerous errors: prescribing a bare number without its population and abandoning a non-stimulant before its pharmacology has had a fair chance to work. It also makes handover safer, because another clinician can see the intended logic rather than having to reverse-engineer it from a number written in isolation.

> Non-stimulant prescribing is safe only when drug, formulation, patient group, dose, titration, onset expectation and review plan are documented as one clinical decision.

12 · Adverse effects and monitoring of ADHD medications (growth, cardiac)

Medication monitoring is active clinical care, not a formality after a prescription. In ADHD, the therapeutic question is never merely whether a medicine has been dispensed. The clinician must repeatedly ask whether the child is benefiting in the settings that matter, whether treatment is being tolerated, and whether an emerging problem represents a drug effect, the disorder itself,

an intercurrent difficulty, or a change in the child's circumstances. Monitoring makes the benefit-harm balance visible before it becomes a reason for avoidable discontinuation or avoidable persistence.

For the examination candidate, a strong answer links adverse effects to a method. It begins with a pre-treatment reference point, follows a small set of clinically meaningful domains, invites the child and caregiver to describe change in ordinary language, and records a reasoned response. The aim is not to create anxiety around ADHD medicines. It is to prescribe with enough attention that benefit can be sustained safely and that a concern is neither dismissed nor automatically attributed to the medicine.

Baseline	Growth	Vitals	Review
REFERENCE POINT	TRAJECTORY	CIRCULATORY SAFETY	BENEFIT AND BURDEN

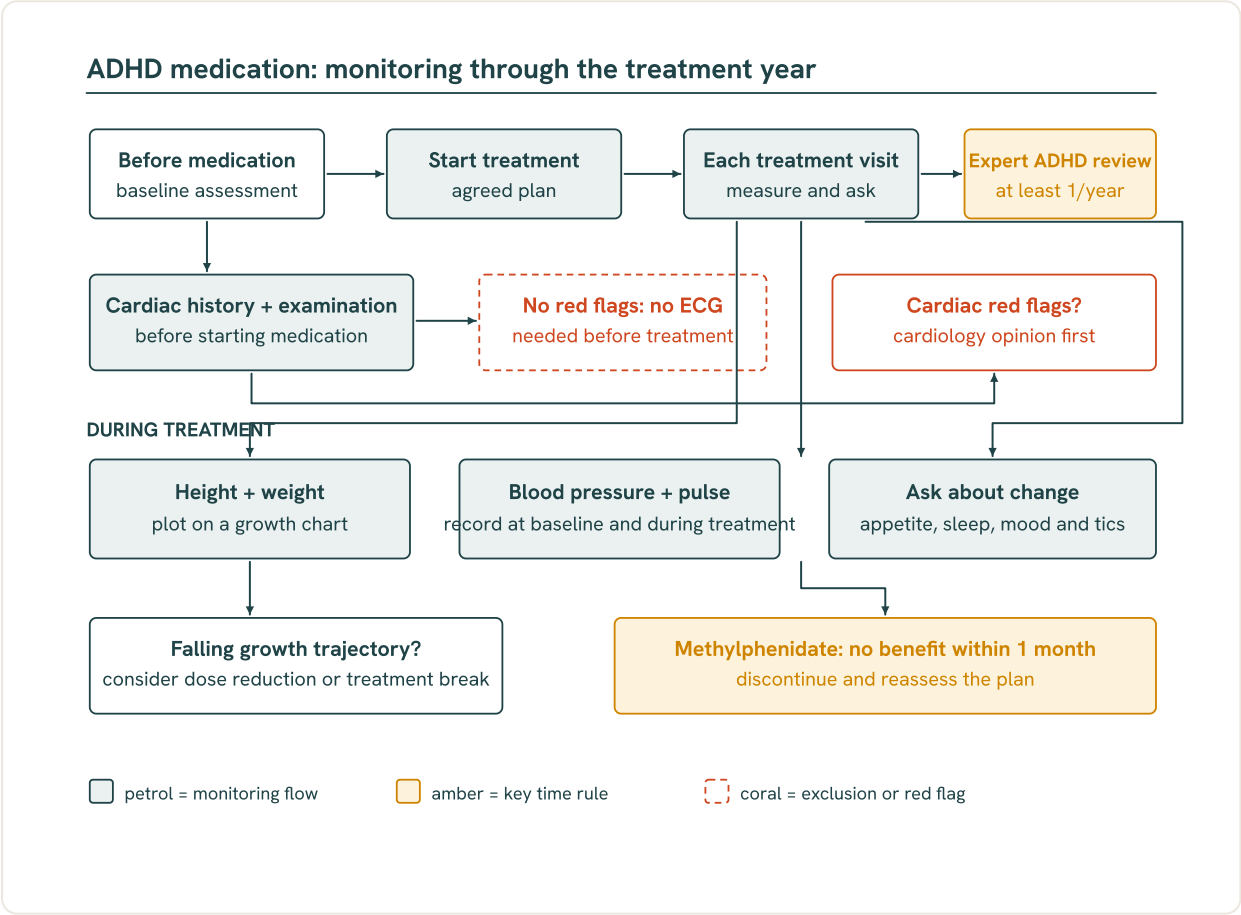


Fig 22.12. Growth, cardiovascular and adverse-effect monitoring during ADHD medication treatment.

12.1 The logic of surveillance

The useful monitoring consultation is longitudinal. An isolated observation has limited meaning unless it is interpreted against the child's prior state, current treatment exposure, reported functioning, and other plausible explanations. The task is therefore to make a clinical narrative from measurements, symptoms, school observations, family accounts, and examination.

Begin by agreeing what change would count as benefit and what change would prompt contact with the treating team. Ask the caregiver to notice the child's appetite, sleep, emotional tone, activity, and physical complaints without turning home into a surveillance ward. Ask the child

directly, in developmentally appropriate language, what feels different. A child may describe a bodily experience, a loss of spontaneity, or a change in evening functioning that an adult observer cannot infer from classroom behaviour. Conversely, a caregiver may notice a pattern across meals, mornings, or family routines that the child cannot place in context.

Monitoring is also an exercise in attribution. A symptom that appears after treatment begins may be related to the medicine, but timing alone does not settle causation. The clinician should reconstruct when it began, how it relates to medication exposure, whether it was present previously, whether it occurs when the medicine is not being taken, and whether illness, stress, sleep disruption, dietary change, or another medicine offers a more coherent explanation. This reasoning matters because the response may range from reassurance and observation to adjustment of treatment or assessment for an independent problem. The record should make that reasoning legible to the next clinician.

RULE **Monitor the child's trajectory, not an isolated complaint.** The reference state, the temporal pattern, the functional consequence, and the family's account together determine whether a finding calls for action.

Monitoring should be collaborative rather than punitive. Families sometimes conceal missed medication, appetite difficulties, or worries about mood because they fear criticism or fear that the only alternative is to stop treatment. A non-judgemental consultation makes clinically useful information more likely to emerge. It also permits a practical distinction between an inconvenience that can be managed and a burden that changes the overall acceptability of treatment. The prescriber retains responsibility for medical decisions, but the child and caregiver supply much of the information on which those decisions depend.

12.2 Growth and nutritional trajectory

Growth monitoring belongs at the centre of stimulant follow-up because treatment can interact with appetite, eating routines, and the child's developing physical trajectory. The core action is to **measure height and weight** and record them on a **growth chart**. The chart matters because it turns a sequence of measurements into a pattern. It helps the clinician distinguish an apparently concerning isolated value from a sustained change in trajectory and creates a shared object for discussion with caregivers.

Long-term stimulant treatment is associated with lower height and weight, described clinically as **growth deceleration**. This should be explained without fatalism. The association justifies systematic observation; it does not turn every child receiving a stimulant into a child with a growth disorder. The clinical question is whether the individual child's physical course remains acceptable in the context of treatment benefit, eating pattern, general health, and the family's concerns. A good note records the finding and the interpretation, rather than merely copying a measurement into a prescription sheet.

Appetite is the practical bridge between medication and growth. Ask about the child's usual pattern of meals, snacks, school-day eating, and what the family sees when the medication effect is most noticeable. Ask whether eating has become effortful, whether favourite foods have

changed, whether meals have become a site of conflict, and whether the concern is reduced intake, altered timing, or distress around food. These questions are not a substitute for measurement. They clarify the lived pathway by which a trend on the chart may matter, and they may reveal that a reported appetite problem has a different explanation.

When a concerning pattern is identified, the response should be individualized. Recheck the measurements and the history before declaring a causal conclusion. Review the treatment benefit and burden with the child and caregiver. The available claim supports considering **dose reduction or treatment breaks** as management options for growth-related concern; the decision must be integrated with functional need and clinical response rather than applied automatically. Nutritional or medical assessment may be appropriate when the history points beyond a medication effect. The fragment does not supply a numerical threshold for intervention, so it should not be invented in clinical practice or in an examination answer.

GOOD TO REMEMBER

A growth chart is a clinical conversation tool. Show the family the recorded trajectory, ask what has changed at home, and make the plan explicit. This converts a vague concern about "poor eating" into a monitored, revisitable decision.

TRAP **Do not equate appetite suppression with proof of clinically important growth harm.** Appetite, measured growth, general health, and treatment benefit must be considered together; either dismissing the complaint or stopping treatment reflexively is poor clinical reasoning.

Growth monitoring also prevents an important communication failure. Families may hear "we will monitor growth" as a warning that harm is expected, while clinicians may assume that a measurement has reassured the family. State the purpose plainly: the team is looking for a pattern early enough to respond thoughtfully. Invite the caregiver to bring observations from home and, where relevant, from school routines. The prescriber should avoid giving a false precision about the amount of change that is acceptable when the available evidence for this fragment does not provide such a threshold.

12.3 Appetite, sleep, mood, and tics

Physical monitoring is incomplete if it ignores the experiences that determine whether a child can live comfortably with treatment. Follow-up should actively enquire about **appetite change, insomnia, mood change, and the development of tics**. These domains deserve direct questions because families may not volunteer them, may regard them as unrelated to treatment, or may use broad labels that conceal an important distinction. "Sleep is worse," for example, needs a description of the child's actual pattern and its daytime consequences; "mood is different" needs clarification of affect, context, timing, and impact.

Sleep inquiry should be practical and neutral. Establish what bedtime and waking are like, whether the child is rested, whether there is distress around sleep, and whether the reported change is linked temporally to treatment. Do not assume that every sleep complaint is medication-related. ADHD, school pressures, family stress, medical illness, and pre-existing sleep

difficulty may all complicate the story. The monitoring task is to identify a clinically meaningful change and to decide whether it is best understood as a treatment burden, a co-occurring difficulty, or both.

Mood change warrants particular care because it can be described in many ways: irritability, tearfulness, emotional flattening, increased sensitivity, or a sense that the child is unlike themself. The clinician should ask the child as well as the caregiver, seek concrete examples, and assess whether the change is transient, context-bound, or functionally impairing. Avoid reducing all emotional change to non-adherence or all distress to a medication adverse effect. A careful history protects the child from both invalidation and inappropriate exposure to a medicine that is not being tolerated.

Tics require equally careful phenomenology. Clarify what is being observed, when it emerged, how it fluctuates, whether the child is distressed, and whether there is functional impact. The purpose of monitoring is not to make an unsupported causal declaration from temporal association. It is to identify change, assess its burden, and decide whether the treatment plan needs reconsideration or whether a broader clinical evaluation is needed. For fuller discussion of tic disorders, see the Child behavioural, emotional and other disorders notes.

- Ask what has changed from the child's own baseline.
- Ask when the change is most apparent and what makes it better or worse.
- Ask about distress, impairment, and the child's interpretation of the change.
- Record the family's observations alongside the clinician's assessment.

PITFALL

Do not ask only whether the medicine is "fine." That question invites reassurance rather than information. Domain-based enquiry about appetite, sleep, mood, and tics gives the family permission to report a concern before it becomes a crisis.

12.4 Cardiovascular assessment before treatment

Cardiovascular monitoring starts before medication is prescribed. Record **blood pressure and pulse** at baseline and continue to record them during treatment. Baseline values provide a reference against which later observations can be interpreted. Their value is not limited to detecting an abnormal result: they also discipline the clinician to ask whether a later change is new, sustained, symptomatic, or better explained by context.

An **ECG** is not a routine pre-treatment requirement for stimulants, atomoxetine, or guanfacine when **cardiac red flags** are absent. This is a useful corrective to indiscriminate testing. A test should answer a clinical question; ordering it automatically can delay care, create incidental findings, and obscure the importance of a careful cardiac history and examination. The absence of a routine ECG requirement is not permission to conduct a cursory screen.

Red flags call for a different route: seek cardiology opinion before starting treatment. The screen should identify known congenital heart disease, prior cardiac surgery, a **first-degree relative**

with sudden death before 40, breathlessness on exertion, syncope with exertion or fright, rapid regular episodic palpitations, chest pain suggestive of cardiac origin, features of heart failure, a murmur, blood pressure in an adult hypertensive range, and concurrent medication that increases cardiac risk. These are not a checklist to recite mechanically. Each finding changes the pre-treatment risk question and therefore requires an appropriately focused history and examination.

The interview must make room for ambiguity. Children and families may use the same words for anxiety-related sensations, ordinary exertional limitation, brief awareness of heartbeat, or a potentially important symptom. Ask for the setting, onset, duration, associated symptoms, recovery, and impact in a calm way. Do not reassure on the basis of a vague negative answer, but do not convert an imprecise symptom into a cardiac diagnosis. The clinical skill is to translate a narrative into a defensible decision about whether specialist input is required.

MONITORING DOMAIN	WHAT THE CLINICIAN ESTABLISHES	CLINICAL QUESTION ANSWERED	HOW THE FINDING IS USED
Cardiac history	Symptoms, prior cardiac care, family history, and concurrent medicines	Is there a cardiac red flag?	Decide whether cardiology opinion is needed before treatment
Examination	Relevant physical signs and cardiovascular observations	Is there a finding requiring further assessment?	Interpret alongside the history rather than in isolation
Blood pressure and pulse	Baseline values and subsequent observations	Has the circulatory state changed during treatment?	Compare with the child's documented course
ECG	A targeted investigation when red flags are present	Is testing clinically indicated?	Use as part of the specialist-directed assessment, not as a universal ritual

IN INDIA

Children may move between private clinics, public services, schools, and relatives who share care. A clear written baseline history, physical record, and explanation of which symptoms should prompt review make monitoring more reliable across these transitions. Ask caregivers to retain the record and bring it to follow-up rather than relying on memory alone.

12.5 Cardiovascular follow-up during treatment

Recording blood pressure and pulse during treatment is a continuing responsibility, not a pre-treatment box to tick. The purpose is to detect change while maintaining the broader perspective: a reading is interpreted in relation to the child's prior record, current symptoms, examination, treatment exposure, and clinical state. Stimulants may raise blood pressure and pulse, so these observations belong in the ordinary monitoring record rather than being reserved for a child who appears unwell.

When a finding is concerning, establish that it is a real clinical signal. Check the context of measurement, ask about symptoms, review the prior record, and examine the child as appropriate. Then decide whether the concern can be safely observed, whether treatment should be reconsidered, or whether medical or cardiology assessment is required. The correct response cannot be reduced to a universal number in this fragment, because no such threshold is supplied here. What matters is a documented clinical judgement that links the finding to the child's overall risk and treatment benefit.

Communicate the distinction between expected monitoring and alarm. Families should understand that blood pressure and pulse are recorded because treatment deserves competent follow-up, not because the clinician expects a cardiac event. At the same time, they should know to report new symptoms rather than waiting for a routine visit. This balanced explanation reduces both complacency and panic, and it preserves trust when the plan needs to change.

MNEMONIC

TRACE

Trend, **R**eported symptoms, **A**ttribution, **C**linical examination, **E**xplanation to the family. Use it to turn an observation into a reasoned cardiovascular follow-up note.

12.6 Review, response, and the decision to continue

A medication review brings efficacy and tolerability back together. The clinician should review treatment with ADHD expertise at least **once a year**. This is not an administrative renewal. It is an opportunity to reconsider whether the original target problems remain the right targets, whether benefit is present in the child's real environments, whether adverse effects are acceptable, and whether the child and caregiver still understand and agree with the plan.

Review is particularly important when the prescription has continued by habit. Function changes as school demands, family circumstances, developmental needs, and supports change. A medicine that was useful may require a different plan; a concern previously judged minor may become important; and an apparent loss of response may reflect a change in the setting rather than a pharmacological problem. The review should therefore integrate reports from the child, caregiver, and, when available and appropriate, school, rather than relying solely on the prescription history.

For methylphenidate, discontinue treatment if there is no benefit within **one month**. This statement is a safeguard against unexamined continuation, not an invitation to make a rushed judgement from a poorly observed trial. Before concluding that there is no benefit, establish whether the treatment was taken as intended, whether the target outcome was observable, whether the available reports were adequate, and whether adverse effects or contextual changes have distorted the picture. Dosing and titration belong to the stimulant pharmacotherapy discussion and should not be improvised here.

Document a concise clinical synthesis at each substantive review: the target symptoms and functioning, the child's account, caregiver observations, adverse-effect enquiry, growth and

cardiovascular observations, the attribution judgement, and the agreed plan. This documentation is not defensive bureaucracy. It preserves clinical continuity, allows later findings to be interpreted as a trajectory, and makes shared decision-making visible. It also prevents a later clinician from mistaking an old prescription for evidence that benefit was ever established.

- Revisit the treatment goal and observed benefit.
- Review growth, circulatory observations, appetite, sleep, mood, and tics.
- Ask the child what has improved and what has become harder.
- Decide explicitly whether to continue, modify, pause, discontinue, or seek further assessment.

12.7 A defensible monitoring plan

The best monitoring plan is simple enough to be followed and rich enough to detect a meaningful change. It starts with a baseline clinical record, including growth measures, blood pressure, pulse, and focused cardiac screening. It then turns routine follow-up into a repeated enquiry about benefit, physical trajectory, appetite, sleep, mood, tics, and cardiovascular symptoms. The plan names who will observe which domains, how concerns will reach the prescriber, and what information should be brought to the next visit.

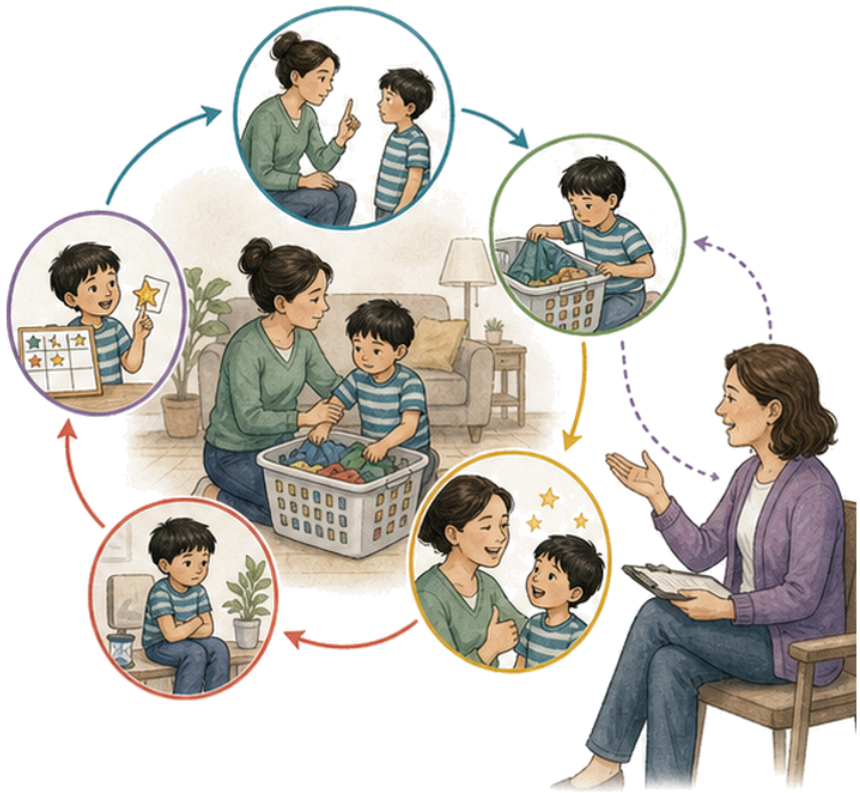
When concerns arise, do not treat monitoring as a choice between reassurance and discontinuation. Return to the clinical sequence: describe the finding accurately, establish its timing and burden, look for alternative explanations, check the objective record where relevant, and weigh it against demonstrated benefit. Some concerns require a change in treatment; some require further assessment; some can be observed with a clear plan. What makes the plan safe is not a formula but disciplined follow-through and honest documentation.

This approach also keeps monitoring within its proper boundary. It does not replace comprehensive ADHD assessment, behavioural intervention, school support, or evaluation of comorbidity. Those elements are addressed elsewhere in this chapter. Medication surveillance contributes a distinct task: to ensure that a pharmacological intervention remains a justified, tolerable, and actively reviewed part of a broader treatment plan.

> Measure growth, record blood pressure and pulse, screen cardiac red flags, ask directly about appetite, sleep, mood and tics, and revisit whether benefit still justifies treatment.

13 · Behavioural and parent training interventions

Behavioural work changes the treatment environment, not merely the child. ADHD symptoms are expressed within ordinary routines: getting dressed, beginning homework, shifting away from a preferred activity, tolerating a limit, or completing a request. These moments can become repetitive coercive cycles in which the adult raises the intensity of instruction and the child either escalates or escapes the task. The purpose of treatment is to make expectations clearer, desirable behaviour more visible, and the adult response more predictable. This is why **behavioural parent training**, also termed parent management training, belongs in the core psychosocial management of childhood ADHD and disruptive behaviour.



- Clear request
- Immediate praise
- Planned reward
- Predictable consequence
- Review one target

Fig 22.13 Behavioural parent training changes the treatment environment through clear requests, immediate attention to desired behaviour, planned rewards and predictable consequences. The parent is coached, not blamed, and progress is reviewed against one observable target.

It is not a programme for blaming parents, nor is it a demand for flawless parenting. The clinical task is to convert understandable family frustration into observable, practicable responses that can be used repeatedly when the child is dysregulated, distracted, oppositional, or simply not yet able to organise behaviour independently. The therapist functions as a **teacher and coach**: explains a skill, models it, rehearses it with the caregiver, anticipates obstacles, and returns to what happened at home. The mark-scoring answer therefore names the intervention, explains its learning principle, and shows how a parent would apply it to a concrete target.

13.1 Therapeutic frame and treatment target

Manualised parent management training gives the clinician a disciplined way to work with behaviour that is impairing family life. The parent is the immediate agent of change because the daily environment supplies prompts, attention, access to preferred activities, and responses to rule-breaking. This does not mean that all difficulty is environmentally caused. Rather, it

recognises that a child with ADHD may need the environment to carry structure that cannot yet be carried consistently through self-direction.

The first move is to replace a global complaint such as “he never listens” with a target that can be seen and recognised by both parent and child. A useful target is described in positive, observable language: starting a task after a request, placing an item where it belongs, returning to an agreed activity, or using an acceptable way to seek attention. This reframing matters because caregivers cannot consistently reinforce an abstraction. They can, however, notice a particular behaviour when it occurs and respond to it in a planned manner.

The intervention also separates the child from the problem. Parents often arrive having tried more explanation, more warnings, louder instructions, or prolonged argument. Those reactions are understandable, but they may accidentally turn a small demand into a prolonged interaction. Parent training asks a different question: what happened immediately before the behaviour, what did the child do, and what followed? That formulation makes the family interaction available for change without reducing the child to “naughty” or the caregiver to “inconsistent”.

RULE **Teach the parent a response that can be delivered consistently at the moment the behaviour occurs.** Behavioural parent training works through coached practice in ordinary routines, not through advice that remains too general to implement.

13.2 The contingency principle

Contingency management is the organising principle of this treatment. It links the parent’s response to a behaviour rather than to the parent’s rising irritation or the child’s promise to improve later. Desired, prosocial behaviour receives **positive reinforcement**; problematic behaviour receives a brief, planned, and proportionate consequence when one is needed. The clinical logic is not that a reward purchases obedience. It is that a child learns more readily when the behaviour that adults want to see is noticed promptly and becomes predictably worthwhile.

For a child with ADHD, delayed benefits often compete poorly with the immediate pull of play, movement, conversation, or escape from an aversive task. Reinforcement makes the immediate pathway towards the desired behaviour clearer. It should be linked to a target the child can genuinely achieve. If the threshold is set beyond current capacity, the system becomes another experience of failure, the parent stops using it, and the child learns that the announced reward is unattainable. The treatment therefore begins with success and adjusts the demand gradually as the routine becomes established.

Consequences are not synonymous with punishment. A consequence may remove attention from a provocative behaviour, restore a missed expectation, or briefly restrict access to a positive activity. Its therapeutic value lies in predictability, calm delivery, and connection to a stated rule. A long moral lecture usually occurs after the learning moment has passed and may give more attention to disruptive behaviour than to the quieter behaviour the family wishes to increase. The clinician should help the parent distinguish an intended consequence from an emotional reaction.

Target	Response	Review
OBSERVABLE BEHAVIOUR	PLANNED CONTINGENCY	PARENTAL COACHING

GOOD TO REMEMBER

A reward system is a clinical experiment, not a test of parental authority. If it repeatedly fails, first review whether the target is clear, whether the reward is attainable, and whether the parent can deliver the response in the actual routine.

13.3 Giving instructions that can be followed

Effective instructions are an antecedent intervention: they alter what happens before the behaviour rather than waiting to react afterwards. The parent gains the child's attention, states one concrete action, uses language matched to the child's capacity, and avoids converting the instruction into a question if compliance is expected. The parent then allows enough space for the child to act before adding another demand. This is not harshness. It is a way of reducing ambiguity for a child whose attention and behavioural organisation fluctuate.

Vague or stacked instructions create avoidable failure. "Stop being difficult and get ready properly" contains several judgments but no clearly observable first action. In contrast, an instruction that identifies the next action gives the child a possible route to success. The parent is coached to notice even partial movement in the right direction. That notice is often more therapeutically useful than waiting until the entire routine has gone perfectly and then discovering that the opportunity for reinforcement has been lost.

Antecedent control also includes changing the routine so that the desired action is easier to initiate. The clinician may ask what prompts are present, whether competing attractions are active, whether the adult can prepare the situation before giving an instruction, and whether the task has been made needlessly broad. Such questions retain the behavioural focus without claiming that the intervention will remove the underlying neurodevelopmental vulnerability. The executive-dysfunction model that helps explain this vulnerability is addressed in the ADHD mechanism section.

- State the action rather than a criticism of the child.
- Give one manageable next step.
- Pause and allow the child to respond.
- Notice compliance promptly and specifically.

TRAP **Do not mistake repeated warnings for behavioural treatment.** Repeating an instruction without a planned follow-through teaches neither the requested behaviour nor the consequence of non-compliance, and it leaves both parent and child in a predictable argument.

13.4 Rewards, token systems, and success

A **token economy** makes reinforcement visible. The child earns a token, mark, or other agreed signal for a specified target and exchanges accumulated credit for an agreed privilege or reward. Its usefulness is practical: it helps a caregiver respond in the moment and gives the child a

concrete record of effort. The system should be explained as a route to practising a behaviour, not as a bargain that applies only when the adult is exhausted.

The clinician should spend time on the mechanics with the family. What exactly earns the token? When will the parent give it? What happens if the child protests? What rewards are meaningful but manageable? Who will remember the system when the household is rushed? These questions are more important than producing an attractive chart. A beautifully designed plan that cannot be used during a hectic morning is less therapeutic than a simple plan that survives the real household.

Rewards need not be material. Positive attention, choice, shared activity, access to a preferred routine, and acknowledgement of effort may all be useful when they are meaningful to that child. The key is that the child experiences the contingency as credible. When a parent makes an elaborate promise and cannot deliver it, the programme loses instructional value. When the parent chooses a small, available reinforcer and gives it reliably, the child encounters success and the adult sees a workable alternative to confrontation.

MNEMONIC

CLEAR

Choose one target, **L**ink it to an immediate response, **E**ncourage effort, **A**void unattainable rewards, and **R**eview what actually happened. This is a practical memory aid for running a reward plan, not a substitute for parent coaching.

Parent training succeeds when the child can repeatedly experience that a clear, achievable behaviour brings a dependable response.

13.5 Planned consequences and time away from reinforcement

Time-out is best understood as time away from positive reinforcement, not as isolation, humiliation, or a venue for prolonged reprimand. In a behavioural plan it is a structured response to a pre-specified behaviour, delivered with as little drama as possible. The parent explains the rule outside the conflict, applies the response when the rule is broken, and returns to ordinary interaction without reopening the argument. Its function is to interrupt the reinforcement that may be maintaining the behaviour and to preserve the adult's capacity to stay regulated.

A modified time-out may be one component of a broader consequence plan. It should never become the only intervention offered to a family. If the child receives most adult attention during disruption and little attention during cooperation, simply adding a consequence will not correct the imbalance. The parent must also practise recognising prosocial behaviour and building positive interaction into daily life. Otherwise the programme risks being experienced as a succession of sanctions rather than a structure for learning.

The clinician should explore feasibility and safety before recommending a consequence. A strategy that requires the parent to manage an intense struggle, cannot be applied in the available home environment, or leads to escalating physical confrontation is not a good plan merely

because it has a familiar name. Return to a smaller target, clearer antecedents, and a consequence the caregiver can deliver calmly. Behavioural treatment should lower the emotional temperature of the household.

> **PITFALL**
>
> Using time-out as an angry banishment reverses its purpose. If the adult lectures, negotiates, threatens, and repeatedly restarts the interaction, the child receives intense engagement rather than a clear, brief consequence.

13.6 Functional analysis beyond the home

The **A-B-C model** offers a compact method for thinking about behaviour in context: identify the antecedent, describe the behaviour without inference, and examine the consequence. It is particularly useful when parents report that the child behaves differently across settings. Rather than assuming that one observer is right and another is wrong, the clinician asks what is different about the demand, the available attention, the escape route, the waiting involved, or the response that follows the behaviour.

PART OF THE SEQUENCE	CLINICAL QUESTION	USE IN PARENT COACHING
Antecedent	What immediately set the episode in motion?	Make the prompt clearer or alter the situation before the demand.
Behaviour	What did the child actually do?	Define one observable target rather than a character judgment.
Consequence	What followed from the behaviour?	Plan reinforcement for the desired alternative and a calm response to the problem behaviour.

Why functional analysis matters. The same outward behaviour can serve different functions on different occasions. A child may be seeking attention in one situation and avoiding an overwhelming task in another. Parent training is therefore not a set of stock rewards pasted onto every complaint. It is a method for matching the adult response to the sequence that is actually occurring. This is also why the clinician reviews examples from the previous week rather than judging the programme solely by the parent's overall impression.

Public settings deserve the same analysis. The aim is not to create a display of parental control in front of others. It is to prepare a brief plan before entering a difficult situation, recognise early signs of dysregulation, reinforce the behaviour that permits the activity to continue, and leave or change the situation when a pre-agreed limit is reached. A parent who has a rehearsed plan is less likely to improvise from embarrassment or anger.

13.7 Collaboration with school and the Indian clinical setting

Home-school daily report cards connect the child's effort across the settings that matter most. The school identifies a limited, observable target and communicates whether it was met; the

caregiver then delivers the planned response at home. The report card is not a behaviour diary for public shaming, and it should not become a channel through which adults exchange frustration. Its purpose is to make the reinforcement pathway coherent for the child.

School-based adjustments, classroom strategy, and wider psychosocial management require their own plan and are considered in the school-based management section. In parent training, the relevant question is narrower: can home and school agree on language, targets, and feedback so that the child is not asked to decode incompatible expectations? When communication is difficult, a simple shared target is more useful than an elaborate form that neither setting completes.

IN INDIA

Parents may have to coordinate with teachers while managing crowded routines, shared caregiving, and uneven access to trained behavioural therapists. Teach a small set of skills that the family can practise without specialised materials, and adapt the home-school communication method to what the school can reliably sustain. The clinical standard is not a sophisticated chart; it is a plan that preserves dignity and can be used consistently.

Grandparents and other caregivers may be central to the child's day. Excluding them can create contradictory contingencies: one adult rewards a requested behaviour while another inadvertently reinforces refusal or argument. Invite key caregivers into the formulation where feasible, describe the target behaviour in plain language, and agree on the immediate response. The goal is not identical parenting styles. It is enough coherence that the child can anticipate what will happen after a behaviour.

13.8 Age, preference, and place in ADHD treatment

For children of preschool age, roughly **3 to 5 years**, behavioural and parent-training intervention is preferred as the initial treatment. This is clinically important because **psychostimulants** have lower short-term efficacy and lower tolerability in preschoolers than in school-aged children. Parent training offers a developmentally appropriate starting point: it increases structure around behaviour while the clinician continues to assess impairment, family capacity, and the need for additional intervention.

Age does not turn treatment into an automatic recipe. **AAP guidance** frames the balance of medication and behavioural treatment differently across development and gives family preference a meaningful role for younger children. For adolescents aged **12-18**, medication with or without behavioural therapy is described as first-line; behavioural therapy alone remains an option when the family declines medication. A candidate should state the age-sensitive principle without presenting behavioural work and medication as adversaries.

Behavioural parent training can be used alongside pharmacotherapy, but this fragment does not teach medication selection, dosing, adverse-effect monitoring, or the evidence for multimodal treatment. Those decisions belong to the pharmacotherapy, monitoring, and multimodal management sections. The parent-training contribution remains distinctive: it changes the

response pattern around behaviour, strengthens caregiver efficacy, and provides a way to work when symptoms continue to create friction despite other treatment.

14 · School-based and psychosocial management

School is a treatment setting, not merely a place where impairment is observed. For a child with ADHD, the classroom repeatedly asks for behaviour that is difficult to organise in the moment: beginning work, persisting through it, waiting, shifting attention appropriately, and responding to correction without disengaging. The clinical task is therefore not to ask a teacher to "manage ADHD" in the abstract. It is to help adults alter the immediate environment so that the desired behaviour is clear, observable, reinforced, and shared across the child's settings.

School-based management belongs within psychosocial treatment because it translates clinical formulation into the places where daily functioning is tested. It does not replace assessment, medication when indicated, parent work, or educational intervention for a coexisting learning difficulty. Its distinctive contribution is practical: the child meets the same understandable expectations at school and at home, and adults receive usable information rather than a succession of global reports that the child was "distracted" or "naughty". Good plans reduce blame on all sides. They make progress visible, preserve the teacher's authority, and give the child a credible route back to success after a difficult period.

School	Home	Plan
CLEAR TARGETS	LINKED INCENTIVES	SHARED REVIEW

14.1 The clinical logic of a school plan

ADHD-related difficulty is often interpreted morally because it is intermittent. A child may complete work under some conditions and fail under another; adults may then conclude that the difficulty reflects unwillingness. A psychosocial formulation asks a more useful question: what happens immediately before the behaviour, what does the adult do next, and what consequence makes the pattern more or less likely to recur? This shifts discussion from personality labels to modifiable contingencies. The target is neither compliance for its own sake nor a perfect classroom. It is participation in learning and relationships with less repeated failure.

The plan should start with a shared functional description. Vague objectives such as "be attentive" or "behave properly" leave each adult to apply a private standard. They are poor teaching targets because the child cannot tell, during a demanding moment, whether success has occurred. A useful target names an action that can be seen and recorded, describes the relevant context, and is phrased positively where possible. "Begins the allotted task when directed" gives adults a common observation point. "Does not create trouble" does not. The distinction matters because the latter invites a running catalogue of errors, whereas the former creates an opportunity to notice competence.

School intervention is most effective when it is formulated collaboratively rather than imposed as a clinical instruction. The teacher brings knowledge of classroom routines, peer dynamics, curricular demands, and what can actually be sustained. Parents bring knowledge of the child's

strengths, interests, pressure points, and how consequences work at home. The clinician protects the formulation from impossible standards and from treating a difficult school period as evidence that the child or adults have failed. The child should understand the plan in developmentally appropriate language and should experience it as help with a real problem, not as public surveillance.

RULE **Specify the behaviour before choosing the consequence.** A consequence cannot teach reliably when adults have not agreed on what counts as the target behaviour, when it occurs, and how it will be noticed.

Targets should be selected for functional importance, not because they are the most irritating behaviour in the room. Establish what blocks access to teaching or damages the child's place in the group, then ask whether the target is within the child's control under current conditions. A plan that begins with an unreachable demand creates repeated evidence of failure and will soon lose adult goodwill. A plan that begins with an achievable, meaningful behaviour gives the child an early experience of agency and gives adults a reason to continue using it.

14.2 Classroom contingencies and teacher partnership

The classroom side of treatment rests on **teacher consultation**, **contingency systems**, and teacher-led observation of the agreed behaviour. Consultation is not a lecture on diagnosis. It is a working conversation about where the target appears, what precedes it, which prompts are already available, how feedback will be delivered, and how information will reach home. The clinician should take the operational burden seriously. A beautifully designed plan that demands more attention than a teacher can spare will quietly disappear.

A contingency system makes the relation between a behaviour and its consequence more immediate and predictable. Recognition, access to a valued classroom privilege, or a token-like marker can all be used when they are tied to the agreed target. The therapeutic element is not the object itself. It is the clarity of the link: the child can see what action has earned the response. Equally important, feedback should not become a stream of criticism. A child who already expects correction may stop trying before the task begins; the plan must therefore create frequent opportunities for adults to catch and name the desired action.

Target-behaviour tracking allows the teacher to move from impressions to observations. It need not become an elaborate record. Its value lies in showing whether the chosen target is improving, whether the context needs modification, and whether home and school are describing the same problem. The record should be intelligible to the people using it. If a teacher cannot complete it within the normal rhythm of class, it is not a clinical instrument; it is an additional task waiting to be abandoned.

ELEMENT	CLINICAL PURPOSE	QUESTION FOR THE TEAM
Observable target	Turns a broad concern into a teachable action	Could each adult recognise it in the same way?
Teacher feedback	Links classroom behaviour to an immediate response	Can it be delivered without disrupting teaching?
Contingency	Makes success meaningful to the child	Does it follow the target consistently?
Brief record	Supports review instead of memory-based judgement	Does it show a pattern that can be acted on?
Home link	Extends the same message beyond school	Do caregivers understand what the record means?

Teacher partnership also requires protecting dignity. The child should not be singled out theatrically or made dependent on a public display of poor performance. Feedback can be clear without being humiliating. The clinician should ask how the plan will look to peers, whether it increases opportunities for repair after mistakes, and whether it preserves ordinary membership of the class. A child with ADHD often needs additional structure; that does not justify making the child the classroom's problem to solve in public.

> **GOOD TO REMEMBER**
>
> When a teacher says that a plan is impossible to carry out, treat this as clinical data rather than resistance. Simplify the target, move the feedback into an existing routine, or redesign the home link. Sustainability is part of treatment fidelity.

14.3 The daily report card as a home-school bridge

The **daily report card**, also described as a home-school report card, is a compact way of joining school performance to family support. It is not a report on the child's worth, and it should never read like a disciplinary diary. It is a brief communication tool focused on a small set of agreed behaviours. The teacher rates the target behaviour during the school routine, sends the information home, and the home response follows the information rather than a parent's guess about what happened in class.

Its strength is the direct bridge between settings. The card makes **parent-teacher collaboration** concrete: the teacher does not have to carry the whole intervention, and parents do not have to reconstruct the school routine from a distressed child's account. The child receives a consistent message that school effort matters at home and that adults are working from the same plan. This is why the report card is a psychosocial intervention rather than an administrative form.

The card should contain **one to four** specific school behaviours; in practice, **two to four** keeps the plan manageable. Keeping the list narrow prevents the card from becoming a score sheet of every difficulty. It also allows the child to know what to do next rather than facing a diffuse demand to improve. The language should describe the action that earns success, not merely prohibit an unwanted act. A meaningful target is tied to a setting where the child can

demonstrate it, such as work initiation, returning to a task after redirection, or following a classroom routine.

The teacher's rating should be simple enough to survive a busy classroom session and should be explained to the child before it is used. The home response should be planned in advance, not negotiated during a conflict at the end of the day. When the target is met, the child earns a home-based reward linked to the school behaviour. When it is not met, the card should signify that the goal was not reached, not that the child deserves shame or an escalating punishment. This distinction protects the learning function of the intervention. A negative card is information about the plan, the context, or the target, not an invitation for adults to intensify hostility.

MNEMONIC

CLEAR

Choose an observable target; **L**ink it to the classroom routine; **E**xplain the expectation; **A**cknowledge the result; **R**eview the record together. It is a practical spine for keeping a report card therapeutic rather than punitive.

Review is essential. If the same target is repeatedly not achieved, the question is not simply whether the child needs a harsher consequence. The team should revisit whether the target was clear, whether the classroom demand exceeded current capacity, whether the teacher had a workable prompt, and whether the home incentive still carries meaning. Conversely, when the child is doing well, adults should avoid silently raising expectations until success disappears. A plan has value when it teaches a skill and supports participation, not when it becomes a moving test of obedience.

TRAP **Do not turn the report card into a punishment ledger.** When every difficult moment is entered and the home response is mainly punitive, the card teaches avoidance and adult conflict rather than the school behaviour it was meant to strengthen.

14.4 Antecedent planning beyond the desk

School plans work better when they do not wait for disruption before acting. **Antecedent-based behaviour management** asks adults to prepare for predictable points of strain. The relevant questions are: what demand is approaching, what environmental feature increases the likelihood of difficulty, what expectation must be stated beforehand, and what response will follow success or non-success? This is a disciplined alternative to reacting only after behaviour has deteriorated.

The **A-B-C model** provides a usable sequence. Adults anticipate likely problems, restructure antecedents where possible, communicate the expectation, plan the consequence, and reward the positive behaviour. In a school context, this may mean thinking ahead about a transition, a demanding task, a period requiring waiting, or a situation in which peer stimulation is high. The point is not to remove all challenge. It is to make the path through a foreseeable challenge explicit enough that the child can practise a different response.

- Identify the situation in which the difficulty reliably emerges.

- State the expected behaviour before the demand begins.
- Arrange the adult response so that success is noticed and mistakes can be repaired.

Antecedent planning has a useful psychosocial effect on adults as well. It interrupts the familiar escalation in which adults interpret a child's difficulty as defiance, increase emotional intensity, and then receive more dysregulation in return. A pre-agreed response allows the teacher and parent to act with less improvisation. That does not make the child passive. On the contrary, it creates a repeated opportunity for the child to predict what is wanted and to experience that a different action leads to a different outcome.

Although it is especially visible in classrooms, the skill generalises to other structured settings. The same clinical logic can be used when a family anticipates a demanding routine outside home, when the child is entering a social situation, or when a planned activity has a known pressure point. The intervention remains psychosocial because it changes the interaction between demands, adult communication, and consequences. It should be coordinated with parent-training work rather than duplicated; the detailed parent-training framework is addressed in the behavioural and parent training interventions section.

PITFALL

Do not confuse anticipation with overprotection. The purpose is to prepare for a demand and teach participation within it, not to remove every situation that might be difficult. If the plan consistently shrinks the child's opportunities, it may reduce short-term conflict while preserving long-term impairment.

14.5 Coordination, review, and clinical boundaries

A school plan has to be embedded in a working relationship. The clinician should clarify who will explain the plan to the child, who will observe the target, how information will be communicated, and how disagreement will be handled. Parent and teacher may hold different views of the child's difficulties. That disagreement should be explored rather than solved by declaring one setting correct. Behaviour may genuinely vary with task demands, adult style, peer context, sleep, treatment effects, and emotional state. The goal is a shared intervention hypothesis, not a forced consensus about blame.

The school record can also improve clinical review. It gives the treating team a window into functional change that is closer to the learning environment than a retrospective global impression. It should not be treated as a diagnostic test, nor should it replace a comprehensive assessment of ADHD, comorbidity, learning needs, family context, or medication effects. Rating-scale selection and interpretation belong to the dedicated rating-scales section. Where a specific learning difficulty is suspected, assessment and remedial planning should be pursued through the relevant learning-disorder sections rather than attributing all academic struggle to ADHD.

Communication requires consent, clarity, and proportion. Families should know what information is being shared, why it is relevant, and who will receive it. Teachers need concise, practical guidance rather than confidential clinical detail that does not alter classroom

management. A note that says “use the agreed target and report-card routine” may be more useful and safer than a long diagnostic summary. The clinician should also resist treating the school as an extension of the clinic. Educational staff make their own professional judgements; psychiatric input is most helpful when it is collaborative, specific, and responsive to the school’s real constraints.

IN INDIA

School collaboration may involve a class teacher, a coordinator, and family members with different expectations about discipline, academic performance, and disclosure. Begin by identifying the adult who can reliably implement the agreed routine, use plain language for targets, and avoid assuming that a written communication channel is the only feasible home-school bridge. If educational accommodations or formal learning assessment are relevant, address them through the learning-disorder management and educational-provisions sections rather than adding unsupported promises to an ADHD behaviour plan.

There are clear limits to what school management can accomplish. It cannot compensate for an unrecognised learning disorder, an untreated emotional disorder, severe family stress, bullying, or a classroom environment that is unsafe for the child. Nor should it be used to postpone needed clinical treatment simply because a teacher has agreed to try harder. Conversely, the presence of medication does not make school intervention unnecessary. Pharmacological and psychosocial approaches address different parts of functioning; the evidence and logic of multimodal treatment are considered in the multimodal treatment of ADHD section.

When a plan is not working, revise the formulation before judging the child. Ask whether the target is meaningful and observable, whether adults are responding consistently enough for the child to understand the connection, whether the home incentive is still linked to the school behaviour, and whether the presumed problem is actually another unmet need. This stance keeps the intervention clinical. It also prevents a damaging drift from support toward surveillance.

14.6 What the candidate should be able to formulate

In an answer or case discussion, describe school management as a coordinated behavioural intervention rather than a list of generic classroom tips. Begin with functional impairment in the educational setting. Then state that the team will define an observable target, arrange teacher feedback and a classroom contingency, track the target behaviour, and link school information to a planned home response. Explain that this creates consistent incentives across settings and strengthens parent-teacher communication. The answer becomes more clinically persuasive when it shows why a target must be achievable, why a negative report should be treated as information, and why the plan must be reviewed rather than mechanically continued.

The most defensible formulation preserves several distinctions. Classroom contingencies are not public shaming. A daily report card is not a punishment sheet. Antecedent planning is not avoidance of all demands. Teacher consultation is not a transfer of medical responsibility to the school. Finally, school intervention is not a substitute for evaluating difficulties that lie outside its

scope. Holding these distinctions allows the clinician to be both practical and appropriately modest.

> A school plan for ADHD succeeds when adults agree on a small observable target, respond predictably to it, and connect school feedback with supportive consequences at home.

15 · Multimodal treatment of ADHD and MTA study evidence

Multimodal treatment is a clinical strategy, not a slogan. ADHD is expressed at home, in school and in relationships, so treatment has to be organised around the child's impairments, comorbidity, family capacity and school context. The important examination question is not whether medication or behavioural work is "better" in the abstract. It is what outcome is being pursued, which component can plausibly change it, and how the components are made to work together.

The **Multimodal Treatment Study of Children with ADHD** is the central comparative trial for this reasoning. Its enduring value is that it separates symptom control from broader functioning, compares an intensive treatment strategy with ordinary care, and forces a more mature conclusion than "combined treatment always wins."

579	7 to 9.9 years	four	14 months
RANDOMISED CHILDREN	ENTRY AGE	TREATMENT ARMS	PRIMARY PHASE

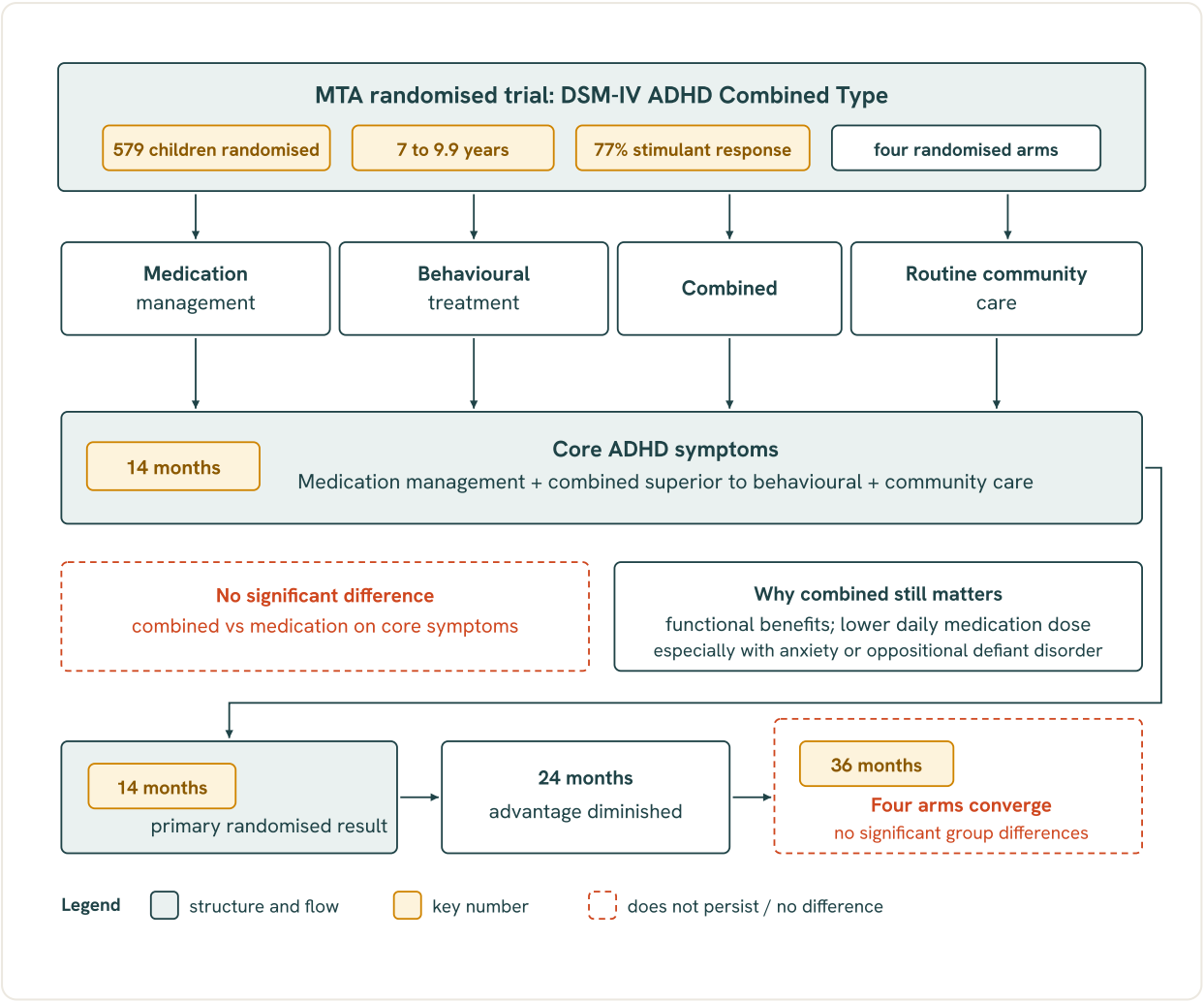


Fig 22.14. MTA four treatment arms: medication strategies led core ADHD symptoms at 14 months, but original-group differences converged by 36 months.

15.1 What multimodal treatment means in practice

Multimodal treatment means a coordinated plan in which biomedical, behavioural, educational and family-facing components have distinct jobs. It does not mean handing every family a standard bundle. A plan becomes genuinely multimodal when its parts are linked to a formulation: medication may be used to reduce core symptoms sufficiently for the child to participate in learning and skill practice; parent work may alter coercive interaction cycles and make routines more predictable; school measures may reduce the mismatch between demands and the child's current capacities. The aim is coherence across settings, not accumulation of referrals.

This distinction matters because a core symptom score and a meaningful improvement in daily life are related but not identical outcomes. A child may be less distractible yet continue to have conflict, academic underachievement, poor peer functioning or family strain. Conversely, a family may report smoother routines while impairing symptoms remain insufficiently controlled. The clinician should therefore specify the target outcome before declaring a treatment successful or unsuccessful. That discipline prevents both premature medication switching and the equally common error of continuing a psychosocial intervention without checking whether it is addressing the problem for which it was selected.

Multimodality is also a way of managing uncertainty. ADHD commonly appears with difficulties that change the treatment task, and the child's needs can differ between home and classroom. A formulation should identify the dominant impairment, available supports and barriers to implementation. The behavioural and school-based components are described in the relevant treatment sections; here, the key point is that they must be coordinated with medical care rather than treated as a competing ideology.

RULE **Match each treatment component to a defined impairment and a measurable outcome.** Medication, parent work and school support should be selected because each has a role in the formulation, not because "multimodal" sounds comprehensive.

15.2 Why the MTA study is clinically useful

The MTA enrolled children with **DSM-IV ADHD Combined Type**. This scope matters when interpreting the evidence. The study provides strong evidence about the population it studied, but it should not be converted automatically into a claim about every presentation, age group or clinical setting. Good evidence use starts with asking whether the child in front of us resembles the study population and whether the care system can deliver an intervention of similar intensity.

The randomised comparison had **medication management, behavioural treatment, combined treatment and routine community care**. These arms were not simply labels for a tablet, a few counselling sessions and "usual care." They represented treatment strategies. The medication arm involved systematic clinical management; the behavioural arm was a deliberately intensive package; the combined arm brought both strategies together. Community care was crucial because it asked whether a carefully delivered study strategy offered more than what families ordinarily received.

The primary comparison was made at **14 months**. This is the anchor for the initial result, not a licence to describe all later observations as though they were part of the same randomised treatment exposure. Once the intensive phase ended, treatment in the real world changed. Subsequent findings therefore illuminate the durability and transportability of early advantage, but they answer a different question from the primary randomised comparison.

For candidates, the study is useful because it tests propositions that are often blurred in clinical discussion:

- Whether a structured medication strategy improves core symptoms more than behavioural treatment alone or community care.
- Whether adding behavioural treatment improves core symptoms beyond well-managed medication.
- Whether a combined plan has advantages on outcomes that extend beyond the core symptom count.

MNEMONIC

Symptoms, Settings, Sustenance

Read the MTA by asking what happens to core symptoms, what changes across home and school settings, and whether the early advantage is sustained when care becomes naturalistic.

15.3 The initial result: symptom control is not the whole result

At the primary endpoint, **medication management and combined treatment** were superior to behavioural treatment alone and routine community care for core ADHD symptoms. This is the headline finding, and it supports a clear clinical conclusion: when core symptoms are the immediate source of impairment, a carefully managed medication strategy is an important part of evidence-based care. It does not imply that behavioural work is unimportant; it means that behavioural treatment alone did not match the symptom effect of the study medication strategies in this comparison.

Just as important, there was **no significant difference between combined treatment and medication management alone for core ADHD symptoms**. This is the sentence that protects against the simplistic claim that every child requires every component to obtain symptom control. Adding a component should be justified by the child's residual problems, comorbidity, family goals and functional setting, rather than by an assumption that a larger package must produce a larger symptom effect.

The combined arm nevertheless showed advantages on **non-core and functional outcomes**, including domains of behaviour, emotional symptoms, social competence, parent-child relations and reading achievement where medication management alone did not show the same advantage. This is not a contradiction. Core symptoms and functioning are related but separable targets. Behavioural and educational work can create opportunities for practice, reduce conflict and change environmental contingencies even when the additional effect on the core symptom outcome is not demonstrably greater.

QUESTION	MTA-INFORMED ANSWER	CLINICAL READING
Core ADHD symptoms	Medication management and combined treatment outperformed behavioural treatment and community care.	Do not mistake a broad plan for a substitute for adequate symptom treatment.
Combined versus medication alone	No significant core-symptom advantage was demonstrated for combined treatment.	Add components for a defined additional target.
Broader functioning	Combined treatment had advantages in selected functional and associated symptom domains.	Ask about relationships, school functioning and emotional burden, not symptoms alone.
Medication dose requirement	The combined arm required a lower average daily medication dose than medication management alone.	Do not translate this finding into an individual dose rule.

TRAP **"Combined treatment was not better, so behavioural work has no role."** This confuses a core-symptom comparison with the full treatment task. Functional outcomes and comorbidity can make a combined plan clinically preferable even when symptom scores do not separate the medication-containing arms.

15.4 What the comparison with community care actually shows

The community-care comparison is often misread as medication versus no medication. It was not. The study medication strategy was superior to **community care despite medication use within community care**. The clinically defensible interpretation is that treatment quality matters: diagnostic review, deliberate titration, follow-up, target monitoring and communication with the family are part of the intervention. A prescription without a management system is not equivalent to structured medication care.

This has a practical implication for follow-up visits. The clinician should not ask only whether the child is "better." Review should be tied to target symptoms, settings, adverse effects, adherence, practical obstacles and the family's account of benefit. When school feedback is available, it can test whether improvement seen in the consulting room transfers to the environment where sustained attention, organisation and inhibition are demanded. The precise medication regimen belongs with stimulant pharmacotherapy; the MTA lesson is about the quality and continuity of the strategy rather than a dose schedule.

It also explains why service context matters. Community care is heterogeneous. Some families receive fragmented reviews, limited school communication or an intervention that cannot be delivered consistently; others receive careful longitudinal care. The trial should therefore make the clinician more demanding about the process of treatment, not contemptuous of community clinicians or families. The question is whether the care plan has a feedback loop that can identify nonresponse, partial response, changing impairment and obstacles to adherence.

IN INDIA

A multimodal plan must be feasible for the family. Build the plan around realistic follow-up, a parent's capacity to carry out home strategies, and a school contact who can observe change. If intensive specialist behavioural input is not locally available, preserve the logic of coordination rather than offering a long, impracticable list of referrals.

15.5 Behavioural treatment in a combined plan

The MTA behavioural intervention was not a token add-on. It was an intensive package combining **parent training, a child-focused summer treatment programme and teacher consultation with classroom support**. This matters for interpretation: a trial finding about such a package should not be casually applied to a brief, poorly coordinated intervention that happens to be called behavioural treatment. Intensity, fidelity and cross-setting implementation influence what an intervention can plausibly achieve.

For the clinician, behavioural work is most useful when it addresses a problem medication alone cannot solve. Examples include conflict around routines, inconsistent reinforcement, difficulty

generalising gains across settings, a child's need for structured skill practice, or family distress that interferes with treatment implementation. Its role is not to prove that the child can manage without medication, nor is it to make parents responsible for a neurodevelopmental condition. It is a way of changing the contingencies and interactions through which impairment is maintained or expressed.

The MTA-derived clinical lesson is that **concomitant behavioural treatment may add benefit in comorbidity**, particularly when anxiety or oppositional defiant disorder is present. This is a formulation-based indication, not a universal rule. In such situations, the treatment plan needs targets that are wider than inattention and activity level: emotional distress, coercive family interactions, oppositional behaviour, avoidance, peer difficulties and school participation may require direct attention. The disorders themselves are addressed in the Child behavioural, emotional and other disorders notes.

GOOD TO REMEMBER

When a child has a satisfactory symptom response but remains impaired, ask what is still failing: the family routine, emotional symptoms, oppositional behaviour, peer functioning, reading, school accommodation or treatment implementation. The residual impairment, not a doctrine of "combination," selects the next component.

PITFALL

Do not call an intervention multimodal merely because several professionals have seen the child. Without shared targets, feedback and role clarity, parallel inputs can burden the family while leaving important impairments unaddressed.

15.6 Stimulant-response figures: define the denominator before quoting one

The MTA is also quoted for stimulant response, but the figure depends on the construct being described. The study reports a **77%** response rate in the medication titration context. This is a useful anchor when discussing response to the initial stimulant strategy, but it should not be made to answer a different question, such as cumulative response after an additional stimulant trial or maintenance of a particular regimen.

A separate framing describes cumulative response to the first or second stimulant trial as **about 90%**. It includes response to an initial methylphenidate trial and a subsequent dextroamphetamine trial. These figures are not interchangeable because the treatment exposure and denominator differ. In an examination answer, state what the number denotes. In a clinical conversation, avoid allowing a group response figure to become a promise about an individual child.

This distinction has broader value. "Response" can refer to symptom change, clinician judgement, parent report, school report, tolerability or continuing treatment. Before using response to guide a decision, define the target and obtain information from the setting in which impairment matters. A child may have a meaningful reduction in symptoms but an incomplete functional

recovery, or may stop a helpful medicine because the balance of benefit and burden is unacceptable. Neither situation is captured by a bare percentage.

15.7 Follow-up: early randomised advantage and later convergence

At **24 months**, the advantage of the medication strategy over behavioural and community care persisted, but was smaller than at the primary endpoint. This is a transition point in interpretation. It does not erase the early evidence for structured medication management; it indicates that effect sizes and between-group differences must be read in the context of changing treatment exposure and ordinary developmental and environmental change.

By **36 months**, the original treatment groups did not differ significantly on outcome measures, and the earlier medication-algorithm advantage was no longer apparent. This is not evidence that the initial result was false. Rather, it warns against treating the original randomisation as a permanent treatment state once families move into naturalistic care. Follow-up answers a different question: what happens to an initially randomised cohort after treatment pathways, adherence and circumstances have had time to diverge.

The follow-up samples remained substantial: 540 of 579 participants, or 93%, contributed at the earlier follow-up, and 485 of 579 participants, or 83.8%, participated at the later follow-up. Retention helps confidence in the observations, but it does not restore the original contrast once treatment is no longer controlled in the same way. Candidates should avoid claiming either that medication has no long-term value or that an early trial advantage proves an unchanging long-term between-group effect.

Across the cohort, **symptoms improved from baseline regardless of original assignment**. Initial severity, comorbidity, public assistance and parental ADHD predicted poorer later outcomes independently of the assigned treatment. This finding shifts the long-term clinical emphasis toward ongoing formulation and review. Treatment is not a single event at diagnosis. The clinician revisits impairment, context, comorbidity and supports as the child's developmental and educational demands change.

15.8 How to use MTA evidence in an individual formulation

The most useful MTA-informed formulation begins with a hierarchy of targets. If core symptoms are driving current impairment, make sure there is an adequately managed symptom treatment strategy. If the child also has family conflict, emotional symptoms, oppositional behaviour, social difficulty or academic impairment, decide which additional intervention has a credible mechanism for that particular target. Build review around observable change in the relevant setting. This is more rigorous than asking whether "multimodal treatment" has been given.

There are limits to what the trial can answer for an individual child. It does not replace assessment of learning, language, developmental history, safeguarding concerns, family stress or treatment preference. It does not tell the clinician which school accommodation will be feasible, nor does it replace a careful adverse-effect review. Those matters belong to the assessment, school management and medication-monitoring sections of this chapter. The MTA supplies a framework for integrating their findings, not a substitute for them.

Finally, communicate the evidence without polarising the family. Explain that medication can be important for core symptoms, that behavioural and school interventions can address meaningful functional problems, and that the plan will be revised according to the child's actual progress. This stance validates parental effort without implying that good parenting is a treatment for ADHD, and it avoids presenting medication as the whole of care. Coordinated, outcome-focused follow-up is the practical form of multimodal treatment.

> The MTA supports structured medication management for core ADHD symptoms, while combined care earns its place by targeting functional impairment, comorbidity and the child's real-world context.

ADHD beyond childhood and its outcome

16 · ADHD in adolescents and adults (persistence, transition)

Why this matters clinically. ADHD does not end at the clinic door when a young person leaves school. The developmental task is to recognise continuity without assuming that the childhood picture has remained unchanged. The adult consultation therefore asks a different question from the paediatric consultation: not merely whether symptoms are still present, but how their current form, context and functional consequences connect with a developmental history.

For the resident, this is a transition problem as much as a diagnostic one. A person may no longer look like the child described in an old school report, yet may still be impaired by a pattern that has changed in visibility rather than disappeared. Conversely, a current complaint of poor concentration should not be made to carry a childhood diagnosis without reconstructing its course. Good adult ADHD work holds both possibilities in mind, uses the patient's account respectfully, and actively tests it against available developmental evidence. That distinction affects engagement and planning as well as diagnostic accuracy.

16.1 Persistence is not an all-or-none outcome

The useful starting concept is **persistence**. It means that clinically meaningful ADHD may continue beyond childhood, but does not imply that every person retains the same symptom burden or the complete diagnostic syndrome. Follow-up findings differ according to how persistence is defined and how information is obtained. That methodological variation is not a reason to dismiss the finding; it is a reason to explain clearly what kind of persistence is being discussed.

One estimate suggests that ADHD persists in some form for **about 65%** of people with childhood ADHD. A separate estimate places persistence into early adulthood at **about 70%**. These figures should be read as convergent support for a substantial developmental continuity, rather than as competing verdicts about one fixed fate. The examiner is usually looking for the distinction between persistence of clinically relevant difficulties and persistence of the entire childhood syndrome.

Full diagnostic syndrome is the narrower outcome. It is retained by **about 15%** of childhood cases in adulthood. This is not a contradiction of the larger persistence estimate. It identifies the subgroup whose adult presentation continues to satisfy the full diagnostic threshold, while other people remain symptomatic or functionally affected without that full syndromal picture.

Partial remission is often the clinically more useful middle category. It refers to a developmental course in which difficulties remain important but no longer constitute the full syndrome. The proportion described in this range is **40% to 60%**. It prevents an unhelpful binary in which a patient is considered either wholly recovered or unchanged. In practice, partial remission may still matter greatly when the person's work, relationships or self-management demands have increased.

about 65%	about 15%	40% to 60%	about 2.5%
PERSIST IN SOME FORM	FULL SYNDROME	PARTIAL REMISSION	ADULT PREVALENCE

RULE **Persistence means continuity of clinically relevant ADHD, not automatic retention of the full childhood syndrome.** State this distinction before interpreting any adult symptom count or outcome label.

Adult ADHD is best understood as a developmental continuation whose expression may be full, partial, or no longer syndromal.

16.2 The adult presentation is a change in expression

Development alters the clinical surface of ADHD. The relevant shift is in the **symptom profile**: hyperactivity and impulsivity tend to decline across adolescence and early adulthood, whereas inattention often persists. The important word is "tend". A developmental tendency should guide enquiry, not become a stereotype that makes the clinician overlook an individual's current difficulties.

In adulthood, diminished overt motor activity may be experienced or described as inner restlessness, impatience, a sense of being driven, or difficulty slowing down. These descriptions need to be placed in the person's developmental narrative rather than treated as self-explanatory. They can be clinically relevant precisely because the visible childlike form has attenuated. The task is not to reproduce a classroom description in an adult consultation; it is to identify whether the present experience belongs to a persisting developmental pattern.

Inattention is often more durable and may be recognised through the person's account of organisation, task initiation, follow-through, distractibility and the effort required to maintain direction. Functional demands can expose these difficulties differently over time. An adult may have less externally imposed structure but more responsibility for creating structure. This can make an old vulnerability newly visible without proving that the disorder is newly acquired.

DEVELOPMENTAL FEATURE	ADULT EXPRESSION TO EXPLORE	CLINICAL IMPLICATION
Overt hyperactivity	Restlessness or difficulty settling	Ask about subjective experience, not appearance alone.
Impulsivity	Hasty responding or difficulty pausing	Place the report in the wider developmental pattern.
Inattention	Persistent difficulty directing and sustaining effort	Explore its functional expression in current roles.
External structure	Greater need to organise one's own tasks	Assess how context reveals or contains difficulty.

The table is a prompt for clinical translation, not a replacement for a developmental history. The core phenomenology of ADHD is addressed elsewhere in this chapter. Here, the key point is that the adult form is neither a miniature copy of the child form nor an unrelated concentration complaint. The meaning of the complaint emerges from its longitudinal pattern.

GOOD TO REMEMBER

When an adult says, "I was never hyperactive," clarify what they mean by hyperactive. A denial of visible childhood behaviour does not settle whether restlessness, impulsive action or attentional difficulty has followed a developmental course.

16.3 Predictors guide vigilance, not deterministic counselling

Persistence is associated with childhood symptom severity, childhood comorbidity and **parental mental health**. These are predictors of a course, not a checklist that can determine an individual outcome. Their clinical value lies in identifying who may need a more deliberate transition review and in prompting the clinician to look for persisting needs that may have been obscured by a change of setting.

Severity matters because a more prominent childhood burden may be more likely to remain clinically relevant. Childhood comorbidity matters because ADHD rarely appears in a vacuum, and the developmental story can become harder to interpret when another condition has affected functioning or reporting. Parental mental health belongs in the formulation as part of the developmental context and may also affect the quality and availability of collateral information. None of these factors should be used to convert a probability into a prognosis delivered as certainty.

An equally useful examination contrast is what should not be overread. **Individual IQ**, socioeconomic status and the quality of the parent-child relationship show no apparent impact on persistence. This does not make those matters irrelevant to care, opportunity or the patient's lived experience. It means that they should not be presented as established predictors of whether ADHD itself persists. The distinction protects against the common error of turning every contextual fact in a history into a causal explanation.

This distinction is also ethically important. A difficult family history, social disadvantage or an uneven educational opportunity may shape the consequences of ADHD and the help a person

can obtain. They should be addressed in care for that reason. They should not be casually recast as proof that the developmental condition will persist, nor should a favourable circumstance be treated as evidence that current impairment is implausible. Formulation is wider than prediction.

- Use recognised predictors to decide how carefully to review continuity.
- Separate a predictor of persistence from a factor that changes access to support.
- Keep comorbidity in the formulation without allowing it to erase the ADHD trajectory.
- Explain uncertainty honestly when discussing an individual course.

MNEMONIC

TRACE

Track the developmental course, **R**eview changing expression, **A**sk the adult, **C**heck collateral, and **E**xamine alternative explanations. It is a consultation spine, not a diagnostic shortcut.

16.4 Transition should preserve the developmental narrative

Transition is vulnerable when responsibility for care changes before the explanatory story has been carried forward. The young person may experience the move to adult services as a demand to begin again, while the receiving clinician may see only current complaints. A useful transition record therefore states the childhood pattern, the way the presentation has changed, the current areas of difficulty, the patient's own priorities, and the evidence that supports continuity. It is a clinical bridge, not an administrative summary.

Adolescent autonomy should be actively respected. The person's account becomes central, and it may differ from the family account without either account being discarded. The consultation should make room for privacy, consent and the patient's developing ownership of treatment decisions. At the same time, it should explain why a developmental condition may require carefully chosen collateral rather than relying on a single present-tense narrative.

Educational, occupational and domestic demands can change during this period. Do not assume that a change in achievement either proves remission or proves persistence. A person may be supported by a setting that compensates for difficulties, or may be struggling despite an outwardly acceptable record. The clinically relevant question is how attention, self-organisation, activity regulation and impulsivity affect the tasks the person is trying to perform, and whether that pattern is continuous with earlier life.

Transition is also a point at which the clinician should reconsider formulation rather than simply renew an inherited label. Current symptoms may have multiple meanings. The developmental history provides an anchor, but it does not excuse a failure to assess alternative explanations for present distress or impaired concentration. This preserves diagnostic rigour without making access to adult care depend on a perfect archive.

IN INDIA

When care moves across settings, create a concise handover that the patient can understand and retain. Agree with the patient whether family collateral may be sought, record what evidence is available, and do not allow missing paperwork to substitute for a developmental enquiry.

PITFALL

Equating an absent school record with an absent childhood history is unsafe reasoning. Records may be unavailable for many reasons; the correct response is to seek a careful developmental account and any feasible collateral, not to manufacture certainty in either direction.

16.5 The adult patient is the primary informant, but not the only source

Adult assessment begins from the patient's account. **Adult self-report** is ordinarily the primary source of information, unlike childhood assessment where parents and teachers are primary informants. This shift follows the patient's autonomy and direct knowledge of current inner experience. It also changes the clinician's stance: the patient is not a bystander to a history obtained from others.

Primary does not mean sufficient in every case. Adult ADHD requires a developmental account, and current self-report cannot independently recreate childhood. Collateral, past records and reports from people who know the person in relevant settings can help test continuity and clarify discrepancies. They should be sought with consent and used to add perspective, not to overrule the adult patient automatically. The quality of collateral depends on its proximity to the period and behaviour being described.

A good interview distinguishes present symptoms, remembered childhood experiences and the patient's interpretation of both. The adult may have learned explanatory language from prior contact, media, family discussion or their own reading. That does not make the account untrustworthy. It means the clinician should ask for concrete developmental examples and functional consequences rather than rewarding a fluent diagnostic narrative.

Collateral is especially valuable when the question is onset and course. It is less useful when it is treated as a vote on whether the person is "really" impaired. Informants observe different settings and may have their own blind spots. The clinician's role is to integrate accounts, identify the common developmental thread, and document remaining uncertainty rather than forcing consensus.

TRAP **Do not mistake "the patient is the primary informant" for "the patient's recall alone establishes childhood onset."** Adult autonomy and collateral history are complementary, not competing, principles.

16.6 Retrospective recall needs methodological humility

Self-report has a known limitation. **Young adults** are frequently poor reporters of ADHD symptoms, although reliability improves later in adulthood. In addition, both adults and parents may recall childhood ADHD poorly. This is not a moral failing and it is not peculiar to one family.

Retrospective memory reconstructs the past through current knowledge, current difficulties and the fragments that remain available.

Where prospective documentation exists, recalled onset may be reported **up to 4 years later** than the onset recorded at the time. The practical lesson is not that retrospective history is useless. It is that its time-line should be treated as an estimate requiring corroboration when the diagnostic question depends on it. A confident narrative can still be imprecise; an uncertain narrative can still contain a true developmental signal.

The consultation becomes stronger when it asks how a conclusion was reached. Explore what the patient personally remembers, what others observed, what documentary traces exist, and where the account remains inferential. This is a clinical reasoning exercise, not an interrogation. It enables the clinician to weigh evidence while preserving rapport and avoiding the false comfort of a single source.

- Separate current experience from remembered childhood experience.
- Ask what supports the proposed developmental time-line.
- Record discrepancy rather than editing it out of the history.
- Use uncertainty to guide further enquiry, not to prematurely close the case.

16.7 Adult-onset presentations remain a live controversy

Adult-onset ADHD is an emerging and unsettled idea. Emerging evidence has suggested that ADHD may arise in adulthood, challenging the assumption that it must always have a childhood neurodevelopmental origin. This should be presented as a controversy under examination, not as permission to abandon developmental assessment or as proof that every adult attention complaint represents a new disorder.

The controversy matters because it sharpens the clinician's reasoning. When symptoms appear to begin in adulthood, ask whether earlier symptoms were absent, unrecognised, compensated for, poorly recalled, or obscured by context. Then ask whether the current syndrome may be better explained by another process. The answer should come from a careful developmental reconstruction and a broad clinical formulation, not from allegiance to one side of a debate.

For examinations, the balanced formulation is strongest: adult presentations are clinically real and deserve assessment; continuity from childhood is often important; retrospective evidence has limitations; and the proposition of adult onset remains provisional. This avoids both extremes. One extreme dismisses adult suffering because childhood documentation is incomplete. The other accepts a current concentration complaint as ADHD without sufficient developmental or clinical scrutiny.

The accompanying prevalence figure reinforces that adult assessment is not a marginal afterthought to child psychiatry, even where the adult's account must still be weighed alongside developmental evidence. It is a distinct clinical task requiring developmental continuity, current functional understanding and disciplined handling of uncertainty.

17 · Prognosis and long-term outcome of ADHD

Prognosis in ADHD is a formulation, not a verdict. The diagnosis names a pattern of difficulty; it does not by itself describe how a particular person will function in later life. A useful account of outcome asks what difficulties have continued, what impairment has accumulated, which comorbid pathway is active, what supports are available, and whether treatment has been sustained. This matters because families often hear prognosis as a prediction of identity or worth, while the clinician needs to translate it into a plan for reducing avoidable harm and preserving participation in ordinary developmental roles.

For the postgraduate trainee, the central task is to move beyond the false choice between "will grow out of it" and "will always be disabled by it". Both statements collapse a heterogeneous course into a slogan. Prognosis should instead be written as a **developmental formulation**: current symptoms, functional demands, coexisting disorders, exposures that amplify risk, and interventions that may change the pathway. The companion discussion of adult presentation and transition belongs in the section on ADHD in adolescents and adults; the present focus is how to reason about long-term outcome without turning a population association into a prophecy about an individual.

Course	Function	Context	Risk
FOLLOW CHANGE OVER TIME	ASK WHAT PARTICIPATION COSTS	IDENTIFY SUPPORTS AND STRESSORS	LOOK FOR THE CONDUCT PATHWAY

17.1 What "outcome" should mean in ADHD

A long-term outcome is broader than whether a diagnostic label is still applied at a later assessment. It includes the person's ability to use attention and self-regulation in the settings that matter to them, to maintain relationships and work roles, to make safe choices, and to access care when needs change. This is a **functional outcome** perspective. It prevents the familiar error of judging success only by visible restlessness, while overlooking disorganisation, conflict, repeated underperformance, demoralisation, or dependence on others to keep daily life on track.

The same symptom pattern can carry different consequences in different environments. A person whose surroundings provide structure, reminders, predictable expectations, and a non-shaming response may have a very different experience from a person facing repeated criticism, unstable routines, academic exclusion, or unrecognised comorbidity. This is not a reason to make prognosis vague. It is a reason to describe the conditions under which difficulty becomes impairment. In clinical notes, it helps to distinguish the symptom burden from its consequences and from the supports that are currently compensating for it.

Outcome is also not restricted to a binary question of remission. A person may show fewer overt difficulties and yet continue to require considerable effort, environmental scaffolding, or treatment to function well. Conversely, an individual may retain symptoms but achieve stable participation when demands fit their strengths and support needs. The clinician should therefore ask about the quality and cost of functioning. This language is less deterministic, more useful for shared decisions, and kinder to the patient without minimising genuine risk.

- Describe the current pattern of impairment rather than assuming that symptom visibility captures the whole problem.
- Identify settings in which the person functions better, because these often reveal usable supports rather than a lack of disorder.
- Separate a present difficulty from an irreversible life conclusion.
- Revisit the formulation when developmental demands, living circumstances, or comorbid symptoms change.

RULE **In ADHD, prognosis is best expressed as an evolving risk-and-function formulation, not as a promise of recovery or decline.** The formulation makes explicit what is known now, what may change, and what can still be modified. It also protects against the clinical laziness of treating the diagnosis as the explanation for every later difficulty.

17.2 Course begins with the early clinical picture

When ADHD is identified in the preschool period, clinicians sometimes assume that the label is merely a transient description of high activity. The available follow-up evidence does not support casual reassurance of that kind. In children with **preschool ADHD**, the diagnostic picture was relatively stable across **6-year follow-up**; the reported course was generally chronic, with substantial symptom severity and impairment, particularly where the presentation was more severe, despite medication.

The correct teaching point is neither fatalism nor therapeutic nihilism. Early identification should prompt a careful longitudinal plan: clarify impairment, obtain collateral information, look repeatedly for changing needs, and support the adults who organise the child's environment. The persistence of difficulty in a follow-up cohort means that an early diagnosis deserves clinical seriousness. It does not mean that every child will have the same later experience, or that treatment has no value because symptoms remain.

Longitudinal thinking also corrects a common sequencing error. Prognosis should not be deferred until a crisis in schooling, family life, substance use, or the law has already developed. From the first assessment, the clinician can record what is impairing, what reduces impairment, and what risks would require a change in the care plan. This makes later review cumulative rather than reactive. It also allows the patient and family to understand that follow-up is not a sign of failure: it is the mechanism by which care responds to changing demands.

GOOD TO REMEMBER

At review, ask what has changed in the person's actual life, not only whether the original symptom description still sounds familiar. A functional account of outcome is more informative than a label carried forward without re-examination.

17.3 Heterogeneity is clinically important

ADHD is not a uniform pathway. The same diagnosis can coexist with very different temperaments, family resources, educational experiences, psychiatric comorbidities, and

opportunities for treatment. Prognostic work therefore begins by identifying **risk stratification** variables rather than searching for a single trajectory. The important question is not "what happens to ADHD?" but "what is happening to this person, through which pathway, and what can be changed?"

Such a formulation has practical consequences. It guides the intensity of follow-up, the urgency of collateral assessment, the need to involve family or other supports, and the threshold for addressing safety-related behaviour. It also disciplines communication. Patients should be told when an association is relevant, but should not be told that an associated outcome is inevitable. The clinician can be honest about risk while leaving room for agency, treatment, and the many contextual factors that influence a person's path.

PROGNOSTIC QUESTION	WHAT IT CLARIFIES	CLINICAL USE
What is the current impairment?	Which activities and roles are being affected	Sets a meaningful target for care
Which difficulties are persistent?	Whether support must be sustained across changing demands	Prevents premature discharge from follow-up
Is a comorbid pathway present?	Whether risk is being attributed too simply to ADHD	Directs assessment beyond core symptoms
What is helping already?	Which environmental or therapeutic supports are protective	Preserves effective supports during transition
What new exposure changes the risk?	Whether the formulation needs revision	Triggers timely intervention rather than retrospective explanation

This approach avoids two opposite mistakes. The first is diagnostic overshadowing: every academic, occupational, relational, or behavioural problem is automatically assigned to ADHD. The other is fragmentation: ADHD is treated as irrelevant once another problem appears. A sound formulation holds both possibilities in view. It asks whether ADHD is contributing to the burden, whether another condition better explains the change, and whether the interaction between them creates a new clinical priority.

MNEMONIC

COURSE

Current function, **O**utcomes already emerging, **U**nderlying comorbidity, **R**isks in the setting, **S**upports, and **E**ngagement with care. Use this as a structure for a prognostic review rather than as a substitute for clinical judgement.

17.4 The conduct-disorder pathway and severe adult outcome

The most consequential prognostic discriminator in the available evidence is not ADHD in isolation. **Comorbid juvenile conduct disorder** is the strongest predictor of severe adult outcomes. This changes the clinical formulation at once. It tells the trainee not to use ADHD as a

shorthand explanation for all externalising behaviour, and not to understate the significance of conduct problems when they are present.

The relevant severe outcomes include increased risk of **substance use disorders, criminality, and early mortality**. These are associations that demand careful assessment and preventive work; they are not labels to apply to a child. Their purpose in a textbook is to sharpen clinical attention to a higher-risk pathway, not to stigmatise young people or make families fear a predetermined future.

A candidate should be able to explain why this distinction matters. If the clinician describes the risk as "the outcome of ADHD", the patient may receive an incomplete assessment and the family may hear an inaccurate moral story. If the clinician identifies the **conduct-disorder pathway**, assessment can focus on behaviour, context, safety, substance exposure, peer influences, family stress, and engagement with care. The disorder itself is discussed in the Child behavioural, emotional and other disorders notes; here, it is the prognostic modifier that must be recognised.

Risk communication must be proportionate. State the association clearly, identify what needs closer review, and describe what the care team can do next. Avoid using severe outcomes as a threat to enforce adherence. Such communication invites shame and concealment, precisely when reliable collateral and continued contact are most needed. A better stance is firm, nonjudgmental, and behaviourally specific: name the concern, assess its current expression, and make a plan with the patient and caregivers.

TRAP **Do not attribute the worst adult outcomes to ADHD alone.** This erases the distinction between ADHD and the conduct-disorder pathway, and can lead to both stigma and an inadequate assessment of the actual risk pathway.

17.5 Substance use: risk, prevention, and causal humility

The substance-use question needs its own clinical discussion within a long-term prognostic review. It should be approached as a problem to detect early and manage collaboratively, not as evidence of personal failure. A useful review asks about use, consequences, attempts to reduce use, circumstances in which use becomes more likely, and the patient's own account of what the substance is doing for them. That conversation is often more informative than a moral warning.

The evidence also supports a potentially protective association: **early and sustained medication treatment** of childhood ADHD is associated with a reduced risk of substance use disorder in young adulthood. The wording matters. An association is not proof that medication alone caused the later difference, nor is it a guarantee for an individual. Treatment continuity may travel alongside many other influences, including engagement with care and the family's capacity to sustain a plan.

For clinical decision-making, causal humility does not mean inaction. The finding supports taking childhood ADHD treatment seriously and avoiding the simplistic claim that appropriate pharmacological treatment inevitably creates later substance misuse. It also reinforces the need to review treatment over time rather than treating a prescription as an isolated event. Medication is

part of a broader care plan that must address impairment, comorbidity, environment, adherence, adverse effects, and emerging risk. Detailed pharmacotherapy and monitoring are covered elsewhere in this chapter.

- Discuss substance use directly and without accusation when the clinical picture raises concern, and explain associations as risk information rather than certainty about the patient's future.
- Keep medication decisions linked to the wider formulation rather than fear-based assumptions, while escalating support when risk is active and maintaining a stance that invites disclosure.

PITFALL

Stopping at a generic statement about substance risk is clinically weak. It obscures the conduct-disorder pathway, ignores current context, and can turn a preventable problem into a stigmatising prediction.

17.6 Treatment changes prognosis, but does not abolish uncertainty

Prognosis is partly a statement about modifiable conditions. The aim of treatment is to improve the fit between a person's capacities and the demands placed upon them, support safer decision-making, and limit avoidable failure experiences. It should not be presented as a promise of a uniform future. The patient may need different forms of help as educational, occupational, relational, and health demands change, and the plan should be revised accordingly.

The preschool follow-up finding is especially useful here. Persistent symptoms or impairment despite medication should not be used to declare treatment futile. It should prompt a review of the formulation: whether the target is clear, whether the treatment is being taken and tolerated, whether environmental demands have changed, whether a comorbid disorder is contributing, and whether additional supports are required. In other words, lack of complete resolution calls for better clinical reasoning rather than either blame or resignation.

The phrase **protective factor** is often used too loosely. In prognosis, it should refer to something that can plausibly reduce exposure to risk or improve functioning, not merely something reassuring to mention. A supportive caregiver, reliable routines, treatment engagement, school accommodation, or a therapeutic alliance may each matter, but their relevance must be demonstrated in the person's own life. The clinician should preserve what works and investigate why it works before changing the plan.

Equally, treatment discussions must be transparent about uncertainty. It is reasonable to say that a treatment is intended to reduce impairment and potentially alter later risk, while also saying that outcome depends on more than a prescription. This protects informed consent and improves adherence because the patient understands the rationale for review. It also keeps the therapeutic relationship honest when progress is uneven.

17.7 Communicating prognosis in Indian clinical practice

Families may arrive with sharply polarised expectations: that ADHD reflects a temporary discipline problem, or that it forecloses education, employment, marriage, and independence. Both assumptions can distort care. The clinician's job is to replace them with a **shared prognostic formulation** that links current difficulty to concrete supports, identifies comorbid risk, and gives the family a reason to remain engaged even when improvement is gradual.

IN INDIA

Prognostic conversations need to account for the patient's family structure, school or workplace demands, access to follow-up, and the practical person who can help organise care. Do not assume that a recommendation is usable merely because it is clinically sound. Build a plan around the supports actually available and revisit it when circumstances change.

This is also where language matters. Avoid saying that a child is "bad", that an adult is "irresponsible", or that a family has failed. Such phrases confuse impairment, behaviour, and moral judgement. Instead, describe observed difficulties, their consequences, and the next workable intervention. When risk is present, be direct about it without presenting it as destiny. When progress occurs, name the supports that made it possible so they are not withdrawn prematurely.

Transition planning deserves the same clarity. The person should know which parts of the care plan need to travel with them, who can provide collateral when appropriate, and what changes should trigger renewed assessment. The detailed assessment battery and service pathways are addressed in the Child psychiatry: assessment, treatment, services and protection notes. The principle here is simpler: a good prognosis is made more useful by continuity of information, realistic expectations, and a plan that remains understandable to the patient.

17.8 Writing the prognostic formulation

A concise prognostic formulation can be organised around present function, course to date, comorbidity, active risks, protective supports, and engagement with treatment. It should identify the conduct-disorder pathway when present, describe substance-related concerns without moralising, and record what requires monitoring. It should also state what remains uncertain. **Clinical uncertainty** is not an omission when it is named and paired with a plan to reduce it through follow-up and collateral information.

This style of formulation is more clinically useful than an isolated phrase such as "guarded prognosis". A label of that kind does not tell another clinician what is driving the concern, what action is needed, or what improvement would look like. By contrast, a formulation connects risk to a next step. It can be updated when treatment engagement changes, when comorbidity emerges, or when a previously effective support is lost.

The prognosis of ADHD is shaped by functional course and modifiable context, but it must distinguish the higher-risk conduct-disorder pathway from ADHD alone.

Specific learning disorder

18 · Diagnostic criteria of SLD (DSM-5, ICD-11)

Why the criteria matter clinically. A learning complaint is not itself a diagnosis. Children, adolescents and adults may struggle because the teaching has been interrupted, the language of instruction is not yet secure, a sensory difficulty has not been corrected, or another developmental or mental disorder is shaping performance. The diagnostic task is therefore to show a persistent, functionally important and developmentally situated difficulty in a circumscribed academic skill, while actively considering better explanations. This prevents both the casual labelling of ordinary variation and the equally harmful dismissal of a person whose difficulty has been repeatedly explained away as poor effort.

DSM-5 specific learning disorder is diagnosed through a clinical synthesis rather than through a score, a school report, or a parental account in isolation. The framework has **four diagnostic criteria, A-D**. Its structure is useful because it forces the clinician to connect the presenting academic problem with its course, measured impact, developmental timing and exclusions. The diagnosis should read as a reasoned formulation of evidence, not as a label appended to a report.

18.1 The diagnostic architecture

The four criteria ask progressively different questions. Is there a persistent problem in an academic skill? Is the attainment meaningfully lower than expected and impairing? Did the difficulty begin in the developmental period relevant to learning? Is there a more adequate account of the presentation? Keeping these questions separate is an excellent safeguard against premature diagnosis. A learner can have an unmistakable complaint yet fail the diagnostic threshold if the complaint is transient, uncorroborated, not impairing, or better explained by circumstances outside a learning disorder.

A-D	1 of 6	6 months	mild to severe
DIAGNOSTIC ARCHITECTURE	ACADEMIC-SKILL SYMPTOMS	PERSISTENCE DESPITE SUPPORT	CURRENT-SEVERITY RANGE

RULE **Diagnose a disorder only when the whole pattern is coherent.** Criterion A establishes the academic difficulty, but the remaining criteria determine whether it is clinically significant, developmental and not better explained by another condition or context.

The wording also guards against a common false dichotomy: a child need not have difficulty in every academic area to have the disorder, and a person with broad educational disadvantage should not be presumed to have a neurodevelopmental disorder merely because attainment is low. The unit of reasoning is the individual learner in a particular educational and developmental context. That is why history, school information and psychometric evidence are interpreted together rather than treated as competing verdicts.

18.2 Criterion A: persistent difficulty in a taught skill

Criterion A academic-skill symptoms require **at least 1 of 6 listed symptoms**. The symptom domains cover inaccurate or slow effortful word reading, difficulty understanding what has been read, spelling difficulty, difficulty with written expression, difficulty mastering number facts or calculation, and difficulty with mathematical reasoning. These are not interchangeable labels for a generally weak student. They direct the interview toward the actual operation that is breaking down: decoding, extracting meaning, producing written language, retrieving or calculating number information, or reasoning with mathematical relationships.

The qualifier in Criterion A is as important as the symptom label. Difficulties must persist for **at least 6 months** despite targeted intervention. This does not mean that every learner must receive identical remedial input before diagnosis, nor does it turn diagnosis into a bureaucratic waiting exercise. It asks whether a relevant, intelligible attempt to help has led to adequate progress. Restricted progress or failure to catch up despite such help strengthens the inference that the problem is not simply a short-lived gap in exposure.

MNEMONIC

POSS

Persistent academic difficulty, **O**bjective low attainment, **S**chool-age onset and **S**creening for better explanations. This is a memory aid for the diagnostic spine, not a substitute for clinical judgement.

In practice, ask what was taught, what support was actually delivered, and what changed afterwards. A vague assurance that the learner “received tuition” is weaker evidence than a clear account of the target skill, the learner's engagement, the observed response and the continuing functional consequence. The diagnosis is not contingent on blaming the child, family or school. It depends on establishing that the academic problem persists even when a reasonable opportunity to learn and respond has been provided.

18.3 Criterion B: low attainment and functional interference

Criterion B achievement threshold requires the affected skill to be substantially and quantifiably below chronological-age expectation, confirmed by individually administered standardized achievement measures. The low attainment must also interfere significantly with academic work, occupational functioning or activities of daily living. This criterion prevents a diagnostic leap from a subjective complaint to a disorder. It asks both for corroboration of the skill deficit and for evidence that the deficit matters in the person's life.

Standardized assessment informs, rather than replaces, judgement. Scores need to be read with the referral question, educational history, language exposure, test behaviour and the particular skill measured in mind. For greatest diagnostic certainty, the diagnostic features describe performance at **1.5 SD below the population mean, a standard score <=78 and below the 7th percentile; clinical judgement may use a more lenient 1.0 SD threshold**. These boundaries are necessarily pragmatic because academic skills vary along a continuum. A clinician

should neither reify a single cut-off nor use the existence of a score just above it to disregard an otherwise compelling, impairing pattern.

Functional interference is the bridge between test performance and clinical relevance. It may be seen in the disproportionate effort required to complete ordinary academic tasks, inability to work independently in the affected area, persistent errors that compromise written communication, or difficulty using numerical skills in everyday demands. The precise manifestation changes with age and educational demands, but the diagnostic question remains the same: does the difficulty create a meaningful limitation in expected participation?

Criterion B is best understood as a convergence requirement. A low score that is inconsistent with the learner's observed work, language background or educational opportunity needs explanation before it is given diagnostic weight. Conversely, a highly coherent history of impairment should prompt careful review of whether the assessment sampled the relevant academic operation. The psychiatrist need not become a psychometric technician, but must be able to distinguish evidence of an affected skill from evidence that merely reflects an unfamiliar task, acute distress, poor attendance or an unsuitable testing context. The formulation becomes stronger when its different strands point in the same direction.

GOOD TO REMEMBER

A report is most clinically useful when it identifies the affected academic operation and links it to a real-world consequence. “Low score” alone is not the formulation; the formulation explains what the learner cannot do reliably and why that limitation matters.

18.4 Criterion C and Criterion D: developmental timing and exclusions

Criterion C onset places the learning difficulty during school-age years. It may not be fully apparent until academic demands exceed the learner's capacity, so a later presentation does not by itself contradict a developmental disorder. The useful question is whether credible history points back to difficulty during the school years, rather than simply when the family first sought help. Later demands can expose a longstanding vulnerability that earlier tasks did not reveal.

Criterion D exclusions require that the academic difficulty not be better accounted for by intellectual disability, uncorrected visual or auditory acuity problems, other mental or neurological disorders, psychosocial adversity, limited proficiency in the language of instruction, or inadequate educational instruction. The point is explanatory priority, not a simplistic rule that one diagnosis automatically cancels another. When a possible exclusion is present, determine whether it more convincingly accounts for the particular academic profile and its course.

- Consider intellectual functioning and adaptive functioning when the difficulty appears broad rather than circumscribed.
- Clarify whether sensory limitations have been recognized and corrected before attributing reading or writing difficulty to a learning disorder.
- Examine mental, neurological and psychosocial contributors in relation to onset, fluctuation and the affected skill.

- Establish the learner's opportunity to acquire the language and academic content in which difficulty is being judged.

The diagnosis generally presumes intellectual functioning above **about 70, allowing plus or minus 5 points**. This is a boundary aid, not permission to reduce assessment to an intelligence quotient. The clinical distinction from intellectual disability requires attention to the overall pattern of functioning, while the detailed differential is addressed in the Intellectual disability and autism spectrum disorder notes.

TRAP **Do not mistake an exclusion screen for a list of automatic exclusions.** The criterion asks whether another condition or circumstance better explains the learning difficulty. A coexisting problem may need treatment or accommodation without being the sole explanation for the academic pattern.

PITFALL

In multilingual settings, low performance in the language of instruction can be mislabelled as a learning disorder without documenting language exposure or teaching opportunity. This is precisely the contextual error Criterion D is designed to prevent.

18.5 Integrating evidence and diagnosing beyond school

The DSM formulation is made from history, school reports and psychoeducational assessment. Each source answers a different question. History establishes development, course and prior help; school information shows the learner's performance in the ordinary educational environment; formal assessment quantifies the relevant academic skill. Discordance is not a nuisance to be averaged away. It is a prompt to ask whether the tested construct, the teaching context, language demands or the time course explains the mismatch.

For people **17 years and older**, documented history of impairing learning difficulties may substitute for standardized assessment. This provision is clinically important when a person presents after leaving school or when an appropriate current assessment cannot be obtained. It does not lower the standard of reasoning. Documentation should still establish a credible history of impairment, developmental onset and absence of a better explanation.

IN INDIA

Educational histories may span changes of school, medium of instruction, curricula and access to remediation. The clinician should record these transitions explicitly before interpreting an academic complaint. The same score can carry very different meaning when opportunity to learn the tested language or skill has differed.

The full psychoeducational assessment process belongs in the assessment section of this chapter. At the diagnostic stage, the psychiatrist's responsibility is to ensure that the evidence has been put into a coherent clinical question: which skill is affected, how has it persisted, what is the functional consequence, when did it begin, and what competing explanation has been

considered? This is also the point at which a referral becomes a meaningful multidisciplinary collaboration rather than a request for a test to “confirm dyslexia”.

18.6 DSM recording and current severity

DSM recording specifies the affected domain or domains. The corresponding ICD-10-CM recording entries are **F81.0 impairment in reading; F81.81 impairment in written expression; F81.2 impairment in mathematics**. Each impaired domain is recorded separately. This matters because a single broad label can obscure the actual target for educational planning and follow-up. The descriptive terms commonly used for reading, written expression and mathematics should not be allowed to replace a clear account of the specific skill impairment.

Current severity runs across mild, moderate and severe levels, graded by the domains affected and the intensity of support needed. Severity is not a moral judgement about intelligence, effort or family engagement. It is a practical description of how much specialist teaching, accommodation and sustained support are required for adequate participation. A learner may show substantial difficulty in one domain and relative strength in another; severity should preserve that clinical texture rather than flatten it.

Severity should also be revisited when the educational context changes. The same underlying difficulty may become more or less disabling as demands alter, supports are introduced or a learner moves into work that depends differently on reading, writing or mathematics. The diagnosis names the disorder; the severity specifier communicates the present support burden.

18.7 ICD-11 developmental learning disorder

ICD-11 uses **6A03 developmental learning disorder**, replacing the older separation into scholastic-skill disorders. Its **essential features** are a significant and persistent limitation in reading, writing or arithmetic that is markedly below age expectation despite appropriate instruction, begins in early school years, is not attributable to external factors, and is not better explained by disorder of intellectual development or another neurodevelopmental, motor or sensory disorder. The overall clinical logic therefore closely resembles DSM reasoning: a persistent, developmentally arising academic limitation must be distinguished from contextual or broader developmental explanations.

The ICD-11 area-of-impairment options are **6A03.0 reading; 6A03.1 written expression; 6A03.2 mathematics; 6A03.3 other specified impairment of learning; 6A03.Z unspecified**. More than one area-of-impairment specifier may be applied. This is clinically useful when the learner's profile crosses domains, while retaining the discipline of describing each affected area rather than treating all academic difficulty as a single undifferentiated problem.

A key contrast is that ICD-11 has **no fixed persistence-despite-intervention duration**. It requires the limitation to be significant and persistent, whereas DSM makes the duration-and-response-to-targeted-intervention requirement explicit. This difference should not be turned into a superficial coding trick. In either system, the clinician still needs a defensible account of persistence, appropriate teaching and the absence of a better explanation.

18.8 Using the two systems without losing the patient

CLINICAL QUESTION	DSM APPROACH	ICD-11 APPROACH
Core academic problem	Symptom-based criterion linked to affected skills	Persistent limitation in reading, writing or arithmetic
Evidence of low attainment	Quantified low achievement and functional interference	Marked limitation below age expectation despite appropriate instruction
Developmental timing	School-age onset, even if demands reveal it later	Onset in early school years
Context and alternatives	Explicit exclusion criterion	External factors and developmental, motor or sensory explanations considered
Persistence wording	Explicitly linked to targeted intervention	Persistent limitation without a fixed numerical duration
Profile description	Affected domains and current support-related severity	Area-of-impairment specifiers, including multiple areas where relevant

The systems should be used to make documentation clearer, not to generate artificial disagreement. Both require an academic difficulty that is substantial, persistent, developmental and not better explained by another condition or by the learner's circumstances. The DSM framework is particularly explicit about the response to targeted help and the integration of standardized achievement evidence. ICD-11 foregrounds the developmental learning disorder category and allows the affected academic area to be specified. In either case, the diagnostic formulation should be intelligible to the family, school and clinician who will act on it.

When criteria are applied well, diagnosis does not end the enquiry. It creates a shared description from which educational intervention, accommodation and follow-up can be planned. When criteria are applied poorly, the same label can become an excuse for unexamined educational failure or for overlooking a remediable sensory, language or psychosocial contributor. The clinical discipline is to retain both truths: a genuine developmental learning disorder deserves recognition, and the learner's context must remain visible throughout the diagnostic process.

> Specific learning disorder is a diagnosis of a persistent, impairing and developmentally arising academic skill deficit after better explanations have been considered.

19 · Why specific learning disorder happens

Why mechanism matters clinically. A learning disorder is not explained by laziness, poor motivation, or a simple failure to try harder. Mechanistic models help the clinician translate an observed academic difficulty into a hypothesis about the mental operations that may be inefficient. That translation matters because children, families, and schools often describe the same problem in moral language: careless, inattentive, slow, or not interested. A mechanism-

based account replaces blame with a more useful question: which part of the journey from spoken language or visual symbols to fluent academic performance is breaking down?

Mechanism is not a diagnosis and does not substitute for a proper psychoeducational assessment. It is a framework for understanding patterns, anticipating associated difficulties, and explaining why two children with apparently similar reading complaints may need different forms of support. The discussion below concentrates on reading disability because its cognitive and neural models are especially well developed. The broader diagnostic framework, the types of specific learning disorder, formal assessment, remediation, and Indian educational provisions are addressed elsewhere in this chapter.

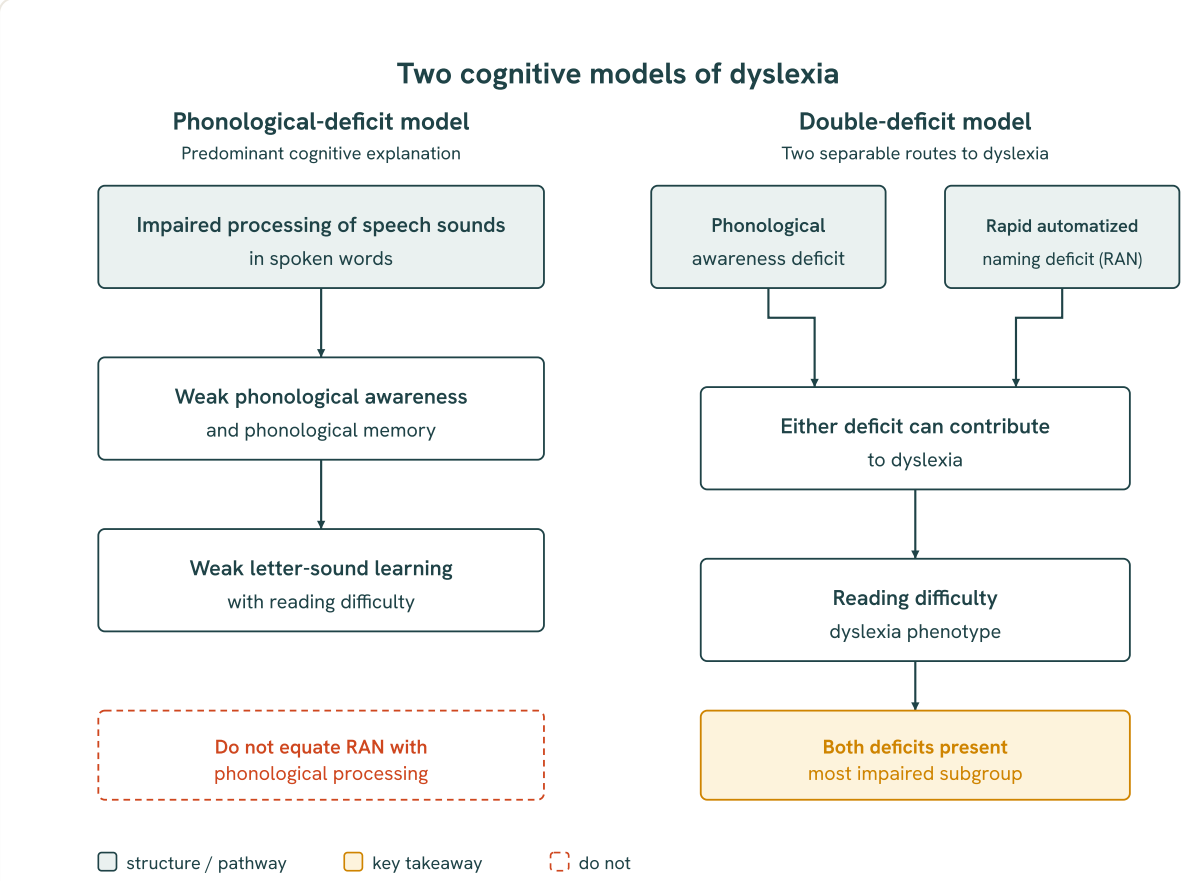


Fig 22.15. Phonological-deficit and double-deficit models of dyslexia.

19.1 From academic failure to component processes

Academic skills are complex achievements. Reading, writing, and mathematics each require a learner to coordinate several processes quickly enough that the task feels automatic. When one process remains effortful, the child may compensate for a time, but the cost is seen in slow output, errors, fatigue, avoidance, or a widening gap as classroom demands become more complex. It is therefore better to ask what operation is vulnerable than to assume that an observed error has a single cause.

The relevant operations are not confined to one sensory channel or one intelligence score. A clinical formulation may need to consider **phonological processing**, orthographic processing,

working memory, executive functions, symbol automatization, perceptual-motor integration, and processing speed. These are best understood as candidate pathways to difficulty, not as interchangeable labels. A weakness in one pathway can affect performance in another, and a child may have more than one weak pathway. The value of this language is that it gives the team a way to describe the pattern without reducing the child to the pattern.

In practice, the distinction between a skill and a process is important. A skill is the observable academic outcome: the child reads inaccurately, cannot spell reliably, or produces work too slowly. A process is a proposed operation contributing to that outcome: retaining speech sounds, linking a symbol to a sound, recognizing a familiar pattern rapidly, holding intermediate information in mind, or organizing a response. The process account should illuminate the observed difficulty. If it becomes a fashionable label with no explanatory link to the child's actual performance, it has ceased to be clinically useful.

- Ask whether the problem is most apparent when language must be analysed as sound, when familiar symbols must be named quickly, or when a written pattern must be recognized efficiently.
- Ask whether the child can demonstrate knowledge orally but loses accuracy or speed when that knowledge must be read, written, or calculated.
- Ask whether errors are stable and patterned rather than simply occurring when the child is distressed, distracted, or unfamiliar with the task.

RULE **Use a process model to explain a pattern of learning, never to replace demonstration of the learning difficulty itself.** The mechanism guides formulation and intervention planning; it does not permit diagnosis from a single cognitive weakness or from a scanner image.

IN INDIA

Language of instruction, home language, exposure to print, and opportunities to learn in a familiar script deserve deliberate attention before a cognitive explanation is fixed. In multilingual classrooms, apparent inconsistency may reflect a mismatch between the language in which a skill was acquired and the language in which it is being demanded. This is a formulation issue, not a reason to dismiss persistent learning difficulty.

19.2 The phonological account of dyslexia

The leading cognitive account of dyslexia is the **phonological-deficit model**. Its central proposal is that the child has difficulty processing the speech sounds that make up spoken words. This is not the same as a problem with hearing ordinary speech in a conversation. The issue is the ability to represent, notice, retain, compare, and deliberately manipulate the sound structure of language when the learning task requires it.

For a beginning reader, print must become connected to speech. The learner has to appreciate that a spoken word can be analysed into smaller sound units and that marks on the page consistently map onto them. If those sound representations are imprecise or difficult to access, letter-sound learning becomes laborious. The child may then rely on guessing from context,

memorizing whole word shapes, or waiting for someone else to read the text. These strategies can conceal the core difficulty briefly, but they do not make decoding automatic.

The model has explanatory reach because it links several commonly observed phenomena without claiming that every child has the same profile. It affects **phonological memory**, awareness of sound structure, and learning of letter-sound relations. Phonological memory matters when a child must hold a sequence of sounds long enough to blend or compare it. Awareness matters when the child must attend to sound as an object of thought rather than simply use language for meaning. Letter-sound learning matters because it provides the bridge by which a new written word can be decoded rather than guessed.

Clinically, this account also explains why comprehension can be misleading. A child may understand a story when it is read aloud and speak with age-appropriate vocabulary, yet struggle substantially when required to derive the same content independently from print. The discrepancy is not proof of a particular diagnosis. It is a cue to distinguish language comprehension from access to the written code. Conversely, weak reading comprehension may arise through several routes, so a phonological formulation should be made only when the pattern supports it.

The practical implication is not that every reading error should be interpreted as phonological. Rather, a clinician should look for convergence: difficulty with sound-based operations, insecure decoding, errors that recur across comparable words, and slow acquisition despite appropriate opportunity. The mechanism is strongest as a coherent account of a pattern, not as an explanation attached to one isolated mistake.

19.3 Naming speed and the double-deficit formulation

A second influential account distinguishes difficulty with sound structure from difficulty with rapid access to familiar verbal labels. **Rapid automatized naming** refers to the ability to name familiar alphanumeric stimuli, such as letters and numbers, and non-alphanumeric stimuli, such as colours and objects, rapidly. It is a marker of naming speed or processing speed and is conceptually distinct from phonological processing. A child may know an item perfectly well but retrieve and articulate its name with insufficient speed for fluent academic work.

This distinction matters because reading fluency is more than correct decoding. A reader who has to pause at each familiar item may eventually identify the word but will lose the rhythm needed to carry meaning across a sentence or passage. Slow naming can therefore make reading effortful even where sound-based work is relatively stronger. It can also help explain why a learner appears accurate in a calm individual setting but struggles to keep up with the pace of classroom reading and written work.

The **double-deficit model** proposes that dyslexia can arise from difficulty in phonological awareness, rapid naming, or both. The combined profile is associated with the greatest impairment. This is a useful corrective to the false choice between a sound-based explanation and a speed-based explanation. They are separable processes, but their effects can accumulate in the

same child: one difficulty makes initial decoding insecure, while the other makes familiar material slow to access.

FORMULATION FOCUS	WHAT IS INEFFICIENT	LIKELY CLINICAL EXPRESSION	REASON FOR DISTINCTION
Phonological pathway	Analysis and retention of speech-sound structure	Insecure decoding and sound-based errors	Explains difficulty linking print to spoken language
Naming-speed pathway	Rapid retrieval of familiar verbal labels	Slow, effortful performance despite recognition	Explains reduced automaticity and fluency
Combined pathway	Both sound processing and rapid access	More pervasive reading difficulty	Prevents an artificially single-cause formulation

The table is a conceptual map, not a substitute for testing. Naming tasks can be influenced by many immediate factors, including familiarity, anxiety, language proficiency, and the child's understanding of the task. Their contribution should be interpreted alongside the developmental and educational history, direct observation, and formal assessment described in the assessment section of this chapter.

TRAP **Do not equate slow naming with low ability or poor effort.** Speeded performance draws on access, coordination, and automaticity. A child may know the answer yet repeatedly fail to produce it fast enough for the task's demands.

19.4 Reading as a distributed neural system

Neural findings should be read as a systems account. Reading is not housed in a single centre; it depends on coordinated activity within a **left-hemisphere reading network** that includes occipito-temporal, inferior frontal, and inferior parietal regions. This network-level view fits the clinical fact that reading combines visual pattern recognition, speech-sound analysis, retrieval, and fluent integration. A disruption at any one point can alter the efficiency of the whole system, while different children may reach a similar behavioural endpoint through partly different routes.

Within this account, altered function of the left occipito-temporal region, often called the **visual word form area**, is relevant to rapid processing of letter and word patterns. This is sometimes described as a ventral route. Its importance is intuitive: fluent readers do not consciously labour over every familiar visual pattern. When recognition remains slow or unstable, reading consumes attention that would otherwise be available for meaning, monitoring, and written expression.

The phonological account has a neural correlate as well. Dysfunction or reduced activation in **left inferior frontal and temporo-parietal cortices** is associated with the phonological deficits of dyslexia. Descriptions of this pathway also include the **mid-temporal lobe**, alongside frontal, parietal, and occipito-temporal reading regions. These findings do not mean that a scan can establish the disorder in an individual child. They provide biological plausibility for a cognitive

model by showing that the processing difficulty corresponds to altered functioning in regions involved in the reading pathway.

It is tempting to turn network language into a neat map in which each area owns one task. That temptation should be resisted. Brain regions participate in interacting circuits; performance depends on connectivity, development, experience, and task demands. The educational consequence is more useful than anatomical reductionism: when a child is struggling, the clinician should describe the observable bottleneck and the support required, rather than claim that a named region has been damaged.

PITFALL

Do not present neuroimaging as an individual diagnostic test for a schoolchild with suspected learning disorder. Group-level evidence can clarify mechanism, but diagnosis remains a clinical and educational judgment based on the child's developmental history and demonstrated academic functioning.

19.5 Genes, families, and the meaning of heritability

Specific learning difficulties commonly aggregate in families. For reading ability and reading disability, heritability is **greater than 0.6**; this is observed across alphabetic and non-alphabetic languages. The clinical meaning is neither that a child's future is fixed nor that family experience is irrelevant. It means that genetic differences make an important contribution to variation in reading, and a careful family history is therefore informative.

Family history should be taken with care. Adults may not have received a formal label, particularly when their education occurred in settings with limited recognition of learning difficulties. Useful questions concern longstanding struggles with reading, spelling, copying, written examination performance, and the extra effort required to complete literacy tasks. A parent may describe having found a workaround rather than having had a disorder. That history can still sharpen the clinician's hypothesis and encourage earlier support for the child.

The observed familial pattern is substantial for both reading and mathematics. The figures below describe relative familial risk, not a prediction that an individual relative will necessarily have a disorder. They should never be used to stigmatize a parent or to imply that parenting caused the child's difficulty. Their value is in deciding who may benefit from attentive developmental surveillance and timely assessment.

4-8 times higher	5-10 times higher	about 20%	about 80%
READING SLD IN FIRST-DEGREE RELATIVES	MATHEMATICS SLD IN FIRST-DEGREE RELATIVES	READING-SKILL VARIANCE AT AGE 6	READING-SKILL VARIANCE AT AGE 12

Heritability is also not a fixed property of an individual child. Estimates of variance attributable to genes can change as educational experience becomes more uniform and environmental variation narrows. One account attributes roughly **50%** of variance in reading to genes overall, while the developmental estimates shown above rise as formal schooling progresses. The

important clinical inference is modest: high heritability does not make teaching or remediation futile. It explains why biological vulnerability and educational response must be considered together rather than placed in opposition.

GOOD TO REMEMBER

A positive family history should change the clinician's threshold for asking careful questions and seeking corroborating school information. It should not be used as a shortcut to label a child, and it should never be framed as parental fault.

19.6 Integrating mechanism into clinical formulation

A useful formulation moves in both directions. From the top down, it starts with the child's presenting difficulty: where academic performance is breaking down, how this affects participation, and what the family and school have already observed. From the bottom up, it asks which processes may account for that pattern. The two directions should meet. If a proposed mechanism does not explain the child's actual pattern of difficulty, it is an interesting theory rather than a clinical formulation.

Mechanistic thinking protects against several common errors. It makes it less likely that a child with slow reading will be dismissed as careless, and less likely that a child who understands spoken material will be assumed to have no genuine educational need. It also prevents the opposite error: attaching every academic problem to a reading mechanism. Poor school attendance, unfamiliar language of instruction, emotional distress, sensory difficulty, inadequate teaching opportunity, and attentional symptoms can all alter academic performance. Their assessment belongs in the broader child psychiatric and educational evaluation.

For psychiatry trainees, the most valuable use of these models is explanatory communication. Families benefit from a concrete account of why repeated practice alone may not produce automaticity. Teachers benefit from knowing that a child may need the task broken into the component that is failing rather than simply more of the same task. The child benefits when adults replace criticism with a coherent plan. That plan must remain individualized and should be linked to the formal assessment and remedial approaches discussed elsewhere in this chapter.

- State the academic skill that is impaired before naming a cognitive process.
- Describe the process as a hypothesis supported by a convergent pattern, not as a moral explanation.
- Explain to family and school that a biologically influenced difficulty still responds to appropriate teaching and support.

MNEMONIC

Sound - Speed - Script - System - Story

For a reading-mechanism formulation, consider the sound structure of language, the speed of access to familiar labels, the handling of written patterns, the distributed reading system, and the family story. The sequence is a prompt for formulation, not a diagnostic checklist.

Dyslexia is best understood as a heterogeneous learning difficulty in which phonological processing, naming speed, and the efficiency of a distributed reading network may each contribute to the child's observed pattern.

20 · Definition and types of specific learning disorder (dyslexia, dysgraphia, dyscalculia)

Why this distinction matters clinically. A child who is bright, articulate and curious can still repeatedly fail at a circumscribed school task. If that failure is dismissed as carelessness, poor motivation or a family problem, the child may acquire shame long before anyone identifies the learning need. If it is treated as evidence of globally limited ability, expectations may be lowered unnecessarily. **Specific learning disorder** provides a way of describing persistent, unexpected difficulty in acquiring particular academic skills while preserving the question that matters clinically: what, precisely, is hard for this learner?

The term is useful because it shifts attention from a vague report of "poor studies" to the architecture of the difficulty. Reading a paragraph, producing written work and doing mathematics all draw on several component skills. A learner may struggle in one domain, in more than one domain, or show a profile in which a weakness in one area makes another appear worse. The task of this section is to establish the language of the disorder and the boundaries of its common labels. Diagnostic criteria, formal assessment and intervention follow in their respective sections.

RULE **Specific learning disorder is a disorder of particular academic skills, not a synonym for low scholastic performance.** The clinical description must identify the affected skill and the way the child experiences failure in that skill.

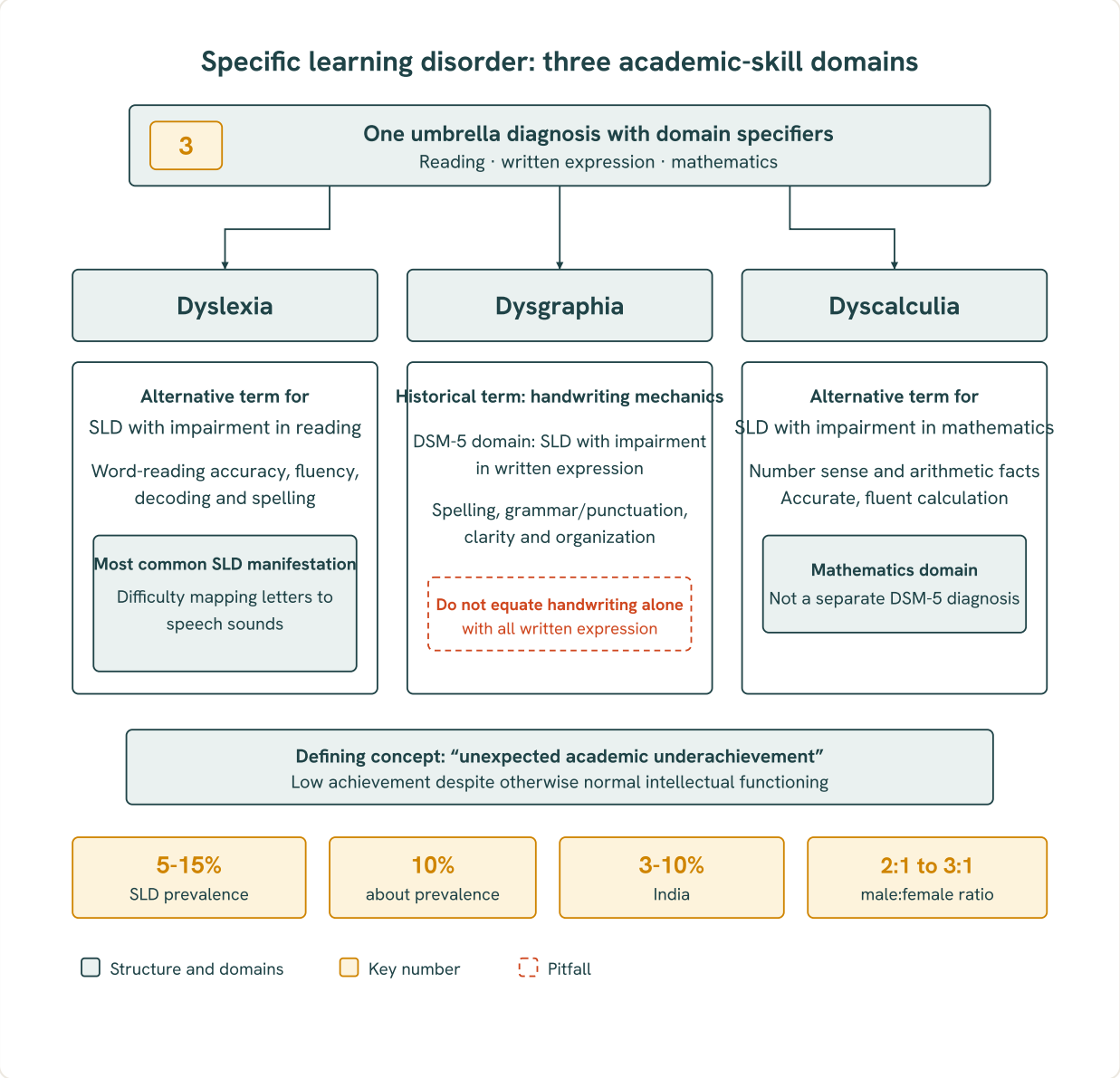


Fig 22.16. Specific learning disorder: dyslexia, dysgraphia and dyscalculia as domain-linked terms.

20.1 The defining clinical idea

The classic clinical idea is **unexpected academic underachievement**. The word "unexpected" is not a casual adjective. It asks the clinician to notice a discrepancy between an otherwise adequate capacity to learn and a sharply impaired route to learning in school. It also protects against a common conceptual error: a child whose schoolwork is poor for broad, pervasive reasons does not automatically have a specific learning disorder. The disorder concerns a selective failure in the acquisition or use of an academic skill.

"Specific" therefore refers to the academic function that is affected, rather than to a trivial or temporary complaint. A child may understand a lesson when it is explained aloud yet be unable to extract the same material from print. Another may answer fluently in class but produce a written answer that does not convey the knowledge they hold. A third may reason sensibly about everyday quantities but become lost when asked to manipulate symbols and procedures. These are not interchangeable presentations, and the label becomes clinically helpful only when it makes the profile clearer.

The phrase should never become a moral judgement about effort. Repeated failure can produce avoidance, irritability, reluctance to attend school, apparent inattention and conflict around homework. Those consequences may be prominent in the consultation, but they should not replace a description of the academic difficulty itself. Equally, a supportive home or a conscientious teacher cannot by itself remove a skill-specific learning disorder. The clinician's role is to translate the complaint into an observable learning problem, while allowing formal assessment to establish its nature and extent.

- Ask which academic activity breaks down first, rather than accepting “weak in studies” as a formulation.
- Ask how the child compensates: by guessing, avoiding, memorising, copying or relying on another person.
- Ask what the child can demonstrate orally that is not evident in written schoolwork.

GOOD TO REMEMBER

A good descriptive formulation names both the academic task and its functional consequence. “Cannot reliably decode unfamiliar written words and avoids reading aloud” is clinically more useful than “has poor scholastic performance.” The latter describes an outcome; the former identifies a learning route that needs examination.

20.2 One diagnosis, domain-based description

DSM-5 specific learning disorder is organised as a single umbrella diagnosis with specifiers for the affected academic domain. This is more than a change in labels. It prevents the clinician from treating reading, writing and mathematics as mutually exclusive illnesses when the same child can have a mixed profile. At the same time, the umbrella category does not erase the practical difference between a child who cannot read accurately and one whose main difficulty lies in constructing written language.

The academic-skill domains are **reading, written expression and mathematics**. The domain language gives a disciplined starting point for history-taking, communication with families and communication with schools. It also avoids treating older informal labels as if each were a complete diagnostic formulation. In clinical notes, the domain of impairment should be named clearly; the familiar term may then be used when it helps the family, teacher or multidisciplinary team understand the pattern.

Reading	Written expression	Mathematics
DOMAIN SPECIFIER	DOMAIN SPECIFIER	DOMAIN SPECIFIER

This approach has an important practical consequence. A child should not be placed in a single informal box merely because one difficulty is most conspicuous. Reading problems may obscure a written-expression problem because the child cannot access the material to be written about. Conversely, a child who reads adequately may still have very impaired spelling, grammar, punctuation, clarity or organisation in written work. Mathematics may be affected alongside

either profile, yet require its own description. The clinical formulation needs enough granularity to guide the next assessment step without converting a classroom observation into a diagnosis.

DOMAIN LANGUAGE	EVERYDAY LABEL OFTEN ENCOUNTERED	CLINICAL FOCUS
Impairment in reading	Dyslexia	Reading words and working with their written forms
Impairment in written expression	Dysgraphia, used loosely in some settings	Putting language into effective written form
Impairment in mathematics	Dyscalculia	Understanding and using numbers and calculations

TRAP **Do not use the umbrella diagnosis as if it made the affected domain unimportant.** "Specific learning disorder" without a domain description is incomplete clinical communication, especially when a school must understand which classroom task is failing.

20.3 Reading impairment and dyslexia

Dyslexia is the alternative term commonly used for specific learning disorder with impairment in reading. Its clinical core is difficulty with word reading, including accuracy, fluency, decoding and spelling. These components matter because the child's complaint is not always simply "I cannot read." Some children read slowly and laboriously, some misread familiar or unfamiliar words, some guess from context, and some avoid reading because the effort required is out of proportion to the task.

Decoding refers to working out the spoken form of a printed word. Accuracy concerns whether the word is read correctly. Fluency concerns the ease and pace with which reading proceeds once basic word recognition is attempted. Spelling is included in this reading-related profile because it requires stable knowledge of written word forms. In the consultation, these distinctions help convert a parent's broad concern into a useful question: is the principal difficulty recognising words, working them out, reading them efficiently, or retaining their conventional written forms?

Reading impairment is the **most common manifestation of specific learning disorder**. This does not permit the clinician to assume that every struggling reader has the same problem, nor does it justify overlooking writing and mathematics. It does explain why dyslexia is often the first label a family hears. A careful clinician should use the familiar term as an entry point, then clarify what the child can and cannot do with print.

The emotional meaning of dyslexia is often shaped by the classroom. Reading aloud may expose errors in front of peers; homework can become prolonged negotiation; a child who has learned to avoid print may appear oppositional or disengaged. Such secondary behaviours are understandable adaptations to repeated difficulty. They should be explored respectfully, but they do not define the reading disorder. The central description remains the impairment in the reading skill itself.

- Word-reading accuracy: the child reads a word incorrectly or substitutes another word.

- Reading fluency: the child can read but does so with marked effort, slowness or loss of continuity.
- Decoding and spelling: the child has difficulty moving reliably between written letters and spoken word forms.

20.4 Written expression and the careful use of dysgraphia

Dysgraphia is a historical term that strictly refers to the mechanics of handwriting. It is often used more broadly in schools and in informal discussion, which is why clinicians must be precise rather than dismissive. The contemporary diagnostic domain is specific learning disorder with impairment in written expression. That domain concerns the written product as language and communication, including spelling, grammar, punctuation, clarity and organisation of writing.

The distinction is clinically useful. Handwriting may be difficult to read, slow or effortful, yet the child may be able to formulate a coherent answer when allowed another means of expression. Conversely, handwriting may be adequate while the child cannot translate an idea into a logically ordered written answer. A child may also have both forms of difficulty. Calling every weak written output "dysgraphia" collapses these different questions and can send assessment in the wrong direction.

Written expression makes demands that oral conversation does not. The learner has to select words, hold a plan in mind, build sentences, apply conventions and monitor whether the reader can follow the argument. In an examination answer, the problem may appear as scant content, disconnected statements, repeated spelling errors or an answer whose organisation obscures what the child knows. The clinician should avoid inferring laziness from an untidy or sparse notebook. The notebook is evidence of difficulty, but it must be interpreted as part of a wider learning profile.

> **PITFALL**
>
> Do not use "dysgraphia" to mean every problem in written work. A handwriting-mechanics complaint and a written-expression complaint overlap in everyday language but focus the clinical enquiry differently. Document the observed difficulty in plain terms, then use the domain terminology accurately.

For families, this distinction can be reassuring without being falsely simplifying. It explains why a child may be able to tell a detailed story yet produce only a few disorganised lines when asked to write it. It also explains why improving handwriting alone may not resolve the difficulty in composition. The purpose of the label is not to create a hierarchy of deficits, but to make the source of the educational barrier visible.

20.5 Mathematics impairment and dyscalculia

Dyscalculia is the alternative term for specific learning disorder with impairment in mathematics. The mathematics profile includes difficulty with number sense, arithmetic facts and accurate or fluent calculation. Number sense refers to an intuitive grasp of quantity and numerical relationships. Arithmetic facts are the basic numerical combinations that should

become available for use. Calculation concerns carrying out procedures correctly and with sufficient ease to support more complex work.

The presentation can be missed when adults focus only on whether answers are right or wrong. A child may arrive at an answer through an unusually effortful route, be unable to judge whether an answer is plausible, lose track of a procedure, or rely heavily on counting strategies when peers have moved to more efficient methods. These observations are clinically more informative than a blanket statement that the child is "weak in maths." They point towards the particular numerical function that needs formal exploration.

Mathematics also places language, attention and working habits under pressure, so a poor score alone cannot settle the nature of the difficulty. The clinician should describe the numerical difficulty before attributing it to a learning disorder. This discipline matters particularly when there are coexisting concerns in reading or written expression: a child may misunderstand the language of a problem, fail to record steps clearly, or have a separate difficulty in numerical understanding. The domain formulation permits these possibilities to remain visible rather than forcing an early, simplistic explanation.

In everyday life, families may notice difficulty with quantities, money-related tasks, time-related calculations or following a numerical sequence. Such reports can guide questioning, but they should not be treated as a substitute for an academic profile. The diagnosis concerns academic skills, and the assessment section addresses how that profile is established. At this stage, the teaching point is narrower: dyscalculia names a mathematics-specific learning difficulty, not a general lack of intelligence or interest.

20.6 Mixed profiles and clinical communication

The **three** domains are analytically separate, but children do not experience schoolwork in separate compartments. Reading supports access to instructions and textbooks. Written expression is required to display knowledge in many examinations. Mathematics problems are often presented in language and require written working. A child with difficulties in more than one domain may therefore present with a broad academic crisis even when the underlying weaknesses can be described separately.

This is why clinical communication benefits from both the umbrella diagnosis and the domain description. The umbrella term acknowledges that the child's learning needs may be interconnected. The domain wording prevents the formulation from becoming vague. It also keeps the conversation with teachers practical: which activity should be observed, what form of schoolwork best demonstrates the problem, and which accommodations or remediation questions should be taken forward? The answers belong to assessment and management, but the quality of those later steps depends on the precision of the initial language.

MNEMONIC

Read - Write - Calculate

Use this simple clinical sweep when a family reports poor scholastic performance. Ask separately about reading printed words, expressing ideas in writing and handling numbers. It is a history-taking prompt, not a diagnostic shortcut.

Do not infer causation from a mixed presentation. It is tempting to explain all failure by the most obvious domain, especially reading, but that can conceal an independent difficulty in written expression or mathematics. Similarly, do not convert secondary distress into the primary disorder. School refusal, low self-confidence and anger around study are important consequences that may need attention, yet they do not tell the clinician which academic skill is impaired.

Name the affected academic domain before using the familiar label: dyslexia for reading, dysgraphia carefully for handwriting mechanics or written expression, and dyscalculia for mathematics.

20.7 Frequency, sex pattern and Indian relevance

Specific learning disorder is common enough that psychiatrists working with children should expect to encounter it. In school-age children, reported prevalence across the academic domains is **5-15%**. A lifetime estimate in the population is **about 10%**. These figures are best read as a reminder of clinical visibility rather than as a substitute for careful local assessment. Prevalence varies with the population studied, the educational context, the method used to identify difficulty and the threshold applied.

IN INDIA

Indian studies of schoolchildren have reported a prevalence range of **3-10%**. For clinical work, the immediate implication is not to apply a prevalence figure to an individual child. It is to recognise that a persistent, specific academic difficulty is a familiar developmental and educational problem in Indian classrooms, including in children whose distress is initially presented as a behavioural or emotional concern.

Specific learning disorder is more common in males, with a reported male-to-female ratio of **2:1 to 3:1**. The practical safeguard is to let the learner's profile, rather than a stereotype about who is likely to have a learning difficulty, determine the enquiry. Avoidance, compensatory effort, internalised distress and disruptive responses to failure may each bring a child to attention, but none is itself the definition of the disorder.

A psychiatrist's contribution is often to make the hidden learning problem discussable without reducing the child to it. Explain that the diagnosis describes a particular route through which academic learning is difficult; it does not describe the whole child, their intelligence, their character or their potential. When questions arise about global developmental functioning or related neurodevelopmental conditions, use the broader framework in the Intellectual disability

and autism spectrum disorder notes. When the concern is whether apparent inattention reflects ADHD, the careful comparison belongs in the chapter section on differentiating SLD from ADHD and slow learner.

21 · Assessment of learning disorder (psychoeducational testing, NIMHANS battery)

Assessment is the point at which a complaint about poor school performance becomes a defensible clinical formulation. The task is not to locate a single low score, nor to decide that a child is unmotivated, inattentive, or simply struggling. It is to establish the pattern of difficulty, its educational consequences, the conditions under which the child performs better or worse, and the alternative explanations that remain plausible. A careful assessment gives the family and school a shared description of the problem. It also prevents the psychiatrist from attaching a diagnostic label to a difficulty that has not been properly characterised.

For the postgraduate candidate, the marks lie in describing a reasoned process rather than naming a test. The assessment must connect the referral concern to the child's developmental and educational history, direct clinical observation, cognitive data, and evidence of actual academic performance. This fragment addresses that psychoeducational work. Diagnostic criteria, remedial planning, educational provisions, and the discrimination from other neurodevelopmental conditions are dealt with in their respective sections of this chapter and in the Child psychiatry: assessment, treatment, services and protection notes.

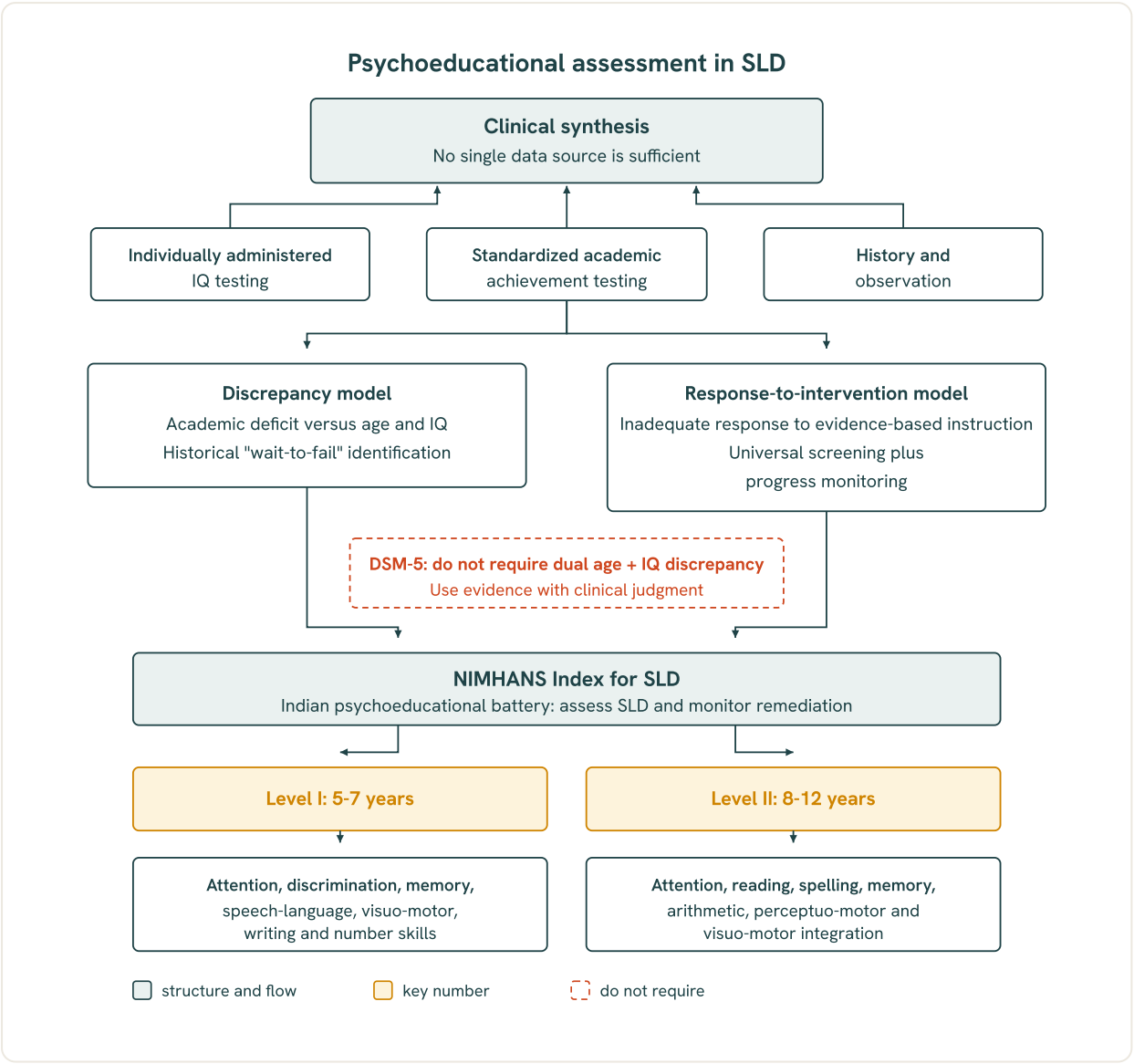


Fig 22.17. Psychoeducational assessment combines testing with clinical synthesis; the NIMHANS Index structures Indian SLD assessment across two age levels.

21.1 The purpose and architecture of psychoeducational assessment

A **psychoeducational assessment** asks a clinical question: does the child's attainment show a circumscribed and meaningful difficulty in learning, and what information is needed to explain it responsibly? It combines individually administered IQ testing, standardised academic-achievement testing, and history with observation. None of these sources can carry the diagnosis alone. A score only acquires meaning when it is interpreted alongside the child's opportunity to learn, language of instruction, behaviour during testing, and the family and school account of how the difficulty has unfolded.

RULE **Interpret the child, not an isolated score.** Cognitive testing, attainment testing, history, and observation must converge before the assessment can support a learning-disorder formulation.

The referral question should be made explicit before testing begins. “Poor studies” is a presenting complaint, not a useful assessment question. Clarify whether the concern is decoding written material, reading fluency, spelling, written expression, number work, classroom pace, or an

uneven profile across these areas. Ask what work is manageable without help, what elicits avoidance, which tasks require disproportionate time or adult scaffolding, and whether the pattern remains similar across settings. This turns a broad complaint into observations that can later be compared with formal findings.

Why the history remains indispensable. Testing samples performance in a bounded setting. The history supplies its ecological validity. It establishes the educational trajectory, changes in demands, attendance and interruptions, teaching language, access to teaching, previous support, and the child's response to such support. It also identifies emotional distress, behavioural resistance, sensory or neurological concerns, sleep problems, medication effects, and family stressors that may alter performance. These possibilities do not invalidate testing; they determine how cautiously a result should be interpreted.

ASSESSMENT STREAM	QUESTION IT ANSWERS	CONTRIBUTION TO FORMULATION
Referral clarification	What is actually failing in daily schoolwork?	Defines the target for assessment.
Developmental and educational history	How has the difficulty evolved in context?	Tests whether the narrative coheres with the measured pattern.
Clinical observation	How does the child approach, sustain, and recover from tasks?	Qualifies the validity and interpretation of performance.
Cognitive assessment	What is the profile of cognitive strengths and vulnerabilities?	Helps interpret the nature of difficulty, not merely its presence.
Academic-achievement assessment	What can the child demonstrate in school-relevant skills?	Documents the functional academic problem.
Clinical integration	Do the strands point to the same explanation?	Produces a usable formulation and report.

The psychiatrist's contribution is often synthesis rather than test administration. The report should be read as a description of performance under stated conditions, not as a verdict on ability or effort. When data conflict, the discrepancy is clinically informative. A child who appears competent in conversation but fails written tasks may need achievement assessment to make the hidden demand visible. Conversely, a weak test performance obtained amid marked distress, refusal, fatigue, or poor comprehension may require corroboration rather than premature certainty.

21.2 From referral complaint to testable clinical questions

Begin by listening to the words used by the child, caregiver, and teacher, but translate them into observable learning behaviours. "He does not study" may describe task avoidance after repeated failure. "She is careless" may refer to omissions in written work, loss of place while reading, inconsistent spelling, or errors under time pressure. The clinician should ask for concrete samples of classwork, homework, notebooks, and examination scripts when available. These reveal whether errors are stable, whether the presentation is uneven across subjects, and whether the school complaint matches the child's own experience.

Observation during the interview and assessment adds a different kind of evidence. Notice how instructions are understood, whether the child asks for clarification, how errors are handled, whether the child can explain a strategy, and whether performance changes with encouragement or structure. Observe the emotional meaning of schoolwork. Shame, anticipatory defeat, irritability, and disengagement may be consequences of chronic academic struggle; treating them as proof of laziness is both clinically crude and practically harmful.

- Clarify the principal academic complaint in the language of actual tasks.
- Map the child's learning history, including changes in curriculum, school, language, and support.
- Obtain collateral that describes classroom functioning rather than only examination results.
- Review representative written work for recurrent rather than incidental errors.
- Record factors during the session that could strengthen or limit confidence in the findings.

TRAP **Do not convert a complaint of inattention into a learning-disorder assessment, or a learning complaint into an attention diagnosis.** The complaint directs the enquiry; the pattern across history, observation, and formal assessment determines the formulation.

It is tempting to use familiar labels to shorten this work. That shortcut obscures the clinical task. The psychiatrist should hold competing explanations in mind without turning the assessment into a catalogue of diagnoses. If broader developmental concerns become evident, follow the relevant assessment pathway and use the Intellectual disability and autism spectrum disorder notes and the Normal child development and milestones notes for the appropriate conceptual framework. The purpose here is to determine what the psychoeducational evidence can and cannot establish.

GOOD TO REMEMBER

Parents often bring a global account of decline, whereas the child's work shows a stable and specific bottleneck. Asking for examples makes the assessment more respectful as well as more accurate: it shows the family that the clinician is interested in the child's actual effort and experience, not merely in a label.

21.3 Cognitive and attainment evidence: complementary, not interchangeable

Individually administered cognitive assessment is useful because it provides a structured account of how the child performs on tasks that draw on different cognitive processes. It should not be treated as a measure of school achievement. An academic-attainment measure is needed because the clinical problem concerns learned skills in educational tasks. The important interpretive question is how the cognitive profile, attainment profile, history, and observed approach to tasks fit together.

The older **IQ-achievement discrepancy model** treated a learning disorder as an academic deficit significantly discrepant from expectations for both age and IQ. Under **DSM-IV**, this dual discrepancy was required. The subsequent approach abandoned that requirement in **DSM-5**.

This historical shift matters because a candidate may still encounter discrepancy language in reports, schools, or older examination answers. It should be recognised as a framework that influenced identification, not used mechanically as the sole gatekeeper for a clinically meaningful learning problem.

Discrepancy thinking had an intuitive appeal: it seemed to identify a child performing below an apparent potential. Its weakness is that it can turn assessment into a search for a sufficiently dramatic gap and postpone help until the gap is conspicuous. It can also make the IQ score appear more decisive than the child's demonstrated difficulties. In clinical practice, the central question is not whether a calculated contrast is impressive. It is whether reliable evidence shows persistent academic difficulty that requires explanation and support.

A cognitive profile may nevertheless deepen the formulation. In the **WISC profile, performance IQ is usually higher than verbal IQ, with an ACID pattern of weaker Arithmetic, Coding, Information, and Digit-span**. Weaknesses in verbal comprehension, working memory, and processing speed may also be relevant. These observations are profile findings, not diagnostic signatures. A profile can prompt more focused enquiry, but it cannot replace evidence from academic achievement or the child's educational history.

> **PITFALL**
>
> Do not tell a family that an IQ result proves or excludes a learning disorder. Such a statement confuses cognitive assessment with attainment assessment, and it can falsely reassure or unnecessarily stigmatise a child whose school difficulties have not yet been directly measured.

Standardised attainment measures make the academic domain visible in a way that a general interview cannot. The available batteries include the **WRAT, WIAT, Woodcock-Johnson III/IV, and KTEA**, among others. Their names are less important than their function: they sample specific academic skills in a standardised manner and permit the clinician to compare the reported problem with observed performance. Selection should be guided by the referral question, the child's language and educational context, and the competence of the assessor.

21.4 Response to instruction as assessment evidence

The **response-to-intervention model** approaches identification differently. Rather than waiting for an IQ-attainment discrepancy, it considers whether the child shows an inadequate response to evidence-based instruction. Universal screening and progress monitoring are central to this approach. The clinical attraction is obvious: it focuses attention on the child's learning trajectory and on what happens when teaching is deliberately matched to the problem.

This approach does not mean that every child who needs extra help has a learning disorder. Nor does it make the school's provision irrelevant. A poor response must be interpreted in context. The clinician needs to know what was offered, whether it was delivered consistently, whether the child could access it, and what changed in observable learning behaviour. The same phrase, "did not improve," can mean very different things when the instruction, attendance, language demands, or emotional state are different.

For psychiatry, response evidence is valuable because it links assessment to ordinary functioning. It shifts the conversation from an abstract contrast between test scores to a practical question: after appropriate teaching has been tried, what still remains difficult, and in what form? It also reduces the tendency to wait for repeated failure before taking a child's difficulties seriously. Yet it must be integrated with individual assessment rather than substituted for it. Inadequate response is evidence to be understood, not a standalone diagnosis.

MNEMONIC

Ask, Observe, Measure, Integrate

Ask what the learning problem is in daily work; observe how the child tackles it; measure cognition and attainment where indicated; integrate every source before writing the conclusion.

A useful report states both findings and limits. It should distinguish direct observations from informant accounts, identify where the data converge, and say when a conclusion is provisional. This is not defensive writing. It protects the child from categorical interpretations based on incomplete evidence and gives the referrer a clear account of what further information would resolve uncertainty.

21.5 The NIMHANS Index in Indian psychoeducational assessment

Why this matters in Indian practice. The **NIMHANS Index of Specific Learning Disabilities** is the most commonly used SLD assessment battery in the Indian context, with established reliability and validity. It is an Indian psychoeducational battery and is administered by clinical psychologists or special educators. For the psychiatrist, its value is not simply local familiarity. It offers a structured way to document the child's pattern of learning-related skills while retaining the clinical obligation to interpret that pattern in educational and developmental context.

IN INDIA

When a referral asks for assessment of specific learning difficulty, know the NIMHANS Index well enough to explain what it examines and what its findings mean. The report is strongest when the clinician links its findings to the child's lived classroom difficulties and to school-based evidence, rather than presenting the battery name as the conclusion.

The Index has distinct levels aligned to the child's age. **Level I is for ages 5-7 years**, while **Level II is for ages 8-12 years**. This structure encourages the assessor to ask developmentally appropriate questions rather than assuming that the same demonstration of skill is expected across childhood. The age band should guide test selection; it does not relieve the assessor of judging whether the child understood the task and whether the results reflect the referral concern.

5-7 years	8-12 years	Assessment + monitoring
LEVEL I	LEVEL II	INDEX FUNCTION

INDEX LEVEL	AGE GROUP	SKILLS SAMPLED	CLINICAL USE
Level I	5-7 years	Pre-academic skills: attention, visual and auditory discrimination, visual and auditory memory, speech and language, visuo-motor, writing, and number skills	Characterises early learning-related vulnerabilities.
Level II	8-12 years	Attention, reading, spelling, perceptuo-motor, visuo-motor integration, memory, and arithmetic skills	Characterises the profile of academic and associated skills.

At the earlier level, the emphasis is on **pre-academic skills**. This is clinically useful because a concern about later academic failure may have a history of difficulty in the foundational processes sampled by the assessment. At the later level, the child's profile includes **reading, spelling, perceptuo-motor functioning, visuo-motor integration, memory, and arithmetic skills**. The value of this organisation is that it preserves the distinction between a broad learning profile and the specific school complaint that led to referral.

The Index is used both to assess SLD and to **monitor progress after remediation**. This is a major practical advantage. A baseline assessment should not be filed away after a diagnostic discussion. It can organise subsequent review around the skills that were difficult at baseline and clarify whether a change in functioning is visible after targeted educational work. Monitoring is most meaningful when the same questions are asked each time: what has changed in daily academic work, what has the school observed, and how do updated findings relate to the original formulation?

21.6 Interpretation, reporting, and the limits of test findings

Interpretation is an act of clinical reasoning. The assessor should ask whether the measured pattern is coherent with the referral complaint, whether it is consistent with available school evidence, and whether the testing conditions permit confidence in the result. A report that merely lists subtests gives the referrer data without a formulation. A report that announces a conclusion without explaining the evidence gives the family no basis for understanding it. The useful middle path is a concise narrative of the problem, the sources of evidence, the observed pattern, and the implications for further assessment or educational planning.

Language deserves particular care. The language spoken at home, the language of instruction, and the language used in assessment can each shape apparent performance. The same applies to familiarity with test materials and prior opportunity to learn. These are not excuses to abandon assessment. They are reasons to record context explicitly and avoid interpreting a language-mediated difficulty as a fixed deficit without adequate corroboration.

The clinician should also avoid turning test labels into explanations. A child may have a recognisable profile and still need a careful account of emotional response, classroom demands, family understanding, and practical obstacles to attendance or study. Conversely, distress around schoolwork should never be used to dismiss the possibility of a genuine learning difficulty. Assessment is strongest when it respects both: the measurable pattern and the child's subjective experience of repeatedly encountering it.

> Psychoeducational assessment is a clinical synthesis of cognitive evidence, academic performance, history, and observation - never a single score or battery name.

21.7 Communicating the formulation and using assessment over time

Feedback is part of assessment, not an administrative afterthought. Families need a clear explanation of what was assessed, what the findings support, what remains uncertain, and what the findings do not mean. Use plain language without collapsing the clinical formulation into blame. Children should hear a description that protects dignity: the assessment has identified areas in which learning is harder, not evidence that they are unintelligent, lazy, or beyond help.

For the school, translate the report into observable needs. A teacher can act on a description of the tasks that become difficult, the conditions that support performance, and the evidence required for later review. The psychiatrist should avoid prescribing a generic educational programme from a test score alone. Detailed remedial planning belongs with professionals and settings able to implement and review it; management and remedial education are addressed elsewhere in this chapter.

Reassessment should be purposeful. It is indicated when the clinical question has changed, when progress is being reviewed, when the original testing conditions limited confidence, or when a major educational transition requires an updated account of functioning. Repeating a battery merely because time has passed produces information only if the result will change understanding or action. The clinician should state the question that the follow-up assessment is expected to answer.

Finally, preserve diagnostic humility. A robust assessment can make a strong formulation, but the child continues to develop and the educational environment continues to change. Keep the report open to new evidence, document the basis for conclusions, and coordinate with the relevant child mental-health and educational professionals. That is how psychoeducational testing becomes clinically useful rather than a bureaucratic endpoint.

22 · Management and remedial education for SLD

Management is an educational treatment, not an afterthought. Specific learning disorder is managed by converting a carefully described pattern of difficulty into teaching that the child can actually use. The psychiatrist does not substitute for the educator. The clinical task is to define the functional problem, explain it without blame, coordinate the adults around the child, and protect participation while the missing academic skill is being taught. A useful plan is therefore neither a

generic tuition referral nor a collection of concessions. It is a linked programme of skill teaching, access support, monitoring, and family-school collaboration.

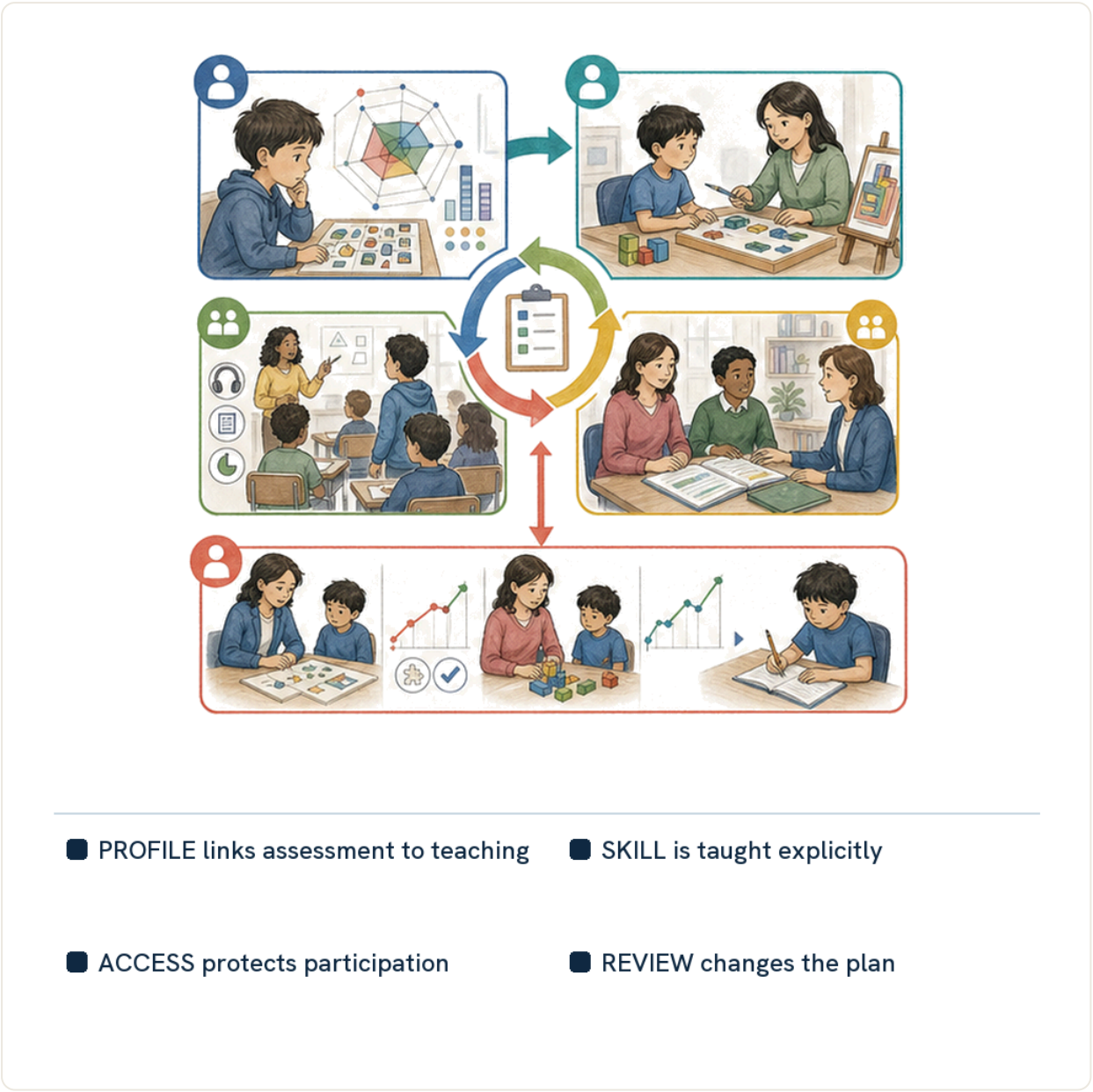


Fig 22.18 Management of specific learning disorder links the assessed learning profile to explicit skill teaching, protects participation through access support, and changes the plan through repeated review. It is an educational treatment, not generic tuition.

The marks in this area are usually earned by making a distinction that is easy to say but often poorly applied: treatment should both change what can be changed and reduce the immediate cost of a continuing difficulty. The child needs an explicit learning plan, rather than repeated exhortations to work harder. When this is done well, schoolwork becomes a source of graded mastery rather than a daily confirmation of failure.

PROFILE	SKILL	ACCESS	REVIEW
LINKS ASSESSMENT TO TEACHING	IS TAUGHT EXPLICITLY	PROTECTS PARTICIPATION	CHANGES THE PLAN WHEN NEEDED

22.1 Therapeutic frame and goals

Remedial education means planned teaching directed at the academic skill that is not developing adequately. It is not merely extra time spent on the same worksheet, and it should never be presented as punishment for poor effort. Its purpose is to build **age-appropriate foundational academic skills** through teaching that matches the child's pattern of strengths and difficulty. The practical implication is that the learning profile must shape the intervention. A child whose difficulty lies in decoding needs a different teaching emphasis from a child whose main barrier is written output or calculation, even when both are described by adults as "weak in studies".

The initial conversation has therapeutic value in its own right. Families and teachers may have accumulated explanations based on laziness, carelessness, oppositionality, or low intelligence. The clinician should reframe the difficulty as a specific problem in learning a particular academic skill. This is not an excuse for abandoning expectations. It is a reason to make expectations teachable, observable, and fair. The child should hear that difficulty is being taken seriously, that improvement requires practice, and that adults will alter the route to learning rather than simply demand a result.

RULE **Teach the impaired skill explicitly, then judge progress against that skill.** A remedial plan begins with the academic task that breaks down, identifies the component skill to be learned, and gives practice at a level where correction can be used. Repeating an activity that the child cannot decode, spell, write, or calculate independently rehearses failure rather than competence.

Goals should be functional and intelligible to the people implementing them. They may concern more accurate reading of instructional material, greater independence with written work, or reliable use of an agreed support. The point is not to promise a global transformation of school performance. A good goal defines what the child will be able to do more effectively and how adults will know whether the teaching approach is working. It also preserves the child's dignity by separating a learning problem from personal worth.

22.2 Designing the remedial programme

The intervention must be **individualized education program** work: systematic, structured skill-building tailored to the child's cognitive profile and the severity of the academic difficulty. Individualized does not mean improvised. It means that teaching content, pace, practice, correction, and review are selected after considering the child's actual performance. Structured does not mean rigid. It means that the teaching sequence is visible, cumulative, and capable of being adjusted when evidence from the child shows that a prerequisite has not been mastered.

- Translate assessment findings into a small set of observable learning targets.
- Identify the prerequisite skill that is preventing success with the current classroom demand.
- Arrange direct teaching, guided practice, and independent application in a predictable sequence.

For the psychiatrist, the formulation protects against a common systems error: referral without communication. A report that merely labels the disorder leaves the educator to guess what to teach. The useful clinical document describes the functional bottleneck, the child's relative strengths, the anticipated emotional consequences of repeated academic failure, and the need for a structured plan. It should support collaboration while respecting the educator's expertise in instruction. The psychiatrist remains responsible for the wider clinical picture, including distress, avoidance, family strain, co-occurring conditions, and whether a mismatch between school demand and support is amplifying impairment.

CLINICAL QUESTION	EDUCATIONAL RESPONSE	WHAT TO REVIEW
Which academic activity repeatedly fails?	Specify the component skill to be taught.	Whether the target matches the observed difficulty.
What can the child already do?	Begin from an accessible level and build from relative strengths.	Whether teaching is sufficiently challenging without becoming overwhelming.
Where does participation break down?	Provide an access support while remediation proceeds.	Whether support is enabling work rather than replacing teaching.
What is maintaining demoralisation?	Give feedback that identifies effort, strategy, and progress.	Whether avoidance, shame, or conflict is reducing engagement.

A programme should be documented so that it survives changes in personnel and can be discussed at review. Recording the target, method, response to correction, practice completed, and barriers to implementation makes the plan clinical rather than aspirational. It also lets the team distinguish a teaching approach that requires adjustment from a plan that was never delivered consistently. The aim is not bureaucratic perfection. The aim is continuity for a child who is often asked to begin again with every new adult.

GOOD TO REMEMBER

Ask the school to describe the task at which the child stops being independent, not simply the subject in which marks are low. That description is often the most useful bridge between a psychiatric formulation and a teachable target.

22.3 Reading remediation: the instructional core

Where reading difficulty is central, remediation should teach the relationship between spoken language and print directly. The core content is **phoneme awareness**: learning to hear and work with the sound units in words, including taking them apart and joining them. This is paired with **phonics**, in which the learner is taught the correspondence between letters and sounds. Contextual reading practice then gives the child an opportunity to use these skills in connected material rather than leaving them as isolated exercises.

The educational logic matters. Reading is not improved by asking a child to memorise larger and larger sets of words when the child does not have a dependable way of mapping print to sound. Nor is it enough to practise isolated sound exercises without helping the child apply them to text.

Direct work on sound structure supports decoding; explicit letter-sound teaching gives a route from print to speech; reading in context tests whether that route is becoming useful. Instruction should make errors visible and correctable. A child who guesses a word needs feedback that returns attention to the print and the sound pattern, not praise for a plausible guess that bypasses the skill being learned.

Multisensory structured language instruction is a helpful organising principle for this work. The teaching remains phonics-based and structured, but it deliberately gives the learner more than a purely passive encounter with print. The point is not novelty for its own sake. It is to make the sound-symbol relationship explicit, actively practised, and repeatedly retrieved in a coherent sequence. Such teaching should remain clear enough for the educator to observe whether the child is learning the intended correspondence.

MNEMONIC

Hear - Map - Read

Use this as a teaching spine: hear the sound structure in spoken words, map sounds to letters, then read the pattern in connected text. It keeps remediation directed at a usable reading skill rather than at nonspecific classroom activity.

TRAP **Do not mistake more reading exposure for reading remediation.** Exposure is valuable only when the child has a supported way to process the print. Unstructured repetition of material beyond the child's current decoding capacity can deepen avoidance and may persuade adults that the child lacks motivation when the actual problem is an unaddressed skill.

22.4 From accuracy to fluent, meaningful reading

Accuracy is necessary, but it is not the whole endpoint. **Repeated oral reading** can be used to improve fluency. It allows the child to revisit the same passage with feedback until word recognition becomes less effortful. This should be understood as supported practice, not as public performance. A child who has experienced correction as humiliation may avoid reading aloud altogether; the remedial setting must make error correction routine, private, and useful.

Fluency work should not be treated as proof of comprehension. A learner may become more rapid while still failing to derive meaning from what is read. The clinician should therefore keep comprehension in view as part of the wider language task. When a child understands spoken material better than independently read material, the barrier may lie principally in access to print. When understanding remains limited even after print has been supported, broader language comprehension becomes important to the educational formulation. This distinction prevents a narrow fluency goal from being mistaken for the child's full learning need.

At review, ask what changed in the child's everyday academic functioning. Has the child begun to approach text with less avoidance? Can the learner use the taught strategy in unfamiliar material? Is reading still so effortful that content learning is blocked? These questions keep teaching linked to participation rather than allowing a practice task to become an end in itself. They also help the

psychiatrist identify the point at which emotional support, classroom access, and remediation need to be intensified together.

22.5 Remediation and accommodation serve different jobs

The distinction is clinically decisive. **Remediation** builds a deficient skill. **Accommodations** enable access to educational material without changing that skill. These approaches work best as partners rather than competitors. The child may need access support now because a current curriculum cannot be put on hold while skill development proceeds. At the same time, access without teaching leaves the underlying academic difficulty untouched.

QUESTION	REMEDIATION	ACCOMMODATION
Primary purpose	Build the impaired academic skill.	Enable participation despite the current barrier.
Immediate focus	Direct, structured instruction and practice.	How the learner receives, produces, or demonstrates educational work.
Clinical error if used alone	Ignoring the child's present access needs.	Assuming that access has taught the missing skill.
Examples	Teaching directed at the identified learning target.	**Audiobooks, spell-checkers, and assistive technology** when these enable access.

An accommodation should be chosen by asking what unwanted barrier it removes. If a support lets a child obtain the meaning of material despite a reading barrier, or express knowledge despite difficulty with mechanics, it may protect access to the curriculum. It should not be framed as an unfair advantage. Equity means that the child is given a route to show learning that is not needlessly dominated by the disability being treated. The detailed statutory, certification, and examination route is outside the scope of this clinical management discussion.

PITFALL

Do not use an access support as a reason to stop remediation. A tool can reduce the immediate penalty of a learning difficulty, but it does not by itself establish the academic skill that the child is still being helped to acquire.

22.6 Working with family, school, and the child

Management fails when adults hold incompatible explanations. Parents may be asked to supervise exhausting homework that does not teach the relevant skill; teachers may interpret slow output as defiance; the child may conceal difficulty to avoid embarrassment. The psychiatrist should bring the discussion back to a shared formulation: which task is difficult, what skill is being taught, what support allows participation, and how progress will be recognised. This gives each adult a role without turning the family home into a remedial classroom.

- Explain the learning difficulty in language that separates it from intelligence, effort, and character.

- Agree on a consistent channel for communication between home, school, and the treating team.
- Notice avoidance, anxiety, irritability, and loss of confidence as signals that the educational burden needs review.

The child's view is indispensable. Ask which classroom moments feel impossible, which supports feel exposing, and what kind of feedback encourages continued effort. This is not merely rapport-building. A plan that is technically sound but experienced as shaming will be poorly used. Conversely, a child who can identify a successful strategy is more likely to apply it outside the remedial setting. Where co-occurring attentional, emotional, behavioural, communication, or developmental concerns affect learning, they should be assessed and managed in their own right rather than being used to explain away the specific learning problem.

IN INDIA

Access to trained remedial educators and assistive tools may differ sharply across schools and localities. The clinical plan should therefore state the instructional principle clearly enough that it can guide whatever educational resource is available, while avoiding a vague recommendation for "special help" that no adult can operationalise. The statutory and examination pathway belongs to the educational provisions section of this chapter.

22.7 Starting early, monitoring honestly, and sustaining hope

Remedial action should begin when the pattern of difficulty is clear enough to justify help; it should not be postponed while adults wait for a formal dyslexia label or for another episode of academic failure. Delay has consequences beyond marks. Repeated failure can reshape the child's expectations, reduce willingness to attempt difficult work, and make school refusal or behavioural conflict appear to be the primary problem. Early, specific teaching is therefore also preventive mental-health care.

The plan should be reviewed using direct information from the learning setting: whether the child is receiving the intended teaching, whether the selected task has become more manageable, whether supports are being used, and whether emotional strain is reducing. Lack of progress is not a cue to intensify blame. It is a cue to reconsider the match between the child's profile, the teaching target, the instructional method, and the environmental demands. Sometimes a target was too broad; sometimes a prerequisite was missed; sometimes implementation was inconsistent; sometimes a co-occurring problem requires parallel attention.

Progress review is also an opportunity to preserve coherence. The family may report a small but important change that is invisible in a broad school result, such as willingness to attempt a previously avoided task or use of a taught strategy without prompting. The school may identify a barrier that was not apparent in the clinic. Bringing these observations together prevents premature abandonment of a useful approach and prevents persistence with an approach that has lost its fit. The question is always practical: what should the child, educator, and family continue, modify, or stop doing?

Prognosis should be communicated with realism and confidence. With appropriate remedial education and relevant provisions, **most children** can achieve academic competence. This statement should not be converted into a promise of effortless parity in every academic task. Its clinical value is that it replaces fatalism with a process: identify the barrier, teach the skill, maintain access, and revise the plan from observed response. It gives the child and family a credible reason to remain engaged.

> Remediation teaches the skill; accommodation protects access while that teaching is taking effect.

23 · Certification and educational provisions for SLD in India

Why certification matters. In specific learning disorder, a clinical formulation does not by itself unlock educational support. Certification is the bridge between a child's demonstrable academic difficulty and enforceable participation measures in school and examinations. The psychiatrist therefore needs to understand the route well enough to guide families, interpret what a certificate does and does not establish, and avoid converting a school complaint into either a global cognitive label or an administrative shortcut.

The legal bridge is deliberately narrow here. **Specific learning disability is a specified disability under the Rights of Persons with Disabilities Act, 2016**. That status places the child within a disability-rights framework, but it does not replace careful clinical assessment, psychoeducational evaluation, or a school plan. The Act's general machinery is dealt with in the Intellectual disability and autism spectrum disorder notes; the present discussion concerns the SLD-specific statutory and educational route.

LAW	SCHOOL	TEAM	BOARD
RIGHTS ROUTE	SCREENING ROUTE	ASSESSMENT ROUTE	ACCESS ROUTE

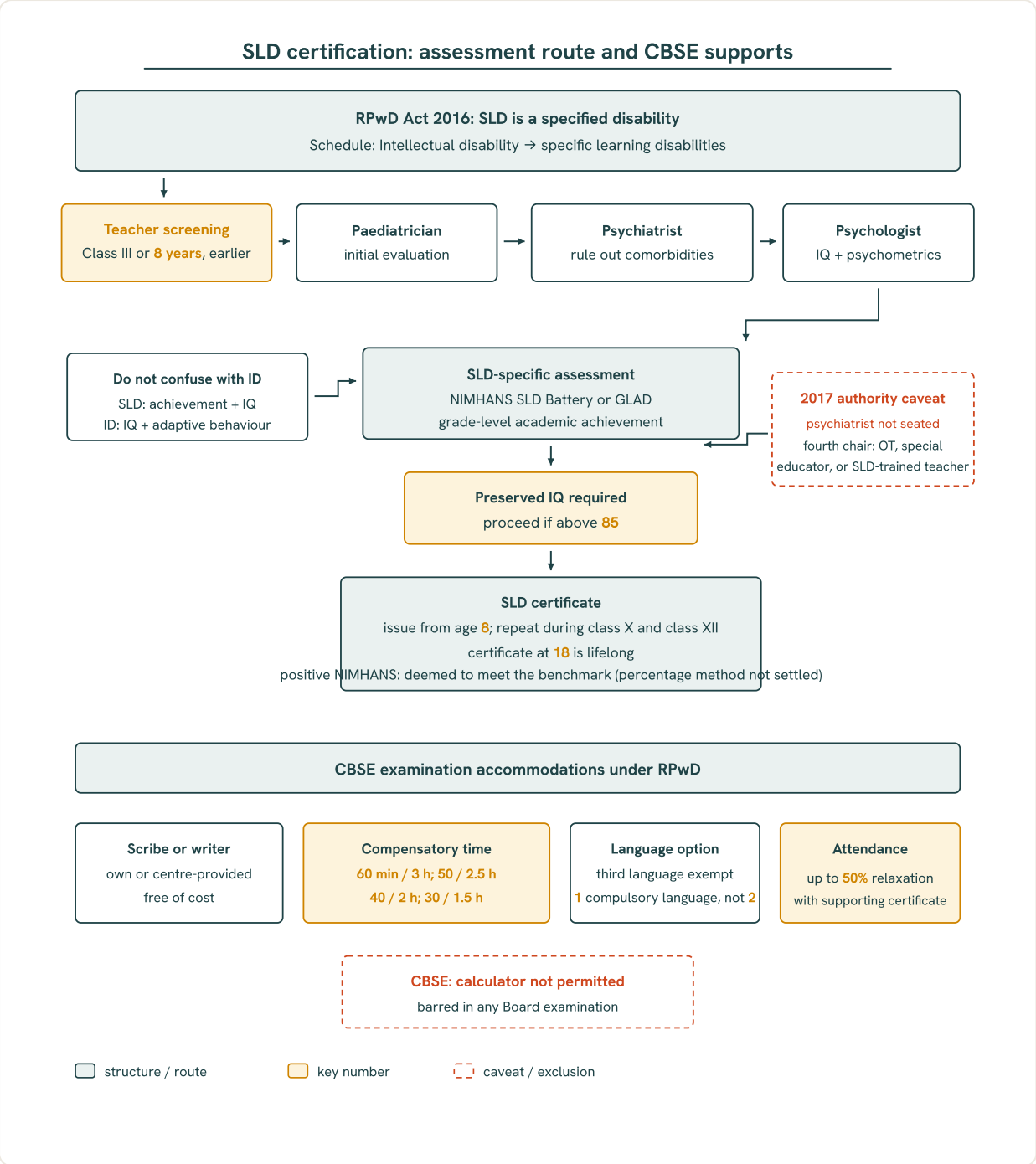


Fig 22.19. Indian SLD certification pathway and CBSE examination accommodations.

23.1 Statutory location and its clinical meaning

The first distinction is between a statutory description and a psychiatric taxonomy. The Act places SLD under the Schedule head concerned with intellectual disability: its **Schedule placement** is as "specific learning disabilities" under that head, alongside autism spectrum disorder. This grouping should not be read as equating SLD with intellectual disability. It is a legislative arrangement for specified disabilities, whereas clinical differentiation rests on the pattern of functioning and the assessment route.

The **statutory definition** describes a heterogeneous group in which difficulty in processing spoken or written language becomes evident in comprehension, expression, reading, writing, spelling, or mathematical work. Its wording includes perceptual disabilities, dyslexia, dysgraphia,

dyscalculia, dyspraxia and developmental aphasia. This is wider than a neat examination list of academic skill deficits. A candidate should neither force all of these labels into a psychiatric diagnosis nor discard a child's functional difficulty because it sits awkwardly beside a clinical classification. In certification work, the relevant question is whether the child's documented pattern fits the notified route.

IN INDIA

Use the statutory language when explaining eligibility and the clinical language when formulating the disorder. They overlap but serve different purposes. Confusing them produces opposite errors: treating every poor scholastic performance as a disability, or assuming that a clinically meaningful learning difficulty cannot attract support because its label is not a familiar diagnostic heading.

RULE **Certification follows the SLD-specific educational assessment route, not a global-intelligence label.** The legal category creates access to support; it does not collapse SLD into intellectual disability.

23.2 From school concern to formal evaluation

School recognition is not a casual referral note. It is a structured initial filter intended to identify children whose persistent academic difficulty warrants a fuller pathway. Under the certification guidance, school-based teacher screening begins at **Class III or 8 years of age, whichever is earlier**. The screening committee is led by the principal, and teachers administer the questionnaire in public as well as private schools. This is useful because teachers see the curriculum demand, the child's response to repeated instruction, and the practical consequences of the difficulty.

Screening is an entry point, not a diagnosis. A teacher can appropriately identify a child who repeatedly fails to acquire expected academic skills despite classroom opportunity, but the teacher cannot determine the cognitive basis, psychiatric comorbidity, sensory contribution, or validity of a disability certificate. Conversely, a normal-looking classroom behaviour profile does not settle the matter if a child is using avoidance, copying, memorisation, or family support to conceal a marked skill deficit.

After a positive screen, the **multidisciplinary pathway** moves through an initial paediatric evaluation, psychiatric assessment for comorbidity, and psychometric and IQ testing by a psychologist. It protects against premature attribution. The paediatric assessment addresses medical and developmental context; psychiatric review asks whether comorbidity is altering performance or participation; and the psychologist documents the psychometric profile. Each professional answers a different question. A referral letter that merely says "rule out SLD" is less useful than a concise account of the scholastic complaint, prior support, course, school observations and relevant emotional or behavioural symptoms.

- Clarify the academic task that is failing, rather than accepting "poor studies" as a formulation.
- Ask what teaching and remedial opportunity the child has actually received, because achievement cannot be interpreted without opportunity.

- Seek school work and collateral that show the pattern over time, not only the family's account of a recent examination result.
- Screen clinically for comorbidity that may coexist with, amplify, or mimic academic underperformance.

GOOD TO REMEMBER

The psychiatrist's most useful contribution is often not administration of an academic battery. It is protecting the formulation from diagnostic overshadowing: anxiety, mood symptoms, attentional symptoms, developmental language difficulty, sleep disturbance, adversity, or a neurological history may change how the child performs and what support is needed.

23.3 Assessment logic and the boundary with intellectual disability

The assessment route differs in kind from the route used for intellectual disability. SLD certification rests on psychoeducational, grade-level academic-achievement assessment with preserved intellectual functioning, whereas intellectual disability certification uses an IQ-plus-adaptive-behaviour route. This distinction is clinically important. A child can be severely disabled in a particular academic domain while showing no global pattern of limitation that would justify intellectual-disability certification.

In the notified SLD pathway, SLD-specific assessment proceeds when IQ is **above 85**. This is not a reason to use an IQ score as the explanation for a child's scholastic struggle. It is a gate within this certification route, intended to separate the educational-achievement assessment from the intellectual-disability pathway. Clinically, the clinician must still consider the quality of the testing, language and schooling context, effort, emotional state, and the consistency of the profile with the child's real-world work.

QUESTION	SLD CERTIFICATION ROUTE	INTELLECTUAL DISABILITY ROUTE
Central concern	Specific academic achievement	Global intellectual and adaptive functioning
Assessment emphasis	Psychoeducational and grade-level work	IQ together with adaptive behaviour
Clinical implication	Plan targeted access and learning support	Plan support around broader functioning
Common error	Calling all low marks SLD	Calling a focal academic deficit global disability

That table is deliberately an assessment distinction, not a substitute for diagnostic criteria. The clinical definition and diagnostic criteria of SLD are addressed elsewhere in this chapter, while the broader differential including slow learner is addressed in the chapter's discrimination section. In practice, the safe sequence is to establish the child's functional academic pattern, examine the testing context, integrate psychiatric and developmental information, and only then determine whether the notified certification threshold and pathway apply.

TRAP **Do not treat the IQ gate as the diagnosis.** A score used for eligibility cannot explain a child's reading, writing, spelling, or mathematical difficulty, and it cannot replace a grade-level achievement assessment.

23.4 Approved batteries and what a result means

The notified academic tools are the **NIMHANS SLD Battery** and the **Grade Level Assessment Device (GLAD)**. Their value is not that they provide a mechanical label. They make the academic judgement auditable by linking the child's performance to expected grade-level work. The report should preserve the profile of strengths and weaknesses, the language and educational context, the source of collateral, and the implications for accommodations and remediation.

The choice of battery must be appropriate to the child's schooling context and the skills being examined. It is tempting to treat any cognitive test, informal dictation exercise, or school mark sheet as interchangeable with a notified achievement battery. They are not interchangeable. Informal material can sharpen the clinical question and can be valuable evidence of functional impairment, but certification needs the designated psychoeducational route. The task for the psychiatrist is to ensure that the evaluation answers the practical question being asked, not simply to accumulate test names.

Current guidance describes a positive result on the NIMHANS Battery as meeting the **benchmark-disability determination**, while not providing a graded percentage method for SLD. Thus, SLD certification is best understood as a positive-or-negative determination based on the notified battery, rather than as a ladder of progressively assigned disability percentages. The cited guidance itself identifies a need for clarification about the continuing application of this position. In a certificate-related consultation, it is prudent to document the source report precisely and avoid inventing a severity percentage that the SLD framework does not supply.

PITFALL

Do not translate a psychoeducational result into a generic "percentage disability" in clinic correspondence. That may sound administratively helpful, but it can misstate the SLD-specific framework and obscure the assessment on which eligibility rests.

23.5 Certificate timing, review and professional roles

Certification is reserved for children **aged 8 and above; the current notified guidelines schedule repeat certification during class X and class XII, and a certificate issued at 18 is valid lifelong**. This schedule recognizes that educational demands and the documented profile need review as the child progresses through schooling. Families should be told early that certification is part of a continuing educational record, not a one-time diagnostic performance. Delayed referral can therefore have practical consequences when schools and examining bodies need documentation within their own processes.

There is an important nuance about the psychiatrist's place in the process. The certifying medical authority described in the earlier rules does not seat a psychiatrist; its additional position may be held by an occupational therapist, special educator, or teacher trained in SLD. This **board-**

composition limitation must not be distorted into "psychiatrists have no role." The amended diagnostic pathway separately describes psychiatric assessment to rule out comorbidity. The sensible reading is functional rather than territorial: the psychiatrist contributes clinical formulation and comorbidity assessment, while certification is completed through the designated authority and educational assessment process.

This distinction also helps with interprofessional communication. The psychiatrist should not demand to control an academic determination, and the school or assessment team should not dismiss mental-health symptoms as irrelevant to performance. A good report states what the psychiatric assessment establishes, what it does not establish, and which part of the certification record must come from the appropriate educational and certifying process.

MNEMONIC

Screen - Sort - Study - Support

Screen at school, **sort** medical and psychiatric contributors, **study** the psychoeducational profile, then arrange certified **support**. The phrase is a workflow memory aid, not a diagnostic criterion.

23.6 Examination accommodations: access, not advantage

Educational accommodations aim to reduce the disability-related barrier to showing knowledge. They should not be presented as rewards for a diagnosis or as a promise that marks will improve. The key question is whether the examination format places a disproportionate barrier on the student's ability to demonstrate the intended competence. The **CBSE scribe or writer facility** permits an eligible candidate to use either a personal writer or a writer provided without charge by the examination centre. A personal writer must have a lower qualification than the candidate. A reader may be used when the candidate does not opt for a writer.

Compensatory time is a distinct accommodation. It may be taken instead of, or in addition to, a writer where the rules permit. In the relevant board schedule, the **compensatory-time allocation is 60 minutes for a 3-hour paper, 50 minutes for 2.5 hours, 40 minutes for 2 hours, and 30 minutes for 1.5 hours**. The clinical point is that extra time addresses speed and written-output burden; a writer addresses a different barrier. A certificate alone does not tell the school which arrangement will preserve the examination's purpose. That decision should be grounded in the documented functional difficulty.

PROVISION	WHAT BARRIER IT ADDRESSES	CLINICAL CLARIFICATION
Writer or scribe	Written output	Do not assume it is needed for every student with SLD
Compensatory time	Slower processing or output	It can be relevant even when a writer is not used
Language option	Additional language demand	It changes subject requirements, not the underlying learning need
Attendance relaxation	Difficulty meeting attendance requirement	Requires the stipulated supporting recommendation

For the language provision, eligible candidates are exempt from the third language and may take a reduced compulsory-language requirement. The **CBSE language exemption** is therefore a defined curricular concession, not a broad waiver from language learning. Counselling should be careful and non-stigmatising: the relevant choice may reduce an avoidable barrier, but it should be considered alongside the child's educational goals, strengths, and confidence rather than imposed as a default.

Attendance relaxation is similarly conditional rather than automatic. The **CBSE attendance relaxation** can extend up to **50%** when the prescribed attendance requirement cannot be met, on the school principal's recommendation and supporting certification from a registered medical practitioner or authorised psychologist. In clinical letters, describe the actual disability-related functional issue and avoid certifying a benefit whose educational criteria have not been met.

23.7 The calculator question and board-specific advice

One of the most persistent sources of misinformation is the assumption that dyscalculia automatically permits a calculator. For examinations conducted by CBSE, use of a calculator is barred. The **CBSE calculator provision** is therefore a prohibition, despite the fact that calculator access is often repeated in generic lists of concessions and may be available in other board settings. This is a useful example of why clinicians should never promise an accommodation from memory.

Advice to families must be board-specific and document-specific. The psychiatrist can explain the functional rationale for an accommodation and can provide an accurate clinical report. The school and examination authority determine what their current rules allow. Where a family is considering subject choices, a writer, extra time, or language exemption, encourage early verification with the relevant authority rather than a late appeal after examination arrangements have closed.

TRAP **Do not promise a calculator for dyscalculia.** A commonly repeated concession is not a universal entitlement, and for CBSE examinations the rule is explicitly restrictive.

23.8 A practical psychiatrist's approach

For the resident, the high-yield approach is to hold the clinical and administrative tasks together without confusing them. Begin with the child's functional academic complaint and the evidence from school. Establish whether the concern has been adequately assessed through the designated psychoeducational pathway. Review psychiatric comorbidity and contextual factors that could alter performance. Explain the certificate as an access document rather than a total account of the child. Then help the family translate the documented functional profile into a realistic school and examination plan.

Communication is often the intervention that prevents harm. A child who has repeatedly been called careless or lazy may hear certification as proof of incapacity; a family may hear it as a guaranteed route to concession. Both interpretations are damaging. The better formulation is that a specific barrier has been identified and documented, and that targeted supports are meant to

allow fair demonstration of learning. Remedial education remains central; accommodations do not teach the skill, and teaching alone may not remove an examination barrier.

- Use school evidence to define the functional problem before discussing a certificate.
- Refer through the notified educational assessment route rather than relying on an informal impression.
- Record psychiatric comorbidity clearly, while avoiding the claim that it establishes SLD.
- Match accommodation discussion to the documented barrier and the applicable board rule.

Treat SLD certification as a psychoeducational access pathway: document the academic profile, assess comorbidity, use the designated authority, and verify each accommodation against the relevant board rule.

Communication and motor disorders

24 · Communication disorders (language, speech sound, childhood-onset fluency, social communication)

Communication is a clinical function, not merely a school subject. A child may have difficulty understanding language, formulating it, producing intelligible speech, maintaining fluent speech, or using communication appropriately with other people. The diagnostic task is to locate the impaired function, establish its developmental pattern and functional consequence, and then ask whether another condition explains the presentation more parsimoniously. These distinctions matter because a child who cannot make an intelligible request, follow a classroom instruction, or understand the implied meaning of a peer's remark will be impaired in a different way, even when the family describes all of them as “speech delay”.

The **communication disorders** are developmental disorders of communication. They sit beside, rather than inside, the broader assessment of neurodevelopmental functioning. A careful formulation therefore separates the child's linguistic or speech difficulty from hearing, oral-motor, neurological, structural, intellectual, emotional, and environmental contributions. It also avoids treating a language difference in a multilingual family as proof of disorder. The relevant developmental context is addressed in the Normal child development and milestones notes, and a full service-based child assessment is addressed in the Child psychiatry: assessment, treatment, services and protection notes.

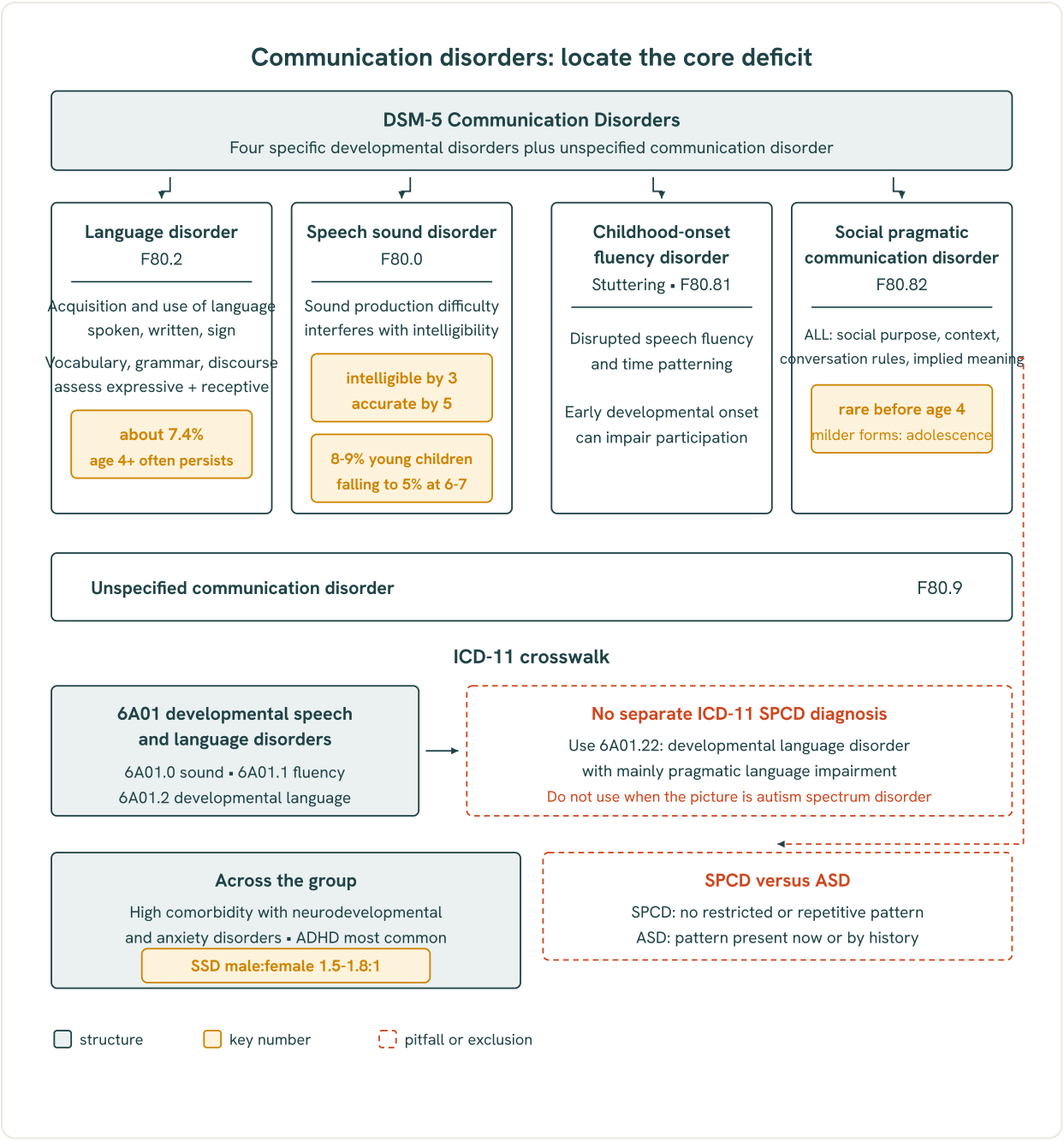


Fig 22.20. Communication disorders map: core deficit, ICD-11 crosswalk and the SPCD exclusion.

24.1 Diagnostic map and the unit of impairment

The DSM communication-disorder group includes **language disorder**, **speech sound disorder**, **childhood-onset fluency disorder**, **social (pragmatic) communication disorder**, and an unspecified category. The names identify the principal clinical bottleneck. Language concerns understanding and expression of meaning through an organised symbolic system. Speech sound concerns the production of sounds that make spoken output intelligible. Fluency concerns the temporal flow of speech. Social communication concerns whether verbal and nonverbal communication is used effectively with another person in a context.

For documentation and examination answers, the corresponding DSM coding labels are language disorder **F80.2**, speech sound disorder **F80.0**, childhood-onset fluency disorder **F80.81**, social (pragmatic) communication disorder **F80.82**, and unspecified communication disorder **F80.9**.

Coding is not a substitute for formulation. A code tells the reader where the principal problem has been placed; the formulation must still say how it affects participation, learning, relationships and family life.

The ICD approach groups developmental speech and language conditions together, including language, speech sound and fluency presentations. This is useful to remember when records use different classificatory languages. The important clinical question remains unchanged: which communicative operation is persistently compromised, and is that compromise the primary explanation for the observed impairment?

RULE **Name the impaired communication function before naming the diagnosis.** "Speech problem" is an initial complaint, not a formulation. Decide whether the child cannot understand, formulate, articulate, speak fluently, or use communication socially.

- Ask what the child understands when contextual cues are removed.
- Ask how the child conveys a novel idea, need, or narrative.
- Listen for intelligibility, sound-pattern errors, effort and fluency.
- Observe reciprocity, turn-taking, repair after misunderstanding and sensitivity to context.

These observations should be gathered from more than the consulting room. A child may speak freely with a parent yet fail when required to comprehend decontextualised classroom language, explain an event, negotiate with peers, or respond to an unfamiliar adult. Conversely, silence in a strange clinic can be an anxious state rather than evidence that language has not developed. The clinician should use the child's strongest available means of communication and seek examples that show both capacity and performance.

24.2 Language disorder: a disorder of learning and using language

Language disorder is characterised by persistent difficulty acquiring and using language across spoken, written, or signed modalities. The deficit may involve comprehension, production, vocabulary, grammar, sentence organisation, or discourse. In assessment, **receptive and expressive language** must both be examined. A child with apparently fluent output can still have poor comprehension, while a child who says little may understand considerably more than they can express. The distinction changes both formulation and prognosis.

Clinically, the difficulty is not simply an absence of a few words. It is a problem in building a usable language system: attaching stable meanings to words, combining them according to rules, understanding relationships within a sentence, and using connected language to explain, recount, infer and learn. The impairment must be persistent and consequential. A quiet child, a child who chooses brief answers, or a child who is still adapting to the language used at school should not be relabelled on the basis of a single brief encounter.

The disorder begins in the developmental period. Before 4 years, ordinary variation can be difficult to distinguish from an enduring disorder; by that age, individual differences become more stable and informative, and a disorder diagnosed then commonly continues into adult life.

This does not mean that a clinician should wait passively when a child is struggling. It means that the assessment should record the developmental trajectory, repeated functional observations and response to appropriate support rather than claiming false precision early on.

The profile may be predominantly expressive, predominantly receptive, or mixed. **Receptive impairment** carries a less favourable outlook and is more resistant to intervention than a largely expressive presentation. This is clinically intuitive: when comprehension is compromised, the child has less reliable access to the language input from which learning, conversation and teaching are built. It should prompt a careful search for the child's actual understanding, not an assumption that fluent repetition or a few familiar routines demonstrate comprehension.

GOOD TO REMEMBER

When a parent says, "He knows everything but does not speak," test that proposition gently. Ask the child to show understanding of unfamiliar instructions, relationships, sequence and implied meaning, using familiar language and low-pressure interaction. The answer often determines whether the formulation is expressive alone or includes comprehension.

Language disorder can affect academic work without being reducible to an academic diagnosis. Classroom tasks place heavy demands on understanding instruction, learning vocabulary, constructing explanations and following discourse. Socially, a child may appear inattentive, oppositional or immature because the conversational load has exceeded their comprehension. These are hypotheses to test, not labels to attach automatically. The evaluation of specific learning disorder is covered elsewhere in this chapter, while the wider assessment of attention and behaviour must preserve the possibility that communication difficulty is contributing to the observed behaviour.

24.3 Speech sound disorder: intelligibility is the functional anchor

Speech sound disorder is a persistent difficulty in producing speech sounds that reduces intelligibility or prevents effective verbal communication. It may reflect difficulty with phonological knowledge, articulatory coordination, or both. The diagnosis requires that the presentation is not better explained by a hearing, structural or neurological cause. This is why "mispronunciation" alone is an inadequate conclusion: one must decide whether the pattern is developmental variation, a primary speech sound difficulty, or a manifestation of another condition.

The clinical anchor is **speech intelligibility**. The question is not whether an adult can identify an occasional imperfect sound after listening carefully. The question is whether the child's usual speech can be understood sufficiently for ordinary communication with familiar and unfamiliar listeners. The functional impact may become conspicuous when the child is expected to answer in class, make needs known outside the family, participate in group play, or be understood over a telephone or audio-only interaction.

Speech development must be interpreted against developmental expectations. Overall speech is ordinarily intelligible by 3 years, whereas at 2 years only about 50% may be understandable; most

words are accurate by 5 years. These anchors prevent two opposite errors: pathologising expected immaturity and reassuring a child whose intelligibility has remained functionally limiting beyond the point at which ordinary maturation is a sufficient explanation.

about 7.4%	about 8-9%	about 5%	about 1.5-1.8:1
LANGUAGE DISORDER AT KINDERGARTEN ENTRY	SPEECH SOUND DISORDER IN YOUNG CHILDREN	SPEECH SOUND DISORDER, SCHOOL AGE	BOYS:GIRLS IN SPEECH SOUND DISORDER

Speech sound disorder is common in young children and becomes less frequent later in childhood. Boys are more likely than girls to be affected. The useful examination point is not to overinterpret the epidemiological figure, but to connect it to the clinical interview: a common presentation still requires a structured differential, and male predominance never makes the diagnosis automatic in a boy or implausible in a girl.

PITFALL

Do not equate a regional accent, home-language transfer, or an isolated unfamiliar sound with disorder. Evaluate the child's speech pattern in the languages and settings in which the child actually communicates, and focus on persistent functional intelligibility rather than an adult's preference for a particular pronunciation.

24.4 Childhood-onset fluency disorder: identify it, then keep the boundary

Childhood-onset fluency disorder is the fluency member of the communication-disorder group. It should be considered when the central difficulty is the flow and temporal organisation of speech rather than language formulation or sound production. Families may use the word "stammering" for many forms of hesitant speech, including a child searching for words, anxiety-linked inhibition, or a normal transient disfluency. The clinician must first establish what is actually occurring during speech and how the child responds to it.

The initial interview should attend to the child's own experience, avoidance, anticipation of speaking, and the contexts in which fluency changes. It should also ask whether the apparent disruption is better accounted for by a primary language difficulty, a motor or neurological condition, medication or substance exposure, a hearing problem, or a situational emotional state. These questions prevent a descriptive label from obscuring the relevant formulation.

This section deliberately does not reproduce the syndrome's features or management. Those belong to the dedicated discussion of stuttering elsewhere in this chapter. Here, the practical point is diagnostic placement: do not call a child's speech "language delay" when the language system is intact and the principal difficulty is fluent delivery; do not call it speech sound disorder when intelligibility is reduced by interruptions in flow rather than sound-pattern production.

TRAP **Do not use "speech delay" as a catch-all.** It collapses language, articulation and fluency into one label, conceals the actual impairment, and leads to an unhelpful referral question.

24.5 Social (pragmatic) communication disorder: language in relation to another mind

Social (pragmatic) communication disorder concerns persistent difficulty in the social use of verbal and nonverbal communication. The problem is not merely shyness, politeness, vocabulary size or grammatical correctness. It is the failure to deploy communication effectively for social purposes: to greet and share information, adjust expression to context, follow conversational and narrative conventions, and understand nonliteral or implied meaning. In this diagnostic construct, all of these pragmatic deficits are required.

Pragmatics are most visible in interaction. The child may give an answer without recognising what the listener needs to know, continue speaking without detecting that the partner is disengaged, take an idiom literally, or fail to repair a misunderstanding. A structured history should seek examples from home, school and peers. Clinic conversation is informative but can be falsely reassuring when the adult carries the conversational burden, supplies the topic, overlooks missed cues, or accepts answers that a peer would not understand.

The disorder begins in the developmental period, but a diagnosis is unusual before 4 years because sufficient speech and language must first be available to judge social use. Milder difficulties may become apparent only in early adolescence, when conversation becomes less scripted and social demands depend more heavily on inference, narrative, tact and flexible adaptation. This later recognition does not make the difficulty newly acquired; it can reveal a longstanding vulnerability exposed by a more complex social environment.

Classification systems describe this area differently. DSM retains a standalone diagnosis. ICD does not use a separate social-pragmatic disorder; it places a predominantly pragmatic profile within developmental language disorder. The distinction is administrative as well as conceptual, so the clinical formulation should describe the observed social-communication pattern rather than rely on the diagnostic label alone.

24.6 Differential diagnosis: use the discriminator, not a superficial resemblance

The essential differential for social-pragmatic communication difficulty is autism spectrum disorder. The discriminator is the presence or absence of **restricted and repetitive patterns** of behaviour, interests or activities. Social (pragmatic) communication disorder requires their absence; autism spectrum disorder requires their presence currently or by history. Similar social-communication symptoms do not settle the question. The history must actively look for the restricted or repetitive dimension rather than infer its absence because it was not volunteered in a brief interview. The wider assessment of autism is covered in the Intellectual disability and autism spectrum disorder notes.

Social anxiety disorder can also resemble social-pragmatic difficulty, but the developmental sequence is decisive. In social anxiety, effective social communication was present and is not used because anxiety inhibits its use. In social (pragmatic) communication disorder, effective social communication has not been established. The observed silence, avoidance or awkwardness may look similar; asking what the child could do before the anxiety emerged often clarifies whether the underlying skill was available.

CLINICAL QUESTION	LANGUAGE DISORDER	SPEECH SOUND DISORDER	SOCIAL-PRAGMATIC DISORDER
Primary difficulty	Learning or using language	Producing intelligible speech sounds	Using communication effectively with others
Useful observation	Understanding and formulation	Intelligibility in ordinary speech	Reciprocity, context and implied meaning
Misleading shortcut	"Quiet means expressive delay"	"Any mispronunciation is pathology"	"Awkward social communication equals autism"
Key corrective step	Assess receptive as well as expressive ability	Exclude hearing, structural and neurological explanations	Ask specifically about restricted and repetitive patterns

Hearing impairment, intellectual developmental disorder, neurological and structural conditions, and selective performance problems should be considered whenever they plausibly account for the communication profile. This does not imply that a communication disorder cannot coexist with another neurodevelopmental condition. It means the psychiatrist should state whether the communication difficulty is expected from the other condition, disproportionate to it, or independently impairing. Intellectual disability and autism require their own full assessment in the Intellectual disability and autism spectrum disorder notes.

24.7 Assessment, comorbidity and care planning

Assessment begins with the referral language, then moves from labels to observable functions. Elicit the developmental history of communication, languages used at home and school, hearing and medical history, family observations, school examples, peer functioning, and the child's own account of difficulty. Observe spontaneous communication and structured demands separately. Clarify what is understood, what is produced, what is intelligible, what happens to fluency, and whether the child can adapt communication to the listener and setting.

Communication disorders show male predominance and commonly coexist with other neurodevelopmental disorders and anxiety disorders. The associated neurodevelopmental conditions include autism spectrum disorder, ADHD, specific learning disorder and intellectual developmental disorder; ADHD is the most common psychiatric comorbidity. Comorbidity should broaden assessment, not erase the communication formulation. For example, inattention may make a child miss an instruction, but poor language comprehension may itself produce behaviour that resembles inattention. The clinician must establish which mechanism is operating in each setting.

IN INDIA

In multilingual practice, document the languages the child hears, understands and uses, and obtain school examples in the language of instruction. An apparent deficit may reflect a mismatch between the language sampled in clinic and the language in which the child is most competent. A communication disorder is identified by persistent functional difficulty, not by departure from the clinician's preferred language or accent.

Care planning should translate the formulation into a functional question. What communication barrier currently blocks participation: understanding instructions, being understood, entering peer interaction, or speaking without avoidance? The psychiatrist coordinates assessment of associated developmental, sensory, neurological and emotional concerns, explains the profile to caregivers and school, and ensures that communication goals are concrete and observable. The intervention plan belongs to the relevant communication and educational professionals, while psychiatric follow-up monitors participation, comorbidity, family burden and barriers to sustained engagement.

MNEMONIC

MAPS the communication problem

Meaning and comprehension, **A**rticulation and intelligibility, **P**ace and fluency, **S**ocial use. It is a bedside organising aid, not a diagnostic instrument.

Classify communication disorders by the function that is persistently impaired, then use development, functional impact and the differential to decide whether that impairment is primary.

25 · Stuttering (childhood-onset fluency disorder) features and management

Why it matters clinically. A child who stutters is often heard through the discomfort of listeners rather than through the child's own communicative experience. The task is not to reward a fluent performance or to make the child speak faster. It is to recognise a disturbance in fluency, establish its developmental course, identify the patterns that create struggle or avoidance, and arrange help that protects participation as well as speech.



- Repetition or prolongation
- Block or visible effort
- Avoidance
- Developmental course
- Protect participation

Fig 22.21 Childhood-onset fluency disorder is assessed through the form and developmental course of dysfluency, visible struggle, avoidance and its effect on participation. Management does not demand faster or perfect speech; it protects communication while arranging proportionate speech-language help.

Childhood-onset fluency disorder, commonly called stuttering, is a developmental disorder of speech fluency. It is coded **F80.81** in a diagnostic classification and **6A01.1** in the international classification. The marks are usually won by describing the speech phenomena accurately, distinguishing a transient developmental pattern from a persistent disorder or an acquired change, and offering a proportionate management plan rather than a reflex prescription.

25.1 What the clinician is hearing

Fluency is the ease and temporal flow with which speech is produced. In stuttering, the disruption is not merely an occasional hesitation. The child may repeat a sound or syllable, prolong a sound, break a word, stop in the middle of an intended utterance, substitute a less difficult route around a word, or force a word out with visible effort. A **block** may be audible, or it may be a silent arrest in which the child appears unable to initiate the intended sound. Whole-

word repetition can also occur, especially when it is brief and effortless, so its meaning depends on the pattern around it rather than on its presence alone.

The useful clinical distinction is between a speaker who is searching for language and a speaker who knows what is to be said but cannot release speech in the expected flow. The latter may show tightening of the face or body, a sudden change of word, reduced eye contact, or an attempt to finish the interaction before the feared word arrives. These are not theatrical additions to a speech problem. They are part of the child's adaptation to an experience of loss of control in communication.

SPEECH OBSERVATION	WHAT TO LISTEN OR LOOK FOR	CLINICAL INTERPRETATION
Repetition	Recurring sound or syllable repetition, especially when effortful	Supports a fluency disturbance when embedded in a broader pattern of dysfluency
Prolongation	A sound carried beyond its usual duration	Suggests difficulty maintaining forward movement of speech
Block	Audible or silent interruption before the intended word emerges	May be missed if the interview attends only to what is spoken
Circumlocution	A word is avoided and the sentence is rerouted	May reveal anticipation and avoidance rather than a vocabulary deficit
Physical effort	Excess tension during word production	Signals struggle and a risk that the speech difficulty is shaping behaviour

The interview should therefore allow enough time for an utterance to emerge. Interrupting, supplying the word, or converting the encounter into a test of speed changes the very phenomenon being assessed. Observe spontaneous conversation and, where feasible, speech with a familiar adult and during a lower-pressure activity. The aim is a description of form, effort, anticipation and effect on communication, not a verdict based on a brief difficult sentence.

25.2 Clinical pattern and situational variation

Stuttering is characteristically variable. Dysfluency may worsen when there is **pressure to communicate** and may be absent while the child reads aloud, sings, or speaks to a pet or an inanimate object. This variation is diagnostically useful because it demonstrates that fluent speech is possible in some conditions. It must not be used to accuse the child of choosing the symptom. The speaking demand has changed: urgency, audience, self-monitoring and fear of interruption may all change at once.

Associated **motor movements**, such as blinking, facial tremor or a head movement, can occur when the child struggles to speak. They should be described in their temporal relation to the dysfluency. A movement that arrives as the child attempts to push through a block has a different clinical meaning from a recurrent vocal or motor tic occurring independently of speech. Stress and anxiety may exacerbate stuttering, but the clinician should avoid the lazy causal narrative

that makes emotional distress the origin of the fluency disorder. Distress can be a consequence of difficult speaking situations and can then maintain avoidance.

RULE **Situational improvement is a clue to speaking demand, not evidence of conscious control.** Ask what the setting changes for the child: time pressure, listener attention, anticipation, fear of interruption, or the need to perform.

In practice, parents may report that the child is fluent at home yet becomes markedly dysfluent when required to answer in class, speak to an unfamiliar adult, or respond before others. Conversely, a parent may notice a change only when the household becomes alert to it. Both reports deserve respect, but neither substitutes for a careful chronology and direct observation. The clinician's language matters here: calling the child "nervous" risks moving attention from communication demands to character.

GOOD TO REMEMBER

Ask the child, in developmentally appropriate language, what happens just before a difficult word and what they do when it happens. This often reveals avoidance, anticipation and the social cost of dysfluency more clearly than an adult observer can.

25.3 Course, frequency and family context

Onset is usually in the preschool period, typically at **2 to 7 years**; by age **6**, onset has occurred in **80 to 90%** of affected people. This developmental timing is why a chronological history is indispensable. Ask when dysfluency was first noticed, whether the onset was gradual or abrupt, whether it has waxed and waned, and how the child and family responded. A late change in fluency requires a different diagnostic frame from a childhood developmental presentation.

about 1%	4 to 5%	about 3 : 1	65 to 85%
CURRENT PREVALENCE IN YOUNGER CHILDREN	EVER AFFECTED IN THE POPULATION	MALE PREDOMINANCE MAY REACH	CHILDREN WHO RECOVER

Current prevalence and the proportion ever affected should not be treated as competing answers. A higher cumulative figure alongside a lower current figure is compatible with substantial natural recovery. For prognosis, severity at age 8 helps distinguish a course that is more likely to recover from one that is more likely to persist. That does not justify either fatalism or reassurance without follow-up. It tells the clinician to observe severity and functional adaptation over time rather than to rely on the first presentation alone.

Stuttering is more frequent in males, with male predominance reported as high as the ratio shown above. Family history is relevant: risk among first-degree biological relatives is more than 3 times that of the general population. A family history should be elicited without implying parental fault. It helps with formulation and vigilance, while the child's current speech pattern and experience remain the basis for clinical action.

Prognostic discussion must be honest and humane. Recovery is common, yet a child who is currently struggling does not experience the problem as a population statistic. The immediate

question is whether dysfluency is narrowing participation, provoking effort, or teaching the child to avoid being heard. This is where apparently reassuring epidemiology can be clinically unhelpful if it is used to minimise a child's present impairment.

25.4 Assessment and differential diagnosis

Assessment begins with a narrative rather than a checklist alone. Establish the onset and trajectory, the observable forms of dysfluency, situations of relative fluency, visible effort, avoidance, the child's own appraisal, and effects at home and school. Invite a parent to describe what they do when the child becomes stuck. The answer often identifies an interactional loop: hurried prompting, sentence completion, repeated correction, or a well-meant demand to begin again. These are modifiable features of the environment, not evidence that the family caused the disorder.

- Clarify whether dysfluency is effortless or accompanied by struggle and physical tension.
- Ask whether the child changes words, remains silent, or withdraws from speaking situations.
- Compare familiar, low-pressure and performance-like situations without treating any setting as a test of sincerity.
- Obtain the school account of participation, oral answering and peer responses.
- Ask about a family history of fluency difficulties in a neutral, non-blaming manner.

Normal childhood dysfluency may include whole-word or phrase repetitions and interjections. The contrast is not made by counting every hesitation. Persistent sound or syllable repetitions, prolongations, silent blocks and visible struggle are more concerning than a relaxed, transient disruption of speech flow. The examination answer should show this distinction clearly: normal dysfluency is a possibility to consider, not a label with which to dismiss a child who is working hard to speak.

Vocal tics can be confused with speech dysfluency when they interrupt communication, but their phenomenology and temporal relationship to intended speech differ. Tourette's disorder and other tic disorders are addressed in the Child behavioural, emotional and other disorders notes. The present assessment should simply determine whether the sound is a disruption of intended verbal output or a recurrent vocal phenomenon with its own pattern.

Adult-onset dysfluency is another important distinction. A new fluency disturbance later in life, particularly in the setting of a neurological insult or medical cause, is not a childhood neurodevelopmental disorder and needs an acquired-disorder evaluation. Do not force a developmental label onto a history that does not fit its course.

TRAP **Do not diagnose from a repetition alone.** A fluent-speech disorder is recognised from the form of dysfluency, effort, persistence, context and effect on communication. Counting a single conversational habit without this frame creates false certainty.

PITFALL

A silent block may be mistaken for refusal, shyness or lack of knowledge because the clinician hears no repeated sound. Watching the attempt to speak, and asking what happened in that pause, prevents a punitive or dismissive response.

25.5 Formulation and the decision to observe or intervene

A useful formulation integrates the speech pattern with its consequences. Describe the predominant dysfluencies, the degree of struggle, triggers that increase speaking demand, avoidance, the child's emotional meaning of the problem, family responses and school impact. This formulation is more useful than a yes-or-no statement that the child either has or does not have stuttering. It tells the treating team what must change: speech motor pattern, anticipatory fear, social participation, listener behaviour, or some combination of these.

Not every preschool dysfluency requires immediate formal treatment. In a preschool child without struggle or self-consciousness, **watchful waiting** with review in about 6 months can be appropriate before speech therapy begins. The point of observation is active surveillance, not abandonment. Parents need a return plan and a clear explanation of what changes should prompt earlier reassessment: increasing visible effort, avoidance, distress, or reduced participation.

Conversely, the presence of struggle or self-consciousness changes the clinical priority. When a child begins to fear a word, to reroute sentences, or to retreat from conversation, waiting can allow the secondary problem to become more entrenched. The decision to refer is therefore based on the child's trajectory and adaptation, not on the clinician's wish to eliminate every imperfect utterance. The child should not be turned into a project for adults who are more uncomfortable with pauses than the child is.

IN INDIA

Explain the referral in functional terms: the aim is to improve ease of communication and participation, not to test intelligence or assign blame. Where specialist speech services are not immediately accessible, the psychiatrist can still prevent harm by coaching the family and school to slow the interaction, allow the child to finish, and avoid public correction while arranging appropriate assessment.

25.6 Speech intervention and psychological support

Speech therapy is the mainstay of management. Its value lies in skilled assessment and in making the work fit the child's actual pattern rather than applying a generic instruction to "speak slowly". Broad therapeutic orientations are useful to understand. **Fluency-shaping** approaches work towards producing more fluent speech. **Stuttering-modification** approaches work towards speaking with less tension, avoidance and interruption even when stuttering occurs. In practice, the clinical aim is not perfection; it is a more manageable, less feared way of communicating.

The psychiatrist's role is collaborative. Ensure that the speech intervention is linked to the child's lived goals, not merely to a listener's judgement of smoothness. Explore embarrassment, anger, anticipatory anxiety, bullying or withdrawal when these are present, and offer counselling for

self-concept effects. Psychological work can reduce the secondary burden of a communication difficulty and help the child re-enter avoided situations. It should not be presented as a substitute cure for the speech disturbance itself.

Psychotherapy alone is not effective for stuttering itself, and anxiolytic or tranquilising medication is not effective for stuttering itself. This is an important corrective to a common psychiatric reflex: anxiety around speech does not make the primary disorder an anxiety disorder. Treat clinically significant emotional consequences in their own right, while maintaining speech-focused intervention as the central treatment for fluency.

Goals should be concrete but person-centred. They may concern initiating a conversation, completing an answer without being rushed, tolerating a moment of dysfluency without abandoning the message, or participating in school despite anticipated difficulty. A good plan makes room for communication agency. It does not tell a child that being an acceptable speaker depends on sounding like everyone else.

25.7 Working with family and school

Families often arrive with a repertoire of intuitive but unhelpful instructions: "take a breath", "think before you speak", "start again", "slow down", or "say it properly". Some children may find a particular cue useful in a therapeutic context, but repetitive correction from every listener can increase self-monitoring and turn speech into a public examination. The more reliable family stance is calm attention to the message, time to finish, and permission not to repair every dysfluency.

School is a treatment setting because it is where speaking is repeatedly evaluated in front of others. The clinician can ask that staff do not complete the child's words, do not demand a restart after dysfluency, and do not use oral performance as a moral test of effort. The child should be offered a predictable, respectful way to participate. This is not an exemption from learning; it is removal of a communication barrier that may otherwise obscure what the child knows.

Parents may need help separating their worry from the child's needs. Persistent watching, recording every disruption, or discussing speech in front of the child can turn an intermittent difficulty into a family preoccupation. Conversely, pretending not to notice when the child is distressed can feel invalidating. The balanced response is simple: notice the effort, listen to the content, make time available, and invite the child to say what kind of help is welcome.

25.8 Review, communication and examination synthesis

Review should return to the same domains used in the initial formulation: speech pattern, effort, avoidance, participation, self-appraisal, listener responses and school experience. Apparent fluency in a brief clinic conversation is not enough to declare success if the child is still avoiding a classroom answer or avoiding particular words. Equally, occasional dysfluency after treatment is not treatment failure if struggle, interruption and fear have diminished and participation has expanded.

For the written answer, lead with the developmental fluency disorder and its characteristic dysfluencies. Then show that age of onset, course, familial risk and situational variation inform formulation. Distinguish normal childhood dysfluency, vocal tics and acquired later-onset dysfluency. Finish with proportionate management: observe selected preschool presentations, refer for speech therapy when indicated, address secondary psychological and social effects, and change the family and school interaction around speech.

> Stuttering management is speech-focused, participation-focused and shame-reducing: assess struggle and avoidance, use speech therapy as the mainstay, and treat the child's communication world as carefully as the dysfluency.

26 · Developmental coordination disorder

Why it matters clinically. A child who is slow with dressing, avoids ball games, produces laborious written work, or repeatedly drops objects can be misunderstood as careless, oppositional, inattentive, or simply insufficiently practised. Developmental coordination disorder is the diagnostic framework for a developmental difficulty in motor coordination when the difficulty is demonstrable, functionally important, early in origin, and not better accounted for by another condition. The task for the psychiatrist is therefore not to label clumsiness. It is to decide whether a recognisable developmental motor difficulty is impairing the child's ordinary participation, while protecting the child from an inappropriate psychiatric explanation for a neurological or sensory disorder.

The diagnostic work is often deceptively demanding because the referral language is usually an activity complaint rather than a motor formulation. A parent may describe untidiness, avoidance, slow self-care, or an inability to keep up with peers. A teacher may describe poor written output, difficulty using classroom materials, or reluctance during play. These observations become clinically useful only when translated into the motor task, the context in which it occurs, the opportunity the child has had to learn it, and the consequence for participation. That sequence is also a good answer structure: establish the motor deficit, establish impairment, establish developmental onset, and exclude better explanations.

26.1 Core clinical construct

The centre of the disorder is **coordinated motor-skill acquisition and execution** that is substantially below what would be expected for the child's chronological age and **opportunity to learn**. Both parts of this formulation matter. A child may know what is wanted, be motivated to do it, and still have trouble converting the intention into a smooth, efficient movement. Conversely, a child who has not had a reasonable chance to acquire a particular skill should not be judged against an assumed competence in that skill.

The clinical picture can involve **fine and gross motor skills**. Fine-motor difficulty may be evident in use of scissors, cutlery, or handwriting, or other tasks requiring control and sequencing. Gross-motor difficulty may be evident while catching, cycling, or participating in sports. Dropping objects and bumping into things convey the everyday meaning of clumsiness,

whereas slowness and inaccuracy show why a child may complete a task only with disproportionate effort. These are examples that make the construct visible; none is diagnostic in isolation.

It is useful to ask what happens when the child repeats the task. The relevant concern is not a single awkward performance in a strange clinic room. It is a consistent pattern across familiar activities, described by people who see the child in ordinary settings. A careful account also distinguishes quality from speed. Some children can eventually complete a task but do so so slowly that its practical use is compromised; others work quickly but inaccurately; still others have both difficulties. The history should preserve this distinction, because it explains the real burden on the child better than the global word "clumsy".

RULE **Diagnose a developmental motor disorder from a pattern of impaired coordination and its consequences, not from an isolated complaint about handwriting or play.** The clinician has to show that the motor difficulty is developmental, materially below expectation after opportunity to learn is considered, and meaningful in the child's life.

26.2 Functional impairment gives the diagnosis clinical weight

Criterion B is not an administrative add-on. It requires **persistent functional interference**: the motor deficit must significantly interfere with age-appropriate activities of daily living and affect participation in school productivity, prevocational or vocational activity, leisure, play, or all of these. The key word is participation. The psychiatrist should ask what the child cannot do independently, efficiently, or reliably enough to take part on the same terms as expected in that setting.

Functional questions convert a vague complaint into an observable formulation. In self-care, ask about tasks that require manipulating clothing or utensils, and whether assistance, extra time, or avoidance is needed. In school, clarify whether the difficulty lies in producing written work, handling materials, copying, or sustaining output over the routine demands of the class. In leisure and play, ask whether the child chooses not to join, falls behind because of motor inefficiency, or is excluded by peers. This approach separates impairment from a parent's understandable worry about performance and also identifies the situations in which support should be designed.

"Persistent" means that the difficulty is not inferred from a transient fluctuation in confidence, a recent injury, or a task that has only just been introduced. Obtain examples over time and across settings, then look for convergence between the child's account, caregiver observations, and school information. A child may minimise embarrassment, while adults may normalise it as a personality trait. The clinician's job is to make the functional cost explicit without converting every difference in skill into pathology.

- Identify the specific motor task that breaks down.
- Ask what the child does instead: avoids it, accepts help, takes excessive time, or persists inaccurately.
- Establish the effect on self-care, school work, play, or leisure.

- Ask whether the difficulty is present in more than one ordinary context.
- Record the child's own experience of frustration, shame, or exclusion without assuming that these feelings constitute the disorder.

GOOD TO REMEMBER

The most useful formulation names an activity rather than merely writing "poor coordination". It links the motor problem to a concrete participation cost, which then gives the family, school, and rehabilitation professionals a shared target.

26.3 Developmental timing and diagnostic caution in young children

The required **early developmental onset** prevents an acquired movement problem from being folded into this diagnosis. The history should seek the earliest recognisable pattern, not merely the age at which a teacher or family first became worried. Delayed motor milestones may be the first sign when intellectual disability is absent, but their presence should lead to a developmental history and examination rather than a reflex diagnosis. Apparent onset is often shaped by the changing demands placed on the child: a difficulty may become obvious only when the child is expected to manage more complex self-care, classroom work, or play.

There is particular value in diagnostic humility in early childhood. Normal variation in motor development is broad at that stage, and performance may be highly dependent on familiarity, attention, confidence, and the demands of the setting. A formal diagnosis **under age 5** is initiated only when impairment is severe; it is usually confirmed with a second motor assessment at least 3 months apart. This is not a reason to dismiss concern. It is a reason to document the observed difficulty carefully, address present functional needs, and revisit the formulation as the developmental picture becomes clearer.

In practice, chronological detail strengthens the history. Ask whether the child has always needed more help with motor tasks, whether there has been loss of a previously acquired ability, and whether the pattern is stable or progressive. Loss or progression changes the clinical question and should prompt reconsideration of the exclusionary assessment. The aim is neither premature certainty nor passive waiting. It is a defensible account of what is known now and what needs reassessment.

IN INDIA

School concerns may reach the clinic through a complaint of slow written work, poor neatness, or avoidance of games rather than through a motor-development referral. Ask the family and school to describe the actual task, the assistance already provided, and the child's opportunity to practise it. This avoids mistaking limited access or unfamiliarity for a developmental motor disorder.

26.4 Exclusion is active clinical work

Criterion D requires that the coordination deficits are not better explained by intellectual developmental disorder or visual impairment, and are not attributable to a neurological condition affecting movement. The relevant **neurological and sensory exclusion** is therefore not a

sentence added after the history. It is the part of the assessment that establishes whether the observed motor difficulty belongs within a developmental coordination formulation at all.

Take a focused account of vision, neurological symptoms, developmental pattern, and change over time, then examine the child sufficiently to decide whether a neurological assessment is needed. Significant ataxia, hypotonia, or asymmetry warrant neurological assessment. A child with such signs should not be reassured by the convenience of a behavioural label. Similarly, when visual impairment or intellectual developmental disorder is present, the question is whether these better explain the motor difficulty, not whether the child also appears awkward. The diagnosis asks for a judgement about explanation, not a checklist of coexisting labels.

Use the examination to test the coherence of the history, not to stage a performance test in front of an anxious child. Observe how the child approaches a task, responds to instruction, corrects an error, and manages the motor demands of the consultation. Then compare that observation with the caregiver's and teacher's accounts of familiar activities. An unexpectedly poor clinic performance may reflect unfamiliarity or distress; an apparently fluent clinic performance does not erase a well-described functional difficulty at home or school. What matters is a reasoned synthesis of longitudinal evidence, direct observation, and the exclusionary examination.

The wording of the final assessment should show this reasoning. State the activity-level evidence, the functional effect, the developmental history, and the findings that make a competing explanation less likely. If an exclusion remains unresolved, record the diagnostic uncertainty and arrange the appropriate assessment rather than treating the provisional label as settled. This is especially important when the presenting complaint is narrow but the examination suggests a wider movement problem.

DIAGNOSTIC QUESTION	WHAT THE CLINICIAN ESTABLISHES	WHY IT CHANGES THE FORMULATION
Motor skill	Motor coordination is materially below expectation after opportunity to learn is considered.	Moves the history beyond a non-specific complaint.
Daily participation	Functional interference is persistent and affects age-appropriate everyday activity or productivity.	Distinguishes a clinically important disorder from an isolated weak skill.
Developmental history	The developmental pattern begins early.	Guards against misclassifying an acquired problem.
Alternative explanation	Alternative explanations have been actively considered.	Protects against diagnostic overshadowing.

TRAP **Do not call every child with poor handwriting "developmental coordination disorder".** Handwriting may be the presenting activity, but the diagnosis requires the full motor, functional, developmental, and exclusionary formulation. A narrow school complaint is a starting point for assessment, not a conclusion.

PITFALL

Do not allow an ADHD label to terminate the motor assessment. Inattention can make performance look disorganised, yet a history of persistent coordination difficulty with functional consequences still needs its own formulation and exclusions.

26.5 Epidemiology and clinically relevant co-occurrence

Among school-age children, the reported prevalence is about **5 to 6%**. This anchors the disorder as a familiar clinical possibility rather than a rare explanation for school difficulty. The estimate is documented across diverse regions, but prevalence should not be used as a shortcut to diagnosis in an individual child. The child still needs the functional and exclusionary work described above. A severe presentation has been reported in about **1.8%** of children at age 7, reminding the clinician that severity is expressed in the extent of everyday burden rather than in the vividness of a single symptom.

Recent population studies report a male:female ratio of about **2 : 1**. This is useful background, not a diagnostic rule. Sex ratio cannot establish or exclude the disorder in a particular child and should never displace the direct account of motor function. Older clinical samples reported higher ratios, which further cautions against making broad inferences from a child's sex.

DCD and ADHD frequently meet in clinical practice. DCD co-occurs with ADHD in about **30 to 50%** of cases. Communication disorders and specific learning disorders may also be comorbid, and inattentive symptoms are most associated with motor problems. The practical implication is not that all difficulties belong to one diagnosis. It is that each domain should be assessed for its independent functional contribution. ADHD is addressed elsewhere in this chapter; communication and learning difficulties should be named and evaluated on their own merits rather than being treated as proof of DCD.

A	B	C	D
MOTOR SKILL	FUNCTIONAL IMPACT	DEVELOPMENTAL ONSET	ALTERNATIVE EXPLANATIONS

26.6 Classification and coding

Cross-system language should be handled precisely. In ICD-11, developmental motor coordination disorder is coded 6A04. The older ICD-10 formulation required an IQ of at least 70 and motor performance at least 2 SD below the mean on a standardised test. DSM-5-TR does not set those ICD-10 numerical thresholds. A candidate who quotes a threshold without naming the classification system creates a false impression of equivalence.

This distinction is more than a coding footnote. Classification language directs the clinician towards different forms of documentation. A descriptive formulation should still state the observed motor difficulty, its functional consequences, developmental timing, and the basis on which alternatives were considered. Coding follows that reasoning; it does not replace it. When reports from different settings use different terminology, make the clinical formulation readable before resolving the administrative label.

RULE **Never transfer a numerical threshold from one classification system into another.** State the system first, then the criterion it actually uses. This preserves diagnostic accuracy and prevents a coding convention from being mistaken for a universal clinical rule.

26.7 From diagnosis to a useful care formulation

A diagnosis is clinically useful only when it clarifies what must change in the child's environment and support plan. Start with the activity that is actually impaired, the setting in which the impairment is most costly, the help already available, and the child's experience of repeated failure. The resulting plan should be coordinated with caregivers, school, and relevant rehabilitation professionals, with goals framed around participation rather than around an abstract wish to make the child less clumsy. Documentation should make it possible to review whether the assistance is reducing the real functional burden.

Psychiatric care also includes protecting the child's self-understanding. Recurrent failure in visible tasks can invite criticism from adults and peers, while the child may respond with avoidance, irritability, or apparent disinterest. These responses require empathic enquiry, but they should not be used to explain away the motor difficulty. Conversely, emotional distress should be assessed on its own terms and not assumed to follow automatically from DCD. A formulation that preserves both the motor problem and the child's psychological experience is more likely to be accurate and humane.

When the diagnostic picture is complex, the broader assessment and service framework is set out in the Child psychiatry: assessment, treatment, services and protection notes. Developmental expectations and milestone interpretation are addressed in the Normal child development and milestones notes. Intellectual disability, autism, and the relevant diagnostic discriminations are addressed in the Intellectual disability and autism spectrum disorder notes. These cross-references prevent a motor formulation from becoming a substitute for a comprehensive developmental assessment.

MNEMONIC

SKILL

Skill deficit, **K**nown functional consequence, **I**nitial developmental onset, **L**ook for better explanations, **L**ink supports to participation. Use it as a sequence for organising the history and examination, not as a replacement for them.

Developmental coordination disorder requires a developmental motor coordination deficit, persistent functional impact, early onset, and exclusion of better explanations.

27 · Stereotypic movement disorder

Why it matters clinically. Repetitive movements are common reasons for referral, but the psychiatric task is not to label every unusual movement as a disorder. The useful distinction is between a pattern that is transient or contained and a pattern whose form, impact, associated

injury, and developmental context demand a diagnostic formulation. **Stereotypic movement disorder** is the diagnosis used when repetitive motor behaviour is apparently driven, non-functional, and often rhythmic. It sits at the junction of developmental psychiatry, behavioural observation, neurological differential diagnosis, and safeguarding. A good answer therefore describes the movement before naming the diagnosis.

The examination value of the topic lies in discrimination. A candidate should be able to recognise a fixed rhythmic movement, determine whether it is impairing or injurious, and distinguish it from tics and compulsions without turning a movement description into a diagnosis by reflex. The same approach matters in practice: the movement may be the most visible part of a broader developmental or medical presentation, while the immediate clinical priority may be the harm it causes or the distress it signals.

27.1 The clinical phenomenon

A stereotypy is best approached as a movement pattern with a recognisable form. It is repetitive, seemingly driven and **non-functional motor behaviour**, often with a rhythmic quality. The term "purposeless" can be useful descriptively, but it should not be mistaken for an accusation that the child is choosing to misbehave. A movement can look non-functional to the observer and still have a subjective regulatory role for the child, for example by easing an aversive internal state. Apparent lack of ordinary purpose does not establish volition, and apparent relief does not turn the movement into a preventive ritual.

The visible repertoire is broad. It may include hand shaking, waving or flapping; body rocking; **head banging**; mouthing objects; self-biting; skin picking; or hitting the body. Describing the exact topography in the history is more informative than recording only "abnormal movements." Ask what body part moves, whether the sequence is recognisably the same on different occasions, whether it is rhythmic, what precedes it, what interrupts it, and what follows it. This preserves the phenomenology that later permits a defensible differential diagnosis.

There is an important conceptual boundary here. Stereotypic movements are defined by their patterned repetition and relative simplicity, not by their dramatic appearance. A striking movement can be benign in context, while a small repetitive act can deserve urgent attention if it causes injury or derails ordinary activity. The assessment should therefore move from description to consequence rather than allowing the observer's discomfort with the movement to determine severity.

RULE **Name the movement before naming the disorder.** A precise account of rhythm, form, context, interruption and consequence is the clinical evidence from which the diagnosis follows.

27.2 When the behaviour becomes a disorder

The diagnosis requires more than a movement that is repetitive. The behaviour must produce **interference with social, academic or other activities**, or it may result in self-injury. This threshold redirects attention from oddness to burden. Interference may arise because the movement repeatedly interrupts participation, draws the child out of a task, limits access to

ordinary settings, or creates conflict around the behaviour. It should be documented in concrete functional terms rather than inferred merely because an adult regards the movement as inappropriate.

The safety question comes early. Self-injury changes the urgency and content of the assessment. Clarify the tissue damage or other harm, the circumstances in which it occurs, the ability of caregivers to interrupt it safely, and the immediate environmental risks. The movement itself may be the target of clinical attention, but the formulation must also ask what makes the child vulnerable at the time it occurs: demand, frustration, arousal, sensory context, separation, boredom, discomfort, or an unrecognised medical problem. These are hypotheses to explore, not assumptions to impose.

Onset belongs in the **early developmental period**. This makes developmental history central, not ornamental. Establish when caregivers first noticed the pattern, whether the movement has retained a similar form, and how it sits alongside the child's broader developmental trajectory. Current diagnostic framing does not require the clinician to prove that the movement is intentional. It also does not impose a fixed minimum duration before the movement can be considered diagnostically. These changes matter because an insistence on demonstrated intent or arbitrary waiting can delay attention to a child whose movements are already harmful or disabling.

- Record the movement in plain observable language before using diagnostic terminology.
- Establish functional impact and injury directly rather than treating either as incidental.
- Place the onset and course within developmental history.

> **GOOD TO REMEMBER**
>
> Caregivers may report that the child "does it when upset" or "does it when excited." Treat this as useful context, not as a substitute for describing the movement itself. The same trigger can accompany different movement phenomena, whereas the form and purpose of the behaviour drive the differential.

27.3 Classification and formulation

Classification should support, rather than replace, clinical description. In DSM terminology, stereotypic movement disorder is coded **F98.4**. The diagnosis is specified as with or without self-injurious behaviour. In ICD terminology, the parent code is **6A06**, with further coding that records the self-injury status. The coding distinction is clinically meaningful because self-injury signals a different risk burden and makes the immediate consequences of the behaviour explicit in the record.

The formulation should also state whether the stereotypy is associated with a known genetic or medical condition, a neurodevelopmental disorder, or an environmental factor. This does not reduce the movement to an automatic by-product of an associated condition. Instead, it forces the clinician to decide whether the repetitive behaviour is clinically important in its own right and what context changes its interpretation. In a child with developmental difficulties, for

example, the question is not simply whether stereotypies are "expected," but whether this particular behaviour is causing injury, functional restriction, or caregiver strain.

The specifier is especially relevant where repetitive self-injury becomes a focus of treatment in the context of intellectual disability. It permits the clinical record to represent the behaviour without assuming that intellectual disability alone explains the current problem. Intellectual disability and autism spectrum disorder should be understood through *the Intellectual disability and autism spectrum disorder notes*; those conditions are named here only because they can shape the setting in which stereotypies are seen.

Rhythmic pattern	Early development	Functional impact	Self-injury
CORE DESCRIPTION	EXPECTED ONSET FRAME	DIAGNOSTIC THRESHOLD	ESSENTIAL SPECIFIER

27.4 Developmental context and frequency

Developmental context prevents overdiagnosis. Rhythmic activity may occur in children without disabilities and recede as more complex functional behaviours are mastered. Available data indicate that **about 80%** of children show rhythmic activities that disappear by age 4. Repetitive body rocking is reported in about 20% of this group. These observations do not make all rhythmic movement reassuring; rather, they explain why diagnosis depends on impairment, injury, persistence in a clinically concerning form, and context rather than simple presence of a movement.

Head banging illustrates the same point. Among children without disabilities, the reported frequency is **3 to 15%**; it is reported in about three times as many boys as girls. It commonly emerges between 5 and 11 months, and only about 5% persist beyond age 3. The lesson is not to reassure indiscriminately. A movement that is developmentally familiar may still warrant a full assessment when it causes harm or interferes with ordinary life.

Conversely, stereotypies are particularly salient in people with intellectual disability. They occur in about two-thirds of institutionalised individuals with intellectual disability and in about 20% of those with severe intellectual disability. Self-injurious behaviour is reported from **about 2 to 3%** among community children and adolescents to about 10 to 15% among adults with severe or profound intellectual disability in residential care. These figures cannot predict risk for an individual child. Their clinical value is to make self-injury an active enquiry, especially where communication limitations make pain, distress, or environmental mismatch hard to express directly.

IN INDIA

Children may reach assessment through paediatrics, a school concern, a disability service, or a child mental-health clinic. Whichever route brings the family, the record should preserve the observable movement, injury, functional consequences, developmental context, and family account. This makes later communication across services clearer and avoids a vague label following the child without the phenomenology that justifies it.

27.5 Associations that change the clinical question

Stereotypies and self-injury can feature in **Lesch-Nyhan, Rett, Fragile X, Cornelia de Lange, Smith-Magenis and Cri-du-Chat syndromes**. Stereotypies are also common in blindness and autism spectrum disorder. These associations should prompt a broader formulation, not a shortcut to genetic attribution. The movement alone neither establishes an associated condition nor explains it. Ask whether there are features in the history or examination that make a developmental, genetic, sensory, medical, or neurological context plausible, and pursue that context through appropriate multidisciplinary assessment.

The distinction between association and explanation is clinically protective. Attributing every self-injurious act to a known developmental diagnosis can obscure pain, environmental stress, or another cause requiring attention. The reverse error is to investigate endlessly while failing to address the injury and daily interference already evident. The best formulation keeps the current behaviour and its possible contributors visible together.

Caregivers often need language that avoids blame. Explain that the assessment is trying to understand the pattern and its consequences, not to decide whether the child is "naughty" or whether the family has caused it. This improves the quality of observation supplied by families and helps clinicians obtain reports that separate a repetitive movement from the emotions surrounding it.

MNEMONIC

RIF: Rhythm, Impact, Framework

Use this brief spine when observing a repetitive movement: define its **R**hythm and form, establish its functional **I**mpact and injury, then place it in its developmental and clinical **F**ramework.

27.6 Assessment: from observation to formulation

Assessment begins with a movement description and expands only as the formulation requires. Obtain an account from the people who have seen the child in ordinary settings, then clarify the setting, antecedents, consequences, and attempts to interrupt the behaviour. The clinician should distinguish an observed fact from an interpretation: "repeatedly struck the side of the head in a similar rhythm during waiting" is a useful observation; "attention-seeking" is a hypothesis that requires evidence.

Direct observation is valuable, but absence of the movement during a brief consultation does not invalidate a carefully elicited history. Ask what the movement looks like at its worst, whether it occurs in more than one setting, what adults do when it appears, and whether those responses alter the sequence. Enquire separately about injury, pain, sleep, feeding, sensory difficulties, medication and substance exposure, and neurological or medical symptoms, because the diagnosis must not be made when another explanation better accounts for the movement.

- Describe form, rhythm, complexity, and fixedness of the movement.
- Map the setting, the child's state, functional interference, and self-injury.

- Review developmental, medical, neurological, medication, substance, and collateral context.

This assessment style is deliberately cautious. It avoids treating a family's account as either unquestionable fact or irrelevant anecdote. It also avoids a false choice between "behavioural" and "medical" explanations. A good formulation can identify a stereotyped pattern, retain uncertainty about its drivers, and still make a clear decision about current risk and functional need.

PITFALL

Do not record "self-injury" as if it explains itself. It is a consequence that demands a description of the act, its severity, the context in which it occurs, and possible contributors. Collapsing these questions into a single label makes risk assessment and later review less reliable.

27.7 Differential diagnosis: tics and compulsions

The most tested discrimination is from tics. **Stereotypies** are more likely to be rhythmic, repetitive, simple, fixed, and present from earlier in development. **Tics** are not rhythmic, carry an involuntary quality, and can be suppressed only for limited periods. This is a comparison of movement phenomenology, not a request for the child to provide a sophisticated account of inner experience. Observe what the movement does over time and ask caregivers whether its form shifts, whether it has a recognisable rhythm, and what happens when it is interrupted. Tics and Tourette syndrome are addressed in the Child behavioural, emotional and other disorders notes.

The other essential differential is from obsessive-compulsive behaviour. **Compulsions** are more complex and ritualised, usually non-rhythmic, and are performed to prevent a feared event or relieve a sense of incompletion. Stereotypies are simpler and rhythmic, and they are not preventive acts. The distinction is especially important when a repetitive action is described using words such as "has to." That phrase can reflect an adult's impression of persistence rather than the child's experience of a feared consequence or incompleteness.

FEATURE	STEREOTYPY	TIC	COMPULSION
Pattern	Rhythmic and fixed	Not rhythmic	Usually not rhythmic
Complexity	Relatively simple	Involuntary quality	Complex and ritualised
Function	Not a preventive measure	Suppression is limited	Preventive act or in-completeness-driven

TRAP **Do not call every repetitive act a compulsion.** A compulsion has a ritualised, preventive or incompleteness-driven quality; persistence alone does not supply that meaning.

27.8 Exclusions, synthesis, and the examination answer

The diagnosis should not be made when the movement is better explained by a substance or medication, a medical or neurological condition, tic disorder, obsessive-compulsive disorder, or trichotillomania. These **exclusions** are not a checklist to recite after the diagnosis. They direct

the history and examination: medication and substance exposure may point to a movement effect; medical or neurological findings may redirect the formulation; the structure and subjective meaning of the act may indicate tic, compulsion, or hair-pulling rather than stereotypy.

In an examination answer, begin with the core phenomenon, then state the requirement for impairment or self-injury and early developmental onset. Follow with the self-injury and association specifiers, then contrast the movement with tics and compulsions using rhythm, fixedness, complexity, and preventive function. Conclude by stating that alternative substance-related, medical, neurological, tic, obsessive-compulsive, and trichotillomania explanations must be excluded. This sequence demonstrates clinical reasoning rather than memorised labels.

For the clinician, the same sequence produces a usable record. It identifies what the child does, why it is currently important, what risk is present, where it sits developmentally, and which alternatives need active consideration. The aim is not to eradicate every repetitive movement from childhood. It is to recognise the pattern that has become impairing or harmful, avoid misclassification, and make the formulation clear enough for the family and treating team to act on it together.

> Stereotypic movement disorder is a non-functional, often rhythmic repetitive movement pattern that is fixed, arises in early development, and becomes clinically significant through impairment or self-injury, after relevant alternatives have been excluded.

Discriminate, apply and consolidate

28 · Differentiating SLD from intellectual disability, ADHD and slow learner

Why it matters clinically. A child who is not progressing at school may look inattentive, unmotivated, immature, anxious, or simply "weak in studies". Those descriptions are observations, not formulations. The diagnostic task is to decide whether the difficulty is confined to a particular learned skill, reflects a broad limitation in intellectual functioning, follows from difficulty regulating attention and behaviour, or represents globally lower but non-diagnostic ability. The labels carry different implications for explanation, documentation, educational planning and the conversation with family and school.

The useful organising question is not "How poorly is the child performing?" but **"Is the problem specific or global?"** A second question follows immediately: is there meaningful difficulty managing the ordinary demands of daily life, or is the concern principally academic? This prevents the common error of treating all low achievement as a learning disorder, and the equally damaging error of treating a circumscribed reading, writing or mathematics difficulty as evidence of global intellectual limitation. These distinctions are especially important when the presenting complaint has been compressed into the school's shorthand.

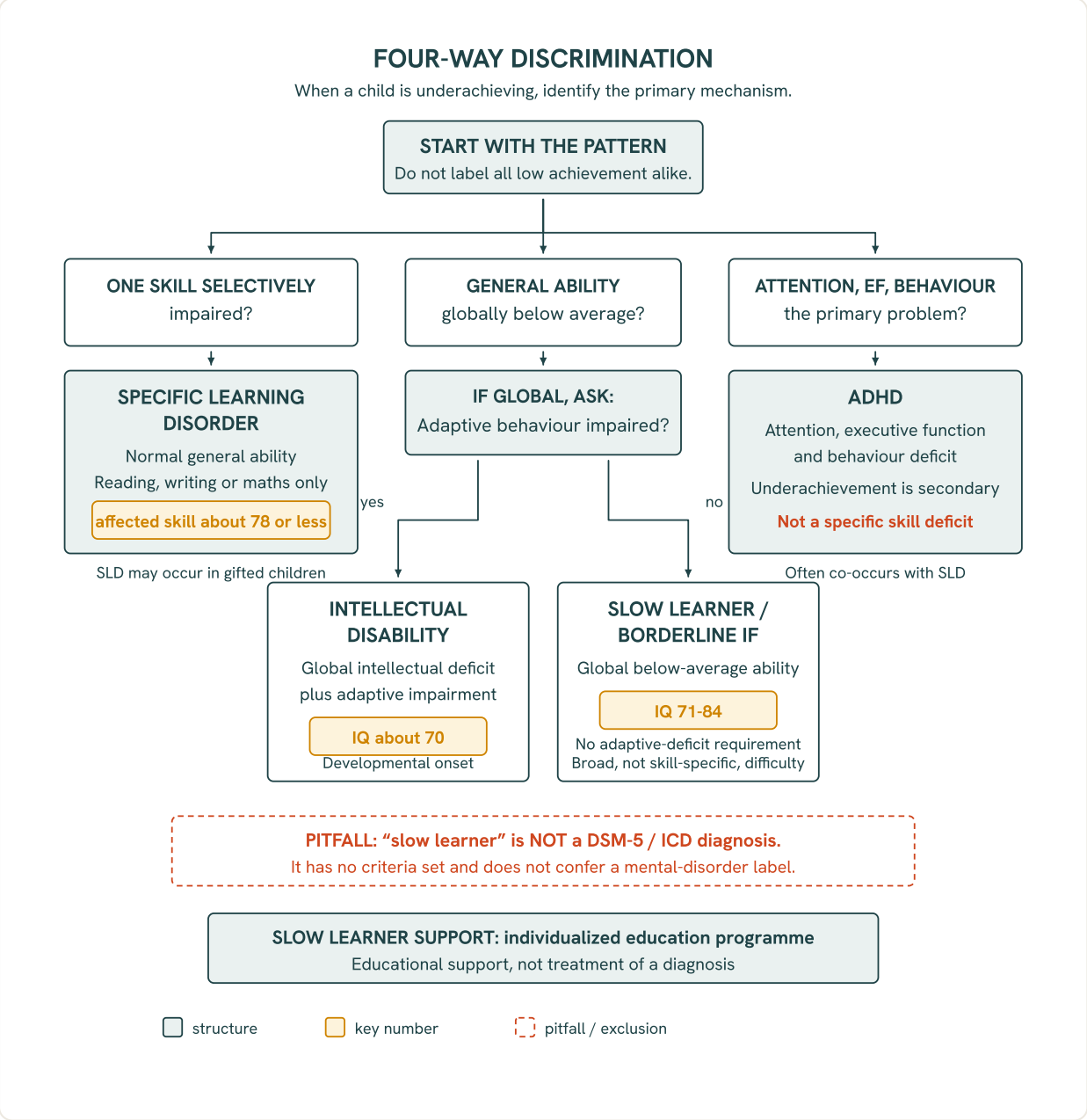


Fig 22.22. Four-way discrimination of specific learning disorder, intellectual disability, ADHD and slow learner / borderline intellectual functioning.

28.1 Start with the pattern, not the school mark

School performance is an outcome produced by several interacting capacities. It is influenced by the match between the child's skills and the curriculum, sustained attention during teaching and independent work, the opportunity to learn, emotional state, language of instruction, attendance, family expectations and the school's response to difficulty. A low mark therefore establishes educational need, but it does not by itself reveal the nature of that need. The clinician should resist premature labels based on a single report such as "poor in everything" or "cannot concentrate".

For differential diagnosis, map the difficulty across tasks rather than accepting a global adjective. Ask whether the child can reason, converse, learn practical routines and understand material when it is presented without the affected academic demand. Then ask whether the failure is sharply concentrated in reading, written expression or mathematics, whether it extends across

school learning, or whether output varies chiefly with the demands on attention and self-regulation. This is pattern recognition, not an exercise in finding a single test score that can settle the case.

Specific	Global	Secondary	Broad
ACADEMIC SKILL	ABILITY PATTERN	ATTENTION EFFECT	EDUCATIONAL NEED

A **specific learning disorder** is suggested when general intellectual ability is in the normal range but achievement in an academic skill is distinctly weak. The weakness is not merely a lower preference for a subject or a temporary fall in performance. It is an isolated deficit in a skill domain against a background of otherwise adequate general ability. A child may show intact oral explanation, practical problem solving and curiosity, yet struggle persistently when required to decode text, produce written work or manipulate numerical material. The discrepancy between what the child can understand and what the child can demonstrate through the affected skill is the clinical clue.

The comparison is not a contest between intelligence and effort. A child with an isolated academic-skill deficit can work very hard and still produce poor output in that skill. Conversely, a child with lower broad ability may be diligent and improve with teaching, while continuing to find the general pace and abstraction of the curriculum difficult. The interview should make room for both truths. Blaming the child obscures the pattern; idealising effort as proof that no disorder is present does the same.

RULE **Classify the shape of the difficulty before naming it.** A skill-bound failure, a broad limitation, and variable work caused by inattention can all produce underachievement, but they are not interchangeable explanations.

28.2 Specific learning disorder and intellectual disability: the central separation

The distinction between specific learning disorder and **intellectual disability** rests on the distribution of impairment. In specific learning disorder, the defining clinical picture is a disproportionate academic-skill deficit with otherwise normal-range general ability. Achievement in the affected skill may be **at least 1.5 SD below** the population mean for age, corresponding to a score of **about 78 or less** on that skill. These figures support the identification of a clinically significant skill deficit; they do not replace the need to understand the child's developmental and educational context.

Intellectual disability is different in kind, not simply in degree. It involves a global deficit across intellectual domains together with significant impairment in **adaptive functioning**, with onset during the developmental period. The relevant intellectual level is approximately **2 SD below** the mean, or an IQ of **about 70**. The decisive clinical addition is adaptive impairment. A child's ability to manage conceptual demands, social judgement and practical everyday tasks gives the score its meaning. Low academic attainment without this broader pattern should not be converted automatically into intellectual disability.

AXIS	SPECIFIC LEARNING DISORDER	INTELLECTUAL DISABILITY
General ability	Normal range overall	Globally impaired
Academic pattern	Deficit concentrated in an academic skill	Difficulty extends across intellectual learning demands
Adaptive functioning	Does not require adaptive impairment	Significant impairment is part of the clinical picture
Clinical inference	Ask what makes the affected skill uniquely difficult	Ask how broad intellectual and daily-life limitations affect support needs

Do not reduce adaptive functioning to academic independence. A pupil may need support with homework because reading is difficult and still manage age-appropriate routines, relationships and practical demands. That presentation fits a skill-specific formulation more readily than a global one. In contrast, when information must repeatedly be simplified across contexts, practical learning is also limited and everyday independence is compromised, the clinician should think beyond a school-skill disorder. Full assessment of intellectual disability belongs with the Intellectual disability and autism spectrum disorder notes; here the point is to preserve the boundary while evaluating the presenting educational complaint.

TRAP **Do not diagnose intellectual disability from school failure alone.** Academic work is only one expression of functioning. The diagnosis requires a global intellectual pattern and adaptive-behaviour impairment, not a disappointing report card or a low score in a single skill.

28.3 Specific learning disorder and ADHD: primary mechanism versus co-occurrence

ADHD is principally a difficulty of attention, executive function and behaviour, rather than a specific academic-skill deficit. Academic underachievement may follow because the child misses instruction, abandons work, makes careless errors, loses materials, rushes through tasks or cannot sustain the sequence needed to complete them. The key clinical question is whether attention-related difficulty explains the underachievement across tasks, or whether a particular skill remains disproportionately impaired even when attention is supported and the child is engaged.

A child with ADHD may perform inconsistently. The same task can be managed better when novelty, structure, supervision or immediate feedback reduces the attentional load, and worse when work is prolonged, repetitive or unstructured. This variability should prompt close examination of the conditions under which work succeeds and fails. It should not be used as a shortcut to conclude that a child with persistent, selective difficulty in reading, writing or mathematics merely has ADHD.

Equally, the presence of a learning disorder does not exclude ADHD. The conditions **frequently co-occur**. In such a child, **secondary academic underachievement** from inattention can coexist with a genuine skill-specific deficit. The formulation must then describe both contributions. If the clinician labels every error as inattentive, the learning need is missed. If the clinician labels every incomplete worksheet as a learning disorder, the behavioural and executive contribution is missed. The task is additive rather than competitive.

- When difficulty is widespread but fluctuates with attention demands, consider whether attention and behavioural regulation are driving the academic outcome.
- When a particular academic skill remains persistently and disproportionately weak, look for a skill-specific deficit even if ADHD is present.
- When both patterns are evident, record both rather than making one diagnosis explain every classroom problem.

The assessment should therefore compare observations from activities with different attentional and academic demands. Review work samples for the nature of errors, not only their quantity. Explore whether the child can explain an answer orally but cannot read or write it, whether calculation fails despite adequate persistence, and whether difficulties are present even in brief, highly supported work. Such questions do not replace formal psychoeducational assessment. They help the clinician decide what hypothesis must be tested and prevent a referral question from becoming the answer.

GOOD TO REMEMBER

When ADHD and a learning disorder coexist, treatment and educational planning must address both. Improvement in attention may make the child more available for teaching, but it does not by itself establish that the academic-skill deficit has resolved.

28.4 Slow learner: an educational descriptor, not a disorder

The term **slow learner** is prominent in Indian educational practice and corresponds to borderline intellectual functioning. It describes globally below-average ability that does not reach the threshold for intellectual disability. The IQ range is approximately **71 to 84**. The term can be clinically useful when it accurately communicates a broad educational vulnerability, but it becomes harmful when treated as a diagnosis, a fixed prognosis or an explanation that ends further enquiry.

Slow learner is **not a diagnosis**. It has no diagnostic criteria set and should not be promoted into a mental disorder merely because a school needs a label. The clinician's responsibility is to describe the observed pattern, identify practical educational needs and avoid granting the phrase a diagnostic authority it does not possess. The distinction matters both ethically and administratively: a non-diagnostic educational descriptor is not a substitute for a careful diagnostic formulation.

Compared with specific learning disorder, the academic difficulty of a slow learner is broad. General ability is lower across domains, and school underachievement tends to reflect that broad pattern rather than a single isolated skill failure. A child may find acquisition slower in several subjects and need more repetition, concrete teaching and a pace matched to capacity. In specific learning disorder, by contrast, general ability is normal range and the prominent weakness is concentrated in an academic skill. The useful contrast is **broad underachievement** versus a circumscribed skill deficit, not "mild learning disorder" versus "severe learning disorder".

Compared with intellectual disability, a slow learner is **above the intellectual-disability threshold** and does not meet the adaptive-deficit requirement. The border can be clinically imprecise, particularly when school reports are sparse or social and practical expectations have been heavily scaffolded by family. That imprecision is an argument for careful assessment, not for casually assigning intellectual disability or for pretending that slow learner has diagnostic status. Where the broader question of intellectual disability remains live, the clinician should assess it explicitly rather than allowing an educational term to conceal uncertainty.

IN INDIA

"Slow learner" is often the phrase brought by parents and teachers. Translate it into a description of broad learning pace and support needs before accepting or rejecting it. An **individualized education programme** can support academic functioning; this is educational intervention, not treatment of a diagnosis.

PITFALL

Writing "slow learner" as the final psychiatric diagnosis can close the assessment prematurely. It may conceal an unrecognised specific learning disorder, ADHD, intellectual disability or an educational mismatch, while also giving a non-diagnostic descriptor an authority it does not have.

28.5 A disciplined route from complaint to formulation

Begin with the exact educational concern. "Cannot read", "does not finish work", "fails in all subjects" and "takes longer than peers" are different referral statements and should not collapse into the same pathway. Establish the temporal course, the settings in which the problem appears, the academic activities that expose it and the activities in which the child is competent. The aim is to define the pattern in the child's actual work, rather than in adult frustration around that work.

Next, examine the breadth of difficulty. A narrow problem in a particular academic skill raises the possibility of specific learning disorder. Difficulty across intellectual learning coupled with limitations in everyday adaptive functioning raises the possibility of intellectual disability. Broad but non-diagnostic lower ability points toward the slow-learner descriptor. Widespread variable underperformance, especially when linked to attention and behavioural regulation, raises the possibility that ADHD is contributing. These are working hypotheses, not labels to be assigned at the first interview.

Then test the hypothesis against disconfirming evidence. A proposed learning disorder formulation should be questioned if difficulties are genuinely global. A proposed ADHD formulation should be questioned if a specific skill remains markedly impaired regardless of structure and effort. A proposed slow-learner formulation should be questioned if performance reveals an unexpectedly sharp, isolated skill deficit or if adaptive limitations are more significant than the school label suggests. This habit of actively looking for what does not fit is what turns a differential list into clinical reasoning.

Finally, state the formulation in layers. Describe the academic symptom pattern, the broad intellectual and adaptive context, the contribution of attention and behaviour, and the resulting educational needs. If evidence supports more than one condition, say so plainly. If the available information supports only a descriptor and educational planning, do not inflate it into a diagnosis. If uncertainty remains, document what needs clarification rather than concealing it beneath a familiar label. Detailed psychoeducational methods are covered in the assessment section on learning disorder, and the broader child psychiatric assessment framework is in the Child psychiatry: assessment, treatment, services and protection notes.

MNEMONIC

Skill - Scope - Supports - State

Ask which **skill** is weak, how far the difficulty extends in **scope**, whether daily-life **supports** are needed because of adaptive impairment, and whether attention and behavioural **state** are altering the child's available performance.

28.6 How the distinction changes clinical communication

The language used with families and schools should explain the pattern without turning it into blame. For specific learning disorder, the central message is that the difficulty is real and confined to an academic skill despite adequate general ability. For intellectual disability, the message concerns broad intellectual and adaptive support needs. For ADHD, explain that attention and behavioural regulation can interfere with learning and may coexist with a skill deficit. For a slow learner, clarify that the term describes a broad educational vulnerability and does not confer a psychiatric diagnosis.

These formulations lead to different practical questions. A skill-specific formulation directs attention to targeted educational support and the school demands that reveal the weakness. A global intellectual and adaptive formulation directs attention to support across daily life as well as learning. An ADHD formulation directs attention to the conditions that help the child engage, organise and complete work. A slow-learner formulation directs attention to expectations, pacing and an individualized education programme. None of these plans should be used as proof of a diagnosis; intervention can begin while assessment is being clarified.

Communication also matters because schools often want a simple binary answer: "learning disorder or not?" The clinician should avoid solving the school's administrative discomfort by erasing complexity. A concise formulation can remain precise: describe whether the evidence is skill-specific, global with adaptive impairment, attention-mediated, broadly lower ability, or mixed. That clarity allows the school to act without asking the child to carry an inaccurate label.

28.7 The synthesis to retain

The most reliable discriminator is the relationship between general ability, academic skill and adaptive functioning. Specific learning disorder has normal general ability with an isolated academic-skill deficit. Intellectual disability has a global intellectual deficit together with adaptive impairment. ADHD affects attention, executive function and behaviour, so academic

underachievement is secondary to those difficulties and may coexist with a learning disorder. Slow learner refers to broadly borderline ability and remains a non-diagnostic educational label. Once that structure is clear, the differential becomes clinically manageable rather than a list of competing school labels.

For the resident, the important discipline is to keep diagnosis, description and support separate. A diagnosis should explain a coherent pattern and meet its defining requirements. A description should be honest about what is observed without claiming more certainty than the evidence permits. Support should be offered because the child needs it, not withheld until every boundary is perfectly resolved. This approach protects against both overdiagnosis and neglect.

> First decide whether the difficulty is skill-specific or global, then determine whether adaptive impairment and attention-related mechanisms change the formulation.

29 · Worked cases

Why vignettes matter. Neurodevelopmental presentations are rarely delivered in the tidy form of a short-answer question. A parent may report that a child is careless, a teacher may report that the child cannot keep up, and the child may describe school as exhausting or humiliating. The task is not to attach the first plausible label to that account. It is to decide what the observed difficulty represents, where it occurs, what demands expose it, and what additional information would change the formulation. The vignettes below rehearse that disciplined sequence.

Use each case as an exercise in clinical reasoning. Begin with the **presenting problem**, but do not stop there. Separate the behaviour that is visible to adults from the function that may be failing for the child. Then seek a **cross-setting pattern**, examine the developmental and educational context, and ask whether the impairment is broad, task-bound, or secondary to another difficulty. A good answer explains both the leading formulation and the reason its nearest rival is less convincing.

Pattern	Context	Demand	Function
WHAT RECURS	WHERE IT EMERGES	WHAT MAKES IT FAIL	WHAT SUPPORT CHANGES

29.1 A method for reading a developmental vignette

A vignette is not a compressed case sheet. It is a deliberately incomplete account designed to test whether the reader knows what is diagnostic, what is contextual, and what remains uncertain. The first move is to translate an adult conclusion such as “lazy,” “naughty,” “weak in studies,” or “not listening” back into observations. What does the child actually do? What happens immediately before the difficulty? What changes when the material is presented differently, when the task is shorter, when the setting is quieter, or when a familiar adult provides structure?

The second move is to identify the **task-specific failure**. A child who loses the thread only when reading is required is presenting a different problem from a child who loses the thread during play, meals, conversation, and written work. Likewise, a child who avoids copying because the

hand is slow or inaccurate may look inattentive to an observer who sees only an unfinished page. The behaviour is real, but its meaning is not yet settled.

- State the difficulty in observable language before naming a syndrome.
- Ask what the child can do when the suspected demand is removed or reduced.
- Compare home, school, and other routine settings without assuming that reports must be identical.
- Look for the emotional consequences of repeated failure, including avoidance, anger, shame, and withdrawal.

RULE **Behaviour is a clue, not a formulation.** A developmental label becomes useful only after the pattern, context, functional impact, and competing explanations have been examined.

Clinical reasoning should remain provisional. In a real assessment, one would return to the child, family, school information, developmental history, physical and sensory considerations, and relevant assessment findings. In a written answer, say what must be clarified rather than pretending that the vignette contains it. This is not evasiveness. It demonstrates that diagnosis rests on converging evidence rather than on a dramatic phrase in the history.

Absence of a reported feature should also be handled with care. A brief school report may be silent about home functioning because no one asked, and a parent may not have observed a classroom difficulty because the setting never places the same demand on the child. Silence in a vignette therefore has different meanings from a clearly stated absence. A defensible answer distinguishes what is present, what is explicitly absent, and what is unknown. This habit protects against premature exclusion as much as it protects against premature diagnosis.

29.2 The child described as careless and disruptive

Vignette. A school-going child is repeatedly sent out of class for calling out, leaving the seat, and abandoning written work. At home, homework becomes a prolonged conflict. The parent says that the child can remain absorbed in a preferred activity but becomes restless when asked to read, copy, or complete a worksheet. The teacher reports that verbal participation is lively, yet work requiring independent reading is often incomplete. The family asks whether this is simply poor discipline.

The tempting answer is to treat every visible behaviour as evidence of **attention regulation difficulty**. That may be part of the formulation, but the vignette has placed a warning sign in plain view: the difficulty intensifies around literacy-heavy demands. The clinician should ask whether inattention and impulsive behaviour are evident across activities that do not rely on reading, writing, or sustained academic decoding. If they are, an ADHD formulation may remain compelling. If the apparent inattention is concentrated around a particular academic demand, a learning disorder may be contributing to the picture or may be the more immediate explanation for the classroom behaviour.

Do not treat focused engagement in a preferred activity as proof against ADHD. The clinically useful question is not whether the child can ever concentrate. It is how attention is allocated when novelty, reward, structure, effort, comprehension, and frustration change. Equally, do not treat classroom disruption as proof of ADHD. A child who expects failure may escape the task, provoke removal from it, or use movement and talking to mask confusion. This is a functional account of behaviour, not an excuse for overlooking impairment.

QUESTION RAISED BY THE VIGNETTE	FINDING THAT WOULD SUPPORT AN ADHD FORMULATION	FINDING THAT WOULD MAKE A LEARNING DIFFICULTY MORE CENTRAL
Where is the behaviour seen?	It recurs across ordinary demands and settings.	It is chiefly linked to a particular kind of school task.
What happens when the task changes?	Organisation and self-regulation remain difficult even when content is accessible.	Behaviour improves when the academic load is presented in an accessible way.
What is the child avoiding?	The pattern is not confined to one academic skill.	A consistent skill demand evokes frustration, delay, or escape.
What should happen next?	Assess the full attentional and behavioural pattern, including impairment.	Clarify the learning profile while also assessing attention where indicated.

The best formulation may include both pathways. Co-occurrence should not be used as an intellectual shortcut, but neither should a search for a single explanation erase a second genuine difficulty. The practical consequence is that management needs to address the mechanism of the unfinished work. Increasing behavioural pressure on a child who cannot access the task is unlikely to restore learning. Providing academic support without addressing pervasive dysregulation may be equally insufficient.

> **GOOD TO REMEMBER**
>
> When a teacher reports inattention, ask for the exact classroom demand that preceded it. The answer often distinguishes a broad self-regulation problem from distress around a specific learning task.

29.3 Uneven attainment, broad difficulty, and the misleading label of slow learner

Vignette. A child is described as quiet, cooperative, and slow to finish schoolwork. The family has accepted the school's description of "slow learner." The child appears comfortable in conversation and is effective in everyday routines, but falls far behind peers in selected academic tasks. Another child in the same clinic struggles more generally with classroom learning, practical problem solving, and independent adaptation to everyday expectations. The referral question is whether both children have the same condition.

They should not be treated as interchangeable. The phrase **slow learner** may express a school's concern about pace or level of performance, but it does not itself explain the pattern. It can conceal a specific learning disorder, broader cognitive difficulty, inadequate opportunity to learn,

emotional distress, sensory problems, language mismatch, or a poorly described classroom environment. It should therefore trigger clarification, not end the assessment.

In the child with uneven attainment, the crucial observation is the contrast between areas of clear difficulty and areas of relative competence. The clinician asks whether the child has had an adequate chance to learn, whether the difficulty persists despite ordinary support, and whether it has functional consequences beyond disappointing marks. In the child with broad difficulty, the question shifts towards a **global learning difficulty** and its relationship to everyday adaptive functioning. The distinction matters because a profile of circumscribed academic difficulty calls for a different educational response from a broadly limited developmental profile.

Intellectual disability must be considered carefully when functioning is broadly affected, but it must not be used as a catch-all explanation for poor school performance. The fuller account of that diagnostic framework is in *the Intellectual disability and autism spectrum disorder notes*. In this chapter, the applied point is simpler: an isolated academic weakness cannot be interpreted without considering the child's broader functioning, and broad difficulties cannot be inferred from marks alone.

IN INDIA

School labels can become part of a family's explanatory model before a clinical assessment occurs. Ask what the school means by "slow," which tasks are difficult, what teaching language is being used, and what support has already been attempted. This protects the child from both inappropriate reassurance and premature diagnostic labelling.

PITFALL

Do not write "slow learner" as though it were a formal diagnosis. It is a prompt to map a learning profile and context, not a conclusion that substitutes for assessment.

29.4 When apparent inattention is a communication problem

Vignette. A young child appears not to follow classroom instructions, gives answers that do not match the question, and often watches peers before beginning an activity. The child is described as distractible and socially aloof. At home, caregivers report that the child becomes frustrated when asked to narrate events, struggles to find words, and uses short or poorly organised responses. In familiar routines, the child participates more readily.

Here, the clinician should not begin by counting inattentive acts. First ask whether the child understood the linguistic demand. A child who cannot reliably process the instruction, formulate a response, or follow a rapid exchange can appear disengaged, oppositional, anxious, or inattentive. Waiting for peers may be a compensatory strategy rather than a sign of indifference. The relevant formulation concerns **communication demands** and the child's ability to meet them.

Observe how the child manages when language is simplified, when visual demonstration accompanies speech, and when the clinician allows time for a response. These observations do

not replace formal evaluation, but they help distinguish a failure to attend from a failure to understand or express. Also examine the social consequences. Repeated misunderstanding can lead a child to withdraw, interrupt, joke, or avoid group activity. Such behaviour may resemble a primary behavioural or attentional disorder while being sustained by communication frustration.

The communication disorders chapter provides the diagnostic framework and management approach. For the vignette, the key lesson is that a child's outward silence or apparent non-compliance must be interpreted in relation to language comprehension, expressive capacity, speech clarity, fluency, and social use of communication. Asking the child to repeat an instruction is less informative than checking whether the instruction was understood and can be acted upon.

TRAP **Do not call a child inattentive before checking whether the child could understand the demand.** An observer can see a delayed response; the observer cannot infer its cause without examining communication.

29.5 The child who avoids writing and games

Vignette. A child avoids handwriting, takes an unusually long time to dress, is reluctant to join games requiring coordinated movement, and becomes tearful before practical classroom activities. The teacher describes poor effort and incomplete work. The family notices that the child knows what to say but struggles to translate an idea into a written page. Behaviour becomes worse when adults insist that the child "try harder."

This vignette calls for attention to **motor coordination** and its daily consequences. The unfinished page may arise from a planning or execution difficulty rather than inattention, defiance, or lack of understanding. Avoidance is often intelligible when a task repeatedly exposes the child to failure in front of peers. The clinician should ask what exactly is hard: initiating the movement, sequencing it, maintaining speed, coordinating both hands, using tools, organising the page, or tolerating the effort involved. The answer helps identify the next assessment question without reducing the child to a handwriting complaint.

It is also important to distinguish a motor-based difficulty from a specific learning problem and from ADHD. These may coexist, and each can amplify the visible impairment. A child with motor difficulty may need much of the available attentional capacity simply to control the task, leaving little capacity for content. Conversely, a child with ADHD may show disorganised output without a primary coordination disorder. The formulation should describe the contribution of each suspected pathway and avoid assuming that one label explains every failure.

Observe the emotional and relational loop. Criticism may increase anticipatory anxiety, which worsens performance and reinforces the adult's impression of poor effort. A useful intervention begins by making the demand achievable, protecting dignity, and coordinating with school rather than escalating punishment. The diagnostic and management details for developmental coordination disorder belong in its dedicated section; the applied lesson is to notice when movement is the hidden bottleneck.

29.6 Turning a vignette into a defensible formulation

A strong answer does not end with a label. It explains the working formulation, names the uncertainty, identifies the information needed next, and links the formulation to a practical response. This prevents the common error of treating diagnostic reasoning and management planning as separate tasks. If the difficulty is most visible under a particular demand, the immediate support should make that demand more accessible while assessment continues. If impairment is broad and persistent, the plan should involve the environments in which it occurs rather than placing responsibility only on the child.

For every vignette, complete the following formulation in prose: the child's main difficulty is seen in a defined context; the leading explanation is supported by a recognisable pattern; the nearest alternative remains possible or less likely for stated reasons; further collateral and assessment are required; and support should reduce barriers while preserving participation. This structure is deliberately portable. It can be used for ADHD, learning disorders, communication disorders, and motor disorders without pretending that these conditions are interchangeable.

MNEMONIC

MAPS the vignette

Map the observed behaviour, **A**sk what demand exposes it, identify the **P**attern across settings, and choose the next **S**tep that tests the formulation or reduces the barrier. The mnemonic is a reasoning sequence, not a diagnostic checklist.

Describe the pattern before naming the disorder, and make the support fit the function that is failing.

What earns marks in an applied answer. The examiner is looking for discrimination, not diagnostic bravado. Show that a behaviour can have more than one pathway, that context can reveal the pathway, and that comorbidity may require more than one response. Where the vignette is incomplete, say what you would seek from the child, family, and school. The detailed child psychiatric assessment approach is available in *the Child psychiatry: assessment, treatment, services and protection notes*; the present task is to use its logic to prevent premature closure.

30 · Consolidate: the master mnemonic, the retrieval prompts and the synthesis map

Consolidation is where recognition becomes usable clinical reasoning. A candidate can know isolated labels, criteria, instruments and interventions yet still produce an unsafe or unconvincing answer when the task changes from recall to a child in front of them. The purpose of this closing section is to make the chapter retrievable as a sequence of decisions: clarify the presenting difficulty, test the leading explanation against alternatives, identify what must be assessed, and state what follows from the formulation. It is deliberately answer-free. Use it to expose an omission before the examination, the case conference, or the clinic rather than to create the comforting illusion of familiarity.

The chapter is best retained as a **clinical map**, not as a pile of headings. The map has room for ADHD, learning difficulty, communication difficulty and motor phenomena, while also forcing the clinician to ask what the child can do, where the difficulty occurs, what collateral evidence supports it, and what functional consequence matters. The same map prevents a false choice between diagnosis and context. A sound answer neither reduces a child to a label nor loses diagnostic discipline in a long narrative of school and family stress.

30.1 Start with the question, not the label

Before retrieving any diagnostic material, restate the clinical problem in ordinary professional language. Is the referral primarily about attention and activity, acquisition of an academic skill, speech or language, fluency, social use of communication, coordination, repetitive movement, or a mixture? That opening move matters because the referral label is often an interpretation offered by someone else. It may be useful, but it is not yet the formulation. A child described as inattentive may be struggling to access teaching; a child described as weak in studies may have a broader pattern of difficulty; a child described as disruptive may be communicating frustration. The consolidation task is to preserve uncertainty long enough to ask discriminating questions.

Build the opening sentence around **functional impairment**. Name the setting in which the concern is visible, the task that becomes difficult, the consequence for participation, and the source of the report. This keeps the answer clinically anchored. It also makes it much harder to mistake an isolated complaint for a pervasive disorder or to dismiss a serious difficulty because the child is doing well in another area. Functional description is not a decorative introduction. It is the bridge between observed behaviour, developmental history, school information and any later diagnostic conclusion.

- What exactly is the referrer asking for help with?
- What does the child, caregiver and teacher each identify as the main difficulty?
- What activity, relationship or educational participation is being affected?

RULE **Formulate the problem before you retrieve the diagnosis.** A label may organise inquiry, but the presenting difficulty determines which evidence is relevant and which alternative explanations deserve active consideration.

In a written answer, this approach also gives the examiner a visible reasoning trail. Rather than launching into a memorised list, state the clinical question and show how history, informants and observation will answer it. The result is more concise as well as more defensible: every later detail has a job. If a detail does not alter the formulation, the differential, the assessment plan or the management plan, it does not need to dominate the answer.

30.2 Retrieve the assessment as a chain of evidence

Assessment should be recalled as **triangulation**. No account, behaviour sample or score can carry the whole clinical judgement alone. The candidate should be able to explain how information from the child, family, school and direct clinical encounter is brought into conversation. Agreement across sources may strengthen confidence, while disagreement is not an

inconvenience to be erased. It can reveal variation by task demand, setting, relationship, structure or support. The question is not which informant is "right" in the abstract. The question is what each account is measuring.

Use a **developmental formulation** to hold the evidence together. Retrieve the history that clarifies the course of the concern, the child's strengths, the educational context, communication and motor development, emotional state, behaviour, sleep, sensory or physical contributors, family experience and previous support. The aim is not a maximal checklist. It is a coherent account of why the problem now looks the way it does. A formulation should leave room for coexisting conditions without assuming that every difficulty has a separate diagnosis.

EVIDENCE SOURCE	QUESTION TO RETRIEVE	HOW IT CHANGES REASONING
Child and caregiver account	What is noticed across ordinary routines and tasks?	Clarifies lived difficulty, expectations and priorities.
School information	What happens when learning, language, behaviour or coordination is observed in context?	Tests whether the reported concern fits educational demands and supports.
Clinical observation	What can be directly described without overinterpreting it?	Connects reported behaviour with the examination encounter.
Focused testing or specialist input	What question requires structured measurement or another discipline?	Refines the formulation rather than replacing it.

When recalling rating scales, psychoeducational assessment or other structured tools, retrieve their purpose before their names. Ask what construct is being sampled, whose perspective is represented, what the result can support, and what it cannot decide on its own. This protects against score-driven diagnosis. A measurement can sharpen a question; it cannot repair a vague referral, a missing school history, or an unexamined alternative explanation.

> **GOOD TO REMEMBER**
>
> If reports conflict, do not average them into a meaningless middle. Describe the contexts in which the difficulty is and is not visible, then ask what those contexts demand from the child. The discrepancy may be the most clinically useful finding.

30.3 Make discrimination explicit

The difficult marks lie in **diagnostic discrimination**, not in repeating a definition. A strong response tells the reader what observation or history finding would make a rival explanation less likely, what evidence remains necessary, and why an apparently similar presentation has a different clinical meaning. This is particularly important when attentional symptoms coexist with academic underachievement, when a broad developmental difficulty is mistaken for a circumscribed learning problem, or when a communication difficulty changes how behaviour is interpreted.

Keep the contrast at the level of the clinical question. Is the problem broad or circumscribed? Is it stable across tasks or most visible when a particular skill is demanded? Does it follow lack of access to instruction or persist despite appropriate opportunity? Are attention and activity the central difficulty, or are they secondary to repeated failure, anxiety, boredom, misunderstanding or environmental mismatch? Does the account suggest a communication barrier, a motor barrier, an emotional difficulty, a sensory or physical issue, or a different neurodevelopmental profile? These prompts organise a differential without pretending that any isolated sign settles it.

- State the leading formulation in a neutral sentence.
- Name the alternative explanation that would cause the greatest error if missed.
- Specify the history, observation or collateral information that separates them.

TRAP **Do not convert poor performance into a diagnosis by relabelling it.** Poor academic output, restlessness, slow completion, unclear speech or clumsiness are clinical starting points. They require a formulation that accounts for pattern, context, development and impairment.

The comparison between ADHD, specific learning disorder, intellectual disability and the educational term “slow learner” should be retrieved from the dedicated discrimination section rather than reconstructed from shorthand. The same restraint applies to the relationship between ADHD and its comorbidities. A consolidated answer should show that coexistence is possible while still asking which condition explains which part of the presentation. For the wider developmental differentials, use the Intellectual disability and autism spectrum disorder notes and the Normal child development and milestones notes.

PITFALL

Once a referral label has become familiar, clinicians may read every subsequent report through it. Counter this by writing down what finding would genuinely change the formulation. If no imaginable finding could do so, the assessment has become confirmatory rather than diagnostic.

30.4 Link diagnosis to action without collapsing the formulation

A diagnosis is clinically useful only when it changes what the team does. Retrieve the **multimodal plan** as a linked response to the child’s needs, not as a menu of unrelated treatments. The plan may include psychoeducation, family work, behavioural support, school collaboration, remediation, communication or motor intervention, treatment of coexisting emotional or behavioural difficulty, and medication where indicated. In an answer, make the connection visible: identify the target difficulty, the intervention directed at it, the person or setting involved, and the outcome that will show whether the plan is helping.

This is also where candidates should distinguish management of a condition from management of its consequences. A child can need help with participation, confidence, behaviour in class, family conflict or access to learning even while diagnostic clarification is continuing. Conversely, an intervention should not be presented as proof that a diagnosis was correct. Support can be appropriate in the presence of uncertainty, provided its purpose is clear and progress is reviewed.

- Which difficulty is the immediate target for change?
- Which adult, service or setting must be involved for the plan to work?
- What observable improvement would justify continuing, adapting or escalating support?

Why the feedback loop matters. The initial plan is a clinical hypothesis in action. Follow-up asks whether the target has moved, whether the child can use the support in ordinary life, whether an unrecognised comorbidity or barrier is now clearer, and whether the balance of burden and benefit remains acceptable. This safeguards against therapeutic inertia. It also prevents the opposite error of changing several things at once and then being unable to explain what helped.

IN INDIA

When an answer has an educational or administrative component, retrieve the relevant local documentation and institutional pathway alongside the clinical formulation. Do not assume that a generic label automatically answers the practical question. The dedicated section on specific learning disorder certification and educational provisions is the place to retrieve the statutory route and accommodations.

30.5 Use active recall to test the whole chapter

Active recall should be demanding enough to reveal where the map breaks. Reading a highlighted page gives rapid recognition, but recognition does not test whether the relevant distinction can be produced under pressure. Close the text, choose a prompt, and speak or write a brief answer from memory. Then reopen the relevant section and compare the structure of the answer with the text. Correct missing reasoning, not just missing nouns. The useful question is not "Did I remember a fact?" but "Could another clinician see how I got from complaint to plan?"

Use **retrieval practice** in mixed order. Do not always move from diagnosis to assessment to treatment, because real cases rarely arrive in that order. Begin at different points: a school complaint, a parent's concern, a finding on observation, a treatment question, or a differential dilemma. Mixing prompts forces the learner to rebuild the clinical pathway rather than recite a fixed sequence. It also reveals whether knowledge of ADHD has become disconnected from knowledge of learning, communication and motor disorders.

MAP	TEST	ACT	REVIEW
PRESENTING PROBLEM	ALTERNATIVE EXPLANATION	TARGETED SUPPORT	RESPONSE AND REVISION

Use the following prompts without looking up the answer until you have committed to a structure:

- Frame an assessment for a child referred for inattention when the school report emphasises academic underachievement.
- Explain how you would distinguish a circumscribed learning difficulty from a broader developmental concern without prematurely naming either.

- Describe how communication, motor, emotional, behavioural, sensory, physical and educational factors alter the meaning of a presenting complaint.
- Set out a management plan that joins family, school and child-focused work to a clear review question.
- Explain why a structured scale or test can strengthen, but not substitute for, clinical formulation.
- Write a concise differential paragraph that names uncertainty and states how it will be resolved.

After each attempt, identify the type of failure. A missing definition calls for focused revision. A confused differential calls for a comparison table. An unlinked management list calls for reformulation around targets and settings. An inability to explain what a result means calls for return to the assessment section. This is more efficient than rereading the entire chapter after every weak answer, and it turns errors into precise revision tasks rather than evidence of global incompetence.

30.6 Write answers that show reasoning

In a long answer, use a **clinical argument**. Begin with the problem and the relevant frame, then move through assessment, differential diagnosis, formulation and management. Within each part, prefer explanation to disconnected lists. A list of scales, treatments or accommodations gains little unless the reader can see when it is used, what it contributes and what limitation is being respected. Conversely, a polished narrative without structured headings makes it difficult to find the core answer. The best balance is explanatory prose supported by short, purposeful lists and comparisons.

For a short note, choose the few ideas that demonstrate command rather than trying to compress the whole chapter into a paragraph. State what is being distinguished, the evidence that matters, the broad management direction and the principle of review. If a prompt asks for an instrument, a medication, a criterion set or a statutory provision, retrieve that detail from its dedicated section rather than guessing from the consolidation. This closing section is a map to knowledge, not a substitute for the precise content held elsewhere in the chapter.

WEAK ANSWER PATTERN	WHAT IS MISSING	REPAIR
A label followed by a long list	The path from presentation to conclusion	State the discriminating evidence and its clinical meaning.
A detailed history with no conclusion	A formulation that orders the information	Summarise the leading explanation and the remaining uncertainty.
A treatment catalogue	A target and a setting for each intervention	Link each action to the difficulty it is intended to change.
A test result treated as a verdict	Context, collateral evidence and limitation	Explain what the result contributes to the broader assessment.

The same discipline matters in clinical documentation. A later clinician should be able to tell what was reported, what was observed, what remains uncertain, what was agreed and what will be reviewed. That record supports continuity without turning uncertainty into indecision. For broader service and protection questions, return to the Child psychiatry: assessment, treatment, services and protection notes.

30.7 Protect against the recurring errors

The recurring error across this area is **premature closure**. It appears in several forms: accepting the referral label without testing it, treating academic struggle as synonymous with a learning disorder, treating a score as synonymous with a diagnosis, attributing every difficulty to the most visible condition, or presenting a plan without deciding how its effect will be judged. These are not merely examination faults. They weaken communication with families and schools because they obscure what is known, what is inferred and what still needs attention.

Counter premature closure with a brief final pause before committing to a conclusion. Ask whether the formulation accounts for the child's strengths as well as difficulties, whether the school context has been understood, whether an alternative explanation has been actively considered, whether coexisting problems have been separated rather than merged, and whether the management plan is proportionate to the evidence. This pause does not require indecision. It creates disciplined confidence: act on what is clear, state what is uncertain, and arrange review around the uncertainty that matters.

Retrieve the pathway: problem, pattern, proof, plan, and progress.

30.8 The master recall spine

MNEMONIC

MAPS: Map the problem, Ask across settings, Probe alternatives, Support and review

MAPS is a recall spine, not a diagnostic shortcut. Map the concern in functional language. Ask across informants and contexts. Probe alternatives and coexisting difficulties. Support the child and systems around the child, then review whether the plan has changed the target difficulty.

Use this spine to close any answer in the chapter. It keeps the candidate from mistaking memorised detail for clinical judgement, while leaving each detail in the section that owns it. If the prompt concerns ADHD, retrieve its criteria, assessment, treatment and outcome from the relevant sections. If it concerns learning, communication or motor disorders, return to the relevant definition, assessment and management sections. If the question crosses categories, use MAPS to decide which material belongs in the answer and in what order.

Previously asked

Genuine past questions from this chapter's territory, with their board of origin. No catalogued theory question falls inside attention-deficit/hyperactivity disorder, specific learning disorder or the communication and motor disorders in the examined window, so none is printed here. No question is reconstructed, paraphrased into a new one, or invented to pad the list. That a topic has not been asked as a set-piece essay does not lower its yield: ADHD pharmacotherapy, the rating-scale discrimination, the specific-learning-disorder criteria and the Indian certification route are all live short-note and viva territory, and the chapter is built to answer them.

TRAP **An unasked topic is not a low-yield topic.** The absence of a past essay is a fact about one board's recent papers, not about what an examiner may ask this year. Prepare the discriminations, not the past paper.

The quick review

One table, read down the left column, cover the right. Every line is taught in full somewhere above; nothing here is new. Where the sources disagree, the disagreement is the answer.

ASK	HOLD
WHAT DSM-5 REQUIRES FOR ADHD	At least 6 of 9 symptoms in a domain (5 if aged 17 or older), several present before age 12, in at least 2 settings, for at least 6 months, with impairment. The count and the age are the marks.
DSM PRESENTATIONS AGAINST ICD-11	Three DSM-5 presentations: predominantly inattentive, predominantly hyperactive-impulsive, combined. ICD-11 codes it 6A05 and asks for 'several' symptoms with no fixed count or onset age. Naming ICD-10 hyperkinetic disorder as identical to DSM ADHD is the error.
WHAT EXECUTIVE DYSFUNCTION IS FOR	It is the mechanism that links the fronto-striatal dopamine and noradrenaline circuit to the symptoms. It explains the domains; it is not a fourth symptom.
THE THREE RATING SCALES ARE NOT INTERCHANGEABLE	Conners 3 is norm-referenced, a T-score instrument (mean 50, SD 10), bought under an MHS licence. Vanderbilt (ages 6 to 12) and SNAP-IV are raw-score cut-off screens, free to obtain and use but not free to republish. Different raters, ages, constructs and cut-off logic. Listing three that measure differently is the exam trap.
FIRST-LINE ADHD MEDICATION AND THE DOSE RULE	Methylphenidate. Every dose carries its population: the typically-developing child starts around 5 to 10 mg immediate-release and titrates weekly, whereas a child with autism starts lower. A dose without its population is not an answer.

ASK	HOLD
THE CLONIDINE AND AMPHETAMINE CAUTIONS	Clonidine and guanfacine doses are small (clonidine about 0.1 mg at night up to about 0.4 mg per day); a mg/kg clonidine figure that looks large is wrong. Amphetamines and lisdexamfetamine are not marketed in India; methylphenidate and atomoxetine are.
WHAT THE MTA SHOWED	At 14 months, medication management and combined care beat behavioural care and community care for core symptoms; by 36 months the groups converged. Cite the stimulant response as about 77 percent; do not print a divergent figure across chapters.
ADULT ADHD	It persists into adulthood in a substantial proportion; overt hyperactivity fades while inattention and inner restlessness remain. This chapter owns adult ADHD in full.
WHAT DSM-5 REQUIRES FOR SPECIFIC LEARNING DISORDER	Difficulty in an academic skill persisting at least 6 months despite targeted intervention, achievement substantially below age expectation, onset in the school-age years, and not better explained by intellectual disability, sensory deficit, adversity or inadequate instruction. General ability is preserved.
THE MECHANISM OF DYSLEXIA	A core phonological-processing deficit; the double-deficit model adds slow rapid automatised naming. The neurobiology is left-hemisphere temporo-parietal and occipito-temporal underactivation.
HOW SLD CERTIFICATION DIFFERS FROM ID CERTIFICATION IN INDIA	SLD rests on psychoeducational, achievement-discrepancy assessment (the NIMHANS battery) with a preserved IQ; intellectual disability rests on an IQ-plus-adaptive-behaviour route. The current guidelines schedule repeat certification during class X and class XII.
SLOW LEARNER	Borderline intellectual functioning, an Indian educational-practice term for an IQ of roughly 70 to 85. It is not a DSM or ICD diagnosis and has no criteria set. Promoting it to a diagnosis is the error item 79 exists to prevent.
SOCIAL COMMUNICATION DISORDER AGAINST AUTISM	Social communication disorder shows the social-pragmatic difficulty without the restricted and repetitive behaviours; their presence, now or historically, points to autism.
STEREOTYPY AGAINST TIC	Stereotypies are rhythmic, fixed, simpler and present from earlier; tics are not rhythmic, involuntary and only briefly suppressible.
WHAT THE SOURCES REFUSE TO TELL YOU	Several Indian prevalence figures, the exact statutory SLD percentage method, and a firm growth-suppression magnitude are simply not in the literature consulted. The chapter says so where it happens rather than inventing them.

References

Every specific in this chapter is bound to one of the sources below, and the count is the number of claims each carried. Books and guidelines are cited author, title and year in the house convention; no PMID is asserted for a book. For the statutory material the primary document is the authority: the Rights of Persons with Disabilities Act 2016 and the CBSE examination-concession circular were read directly, and where a textbook paraphrase diverged from the primary text the primary text was followed and the divergence named where it falls. The must-have-papers cross-check was NOT performed for this Paper III chapter, because the paper lists do not yet exist in the intel index; for Paper III the topic bank plus the syllabus scaffolding is the completeness authority.

SOURCE	CLAIMS CARRIED
DSM-5-TR (2022)	79
Kaplan & Sadock CTP 2024	36
Maudsley 15th ed	19
Kaplan & Sadock's CTP 2024	17
IPS CPG for ADHD (Shah et al.)	15
ICD-11 CDDR	12
IPS CPG CAP (Shah et al.)	11
Lewis Child and Adolescent Psychiatry, Chapter 5.1.1 ADHD	10
IPS CPG for ADHD (Shah et al.), Table 5	10
Stahl Prescriber's Guide	9
Dulcan's Textbook of Child and Adolescent Psychiatry	6
Dulcan's Textbook of Child and Adolescent Psychiatry, Chapter 15 ADHD	5
Tasman Psychiatry	5
MHS Conners 3 Update supplement	5
50 Studies Every Psychiatrist Should Know	4
Contemporary Intellectual Assessment 4E (Flanagan)	4
NICHQ Vanderbilt (form)	4
Swanson SNAP-IV scoring guide	4
PubMed	3
PubMed (MTA 1999) + 50 Studies	3

SOURCE	CLAIMS CARRIED
New Oxford Textbook of Psychiatry	3
Savita Malhotra Child & Adolescent Psychiatry	3
Lewis Child and Adolescent Psychiatry	3
KDT Essentials	3
Maudsley 15th ed + Stahl Prescriber's Guide	3
Rights of Persons with Disabilities Act, 2016 (India Code, full text PDF)	3
CBSE Circular No. 3/2018 (Class X and XII)	3
MHS Conners 3 brochure	3
Child and Adolescent Psychopathology (Beauchaine & Hinshaw)	2
Dulcan's Textbook of Child and Adolescent Psychiatry (sleep chapter)	2
PubMed (Jensen et al. 2007)	2
Rutter's Child & Adolescent Psychiatry 6E	2
day-22.licensing.md (verified primary sources)	2
Savita Malhotra, Child and Adolescent Psychiatry	1
Kaplan & Sadock's CTP 2024 / Dulcan's Textbook of Child and Adolescent Psychiatry	1
IPS CPG for ADHD (Shah et al., Indian J Psychiatry 2019;61(Suppl 2))	1
IPS CPG for ADHD (Shah et al.); corroborated Lewis	1
Dulcan Chapter 15 ADHD; corroborated Beauchaine & Hinshaw	1
IPS CPG for Conduct Disorder (Sagar et al., Indian J Psychiatry 2019;61(Suppl 2))	1
cross-day ownership binding (_OWNER-SHIP.md item 60; _OWNERSHIP-MATRIX.md construct 12)	1
IPS CPG for ADHD (Shah et al.), Medical history	1
IPS CPG for ADHD (Shah et al.); corroborated Malhotra CAP	1
Lewis Chapter 5.1.1 ADHD; corroborated Malhotra CAP	1

SOURCE	CLAIMS CARRIED
IPS CPG for ADHD (Shah et al.), Table 5 categories / MSE	1
own knowledge (structure); not corpus-verified in ADHD differential	1
PubMed (MTA Cooperative Group 1999, Arch Gen Psychiatry) + Kaplan & Sadock CTP 2024	1
PubMed (MTA 1999) + Kaplan & Sadock CTP 2024	1
PubMed (MTA 1999) + 50 Studies Every Psychiatrist Should Know	1
PubMed (MTA 1999) + 50 Studies + Tasman Psychiatry	1
PubMed (MTA 1999)	1
PubMed (MTA 1999) + 50 Studies + Tasman	1
PubMed (MTA follow-up 2004, Pediatrics)	1
PubMed (Jensen et al. 2007, JAACAP)	1
Tasman Psychiatry (same source as the Intellectual disability & autism spectrum disorder notes ASD-MGMT-74)	1
PubMed (MTA follow-up 2004) + Kaplan & Sadock CTP 2024	1
50 Studies (MTA cohort long-term outcomes) + Kaplan & Sadock CTP 2024	1
Kaplan & Sadock CTP 2024 (PATS follow-up)	1
Kaplan & Sadock CTP 2024 (MTA/PATS comparison)	1
Dulcan's Textbook of Child and Adolescent Psychiatry + 50 Studies	1
PubMed: Kim SK 2021, Clin Exp Pediatr 64(10):497-503	1
Savita Malhotra Child and Adolescent Psychiatry	1
KDT Essentials + Stahl Essential Psychopharmacology	1
KDT Essentials + Stahl Prescriber's Guide	1
Maudsley 15th ed + Stahl Essential	1
Stahl Prescriber's Guide + Maudsley 15th ed + KDT	1

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Maudsley 15th ed + KDT	1
RC Jiloha - Forensic Psychiatry - An Indian Perspective; corroborated by Indian J Psychol Med 2025 (SLD: Ten Challenges) citing the RPwD gazette	1
RC Jiloha - Forensic Psychiatry - An Indian Perspective; corroborated by Indian J Psychol Med 2025 (Ten Challenges) citing the 2024 RPwD gazette	1
Indian J Psychol Med 2025 (SLD: Ten Challenges) citing the RPwD gazette notification; NIMHANS battery also in RC Jiloha - Forensic Psychiatry	1
RPwD 2024 assessment guidelines (via Indian J Psychol Med 2025, PMC11966623); textbook near-equivalent RC Jiloha Forensic Psychiatry	1
RC Jiloha - Forensic Psychiatry - An Indian Perspective (critique of RPWD Rules 2017)	1
Rights of Persons with Disabilities Act 2016 (ID definition, Schedule para 2); RC Jiloha - Forensic Psychiatry; Indian J Psychol Med 2025	1
Indian J Psychol Med 2025 (Ten Challenges) quoting the notification dated 09 December 2020	1
CBSE Circular No. 3/2018, Exemptions/Concessions for Persons with Benchmark Disabilities (Class X and XII Examinations)	1
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PART IV

IV

Child Behavioural, Emotional and Other Disorders

The behavioural and emotional disorders of childhood, from conduct and oppositionality through anxiety, tics and elimination.

01 Conduct disorder

02 Oppositional defiant disorder and the impulse-control disorders

03 Childhood anxiety, OCD and trauma disorders

04 Childhood mood disorders, disruptive mood dysregulation, early-onset psychosis and paediatric suicidality

05 Attachment disorders of childhood

06 Tic disorders and Tourette syndrome

07 Elimination and feeding disorders

08 Discriminate, apply and consolidate

PAPER III

Child behavioural, emotional & other disorders

Seven bands . one complete notes document

Conduct disorder

1 · The five groups and the shape of the chapter

A chapter reads more easily once you can see its skeleton. The disorders gathered under this heading are the ways children and adolescents come to behave, feel and function outside the expected range, and set out as a bare list they can look like a loose and only distantly related collection: conduct problems next to bedwetting, tics next to school refusal, a withdrawn deprived toddler next to a defiant teenager. That impression is misleading, and it is worth dissolving at the outset, because the candidate who carries a shape into the exam answers a mixed vignette far better than one who has memorised each entity as an island. The chapter's own title supplies the shape. It names three things in order: the behavioural disorders, the emotional disorders, and the other disorders, and those are not three arbitrary drawers but a genuine organizing logic that the rest of this material fills in.

The aim of this opening is to hand you that logic before any single disorder is taught. Three moves do the work. The first is an axis that links the two largest groups, distinguishing distress that a child turns outward from distress a child turns inward. The second is the recognition that not every childhood disorder belongs on that axis: three further families keep their own logic and are misread if forced onto it. The third is a principle that runs underneath the whole chapter, that these are disorders of degree and of context, judged against a developmental baseline that is itself moving. Hold those three and the individual diagnoses that follow slot into place rather than accumulating as a list.

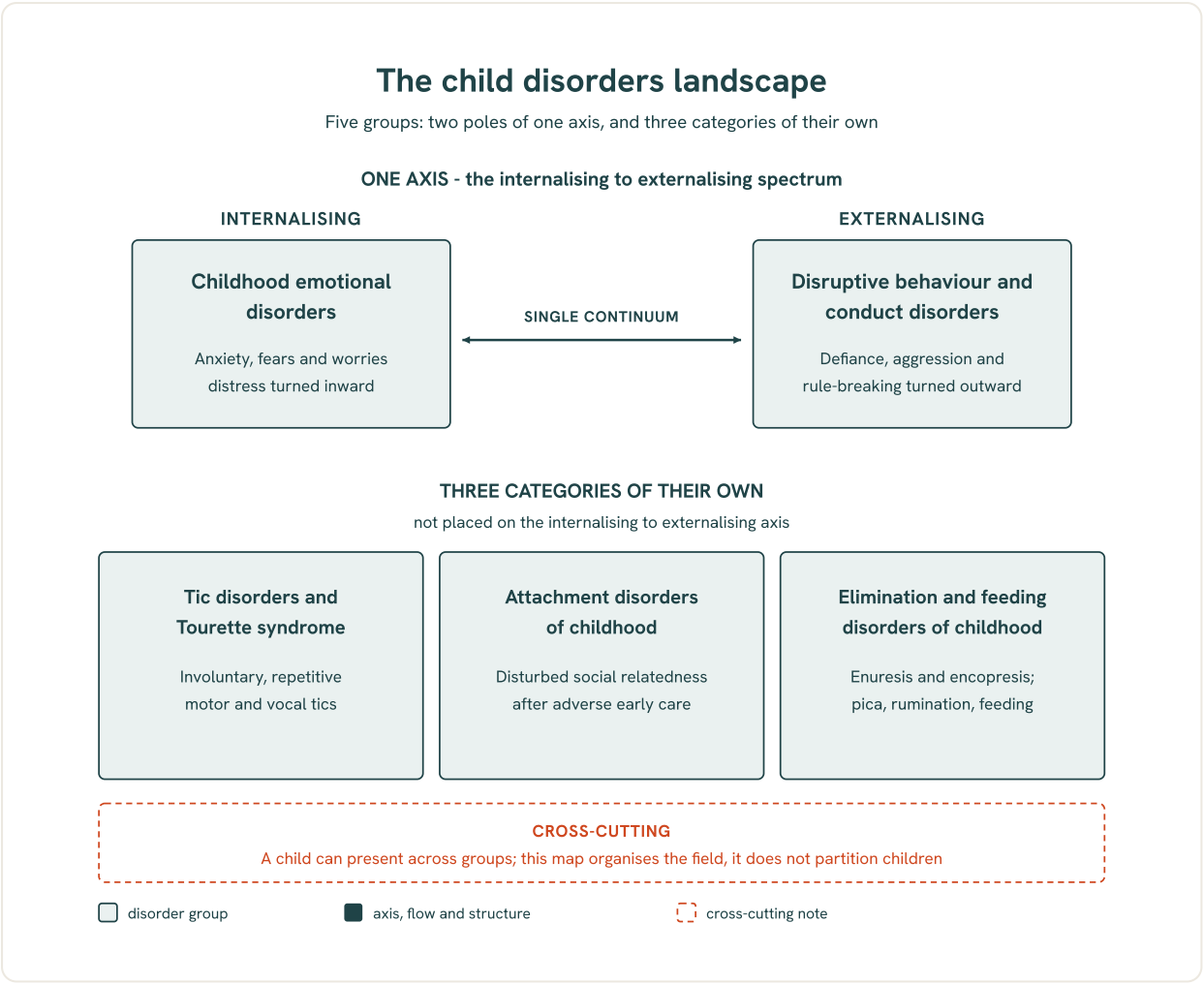


Fig 23.1. The child disorders landscape: emotional (internalising) and disruptive or conduct (externalising) disorders sit at the two poles of one axis, while tic, attachment, and elimination or feeding disorders form three categories of their own.

1.1 The organizing axis: distress turned outward and distress turned inward

The two largest groups are two directions of the same problem. The most useful single distinction in child psychiatry is between the disorders in which difficulty is expressed **externally**, as behaviour that impinges on other people and on the surrounding world, and those in which it is experienced **internally**, as suffering the child largely carries within. The externalising, or behavioural, group is the disruptive one: conduct disorder, oppositional defiant disorder and the impulse-control disorders, where the presenting problem is what the child does to others and the first complaint usually comes from an adult. The internalising, or emotional, group is the group of anxiety, obsessive-compulsive and trauma-related disorders and the childhood mood disorders, where the presenting problem is what the child feels and the first complaint, if it comes at all, often comes late and quietly. The value of the axis is not taxonomic tidiness but clinical direction: it tells you who is likely to be referred and who is likely to be missed, whose distress announces itself and whose has to be sought.

RULE **Externalising and internalising is one organizing dimension, not a complete classification.** It is a lens laid across the disorders to show a pattern, chiefly that outward-directed problems are referred and inward-directed ones are overlooked. Read it as a filing system into which every childhood disorder must drop and it stops helping, because several of the disorders in this chapter do not sit on it at all.

1.2 The three families that keep their own logic

The "other disorders" of the title are three groups with their own organizing principle. A frequent error is to treat the outward-inward axis as exhaustive and then to squeeze the remaining disorders onto it. They do not belong there, and each is better understood on its own terms. The **tic disorders**, including Tourette syndrome, are neurodevelopmental and motor in nature; their defining feature is an involuntary movement or vocalisation, not an emotional state turned in or a behaviour turned out. The **attachment disorders** are relational disorders that arise specifically from grossly deficient early care, so their organizing principle is the child's history of caregiving rather than any internalising or externalising temperament. The **elimination and feeding disorders** are disorders of bodily function and its regulation, from enuresis and encopresis to the feeding and eating problems of early childhood. Naming these three as their own categories, rather than as odd members of the behavioural or emotional groups, is itself a piece of examinable understanding, and it is why the chapter is built as five families and not two.

FAMILY	ORGANIZING LOGIC	REPRESENTATIVE MEMBERS (TAUGHT IN FULL IN THEIR OWN PLACE)
Behavioural (externalising)	Distress turned outward onto others and the world	Conduct disorder, oppositional defiant disorder, the impulse-control disorders
Emotional (internalising)	Distress carried within, often referred late	The childhood anxiety, obsessive-compulsive and trauma-related disorders, the childhood mood disorders
Tic disorders	Neurodevelopmental and motor; involuntary movement or vocalisation	Transient and chronic tic disorders, Tourette syndrome
Attachment disorders	Relational; rooted in grossly deficient early care	Reactive attachment disorder, disinhibited social engagement disorder
Elimination and feeding	Disorders of bodily function and its regulation	Enuresis, encopresis, and the feeding and eating disorders of childhood

The five families of the chapter set against the principle that organizes each. The axis of the first section explains only the top two rows; the lower three are named here as their own categories and are developed, each in full, later in this chapter.

1.3 Why the axis is a lens and not a wall: comorbidity across it

Outward and inward disorders live together far more often than the neat split suggests. The axis earns its keep by directing attention, but a candidate who treats it as a partition will be

caught by the commonest examination presentation of all, the child who sits on both sides at once. The disruptive, acting-out child very frequently carries an internalising disorder underneath the behaviour, and the anxious or depressed child not uncommonly presents through irritability and rule-breaking that look, at first glance, purely behavioural. That the two directions co-occur is not an untidy exception to the scheme; it is the clinical rule, and it is precisely why the outward-inward distinction has to be held as a way of looking rather than as a boundary between separable populations.

TRAP **Treating externalising and internalising as mutually exclusive.** The vignette that describes a defiant, aggressive boy invites the label of a pure behavioural disorder and tempts the candidate to stop there. The stronger answer notices that the behaviour may be the visible surface of an anxiety, trauma or mood disorder beneath it, and that the two so-called opposite groups are the disorders most likely to be found in the same child.

GOOD TO REMEMBER

When a child is referred for what one side of the axis makes obvious, look deliberately for the other. Screen the acting-out child for the anxiety, trauma and mood that hide behind conduct, and ask the withdrawn or anxious child about the irritability and defiance that a caregiver may not have thought worth mentioning. The referral tells you which door the family came through, not the whole of what is inside.

1.4 Disorder against a moving baseline: the developmental continuum

Almost every symptom in this chapter also exists as a normal part of growing up. Tantrums, fears, defiance, bedwetting, repetitive movements, clinginess at separation and the odd untruth are ordinary features of childhood, present in well children and expected at particular ages. This is the principle that sits under the whole chapter and separates its disorders from the developmental noise around them: a childhood disorder is rarely a behaviour that healthy children never show, and is far more often the same behaviour grown persistent, pervasive, developmentally out of step, and impairing. The **developmental continuum** is therefore not a soft caveat but the working definition of pathology here, because what is normal at one age is a red flag at another, and the baseline against which any symptom is read keeps shifting as the child grows. What counts as expected at a given age is set out in the Normal child development and milestones notes; the specific thresholds that separate each disorder from its normal counterpart, and the map that sets the whole set of them side by side, are drawn together toward the end of this chapter, where the comparisons can be made once and properly.

PITFALL

The characteristic error at this level is to diagnose from the behaviour alone, without asking where the child sits on the developmental continuum. A defiant three-year-old, a frightened five-year-old and an occasionally wet seven-year-old are, far more often than not, well children doing age-appropriate things. Reaching for a disorder because the behaviour is present, rather than because it is persistent, pervasive and impairing for that age, over-pathologises ordinary development and is the mirror image of the more familiar failure to recognise a genuine disorder.

1.5 Reading the chapter, and a word on classification in Indian practice

The map is worth carrying into every question this chapter can ask. With the five families and the two principles in hand, the chapter equips you to do a small number of things reliably, and it is worth naming them before the detail begins:

- place any child presentation into its family, and recognise when a presentation straddles two of them;
- read the outward-inward axis as a lens on referral and detection, not as a partition;
- separate a disorder from its normal developmental counterpart by persistence, pervasiveness and impairment rather than by the behaviour alone;
- and know which of these childhood presentations point outward, to the adult disorders and to the wider systems of assessment, services and protection that lie beyond this chapter.

Where the child's presentation reaches into the domains this chapter deliberately leaves to others, the pointers are fixed: attention-deficit/hyperactivity disorder and its treatment belong to the ADHD and specific learning/communication disorders notes, and the full assessment battery, the child mental health services and the machinery of child protection to the Child psychiatry: assessment, treatment, services and protection notes.

IN INDIA

Two realities colour how this chapter is used in Indian practice. The operative classification is ICD-11, so the labels that appear in most case files and referrals are its labels rather than the DSM equivalents, and the family-based, service-scarce setting means these children very often reach a paediatrician, a general physician or a school long before they reach a child psychiatrist. The organizing consequence is practical: the outward-inward axis predicts which of them arrive at all. Disruptive, externalising problems are brought in because they trouble the adults around the child, while the internalising disorders, which cause the child the greater private suffering, are the ones most likely to go unrecognised in a system with few dedicated child mental health services. The frame is not only a way to revise the chapter; it is a reminder of where to look hardest.

MNEMONIC

Out, In, and three apart

Two families share a single axis, the child who turns distress **Out**, the behavioural or externalising disorders, and the child who turns it **In**, the emotional or internalising disorders. **Three** further families keep their own logic **apart** from that axis: the tic disorders (neurodevelopmental and motor), the attachment disorders (relational, rooted in early care), and the elimination and feeding disorders (of bodily function). The whole chapter hangs on those five, and every one of them is read against the moving developmental baseline.

The spine of the chapter: two families on one axis, distress turned Out (behavioural, externalising) against distress turned In (emotional, internalising), and three families apart from it - tic, attachment, and elimination and feeding disorders - with every disorder defined against the developmental baseline rather than by the behaviour alone.

Out	In	Apart
THE BEHAVIOURAL, EXTERNALISING DISORDERS	THE EMOTIONAL, INTERNALISING DISORDERS	TIC, ATTACHMENT, ELIMINATION AND FEEDING

2 · Conduct disorder diagnostic criteria and subtypes (childhood-onset, adolescent-onset)

The diagnosis turns on a pattern, not on a single act. **Conduct disorder** is the syndrome of childhood and adolescence in which a young person repeatedly and persistently behaves in ways that violate the basic rights of others or the major age-appropriate rules of society. It is one of the commoner reasons a child reaches psychiatric attention: one-year population prevalence in high-income settings has been estimated at a median of about **4%**, with estimates ranging from 2% to more than 10% across studies, and it falls more heavily on boys and men, whose lifetime prevalence has been put at about **12.0% in men and 7.1% in women**. Marks accrue here because the diagnosis is deceptively easy to reach for and genuinely hard to make well. The behaviours are dramatic, the temptation to label a difficult adolescent is strong, and the criteria exist precisely to separate a disorder from ordinary misbehaviour, from isolated delinquency, and from the friction of a hard upbringing.

This topic owns the diagnostic architecture: the essential feature, the count and timeframe of Criterion A, the behavioural groupings the criteria fall into, the impairment and adult-exclusion criteria, the developmental onset subtypes that are the item's real teaching point, and the severity grading. The callous-unemotional presentation captured in the limited prosocial emotions specifier, the causes and risk factors, the full assessment and its instruments, the treatments, and the long-term trajectory into adult antisocial outcomes are each developed in their own right elsewhere in this chapter. Here they are named where the criteria demand it, not reopened.

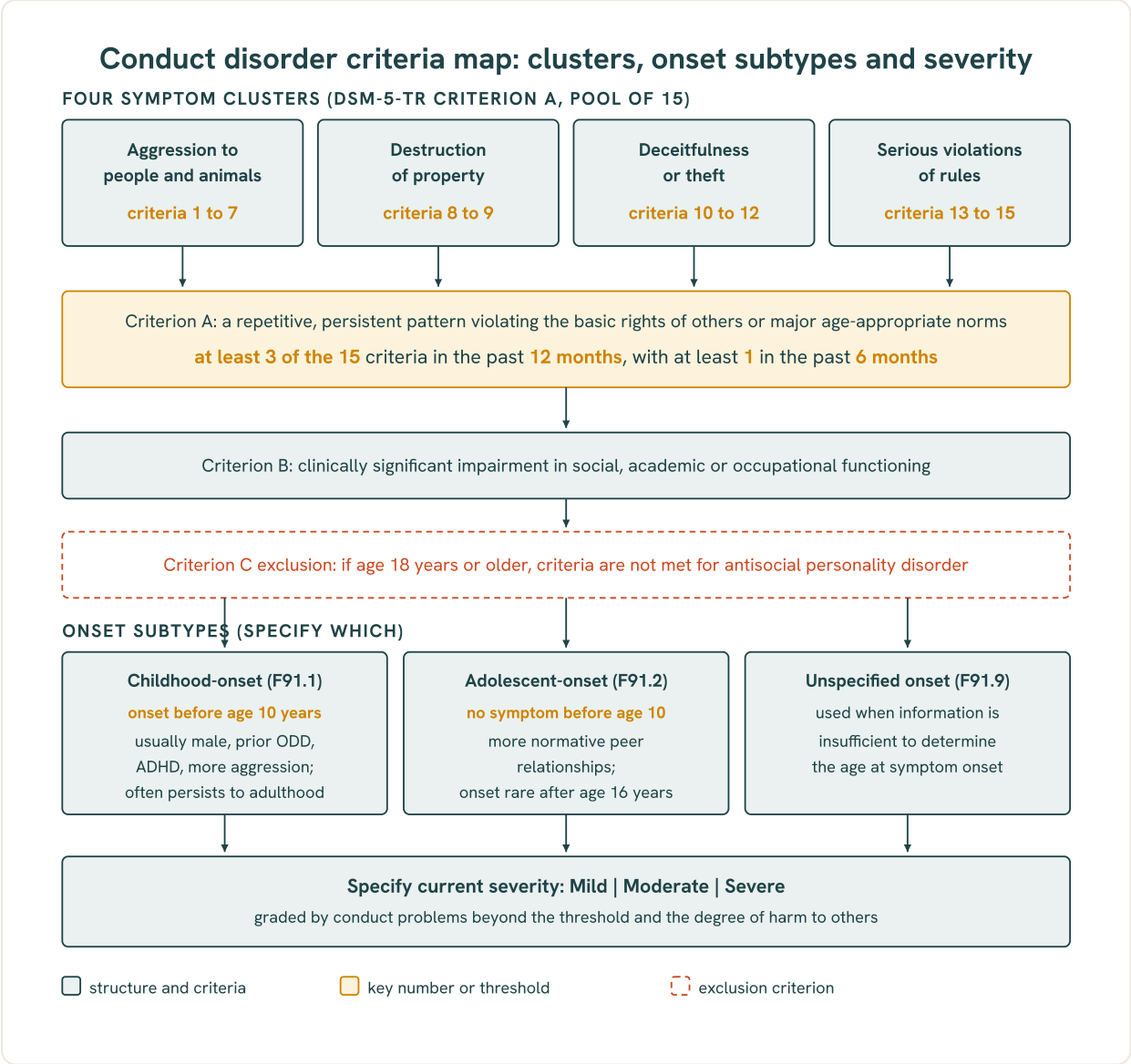


Fig 23.2. Conduct disorder criteria map: the four DSM-5-TR symptom clusters feeding the three-of-fifteen Criterion A threshold, the impairment and antisocial-personality-disorder gates, the childhood-onset and adolescent-onset subtypes, and the mild to moderate to severe severity grading.

2.1 The essential feature: a pattern, not an incident

The unit of diagnosis is a pattern of conduct over time. The essential feature is a repetitive and persistent pattern of behaviour in which the young person violates either the basic rights of others or the major age-appropriate norms and rules of society. Each part of that definition matters. Violating the rights of others captures aggression, cruelty, intimidation, and the taking of what belongs to someone else; violating major societal norms captures the serious rule-breaking, from chronic truancy to running away, that need not have a direct victim at all. What unifies the picture is not any single behaviour but its repetition and its persistence, and this is exactly why a solitary serious act, however shocking, does not by itself constitute the disorder. A first arrest, a single fight, or one episode of theft is an event to be understood, not a diagnosis to be made. The clinician's task is to establish whether a durable pattern sits behind the presenting incident, because it is the pattern, and not the incident, that predicts the course and justifies the label.

RULE **Conduct disorder is a pattern, never a single act.** The diagnosis rests on a repetitive and persistent course of rights-violating or norm-violating behaviour, so the assessor's first question is never what did the child do but what pattern does this belong to. An isolated offence read as a disorder is the error the criteria are built to prevent.

2.2 Criterion A: the count and the clock

The threshold and the timeframe are the examinable core. Criterion A operationalises the pattern into a rule that can be applied and defended. It requires that at least **three** of the **15** defined behaviours have been present within the past 12 months, with at least one of them present within the past 6 months. Each number earns its place. The count separates a genuine syndrome from a handful of troubling behaviours, and the recency window forces the clinician to show that the problem is current rather than historical, so that a child who has genuinely settled is not carried indefinitely under an old label. The number of symptoms present beyond the minimum is not wasted information either, because it feeds directly into the severity rating. Applied honestly, Criterion A is what stops the diagnosis drifting into a catch-all for any troublesome adolescent.

The core rule to carry into the exam: at least three of the 15 behaviours within 12 months, at least one within the past 6 months, forming a pattern and not a single act.

2.3 The four behavioural groupings

Fifteen behaviours, grouped into coherent families. The criteria are not a random list; they sort into four groupings that together describe the reach of the disorder from covert acts to overt ones. The first is **aggression to people and animals**, the behaviours that threaten or inflict physical harm, including bullying, fighting, cruelty, and the use of a weapon. The second is destruction of property, such as deliberate firesetting and other damage done on purpose. The third is deceitfulness or theft, the covert dimension of lying, conning others, and stealing with or without confrontation. The fourth is serious violations of rules, such as staying out at night against parental prohibition, persistent truancy, and running away from home. Reading a young person's symptoms as a profile across these families, rather than as a scatter of unrelated incidents, is what turns a list of complaints into a clinical picture.

MNEMONIC

Hurt, Wreck, Lie, Break

The groupings in order of how overtly they present: **Hurt** (aggression to people and animals), **Wreck** (destruction of property), **Lie** (deceitfulness or theft), and **Break** (serious violations of rules). Holding the families in mind stops the assessor cataloguing behaviours singly and missing the pattern that the diagnosis actually requires.

2.4 Impairment and the adult boundary: Criteria B and C

The behaviour must cost something, and the label must not outlive its usefulness. Criterion B keeps the diagnosis clinical rather than merely descriptive: the disturbance of conduct must

cause clinically significant impairment in social, academic, or occupational functioning. Behaviour that breaks rules but carries no cost to the young person's functioning does not qualify, which guards against pathologising nonconformity. Criterion C then draws the upper boundary. Conduct disorder can still be diagnosed in an adult, but only where the person, if aged 18 years or older, does not meet the criteria for **antisocial personality disorder**. Once that adult syndrome is established it takes precedence, and conduct disorder is reserved for those who have not crossed into it. The adult disorder itself, and the pathway a proportion of children take toward it, belong respectively to the Personality disorders notes and to a later discussion in this chapter; here the point is only the diagnostic hierarchy that Criterion C encodes.

TRAP **Conduct disorder does not automatically stop at adulthood.** Candidates assume the diagnosis is purely paediatric and expires the moment the patient turns adult, or conversely that every antisocial adult once carried it formally. Criterion C is subtler: in a person aged 18 or older the diagnosis still stands, provided the full criteria for antisocial personality disorder are not met. The exclusion is conditional, not automatic.

2.5 The developmental onset subtypes

When the trouble began matters more than what form it takes. DSM-5-TR requires the clinician to specify the developmental course, because the age of onset is the specifier with the greatest prognostic weight. In the **childhood-onset type**, at least one characteristic symptom of conduct disorder is present before age **10**; it is coded F91.1. In the **adolescent-onset type**, no characteristic symptom is present before age 10, the first appearing only in the teenage years; it is coded F91.2. Where the history is too incomplete to establish which course applies, for instance when the early childhood years cannot be reliably reconstructed, the diagnosis is left as unspecified onset, coded F91.9. The division looks administrative, but it is anything but: it sorts children who can look broadly similar at presentation into groups whose correlates and outlook differ sharply, which the next section takes up.

2.6 Why onset age matters: the clinical correlates

Early onset marks the more severe and more persistent illness. The reason the subtypes are worth specifying is that they carry different clinical company and different trajectories. The childhood-onset form is the more ominous. Such children are usually male, their peer relationships are frequently disturbed, and their conduct problems are often preceded in the earlier years by **oppositional defiant disorder**. They tend to show more aggression, and they frequently carry a concurrent attention-deficit/hyperactivity disorder, the assessment and treatment of which belong to the ADHD and specific learning/communication disorders notes. Crucially, the childhood-onset form is the one more likely to persist into adult life, which is why it, and not the adolescent-onset form, is the subtype that carries the recognised risk of an antisocial adult outcome. The adolescent-onset form, by contrast, tends to arise against a background of more normative peer relationships and is more often a reaction to the pressures and affiliations of adolescence than the expression of a long-standing trait. That contrast is the clinical heart of the distinction: conduct that is present from early childhood tends to reflect a more pervasive and enduring vulnerability, whereas conduct that emerges only in adolescence is

more often tied to a particular developmental phase and its social affiliations, and is correspondingly more likely to remit as that phase passes. Onset of the disorder is rare after age 16. A further high-risk subgroup, marked by the callous-unemotional presentation captured in the limited prosocial emotions specifier, is developed in its own right elsewhere in this chapter.

FEATURE	CHILDHOOD-ONSET	ADOLESCENT-ONSET
First symptom	Before age 10	Not before age 10
Peer relationships	Often disturbed	More often normative
Aggression	More prominent	Comparatively less
Course into adulthood	More likely to persist	More likely to remit

The onset subtypes set against the correlates that give the childhood-onset form its worse outlook; the adolescent-onset column is defined chiefly by the absence of early symptoms and by more normative peer relationships.

2.7 Grading the disorder: the severity specifier

The diagnosis is incomplete until it is graded. DSM-5-TR asks for a rating of **current severity** as mild, moderate, or severe. The grade reflects the number of conduct problems present beyond the minimum needed to make the diagnosis, together with how much harm those problems do to others. A young person who just clears the threshold, with problems that are minor and cause limited harm, sits at the mild end; one with many problems, or with conduct that inflicts considerable harm, sits at the severe end. Severity is rated independently of onset, so either developmental subtype can present in mild, moderate, or severe form. The grade is not cosmetic. It summarises the current burden and travels with the young person into every service and record that follows, shaping the urgency and intensity of the response.

> **GOOD TO REMEMBER**
>
> Always assign the severity, and treat it as clinical information rather than a formality. A mild adolescent-onset case and a severe childhood-onset case share a diagnostic label but are different clinical problems with different outlooks, and the grade you record is often the single most useful line in the entry for whoever reads it next.

2.8 The nearest neighbours: oppositional defiant disorder and normal limits

Most diagnostic errors cluster at the borders of the diagnosis. The first border is with oppositional defiant disorder. The two share defiance, anger, and a tendency to blame others, and childhood-onset conduct disorder is frequently preceded by it, but they part on a single decisive line: oppositional defiant disorder does not involve the violation of the basic rights of others or of major societal norms that defines conduct disorder. Argumentative, spiteful, and rule-refusing behaviour that stops short of aggression, destruction, deceit, and serious rule-breaking is the lesser diagnosis, which is developed in its own right elsewhere in this chapter. The second border is with ordinary development. Rule-testing, occasional lying, the odd fight, and adolescent risk-taking are common and usually self-limiting, and what counts as expected at a given age belongs to the Normal child development and milestones notes. The diagnosis is reserved for the persistent, impairing, rights-violating pattern, and not for any one behaviour taken alone.

- a single serious act, however grave, does not meet the pattern requirement;
- defiance and argumentativeness without violation of others' rights point toward oppositional defiant disorder, not conduct disorder;
- transient, situational rule-testing that fits the child's developmental stage is not a disorder;
- the behaviour must cause clinically significant impairment before it counts at all.

PITFALL

The commonest clinical error is over-reach: attaching the label to a defiant, delinquent, or simply hard-to-manage adolescent because the behaviour alarms the adults around them, rather than because a persistent pattern of rights-violating conduct has actually been established over time. A chaotic or depriving environment can generate rule-breaking that is adaptive to its setting; the diagnosis asks for a pattern in the young person's conduct, not a verdict on their circumstances.

2.9 The ICD-11 counterpart and how it differs

The manual that governs most Indian practice draws the same disorder with a different rule.

In ICD-11 the entity is **conduct-dissocial disorder**, coded 6C91. Its required feature is the same repetitive and persistent pattern of behaviour violating the basic rights of others or major age-appropriate social or cultural norms, sustained and recurrent over an extended period, for example 1 year or more, and it states explicitly that the mere commission of isolated delinquent acts is not sufficient. The behaviours fall into the same four groupings. The material difference is at the threshold: ICD-11 sets no fixed symptom count of the kind DSM-5-TR uses, treating the diagnosis as a clinical judgement about the pattern rather than a tally against a list. The same developmental split is preserved, as childhood onset (6C91.0, with one or more features before age 10) against adolescent onset (6C91.1, with none before that age).

AXIS	DSM-5-TR	ICD-11 (CONDUCT-DISSOCIAL DISORDER)
Symptom threshold	At least three of 15 criteria, with a recency rule	No fixed count; a persistent pattern over an extended period
Behaviour groupings	The same four	The same four
Onset subtypes	Childhood (F91.1) and adolescent (F91.2)	Childhood (6C91.0) and adolescent (6C91.1)
Diagnostic logic	Operationalised count and timeframe	Clinical judgement of the pattern

The same disorder under the two classifications; the load-bearing difference is that ICD-11 requires a persistent pattern but not a fixed count, which places the weight on documented clinical judgement.

IN INDIA

Because Indian services classify under ICD, the operative label in most case files, referrals, and official reports is conduct-dissocial disorder rather than the DSM term. The absence of a fixed symptom count is not a licence for looseness: it puts a premium on documenting the pattern, its persistence, and its impact carefully, since the diagnosis rests on the clinician's recorded reasoning rather than on a number that can be checked off. Where a young person's conduct intersects with the law, the juvenile-justice framework is taken up separately in this chapter, and the wider machinery of child protection and services in the Child psychiatry: assessment, treatment, services and protection notes.

3 of 15	age 10	4%
CRITERIA NEEDED FOR THE DIAGNOSIS	ONSET CUT DIVIDING THE SUBTYPES	MEDIAN ONE-YEAR PREVALENCE

3 · Limited prosocial emotions specifier (callous-unemotional traits)

The specifier answers a different question from the diagnosis itself. The diagnosis of conduct disorder tells you that a young person repeatedly violates the rights of others or the major rules of society; it says nothing about the emotional machinery driving that behaviour. The **limited prosocial emotions** specifier, the formal home of what the developmental literature calls **callous-unemotional traits**, is the manual's attempt to mark out the subgroup whose conduct problems are accompanied by a genuine deficit in the affective and interpersonal capacities that normally restrain antisocial behaviour. Marks accrue here because this is a high-yield discrimination that examiners love: the same headline behaviour, delinquency and aggression, can sit on top of two very different internal pictures, and the presence of this specifier changes what the clinician expects of severity, of persistence, and of response to the usual behavioural treatments.

This topic owns the specifier: its defining logic, its threshold, its four constituent features, the assessment demands it imposes, and the way it maps onto the international classification differently from the American one. The conduct disorder criteria and the onset subtypes, the wider etiology in which callous-unemotional traits sit as one developmental pathway, and the trajectory into adult antisocial outcomes for which these traits are a recognised predictor are each developed in their own right elsewhere in this chapter. Here they are named where the argument needs them, not reopened.

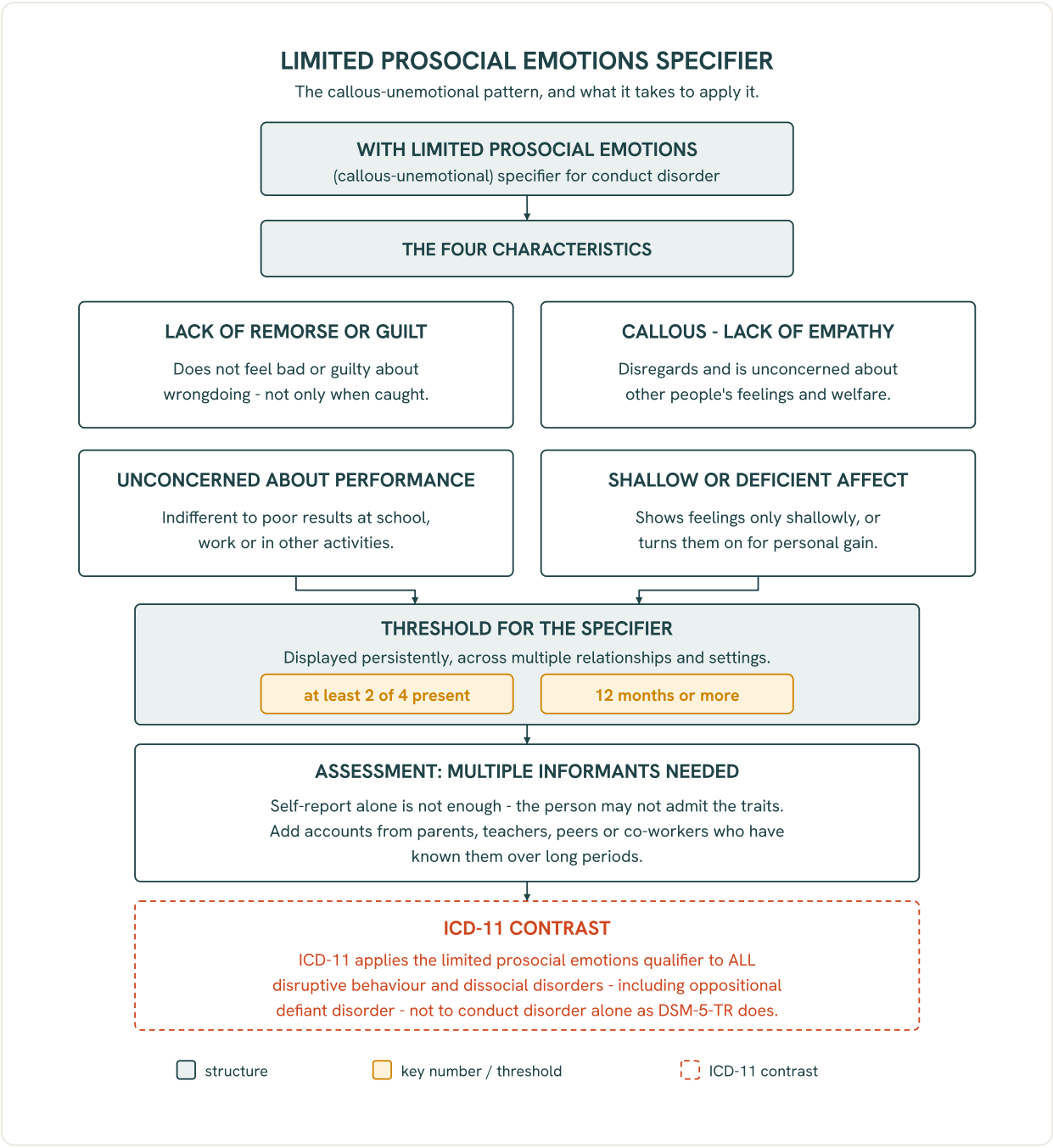


Fig 23.3. Limited prosocial emotions specifier: the callous-unemotional pattern for conduct disorder, its four characteristics, the threshold to apply it, and the ICD-11 contrast.

3.1 What the specifier marks, and why it is not the same as severe conduct disorder

It grades the emotional style of the behaviour, not its quantity. The commonest conceptual error is to treat this specifier as simply the top end of a severity scale, so that the most violent or most prolific offender automatically earns it. That is wrong, and understanding why is the whole point of the topic. Severity in conduct disorder counts how many behaviours are present and how much harm they do; the specifier instead asks about the affective-interpersonal quality that underlies the behaviour, the presence or absence of guilt, empathy, concern and genuine feeling. A frightened, reactive adolescent whose aggression is impulsive and who feels real remorse afterwards may carry a severe rating and still fall well short of the specifier. Conversely, a young person whose offending is more calculated and less florid may show exactly the cold, unemotional style the specifier captures. The two axes are orthogonal: one measures how much, the other

measures of what kind. Reading the specifier as a synonym for "worst" collapses that distinction and loses the clinical information the manual was trying to preserve.

RULE **The specifier describes the affective style of the conduct problem, not its magnitude.** It is applied on the presence of a callous, guilt-poor, empathy-poor interpersonal pattern, independently of how many symptoms or how much harm the severity rating records. A severe case need not qualify; a qualifying case need not be the most severe.

3.2 The threshold: a stable pattern, not an occasional coldness

Two of four features, sustained over time and across relationships. To apply the specifier the clinician must establish that the young person has displayed **at least two** of the **four** defining characteristics, and the qualifying words do more work than the count. The features must have been present persistently, over a period of **12 months** or more, and they must show themselves in multiple relationships and settings rather than in one strained situation. This is a deliberate guard against over-diagnosis. Every adolescent is capable of a cold, dismissive moment, particularly toward an adult they are in conflict with; what the specifier is reaching for is a typical way of relating and feeling, a trait rather than a state. Requiring the pattern across settings and informants means the clinician is describing how this young person characteristically operates in the world, and not simply how they presented in a single tense encounter. The threshold is low in number and high in stringency of pattern, and that combination is exactly what the examiner wants you to be able to state.

> The must-memorise threshold: at least two of the four features, present persistently for at least 12 months and shown across multiple relationships and settings, so that a typical pattern and not an occasional occurrence is being described.

3.3 The four features

Each feature names a specific missing capacity. The four characteristics are not interchangeable synonyms for coldness; each points at a distinct deficit, and being able to name and illustrate all four is standard examination fare. The first is a **lack of remorse or guilt**, an absence of feeling bad about wrongdoing that is genuine and not merely the sullen regret of having been caught. The second is being **callous, with a lack of empathy**, a disregard for and unconcern about the feelings of others that shows in how the young person treats the people they harm. The third is being **unconcerned about performance** at school, at work or in other activities, where the ordinary drive to do well and the discomfort of doing badly appear muted. The fourth is a **shallow or deficient affect**, an emotional life that seems thin, or feelings that are expressed only superficially or turned on and off in a way that looks instrumental. Read together they sketch the affective core of what, in the adult, becomes the interpersonal-affective dimension of antisocial pathology.

FEATURE	WHAT IT NAMES	THE DISCRIMINATING MARKER
Lack of remorse or guilt	No genuine bad feeling after wrongdoing	Regret only when caught does NOT count
Callous, lack of empathy	Disregard for others' feelings	Cold toward those they have harmed, not just detached generally
Unconcerned about performance	Muted drive to do well	Poor results provoke little discomfort or effort
Shallow or deficient affect	Thin or instrumental emotional expression	Feelings shown superficially or switched on for gain

The four features set against the marker that separates each from an ordinary adolescent equivalent; the "only when caught" qualifier on remorse is the one most often tested.

MNEMONIC

No Regret, No Feeling-for-others, No Drive, No Depth

The four features as four absences: **No Regret** (lack of remorse or guilt), **No Feeling-for-others** (callous, lack of empathy), **No Drive** (unconcerned about performance), and **No Depth** (shallow or deficient affect). Holding them as a quartet of deficits, rather than one vague idea of coldness, is what lets you demonstrate that at least two are present.

3.4 Assessment: why a single interview cannot make the call

The specifier is the one place where self-report is least trustworthy. There is a structural problem in assessing these traits, and the manual is explicit about it: the very features being sought, low guilt and a willingness to present a self-serving surface, make the young person an unreliable narrator of their own callousness. Some will minimise, some will manage the clinician's impression, and few will volunteer that they do not care about the people they hurt. For this reason the assessment cannot rest on the clinical interview or on self-report alone. It requires information from others who have known the individual over extended periods, and their observations are weighed alongside, and often above, what the young person says of themselves.

- parents and other caregivers, who see the child across the domestic and emotional life a clinic never observes;
- teachers, who see performance, peer conduct and response to correction over months;
- the extended family, peers and, in older adolescents, co-workers, who see the pattern in relationships the clinician has no access to;
- direct observation and history, set against self-report rather than replaced by it.

GOOD TO REMEMBER

Treat a bare clinic interview as insufficient to apply or exclude this specifier. If you cannot corroborate the affective pattern with someone who has watched the young person over time and in more than one setting, the honest position is that the specifier is not yet established, not that it is absent. Building the multi-informant picture into the assessment from the start saves you from a judgement the data cannot support.

3.5 Who qualifies, and why it matters for the outlook

The specifier identifies a smaller, harder subgroup. Only a minority of young people with conduct disorder meet the threshold for limited prosocial emotions, and those who do are not a random slice of the diagnosis. The specifier is more likely to be present in the childhood-onset presentation and in cases carrying a severe severity rating, which is to say it concentrates in exactly the group whose conduct problems are already the most entrenched. This is why it earns its place clinically rather than merely descriptively. Callous-unemotional traits function as one developmental pathway into persistent antisocial behaviour, and as a recognised predictor of the poorer long-term trajectory, both of which are developed where this chapter takes up etiology and prognosis. The traits also colour treatment expectations: interventions that lean on the child's attunement to others' distress and on a wish to please have less to work with when empathy and the drive to perform are precisely what is thinned, which is one reason the management of these cases is harder and the response often more limited. None of that lowers the therapeutic obligation; it sharpens what the clinician must plan for.

3.6 Where the two classifications part: scope of the qualifier

A material difference the Indian candidate must hold. The American manual attaches the limited prosocial emotions specifier to conduct disorder alone. The international classification takes a wider view: its equivalent **with limited prosocial emotions** qualifier may be applied across the whole grouping of disruptive behaviour and dissocial disorders, and in particular it may be applied to oppositional defiant disorder (**6C90**) as well as to conduct-dissocial disorder. This is not a cosmetic wording change. It reflects a genuine difference of view about where the callous-unemotional dimension belongs: as a modifier reserved for the full conduct syndrome, or as a cross-cutting affective specifier that can qualify the milder oppositional presentation too. For an examination governed by the international system, being able to state that the qualifier reaches oppositional defiant disorder in that scheme, and does not in the American one, is the discrimination that is actually asked.

AXIS	DSM-5-TR	ICD-11
Name of the marker	Specifier: with limited prosocial emotions	Qualifier: with limited prosocial emotions
Where it may be applied	Conduct disorder only	All disruptive behaviour and dissocial disorders
Reaches oppositional defiance?	No	Yes, including oppositional defiant disorder (6C90)

The same affective construct, differently scoped; the load-bearing contrast is that the international scheme lets the qualifier modify oppositional defiant disorder while the American one confines it to conduct disorder.

IN INDIA

Because Indian services classify under the international system, the operative form in case files and reports is the qualifier that may sit on any disorder in the disruptive-behaviour grouping, not the conduct-disorder-only specifier of the American manual. In practice this means the callous-unemotional pattern should be actively considered, and documented, even in a young person carrying only an oppositional defiant diagnosis, and not held back until the full conduct syndrome is reached. The wider scope is a prompt to look for the affective deficit earlier, which fits the pathway on which these traits are known to precede the more entrenched picture.

3.7 The traps and the near misses

Most errors here are errors of over-attribution or of mistaken equivalence. Three confusions recur. The first is reading regret-on-being-caught as remorse; the specifier explicitly requires that the absence of guilt be genuine, so contrition that appears only once consequences arrive counts toward the feature, not against it. The second is equating the specifier with a formal adult diagnosis: callous-unemotional traits in a child foreshadow, but are not the same as, the interpersonal-affective dimension of the adult antisocial personality, which is taken up in the Personality disorders notes, and applying an adult label to a child on the strength of these traits is a category error. The third is confining the assessment to the consulting room, where the young person controls the impression and the traits are least likely to declare themselves.

TRAP **Remorse only when caught is not remorse.** Candidates count a display of regret after discovery as evidence against the lack-of-guilt feature, and mark the specifier absent. The criterion is the opposite way round: guilt that surfaces only once the young person is caught does not rescue them from the feature, because the feature is about the absence of genuine, unprompted bad feeling about the wrongdoing itself.

PITFALL

A quieter clinical error is diagnosing the callous-unemotional pattern from a single hostile interview, in which a frightened or defended adolescent presents as flat and indifferent because that is how they cope with the encounter, not because it is how they characteristically feel. Detachment produced by the assessment situation is not the trait the specifier names, and treating one guarded meeting as sufficient evidence is how the label gets over-applied to children who do not warrant it.

2 of 4	12 months	all DBD
FEATURES NEEDED FOR THE SPECIFIER	MINIMUM PERSISTENT DURATION	SCOPE OF THE ICD-11 QUALIFIER

4 · Etiology and risk factors of conduct disorder

There is no single cause, and the examinable skill is holding several at once. The causes of conduct disorder are asked about precisely because a candidate who reaches for one explanation -

bad parenting, bad genes, bad company - has already failed. The disorder is the end-point of a developmental system in which an inherited liability, a temperament, a family, a peer group and a neighbourhood act on one another over years, and no term in that chain is sufficient on its own. What earns the marks is the ability to name the contributors at each level, to say how they combine rather than merely coexist, and to keep the honest uncertainty that the evidence itself carries: much of what is measured is a correlate of the disorder, not a proven cause of it.

This topic owns the etiology and the risk factors: the heritable liability and what is actually transmitted, the gene-environment interplay, the temperamental and neurocognitive substrate, the family and social adversities, the self-amplifying family process, the two developmental trajectories, the callous-unemotional route, and the neurobiological correlates. The diagnostic criteria and the onset subtypes belong to the definition of the disorder and are developed in their own right elsewhere in this chapter; the callous-unemotional specifier and its features have their own section; the trajectory into adult antisocial personality disorder, and the treatments that follow from these causes, are each taken up separately. Here those are named where the causal story demands them, not reopened.

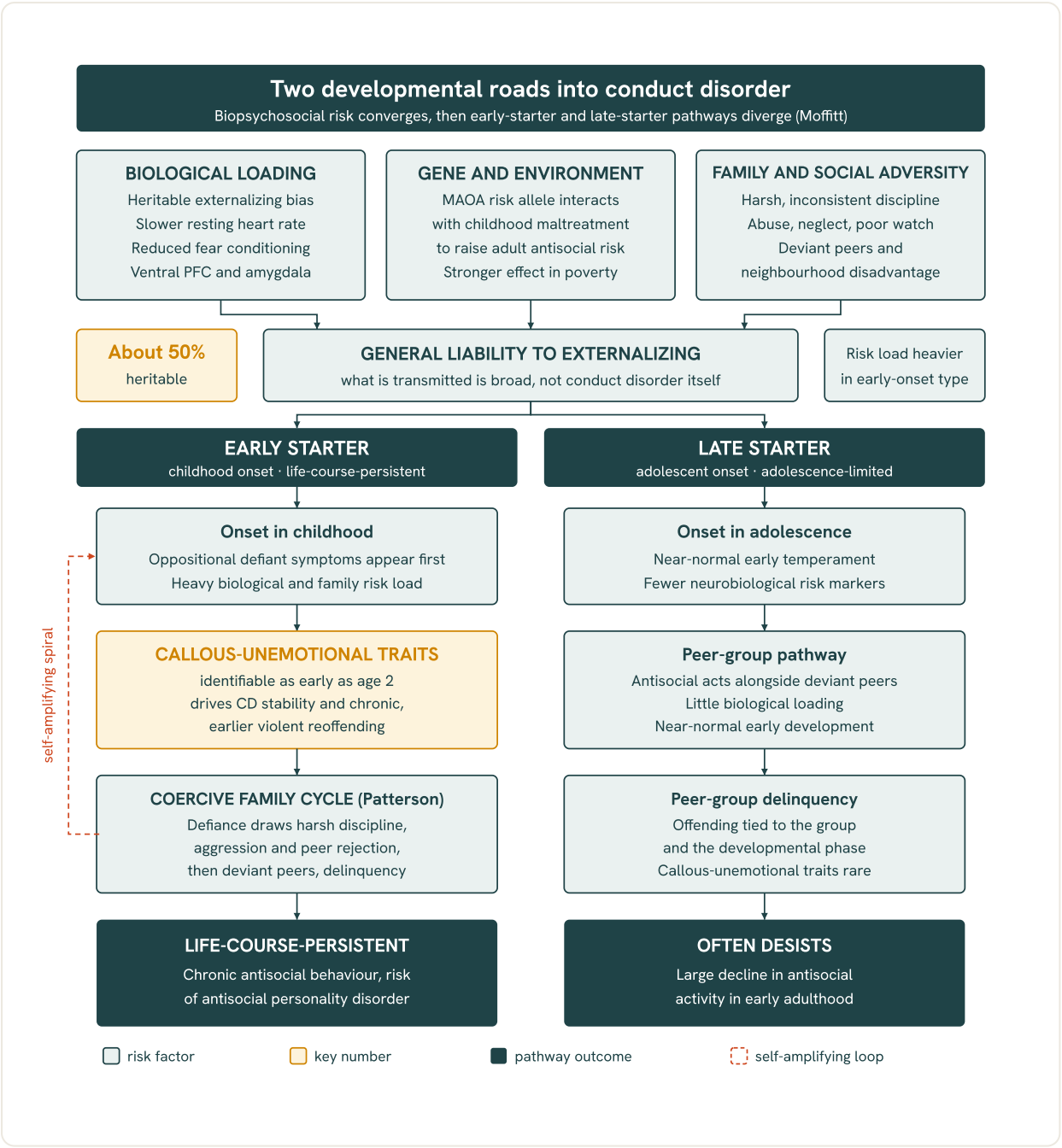


Fig 23.4. Developmental pathway to conduct disorder: biopsychosocial risk converges on a general externalizing liability, then diverges into an early-starter, life-course-persistent road and a late-starter, adolescence-limited road.

4.1 Etiology as a system, not a cause

The right frame is a developmental cascade, not a checklist of causes. Conduct disorder is best understood as the visible result of risk accumulating and compounding across development. A vulnerability present early, whether constitutional or temperamental, shapes how the child acts on the world; those actions shape how caregivers, teachers and peers respond; and those responses feed back to entrench or to soften the original vulnerability. The same starting liability can therefore end in very different places depending on what the environment does with it, which is why identical twins are discordant and why prevention is possible at all. This is not a soft statement that everything matters. It is the specific claim that the causes are probabilistic and interactive, so that any single factor raises risk without determining outcome, and the clinician's job is to read where in the cascade a given child sits and which links are still movable.

RULE **Conduct disorder has no single cause; it is the outcome of interacting risks across development.** Genetic liability, temperament, family process, peers and community each raise probability without any one being sufficient or necessary, so an etiological formulation names contributors at every level and, more importantly, says how they combine. A candidate who offers one cause has answered a different question.

4.2 The heritable liability, and what is actually inherited

Antisocial behaviour is substantially heritable, but heritability is not diagnosis-specific. Twin and adoption studies put the **heritability** of the antisocial behaviour underlying conduct disorder at **about 50%**, which sounds like a strong genetic case until the second half of the finding is added. What appears to be transmitted is not conduct disorder as a discrete entity but a broad, general liability to the externalizing disorders as a family, the shared disposition that also surfaces as oppositional behaviour, attention-deficit/hyperactivity disorder and, later, substance use and antisocial personality. The specifically conduct-disordered shape of that liability is contributed largely by the shared environment rather than by genes. This is why the same familial loading can express as several different externalizing outcomes in different children, and why a family history is a risk marker for the class of problems rather than a prediction of this one diagnosis. Reading heritability as if a gene for conduct disorder were being passed down is the commonest way to misuse the number.

> Carry this as the spine of the genetics: heritability of the underlying antisocial behaviour is about 50%, but what is inherited is a general liability to externalizing disorders, with the shared environment shaping it specifically into conduct disorder.

4.3 Genes and environment interact, they do not merely add

The genome sets a reactivity to experience, not a fixed destiny. The most instructive genetic findings in this field are not main effects of any gene but interactions in which a genotype changes how strongly an environmental adversity bites. The classic example concerns an allele of the **monoamine oxidase A (MAOA)** gene, which was found to raise the risk of adult antisocial behaviour specifically among individuals who had experienced childhood adversity, while carrying little consequence for those who had not. The gene did not code for antisociality; it conditioned the impact of maltreatment. The same logic appears at the population level, where genetic influences on problem behaviour are stronger in children growing up in poor families than in affluent ones - adversity does not swamp the genes, it unmasks them. For the exam this reframes the whole nature-nurture question: the two are not competing percentages to be apportioned but partners whose product is what matters, and an intervention that changes the environment can blunt a genetic risk that would otherwise have been expressed.

IN INDIA

The environmental half of that interaction is not evenly distributed. Overcrowding, large family size, harsh corporal discipline as an accepted norm, parental alcohol use, disrupted or absent caregiving and periods of institutional living are all more prevalent in the settings many Indian children grow up in, and the gene-environment finding implies that an identical inherited liability will be expressed more readily where such adversity is dense. The practical reading is optimistic rather than fatalistic: because so much of the operative risk is environmental and modifiable, the leverage sits in the family and the neighbourhood, and the wider machinery of child protection and welfare services relevant to these children is taken up in the Child psychiatry: assessment, treatment, services and protection notes.

4.4 Temperament and the neurocognitive substrate

The child brings something to the interaction from the start. Long before any conduct problem is diagnosable, some children show a temperament that raises risk: a **difficult, undercontrolled** infant style, marked by high negative emotionality, poor regulation of arousal and low behavioural inhibition, is one of the earliest measurable contributors. Alongside it sits a neurocognitive profile in which lower verbal IQ is characteristic - a relative weakness in language and verbal reasoning that impairs the capacity to talk problems down, to represent consequences in words, and to profit from purely verbal correction. What separates such a temperament from ordinary difficultness, and what counts as within the normal range of infant reactivity, belongs to the Normal child development and milestones notes; the point here is that these constitutional features are not the disorder but a soil in which it grows more easily. A hard-to-soothe, verbally weaker child evokes harsher and less consistent handling, does worse at school, and is more readily pushed toward the aggressive and rule-breaking solutions that the later diagnosis is built from. Temperament is thus both a direct risk and, more importantly, the child's opening move in the cascade that follows.

PITFALL

The clinical error here is to collapse into one side of the causal story. A family in crisis invites the verdict that the conduct is simply a product of bad parenting, which erases the child's heritable and temperamental contribution and the way a difficult child shapes the adults around them; the opposite error reads a slow-to-soothe, verbally weak child as constitutionally destined and quietly abandons the family work that is the most modifiable link in the chain. Both are reductions. The formulation has to hold the child's disposition and the family's response as reciprocal, because that is where the intervention actually acts.

4.5 Family and social adversity

The environmental risk factors are the densest and, mercifully, the most modifiable. The evidence identifies a consistent cluster of family-level adversities that raise the risk of conduct disorder and, importantly, are more common and more severe in the earlier-onset presentation. They are worth knowing as a family rather than as isolated items, because they tend to travel together and to reinforce one another.

- parental rejection and neglect, and inconsistent, unpredictable child-rearing;
- harsh or erratic discipline, and physical or sexual abuse;
- lack of supervision and monitoring of the child's whereabouts and company;
- early institutional living and frequent changes of caregiver, disrupting stable attachment;
- large family size and parental criminality in the home.

Beyond the household sit the community-level factors, which take over as the child moves outward into the social world: peer rejection in the early school years, subsequent affiliation with a delinquent peer group, neighbourhood disadvantage, and exposure to violence in the surrounding environment. The developmental sequence matters as much as the list: family adversity dominates the early years and peer and neighbourhood factors gather force through middle childhood and adolescence, which is why the same risk factors carry different weight at different ages.

DOMAIN	REPRESENTATIVE FACTORS	CLINICAL LEVERAGE
Temperamental / neurocognitive	Difficult undercontrolled temperament; lower verbal IQ	Largely fixed; guides how, not whether, to intervene
Family	Rejection, neglect, harsh or inconsistent discipline, abuse, poor supervision, caregiver instability, parental criminality	The most modifiable link; target of parenting work
Community	Peer rejection, delinquent peer group, neighbourhood disadvantage, exposure to violence	Partly modifiable; the focus of wider system work

The risk factors sorted by level and by how much the clinician can move them; the family row carries the most leverage, which is why the treatments that follow are built around it.

4.6 The coercive family process

Risk is not only a set of factors but a self-amplifying process between child and parent. The single most useful mechanistic model of how disruptive behaviour is built and maintained is the **coercive** family process described by Patterson. Its power is that it is dynamic rather than static: early defiance in the child provokes harsh and inconsistent discipline from the parent, which breeds further aggressiveness and, at school, peer rejection; the rejected, aggressive child then drifts toward association with deviant peers, and from there into antisocial acts, substance use and conflict with the law. Each step is both a consequence of the last and a cause of the next, so the chain tightens on itself over time. This model is not academic. It explains the observed dose-response relationship, in which the higher the number and variety of disruptive behaviours a child shows, the worse the adult outcome, because a busier, broader early pattern feeds a faster-turning coercive loop. It is also the explicit rationale for parent management training, the intervention that tries to interrupt the cycle at the parent-child step, whose detail belongs to the treatment section of this chapter.

MNEMONIC

Defiance draws discipline, discipline drives deviance

The coercive loop in three beats: a child's early **defiance** pulls harsh, inconsistent **discipline** from an overwhelmed parent, which breeds aggression and peer rejection and pushes the child toward **deviant** peers, antisocial acts and trouble with the law. Holding the loop as a cycle rather than a list is what makes the point that it can be interrupted.

GOOD TO REMEMBER

The etiology is not just background - it prescribes the treatment. Because so much of the operative risk lives in a modifiable family process rather than in fixed constitution, the first-line response to a young child with conduct problems works on the parent-child interaction, not on the child in isolation. When a formulation names the coercive cycle, it has already named where the intervention must act.

4.7 Two developmental trajectories

The same behaviour can sit on two very different developmental paths. One of the most robust organizing ideas in the field is Moffitt's distinction between a **life-course-persistent** path and a desisting, **adolescence-limited** one. The life-course-persistent group carries the heavier causal load: it is predicted by early onset, with oppositional defiant symptoms typically appearing first, by greater severity of the conduct problems, and by dense exposure to the risk factors already described. Its antisocial behaviour begins early, runs on across development, and is the pattern that carries forward. The adolescence-limited group looks similar at the peak but has a different origin and a different fate - it arises against a more normative background, is more a phenomenon of the adolescent phase and its affiliations, and desists. Consistent with this, a large decline in delinquent and antisocial activity is commonly seen as young people move into early adulthood, which reflects the adolescence-limited majority ageing out rather than everyone improving. Distinguishing the two prospectively is imperfect, but the predictors of persistence - early onset, severity, and the weight of accumulated risk - are exactly what the etiological assessment is trying to read.

AXIS	LIFE-COURSE-PERSISTENT	ADOLESCENCE-LIMITED
Onset	Early, oppositional symptoms first	In adolescence
Predicted by	Early onset, severity, dense risk exposure	Adolescent phase and peer affiliation
Background	Heavy constitutional and family risk	More normative
Course	Persists across the life course	Desists, with a large decline in early adulthood

The two pathways set side by side; the load-bearing difference is that early onset, severity and accumulated risk mark the persistent path, while the adolescence-limited majority accounts for the marked decline in antisocial activity in early adulthood.

4.8 The callous-unemotional pathway

A distinct early route runs through low affective empathy rather than through adversity. Not every child on the persistent path arrives there by the coercive, adversity-driven route. A separable developmental pathway runs through **callous-unemotional traits** - a style of low empathy, shallow affect and limited guilt that can be identified as early as **2 years of age** and appears to be largely responsible for the stability of conduct disorder in the children who show it. This pathway is more heritable and less obviously a product of harsh parenting than the coercive route, which is part of why it is worth separating out: adolescents with these traits are at higher risk of earlier and more chronic violent reoffending, so the pathway carries real prognostic weight. The trait cluster is formalised as a diagnostic specifier with defined features, which are taught in their own section of this chapter; the etiological point here is only that it names a second, affect-based road into persistent conduct disorder that sits alongside, and can combine with, the adversity-and-process road of the earlier subtopics.

4.9 Neurobiological and psychophysiological correlates

There are reproducible biological markers, and the trap is to over-read them. Several biological findings recur reliably in conduct disorder. The most striking is autonomic: a **slower resting heart rate** has been found consistently and is notable for not being characteristic of any other mental disorder, which makes it the field's most specific psychophysiological signature. Alongside it, reduced autonomic fear conditioning - indexed by low skin conductance responses - is well documented, fitting a picture of blunted responsiveness to cues of threat and punishment that would ordinarily restrain rule-breaking. Structural and functional neuroimaging points to differences in the ventral prefrontal cortex and the amygdala, regions central to the appraisal of emotion, threat and reward and to the inhibition of prepotent responses. These findings cohere into a plausible account of a nervous system that is under-aroused and under-deterred, and they matter for understanding mechanism. What they are not is diagnostic: none of them is sensitive or specific enough to identify the disorder in an individual, and they belong to the explanation of conduct disorder, not to its detection.

TRAP **The biological markers explain, they do not diagnose.** Candidates recite the slow resting heart rate, the low skin conductance and the ventral-prefrontal and amygdala findings as though they confirmed the disorder. They are group-level correlates, robust in the aggregate but neither sensitive nor specific in the individual; the diagnosis remains clinical, and presenting any of these as a diagnostic test is the error the examiner is watching for.

~50%	2 years	slower
HERITABILITY OF THE UNDERLYING ANTISOCIAL BEHAVIOUR	AGE FROM WHICH CALLOUS-UNEMOTIONAL TRAITS ARE IDENTIFIABLE	RESTING HEART RATE, A MARKER SEEN IN NO OTHER DISORDER

5 · Assessment and clinical evaluation of conduct disorder

A conduct disorder assessment is won or lost on where the information comes from, not on how the child behaves in the room. Assessing **conduct disorder** is a distinct clinical skill, separate from knowing the criteria, because the young person in front of you is the one

informant with the least incentive to describe the problem accurately. Children and adolescents with conduct disorder characteristically minimise their conduct problems, so a clinician who takes the interview with the child as the primary evidence base will systematically underestimate the disorder. The whole method is built to correct for that: it draws on several informants who each see the young person in a different setting, it treats disagreement between them as informative rather than as noise, and it anticipates that the young person, and sometimes the family, will not cooperate freely.

The marks here reward candidates who can describe a defensible process rather than recite a checklist. This topic owns the evaluation method: how a reliable diagnosis is assembled from multiple sources, how the purpose of the referral changes the way the assessment is conducted, what history domains and functional understanding must be covered, and the standardised instruments that quantify and track the picture. The diagnostic criteria and subtypes, the callous-unemotional specifier, the causes and risk factors, the treatments, and the long-term trajectory are each developed in their own right elsewhere in this chapter and are named here only where the assessment reaches for them.

5.1 The purpose of the referral shapes the whole assessment

Ask first who wants this assessment and why. Conduct disorder is unusual among child psychiatric presentations in how often the request originates outside the family. An evaluation may be requested by **parents, schools, courts, children's lawyers or social services**, and each of those origins carries a different question, a different standard of proof, and a different limit on confidentiality. A parent asking why their child is unmanageable wants a clinical formulation and a plan. A court or a child's lawyer wants an opinion that may be tested adversarially and disclosed, which changes what you can promise the young person about privacy before you begin. Establishing the purpose at the outset is therefore not a courtesy but a structural decision: it determines who you will speak to, what you will document, what you can keep confidential, and how you frame the evaluation to the child and family. A clinician who begins gathering history without settling this can find that the confidentiality they implied cannot be honoured, or that the assessment they conducted does not answer the question that was actually asked.

IN INDIA

A large share of conduct disorder assessments reach services through schools and through the statutory child-welfare and juvenile-justice route rather than through parents seeking help, which means the confidentiality and consent frame is frequently set by an institution before the child arrives. The psychiatric perspective on juvenile delinquency is taken up separately in this chapter, and the wider machinery of child protection, welfare committees and services sits in the Child psychiatry: assessment, treatment, services and protection notes. The practical lesson for the assessment itself is that the referral source is often a third party with its own agenda, so clarifying whose question you are answering, and what will be shared with whom, is the first task in the room.

5.2 The multi-informant, collateral method

No single informant is sufficient, and the child least of all. The reliable diagnosis of conduct disorder rests on **an evaluation by an experienced clinician drawing on several sources**, typically the child, the parents and the teachers, supplemented by questionnaire data. The reason this is doctrine rather than preference is the informant problem set out at the start: because the young person minimises, the clinician must actively seek out additional informants, and because behaviour is situation-specific, an informant who sees the child in only one setting gives only part of the picture. Parents see the home; teachers see the classroom and the playground; the child alone can report internal states, fears and motives that no observer can access. The skill lies in holding these accounts together. Reports from different informants frequently disagree, and the beginner reads that disagreement as one source being wrong. It is better understood as each source being right about a different context: a child who is compliant at school and defiant at home, or the reverse, is telling you something real about where the behaviour is triggered and maintained. The accounts complement each other precisely because they diverge.

RULE **Diagnose conduct disorder from collateral sources, never from the child's self-report alone.** The young person minimises the very behaviour under evaluation, so an experienced clinician assembles the picture from parents, teachers and the child together, supplemented by questionnaires. Discrepant reports are not a problem to resolve down to one true version; they map where the behaviour is and is not expressed, and that map is itself diagnostic and treatment-relevant.

Expect resistance and plan for it. Because the referral is often involuntary and the behaviour often brings the young person into conflict with authority, noncooperation and resistance are to be expected rather than treated as a complication that derails the assessment. A refusal to engage, a flatly minimising account, or open hostility is part of the presentation, not a failure of the interview, and the collateral method exists so that the evaluation does not collapse when the child will not talk. The experienced assessor builds the diagnosis from what the informants and instruments provide and reads the young person's reluctance as data about the therapeutic task ahead.

5.3 History domains and the functional understanding

Map the behaviour onto its context and its function. A conduct disorder history has to reach well beyond the catalogue of behaviours into the environment that shapes them. The domains that must be explored include **parenting style, the quality of parent-child interactions, inconsistent parenting, maternal depression, parental drug use, and the possibility of sexual abuse**. These are asked about here not to settle causation, which belongs to the discussion of etiology and risk factors elsewhere in this chapter, but because they are the modifiable context in which the behaviour is embedded and because some of them, notably abuse and a depressed or substance-using parent, are urgent findings in their own right. Alongside the content of the history sits its logic. A good assessment builds a **functional understanding** of the behaviour: what antecedents reliably precede it and what consequences follow and maintain it. Reading each problem behaviour as a link in an antecedent-behaviour-consequence chain turns a list of

complaints into an account of why the behaviour persists, and it is this functional account, not the diagnostic label, that points toward what an intervention should target.

PITFALL

The recurring clinical error is to assess the child and skip the context, producing a diagnosis that names the behaviour but explains nothing and guides no treatment. A behaviour that looks like pure defiance often turns out, once the antecedents and consequences are traced, to be maintained by an inconsistent contingency at home or by escape from an intolerable classroom demand. Stopping at the label, without the functional analysis and without probing parenting, parental mental illness and possible maltreatment, both misses treatable maintaining factors and risks leaving a safeguarding concern unaddressed.

5.4 Assessing across all symptom domains: comorbidity

Conduct disorder rarely travels alone, and the comorbidity is often the more treatable half. A competent evaluation deliberately covers all symptom domains so that comorbid disorders are not overlooked, because the conditions that accompany conduct disorder are frequently what respond best to treatment. The three that must be actively screened for are attention-deficit/hyperactivity disorder, mood disorders and substance misuse. The overlap with ADHD is close enough that the two are easily conflated, and its assessment and treatment belong to the ADHD and specific learning/communication disorders notes; the point for the conduct disorder evaluation is simply that it must be looked for rather than assumed absent. A depressive disorder can drive irritability and acting-out that mimics or amplifies conduct problems, and substance misuse both worsens and is worsened by the behaviour. An assessment that stops at conduct disorder because the disruptive behaviour is the loudest presenting feature will miss the disorder that is quietly doing much of the damage and is often more amenable to intervention.

- attention-deficit/hyperactivity disorder, closely overlapping and easily conflated, screened for and cross-referred rather than assumed;
- mood disorders, where irritability and acting-out may be depressive in origin;
- substance misuse, which both aggravates and is aggravated by the conduct problems.

5.5 Standardised rating instruments

Questionnaires quantify and track what the clinical interview establishes. The clinical evaluation is supplemented by structured questionnaires, chief among them the broad-band **Child Behavior Checklist**, together with narrower disruptive-behaviour scales such as the **Eyberg Child Behavior Inventory**, the **New York Teacher Rating Scale for Disruptive and Antisocial Behavior**, and the **Home and School Situations Questionnaire**, the last of which locates where the behaviour occurs. Their value is specific and bounded. Questionnaires provide quantifiable data, reliably supplement the interview, and are useful for measuring progress and outcome over the course of treatment, which is something a narrative interview does poorly. What they do not do is replace the multi-informant clinical evaluation. A score is a number attached to a rater's perception in a setting, and it acquires meaning only when the clinician

integrates it with the rest of the picture. The instruments are the measuring tape, not the diagnosis.

INSTRUMENT	TYPE	WHAT IT ADDS
Child Behavior Checklist	Broad-band	Wide behavioural and emotional coverage across informants
Eyberg Child Behavior Inventory	Disruptive-behaviour	Focused measure of conduct problems and their intensity
New York Teacher Rating Scale	Teacher-report	The classroom view of disruptive and antisocial behaviour
Home and School Situations Questionnaire	Situational	Where the behaviour occurs, across home and school settings

The instruments that supplement the interview, each contributing a different angle; none substitutes for the clinician's integration of the multiple accounts.

TRAP **A high questionnaire score is a screen, not a diagnosis.** Candidates treat a raised Child Behavior Checklist or a positive rating scale as if it made the diagnosis, when the instruments only quantify a rater's perception in one setting and are properly used to supplement the interview and to track outcome. The diagnosis remains the experienced clinician's integration of the collateral accounts; the number measures change, it does not replace judgement.

5.6 The Strengths and Difficulties Questionnaire

The workhorse behavioural screen of child mental health. The single instrument worth knowing in detail is the **Strengths and Difficulties Questionnaire**, developed by **Goodman**. It is a brief behavioural screening questionnaire of **25** items, each rated on three response options - Not True, Somewhat True and Certainly True - which makes it quick enough to use routinely. Its reach is one of its strengths: it is completed by parents and teachers, and by children and adolescents themselves as a self-report, so a single short instrument delivers the multi-informant, multi-setting perspective that the conduct disorder assessment demands. It spans roughly **ages 3 to 17**, is in the public domain, and has been translated into many languages, which is much of why it is so widely used. An optional impact supplement of up to about eight further items extends it beyond symptom counting to ask how much the difficulties actually burden the child and the family, which is often the more clinically decisive question.

5.7 SDQ structure: the five subscales and the Total Difficulties Score

The scoring architecture is examinable and elegant. The aptly named questionnaire carries both a strength scale and difficulty scales. It resolves into **five subscales of five items each**: emotional symptoms, conduct problems, hyperactivity and inattention, peer relationship problems, and prosocial behaviour. Four of these describe difficulties and one, prosocial behaviour, describes a strength, which is what the questionnaire's name announces. The scoring then does something that trips up candidates who assume all five simply add together. A **Total Difficulties Score** is generated by summing only the **four** problem subscales - emotional symptoms, conduct problems, hyperactivity and inattention, and peer relationship problems. The prosocial behaviour subscale is deliberately left out of that total and is scored separately against

its own cut point, because a low level of prosocial behaviour is conceptually a different kind of finding from a high level of difficulty. Keeping the strength scale out of the difficulty total is the design feature that distinguishes the instrument, and it is exactly the point an examiner probes.

MNEMONIC

Five by five, four make the total

Five subscales of **five** items each, and only the **four** problem scales sum to the Total Difficulties Score. The fifth scale, prosocial behaviour, is the strength and stands apart with its own cut point. The phrase fixes both the structure and the one scoring rule most often got wrong.

The must-memorise line: the SDQ Total Difficulties Score sums the four problem subscales only; the prosocial behaviour subscale is scored separately and is not part of the total.

5.8 Interpreting the scores and the banding caution

A screen produces a band, and the band is only as good as the threshold behind it. The subscale and total scores are interpreted by comparison against clinical cut points, and the familiar reporting frame sorts a child into a normal, borderline or abnormal band, with newer versions using a four-way categorisation from close-to-average through to very high. This is where discipline matters. The exact numeric thresholds that separate one band from the next are set by the instrument's own scoring instructions and are revised periodically, and they differ by informant and by version, so they are not something to reproduce from memory in a clinical or examination answer. The safe practice is to state the banding concept and to apply the current published thresholds from the questionnaire's own scoring guidance rather than to quote a boundary you cannot verify. The larger caution is the same one that governs every instrument in this topic: the SDQ, however well banded, is a screening and outcome-tracking tool. It flags children who warrant fuller evaluation and it measures change over time; it does not, on its own, make the diagnosis of conduct disorder, which remains the product of the multi-informant clinical assessment.

GOOD TO REMEMBER

Use the SDQ to open and to follow a case, not to close it. Its brevity, its public-domain availability, its coverage across parents, teachers and the young person, and its impact supplement make it an efficient front door and an honest outcome measure. Record a baseline, treat, and re-administer to show whether the difficulties have actually moved, but let the diagnosis rest on the integrated clinical picture and confirm any band you report against the questionnaire's current thresholds.

25	5 by 5	3 to 17
SDQ ITEMS	SUBSCALES, FIVE ITEMS EACH	AGE RANGE IN YEARS

6 · Management of conduct disorder (parent training, multisystemic therapy, pharmacotherapy)

The treatment of conduct disorder is where the diagnosis earns its keep, and where the commonest instinct is the wrong one. Faced with an aggressive, rule-breaking young person, the pull toward a sedating prescription is strong, and it is almost always the second move rather than the first. The management of conduct disorder is built on a settled principle: the disorder is a problem of behaviour embedded in relationships and systems, so the treatments that change it are the ones that work on those relationships and systems. Most guidelines concur that structured psychosocial and behavioural interventions are the first line of treatment for the disruptive behaviour disorders, oppositional defiant disorder and conduct disorder alike, and that these interventions continue even where medication is later added. Marks accrue on this topic because it rewards a candidate who can name the right intervention for the right age, explain why it works, and place medication precisely where it belongs, which is at the margin and never at the centre.

This topic owns the management of conduct disorder in full: the treatment hierarchy, parent management training as the core intervention for the younger child, multisystemic and community interventions for the adolescent, and the adjunctive, aggression-directed role of medication with its dosing and monitoring. The diagnostic criteria and subtypes, the callous-unemotional specifier, the causes and risk factors, the assessment, and the long-term trajectory into adult antisocial outcomes are each developed in their own right elsewhere in this chapter and are named here only where the treatment reasoning demands them.

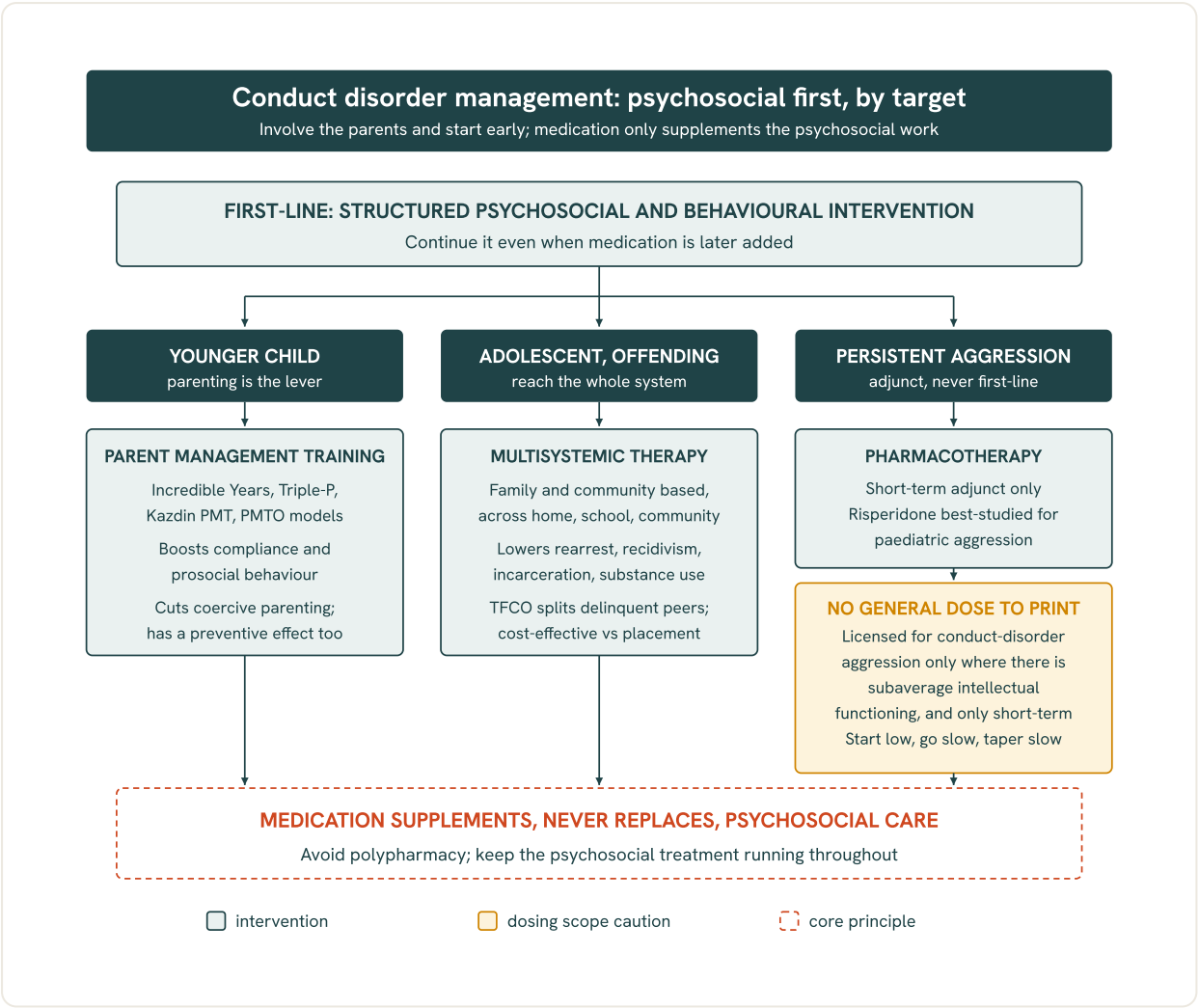


Fig 23.5. Conduct disorder management ladder: psychosocial intervention first, matched to the target - parent training for the younger child, multisystemic therapy for the offending adolescent, and short-term risperidone as an adjunct for persistent aggression. No dose is printed on the plate: the only licensed conduct-disorder dose is restricted to young people with subaverage intellectual functioning, so dosing is scope-bound and is set out in the text.

6.1 The treatment hierarchy: psychosocial first, medication as adjunct

The order of operations is itself examinable. The governing rule is that treatment leads with structured psychosocial and behavioural work and reserves pharmacotherapy for defined targets on top of it. Two features of that rule are easy to lose. The first is that the psychosocial intervention should be continued even if medication is subsequently initiated; the drug does not replace the behavioural programme, and the moment it is treated as a replacement the plan has already failed. The second is that this treatment should involve the parents, because improving parenting skills and the quality of parent-child interactions are core goals rather than incidental ones. There is also a timing effect that shapes prognosis and effort: intervention is more likely to be effective when administered early in the course, before coercive patterns and antisocial affiliations have consolidated. The clinical implication is direct. A young child brought in early is a genuine opportunity; an entrenched adolescent is harder work and the plan must be built accordingly.

RULE **Psychosocial and behavioural intervention is first-line for conduct disorder, and it continues even when medication is added.** Medication is layered onto the behavioural programme for a specific target; it never becomes the programme. An author who leads with a drug has inverted the hierarchy the evidence actually supports, and the earlier the psychosocial work begins, the more it achieves.

Carry this into the exam: for conduct disorder the first-line treatment is a structured, parent-involving psychosocial intervention, delivered early, and medication is a short-term adjunct for aggression, never a substitute for it.

6.2 Parent management training: the core intervention

The single best-evidenced treatment for the younger child works through the parent, not directly on the child. **Parent (behavioural) management training** programmes teach caregivers a set of concrete strategies that increase compliance and prosocial behaviour and reduce oppositional and aggressive behaviour. The logic is behavioural: much of the child's disruptive conduct is being inadvertently maintained by the family's own responses, and the intervention retrains those responses. Parents are coached to give clear, achievable instructions, to attend to and reinforce desirable behaviour, to use consistent and non-escalating consequences, and above all to interrupt the **coercive parenting** pattern in which harsh, inconsistent discipline and child noncompliance drive each other in an escalating loop. The change is achieved indirectly and deliberately so: rather than counselling the child, the clinician equips the parent to alter, session by session, the contingencies that surround the behaviour at home. Positive attention is shifted onto the behaviours the family wants to see, previously reinforcing responses to defiance are withdrawn, and predictable, proportionate consequences replace the cycle of threats that are not carried through. Because the parent is present for far more of the child's day than any clinician can be, a small, consistent change in the parent's response compounds across hundreds of daily interactions, which is why a treatment that never addresses the child directly can move the child's behaviour so reliably. Several programmes are well researched and share this backbone:

- Helping the Noncompliant Child, focused on younger children and instruction-following;
- Incredible Years, a structured video-based parent, child and teacher programme;
- Parent Management Training in the tradition of Kazdin, delivered to the parent as the agent of change;
- Triple-P (the Positive Parenting Programme), delivered across a tiered intensity of contact.

The evidence is not soft, and it is durable. The **Parent Management Training Oregon Model** (PMTO) reduces coercive parenting, and its benefit is measurable long after the sessions end: **nine years** post-intervention it was associated with lower teacher-rated delinquency and reduced arrest rates. Parent training is, on this evidence, an established evidence-based treatment for clinically significant disruptive and externalising behaviour, and it carries a preventive dividend as well, reducing later problems in children at risk rather than only treating those already

diagnosed. That combination, a treatment that both remediates and prevents, is why it sits at the head of the plan for the child in whom parental influence is still the dominant force.

6.3 Multisystemic therapy and the community interventions for the adolescent

When the adolescent's world has widened beyond the family, the intervention has to widen with it. By mid-adolescence the drivers of conduct problems are rarely confined to the home: school failure, delinquent peer groups, and neighbourhood factors all feed the behaviour, and a parent-only programme can no longer reach them. **Multisystemic therapy** is the intensive, family- and community-based intervention designed for exactly this situation, for antisocial behaviour in adolescent juvenile offenders. Its defining feature is that it works simultaneously across home, school and community settings rather than in a clinic room, treating the young person's behaviour as a product of the systems around them and intervening in each. The outcome data are among the strongest in this field: it is associated with decreased rates of rearrest, recidivism, incarceration, psychopathology and substance use. It is also, importantly for a resource-conscious service, a cost-effective alternative to out-of-home placement, keeping the adolescent in their own context while changing it. A related community intervention, **Treatment Foster Care Oregon** (TFCO), takes the complementary approach of placing the young person in a trained, structured foster setting that deliberately separates them from delinquent peers while the family situation is worked on. The peer emphasis is not incidental. Interventions that gather antisocial adolescents together can inadvertently strengthen the very behaviour they aim to reduce, as the group becomes a training ground for deviance and a source of mutual reinforcement, and both the multisystemic model and structured foster care are built to work with or around the peer network rather than to concentrate it. Both share the same premise that the peer group and the wider environment are not background but active ingredients of the disorder, and that an intervention confined to the individual or the clinic will not reach the systems that actually maintain the behaviour.

6.4 Matching the intervention to the developmental stage

The right treatment is a function of who still holds the levers of the child's behaviour. The two psychosocial pillars are not competitors but a developmental sequence. For the younger child, whose behaviour is still shaped chiefly within the family, the parent is the most powerful available lever, and so parent management training is the intervention of choice. For the adolescent, in whom peers, school and neighbourhood have taken on independent force and whose behaviour has often already drawn in the justice system, a family-only approach is necessary but no longer sufficient, and the multisystemic and community models that reach every system become the appropriate frame. This is why age of presentation changes the plan so decisively, and why the early-presenting child carries such a premium: the same effort applied while the family is still the dominant influence buys far more than it will a decade later. None of these interventions is a quick fix. Each asks sustained engagement of an often exhausted and demoralised family, and the clinician's task is to match intensity to the developmental reality rather than to reach reflexively for the most intensive option available.

6.5 The place of medication: adjunctive, aggression-directed, never first-line

There is no drug that treats conduct disorder; there are drugs that help a specific target within it. Medication in the disruptive behaviour disorders is deployed against aggression, and it is deployed as an addition to psychosocial treatment, not as a route around it. Antipsychotic medication for aggression in disruptive behaviour disorders is used as an adjunct in the short term and is never first-line. The framing that matters is that medication supplements, and does not replace, psychosocial treatment, and that polypharmacy should be avoided: a child accumulating agents is usually a child whose behavioural plan has been abandoned rather than one whose illness demands three drugs. Comorbidity is where pharmacotherapy earns a clearer place. Where attention-deficit/hyperactivity disorder coexists, psychostimulants help the oppositional and aggressive symptoms as the underlying ADHD is treated, which is one reason the comorbid picture must be actively sought and managed; the ADHD itself, its stimulant and non-stimulant treatment, belongs to the ADHD and specific learning/communication disorders notes.

TRAP **Treating pharmacotherapy as the primary treatment for conduct disorder.** Candidates reach for the antipsychotic as though it were the answer, because the aggression is the frightening part and a drug feels decisive. It is an adjunct for aggression only, layered onto a psychosocial programme that continues underneath it. Naming a medication before naming parent management training or multisystemic therapy is the inversion the examiner is looking for.

GOOD TO REMEMBER

Actively screen every child presenting with conduct problems for comorbid ADHD, because it is common in this group and it is treatable. Bringing the ADHD under control with a stimulant can reduce the oppositional and aggressive symptoms directly and can change the whole trajectory of the case, whereas leaving it unrecognised leaves a large, remediable driver of the behaviour untouched.

6.6 Risperidone: the best-studied agent, and the narrow scope of its licensed dose

When an antipsychotic is used there is a best-studied choice, a disciplined method, and a licence far narrower than the reflex assumes. Among the atypical antipsychotics, **risperidone** is the best-studied for aggression in paediatric populations, which is why it is the usual agent when the short-term adjunctive step is taken for severe disruptive behaviour and aggression in conduct disorder. What cannot be done is to quote a dose in the abstract, because the only licensed conduct-disorder dose in any labelling this chapter has read is tied both to a jurisdiction and to a population. The United Kingdom, the European Union and Australia license risperidone for the short-term symptomatic treatment of persistent aggression in conduct disorder, in children from five years of age and in adolescents, and only where there is subaverage intellectual functioning; the United States licenses no conduct disorder indication for risperidone at all, its paediatric approvals being schizophrenia, bipolar mania and irritability associated with autistic disorder. The restriction to subaverage intellectual functioning is part of the indication itself and can never be dropped when the dose is quoted.

Within that licensed population the labelled oral regimen is weight-banded and once daily, and it sits far below the antipsychotic doses used for paediatric schizophrenia. For a child under 50 kg the starting dose is **0.25 mg once daily**, increased in steps of 0.25 mg no more often than every other day, to an optimum of 0.5 mg once daily within a licensed range of 0.25 to 0.75 mg once daily. For a young person of 50 kg or more the starting dose is **0.5 mg once daily**, increased in steps of 0.5 mg no more often than every other day, to an optimum of 1 mg once daily within a licensed range of 0.5 to 1.5 mg once daily. The oral solution is the formulation that delivers the 0.25 mg and 0.75 mg doses, which the tablet cannot, and the licensed treatment period is **up to six weeks**, with any continuation evaluated and justified on an ongoing basis. The label itself carries the hierarchy this topic teaches: the drug is to be an integral part of a more comprehensive treatment programme including psychosocial and educational intervention, prescribing is recommended to be by a specialist in child neurology or child and adolescent psychiatry, and physical and social causes of the aggression, such as pain or an inappropriate environmental demand, are to be assessed before any prescription is written. In renal or hepatic impairment the starting and consecutive doses are halved and titration is slower. Risperidone is not recommended below five years of age, where there is no experience.

The gap that remains is the point, not a deficiency in the teaching. Outside that licensed population, which is to say for the young person who has conduct disorder with normal intellectual functioning and who is the subject of this topic, no label this chapter has read supports a risperidone dose; use there is off-label and unlicensed, no number is printed for it here, and the dosing of the antipsychotics themselves belongs to the antipsychotics chapter. Intellectual disability as a construct, and the separate risperidone indication for irritability in autism, are developed in the Intellectual disability and autism spectrum disorder notes; they are named here only because the licence for conduct-disorder aggression happens to be written around the first of them. What survives all of this unchanged is the method. The dose is reached, and later withdrawn, cautiously: begin low, increase gradually, and taper slowly when stopping, with routine monitoring throughout, so that both efficacy and adverse effects are tracked deliberately rather than discovered by accident. Because this is an antipsychotic in a growing child, the monitoring is specific: weight and metabolic parameters, and prolactin, are followed, since weight gain, metabolic disturbance and hyperprolactinaemia are the liabilities that most often force a change of plan.

MNEMONIC

Start low, go slow, taper slow

The dosing discipline for the aggression-directed antipsychotic in a child: **start low** at the bottom of the range, **go slow** in titrating upward against response and tolerability, and **taper slow** rather than stopping abruptly, all under routine monitoring. The phrase encodes the whole safety posture of adjunctive pharmacotherapy in this population.

PITFALL

Starting risperidone and then not monitoring for its metabolic cost. It is easy to prescribe and it does reduce aggression in the short term, so the follow-up drifts and the weight, metabolic indices and prolactin go unchecked. The commonest real-world harm from this agent in children is not treatment failure but unmonitored metabolic and endocrine adverse effects accumulating quietly on a drug that was only ever meant to be a short-term adjunct.

6.7 Assembling the plan, and the Indian reality

A defensible management answer names the whole staged plan, not one favourite piece of it. Put together, the plan begins with a thorough assessment of the young person and the family, leads with the psychosocial intervention matched to developmental stage, treats comorbidity actively, and adds aggression-directed medication only as a short-term adjunct with proper monitoring, keeping the behavioural work running throughout. The accompanying figure sets the modalities against the population each fits, the setting each works in, and the role each plays, and the table below does the same in summary form.

MODALITY	BEST SUITED TO	WORKS ACROSS	ROLE IN THE PLAN
Parent management training	The younger child	The family	First-line; retrains coercive interactions
Multisystemic therapy	The adolescent offender	Home, school and community	First-line for the older youth; a cost-effective alternative to out-of-home placement
Treatment Foster Care Oregon	The adolescent needing placement	A structured foster setting	Separates the young person from delinquent peers
Risperidone and related agents	Marked aggression on top of the above	Added to psychosocial care	Short-term adjunct only; never first-line

The four building blocks of management set against who each fits and what each contributes; the psychosocial rows lead, and the pharmacological row is deliberately last and conditional.

IN INDIA

The evidence base is Western, and the delivery gap is the exam-relevant point. Manualised parent management training programmes and, still more, multisystemic therapy and structured therapeutic foster care are largely unavailable in routine Indian services, which are thinly staffed and family-dependent. In practice the psychosocial first line is often delivered as pragmatic parent guidance, psychoeducation and school liaison built around the same behavioural principles rather than as a branded programme, and much of the work falls to families themselves. The mismatch this creates is a real risk: because an antipsychotic is cheap, quickly available and requires only a prescription, the temptation to lean on medication in place of the harder psychosocial work is greater here than in better-resourced settings, and that is precisely the inversion of the hierarchy the treatment principles warn against. One caution about scope belongs here rather than in a footnote: the licensing positions named above are those of the United Kingdom, the European Union, Australia and the United States, and the Indian labelling position for risperidone in conduct disorder is not stated in these notes because it was not verified for them. A prescriber here should read the current Indian package insert rather than assume that any of those licences transfers, and should not treat the drug's easy availability as evidence that a licence exists. Where conduct problems bring a young person into contact with the law, the child-protection and juvenile-justice machinery is handled in the Child psychiatry: assessment, treatment, services and protection notes.

nine years DURABILITY OF THE PMTO BENEFIT	**six weeks** LICENSED CAP ON ADJUNCTIVE RISPERIDONE, IN THE ONE POPULATION LICENSED FOR IT	**None** CONDUCT DISORDER INDICATION FOR RISPERIDONE IN THE UNITED STATES	**No dose** LICENSED FOR CONDUCT DISORDER WITH NORMAL INTELLECTUAL FUNCTIONING

7 · Prognosis and link to antisocial personality disorder

Prognosis is where conduct disorder stops being a description and becomes a prediction. Having established the diagnosis, its subtypes and its severity, the examiner now wants to know what becomes of these young people, and whether the diagnosis is the childhood face of a life-long antisocial trajectory or a phase that most will grow out of. The honest answer is that both outcomes are common, and the marks lie in being able to say which child is heading which way. The single most consequential fact about the natural history of conduct disorder is that its course is heterogeneous: it is not a uniformly grim sentence, and it is not a benign rite of passage either. A large proportion of affected young people improve, while a smaller high-risk subgroup carries the disorder into an adult life of persistent offending and personality pathology. The clinical and the examinable skill is the same one - reading, from features present in childhood and adolescence, where a given young person sits on that spread.

This topic owns the trajectory itself: the overall course into adulthood, the features that predict persistence against those that predict recovery, and the specific developmental bridge that links conduct disorder to **antisocial personality disorder**. The diagnostic criteria and the onset subtypes are established in their own right elsewhere in this chapter and are named here only as prognostic markers, not re-taught. Antisocial personality disorder as a full adult diagnosis, with

its own criteria and management, belongs to the Personality disorders notes; what is developed here is the one-way developmental corridor that runs from the childhood disorder toward it, and the fact that most children never travel down it.

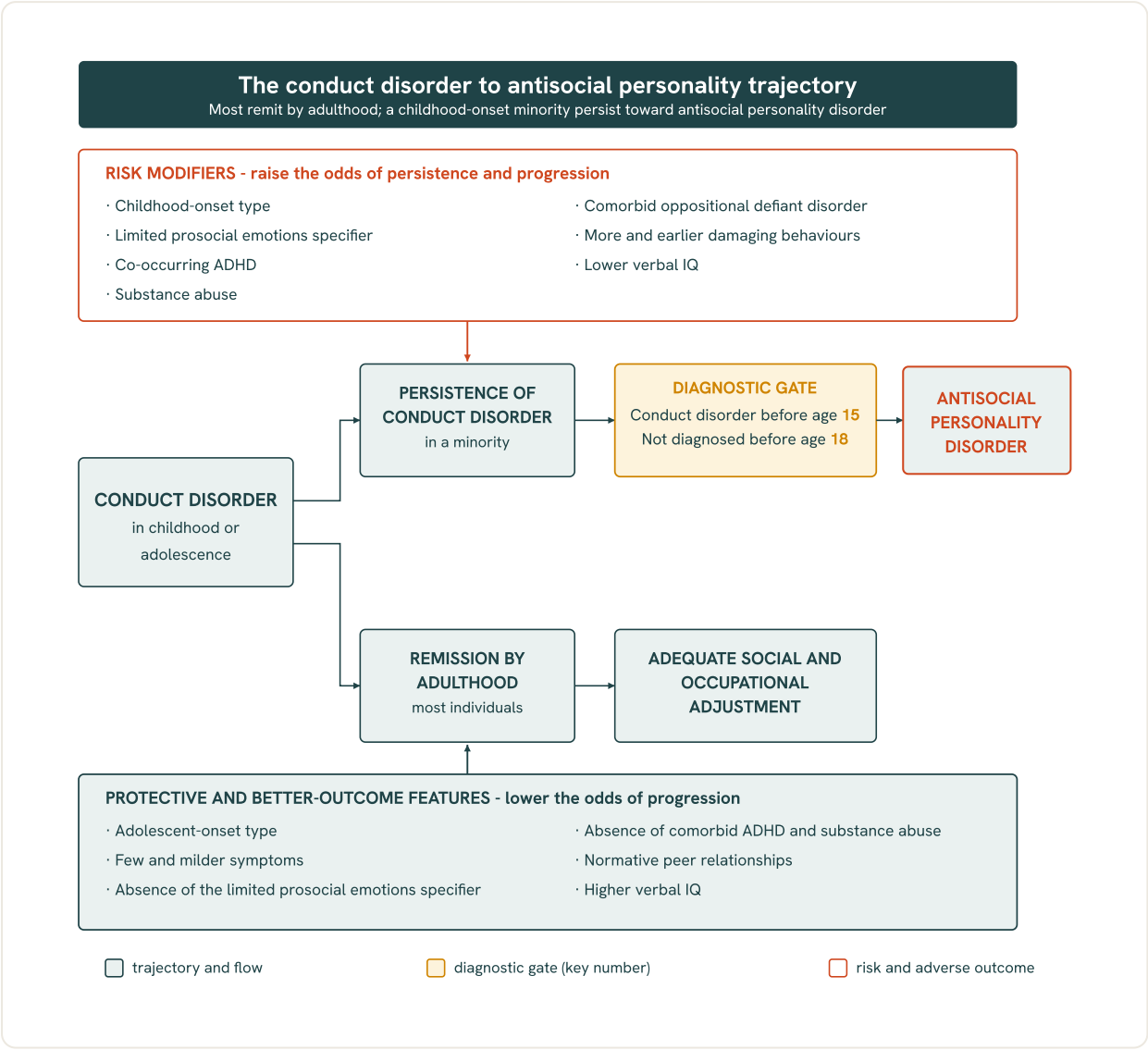


Fig 23.6. Conduct disorder to antisocial personality trajectory: most cases remit by adulthood, while a childhood-onset minority persist across the age 15 and age 18 diagnostic gates, with risk modifiers driving progression and protective features favouring remission.

7.1 The shape of the outcome: heterogeneity and remission

The default trajectory is improvement, not deterioration. The most important corrective to clinical pessimism is that in the majority of individuals the disorder **remits** by adulthood. Many young people, particularly those with the adolescent-onset course and with few and milder symptoms, go on to achieve adequate social and occupational adjustment as adults, holding down work and relationships that their teenage conduct would not have predicted. The clinical picture in early adult life is typically one of desistance: a large decline in delinquent and antisocial activity is commonly reported as the young person moves out of adolescence, matures, and acquires the stakes in conventional life - employment, a partner, responsibilities - that make offending costly and unrewarding. This does not mean the disorder is trivial, because the minority whose course does not follow this benign arc account for a great deal of harm, and

because even a self-limiting course can leave educational and legal scars. But the base rate matters enormously for how the clinician frames the problem to a family, and for resisting the pull toward writing a child off.

RULE **Conduct disorder is prognostically heterogeneous, and its commonest outcome is remission.** The disorder resolves in most affected individuals by adult life, with a marked fall in antisocial activity in early adulthood. Prognosis is therefore a question of identifying the high-risk minority who will not follow that path, not a foregone conclusion applied to everyone who carries the label.

7.2 Childhood onset as the pivot of prognosis

When the trouble began is the strongest single prognostic marker. The onset subtype is not a bookkeeping detail; it is the axis on which the outlook turns. The **childhood-onset type** predicts a worse prognosis and an increased risk of criminal behaviour, of persistent conduct disorder that does not remit on the usual schedule, and of substance-related disorders in adulthood. Alongside the age at which problems first appeared, the nature of those early problems carries weight of its own: engaging in more damaging behaviours at an early age is itself predictive of a worse outcome, so a young child whose conduct is already seriously harmful sits in a different prognostic band from one whose early problems are milder. The **adolescent-onset type**, by contrast, is the course most associated with the benign trajectory of the previous section - later onset, milder and fewer symptoms, and a stronger tendency to remit as adolescence passes. Reading onset age as a prognostic variable, and not merely as a descriptive specifier, is the reasoning a candidate is expected to show.

PITFALL

The mirror-image clinical error to over-diagnosis is therapeutic nihilism: treating a child with the childhood-onset, high-risk profile as already destined for an antisocial adult life and quietly withdrawing effort. Worse prognosis is a shift in probability, not a sealed fate. This is precisely the subgroup in which early, intensive, evidence-based intervention has the most to offer, and writing them off both misreads the evidence and forfeits the window in which the trajectory is most malleable.

7.3 What keeps the disorder going: predictors of persistence

Persistence clusters around a recognisable profile. The features that predict that conduct disorder will not remit but will run on into adult antisocial pathology are worth memorising as a set, because they recur in vignettes and in real referrals alike. **Persistence** is more likely when the young person's course meets the childhood-onset pattern and also qualifies for the limited prosocial emotions specifier - the callous-unemotional presentation whose four defining features are set out in their own right elsewhere in this chapter and are named here only as a prognostic amplifier. The risk of persistence is further increased by co-occurring **attention-deficit/hyperactivity disorder**, whose own assessment and treatment belong to the ADHD and specific learning/communication disorders notes, and by **substance abuse**, which both reflects and drives an escalating antisocial course. Comorbid ADHD and oppositional defiant disorder

each predict worse outcomes. The unifying theme is that the disorder persists when it is early, callous, comorbid and chemically fuelled: each of these adds to the load and lowers the chance of the spontaneous desistance that carries most young people out of the disorder.

- childhood-onset course rather than adolescent onset;
- the limited prosocial emotions (callous-unemotional) specifier present;
- co-occurring attention-deficit/hyperactivity disorder;
- co-occurring oppositional defiant disorder;
- substance abuse compounding the antisocial course.

MNEMONIC

Early, Callous, Hyperactive, Intoxicated

The persistence profile, in the order the features tend to appear: **E**arly onset (childhood-onset course), **C**allous (the limited prosocial emotions specifier), **H**yperactive (co-occurring ADHD, with oppositional defiant disorder alongside), and **I**ntoxicated (substance abuse). Each is a claim only about which conduct disorder runs on; none re-teaches the disorder it names.

7.4 The bridge to antisocial personality disorder

Conduct disorder is the mandatory childhood antecedent of the adult diagnosis, but it is far from a guarantee of it. The link that the examiner most wants stated precisely is the developmental corridor between the two disorders. Antisocial personality disorder cannot be diagnosed until adulthood, and it is given only where there is evidence of conduct disorder with onset **before age 15** years. That childhood requirement, written into the adult criteria themselves, is the structural reason the two disorders are taught together: conduct disorder before the mid-teens is a necessary building block of the adult diagnosis, so no one acquires antisocial personality disorder de novo in adult life without an antisocial childhood behind it. What makes the relationship so easily misremembered is that necessity runs in only one direction. A childhood history of conduct disorder is required for the adult diagnosis, yet the great majority of adolescents with conduct disorder do not go on to develop antisocial personality disorder at all. The corridor is real but narrow: most children who enter it turn off it, and only the high-risk minority identified by the persistence profile of the previous section travel its full length. The adult disorder in its own right - its criteria, its differential and its management - is the Personality disorders notes'; what belongs here is only the trajectory that connects it back to childhood.

The must-carry line: antisocial personality disorder requires evidence of conduct disorder with onset **before age 15** years, yet most adolescents with conduct disorder never develop it - necessary, not sufficient.

TRAP **The direction of the conduct-disorder-to-antisocial link is routinely reversed.** Candidates read the required childhood antecedent as though it ran the other way and assert that conduct disorder usually, or even always, becomes antisocial personality disorder. The correct statement is the opposite: conduct disorder before the mid-teens is a precondition of the adult diagnosis, but the majority of young people with conduct disorder do not progress to it. Stating the base rate as high is the single commonest error on this topic.

7.5 The other side of the ledger: protective and better-outcome features

The features that predict recovery are, for the most part, the mirror image of those that predict persistence. Prognosis is not read only from what is wrong; the examiner also expects the protective side. A better adult adjustment, and a lower likelihood of progression to antisocial personality disorder, are associated with the adolescent-onset course, with few and milder symptoms, with the absence of the limited prosocial emotions specifier, with the absence of comorbid ADHD and of substance abuse, and with **normative peer relationships** rather than an entrenched deviant peer group. Temperament contributes too: a higher verbal intelligence is protective, given that a lower verbal IQ is a recognised temperamental risk factor for the disorder. These are not a separate list to be learned in isolation but the same prognostic axis read from its favourable end, which is why they map cleanly onto the persistence predictors reversed. The clinical value of holding both columns in mind is that they convert prognosis from a vague impression into a structured judgement: the young person is placed by counting how many protective and how many adverse features are present, rather than by the emotional impression the presenting behaviour makes.

PROGNOSTIC AXIS	POINTS TOWARD PERSISTENCE AND ANTISOCIAL OUTCOME	POINTS TOWARD REMISSION AND GOOD ADJUSTMENT
Onset subtype	Childhood-onset	Adolescent-onset
Symptom load and severity	Many symptoms, damaging behaviours early	Few and milder symptoms
Limited prosocial emotions specifier	Present	Absent
Co-occurring ADHD	Present	Absent
Substance abuse	Present	Absent
Peer relationships	Deviant peer affiliation	Normative
Verbal intelligence	Lower verbal IQ	Higher verbal IQ

The prognostic ledger for conduct disorder read across shared axes; the protective column is largely the persistence column reversed, which is why the two are learned together rather than as separate lists.

7.6 Turning prognosis into practice

Prognosis is only useful if it changes what the clinician does. The reason the examiner cares about outcome prediction is that it is meant to be acted on. A structured reading of the prognostic profile does two things at once. It identifies the high-risk young person - early onset, callous-unemotional features, comorbid ADHD, emerging substance use - in whom the most

intensive, evidence-based intervention is justified and in whom the window for altering the trajectory is widest. And it gives the clinician language to hold a family's fear at the right level: neither the false reassurance that a seriously disordered child will simply grow out of it, nor the false verdict that a child is already lost. The prognostic features are also the natural targets of intervention, because several of them - the comorbid ADHD, the substance use, the deviant peer affiliations - are modifiable, and modifying them is one of the mechanisms by which good treatment shifts outcome.

GOOD TO REMEMBER

Record the prognostic profile explicitly in the formulation, not just the diagnosis. Whether the course is childhood or adolescent onset, whether the limited prosocial emotions specifier applies, and whether ADHD or substance use co-occurs, together place the young person on the outcome spread and set the intensity of the response. The same features that predict a poor outcome are the ones worth targeting, so the prognostic list doubles as an intervention checklist.

IN INDIA

Because Indian services classify under ICD, the operative label in case files is the conduct-dissocial disorder of that system, and the prognostic principles carry across unchanged: onset age, callous-unemotional features and comorbidity still sort the persistent minority from the many who remit. The practical constraint is continuity. The desistance seen in early adulthood is easiest to support where a young person can be followed over years, but fragmented follow-up, limited child mental health services, and loss to care after a first contact mean many are seen once at a crisis and not again. Where conduct intersects with the law, the juvenile-justice interface is taken up separately in this chapter, and the wider machinery of services and protection in the Child psychiatry: assessment, treatment, services and protection notes; the prognostic point for practice is that a single contact is rarely enough to change a trajectory that is defined by its persistence.

before 15	childhood-onset	majority
AGE OF CONDUCT DISORDER ONSET REQUIRED FOR THE ADULT ANTISOCIAL DIAGNOSIS	THE SUBTYPE CARRYING THE WORSE PROGNOSIS	OF AFFECTED YOUNG PEOPLE REMIT BY ADULTHOOD

Oppositional defiant disorder and the impulse-control disorders

8 · Oppositional defiant disorder (criteria, course, management)

The diagnosis lives in the space between a difficult temperament and a rights-violating illness. **Oppositional defiant disorder** is the syndrome of childhood and adolescence in which anger, argumentativeness, defiance and a streak of vindictiveness cohere into a pattern that is out of proportion to the child's developmental stage and that costs the child or the family something real. It is one of the commonest referrals to child mental health, and it is examined heavily for a reason that is easy to state and hard to apply: almost every young child is oppositional some of the time, so the whole art of the diagnosis is telling a disorder apart from an ordinary phase, a

temperamental extreme, or the friction of a coercive home. Marks are lost not on the symptom list, which candidates memorise, but on the thresholds, the developmental caveats and the borders with conduct disorder and the chronically irritable presentations, which is where the criteria actually do their work.

This topic owns the diagnostic architecture of the disorder: the essential feature, the symptom count and timeframe, the three symptom clusters and what each predicts, the age-graded frequency rule that separates symptom from normality, the severity grading, the local differential against conduct disorder, and the way the two major classifications part company over chronic irritability. The full conduct disorder criteria, disruptive mood dysregulation disorder, the cross-cutting normal-limits map and the attention-deficit/hyperactivity comorbidity are each developed in their own right elsewhere; here they are named where the reasoning demands it, not reopened.

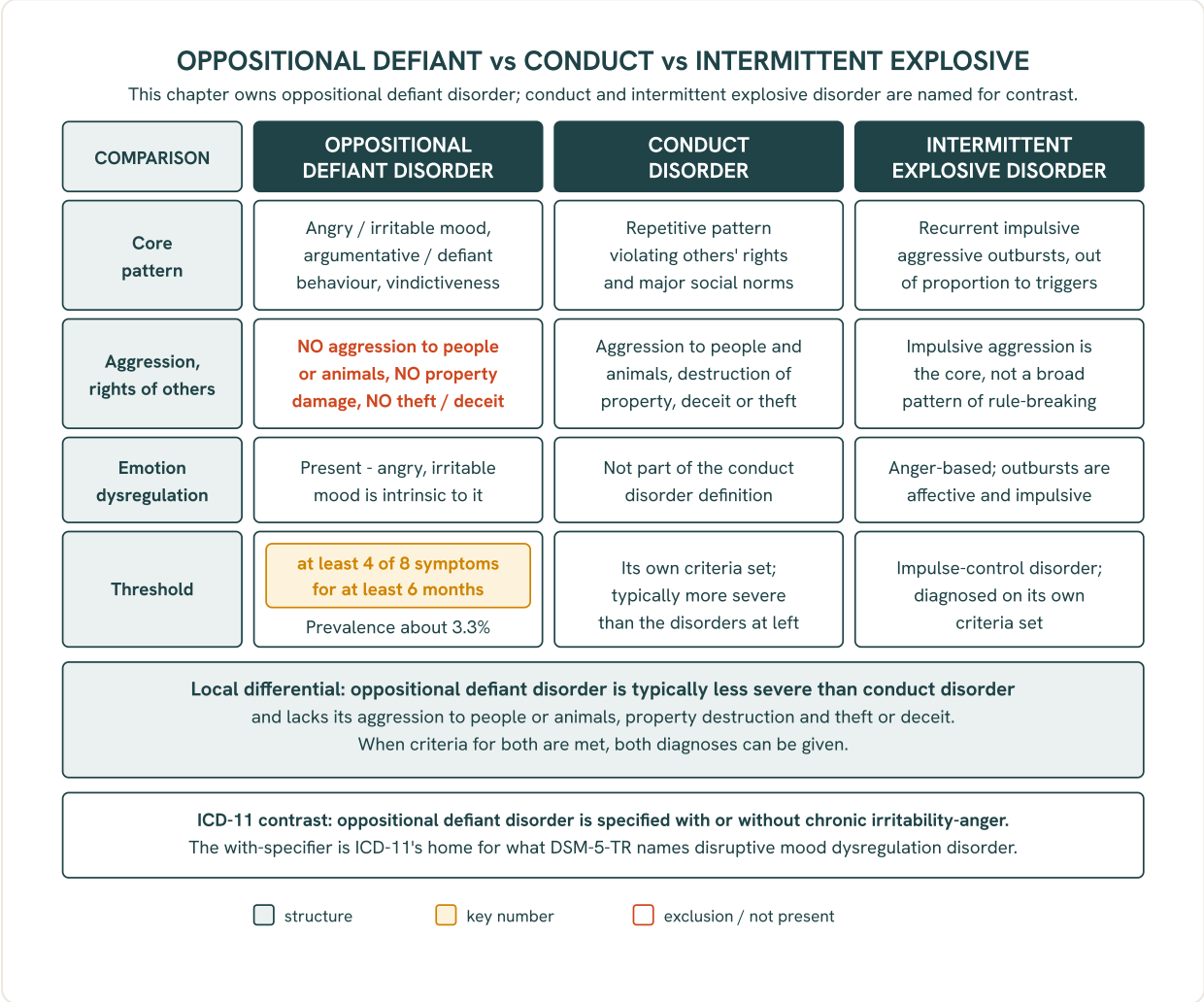


Fig 23.7. Oppositional defiant disorder against conduct disorder and intermittent explosive disorder: the same core-pattern, aggression, emotion and threshold axes that separate a persistent defiant pattern from rule-violating conduct and from impulsive aggressive outbursts.

8.1 The essential feature: a disposition, not a single scene

The unit of diagnosis is a durable pattern of three affective-behavioural dispositions. The essential feature is a recurring pattern of **angry/irritable mood**, **argumentative/defiant behaviour** and **vindictiveness**, sustained rather than sporadic and directed at the people around

the child. What makes it a disorder is not any one tantrum, argument or spiteful act, all of which are near-universal in childhood, but the consolidation of these tendencies into a stable way of relating. The framing is deliberately broader than pure behaviour: unlike the frankly antisocial syndromes, this disorder puts a mood dimension at its centre, so that the irritable, easily-provoked child who is not yet aggressive to others still belongs here. That affective core is what later separates the disorder from conduct disorder and links it to the mood and anxiety outcomes. The clinician's first task is to establish that a pattern sits behind the presenting complaint rather than be captured by the single episode that brought the family in.

8.2 Criterion A: the count, the clock and the non-sibling rule

The threshold, the timeframe and the target of the behaviour are the examinable core. The operational rule requires at least **four** symptoms drawn from a set of **eight**, present over a period of at least 6 months. Two features of the rule are quietly load-bearing. First, the four symptoms may be drawn from *any* of the three clusters, so a purely irritable child and a purely defiant child can both reach the threshold by different routes, which is why the clusters must be tracked separately rather than summed blindly. Second, the pattern must be shown during interaction with at least one individual who is not a sibling. This last clause is frequently missed and frequently tested: ordinary sibling conflict, however fierce, does not count toward the diagnosis, because rivalry and squabbling between brothers and sisters is developmentally expected and says little about a generalised oppositional disposition. The behaviour must reach beyond the sibling relationship before it becomes diagnostic.

> The core rule to carry into the exam: at least four of eight symptoms across the three clusters, for at least 6 months, shown with at least one person who is not a sibling.

8.3 The three symptom clusters and why the split predicts the future

Eight symptoms sort into three clusters that carry different prognostic freight. The criteria are not a flat list. They fall into an angry/irritable mood cluster (losing one's temper, being touchy or easily annoyed, and being angry and resentful); an argumentative/defiant behaviour cluster (arguing with authority figures, actively defying or refusing to comply with rules, deliberately annoying others, and blaming others for one's own mistakes); and a vindictiveness cluster. Grouping matters because the clusters point in different directions. The argumentative, defiant and vindictive dimension carries most of the risk for progression to conduct disorder, whereas the angry and irritable mood dimension carries most of the risk for later mood and anxiety disorders. This is the most useful prognostic reasoning the topic offers: two children who both satisfy the count can face different futures depending on which cluster dominates, so recording the profile rather than the bare tally is what lets the clinician anticipate an externalising or internalising trajectory.

CLUSTER	WHAT IT CAPTURES	WHAT IT CHIEFLY PREDICTS
Angry/irritable mood	Loses temper; touchy or easily annoyed; angry and resentful	Later mood and anxiety disorders
Argumentative/defiant behaviour	Argues with authority; defies rules; deliberately annoys; blames others	Progression toward conduct disorder
Vindictiveness	Spiteful or vindictive behaviour	

The three clusters set against what each chiefly forecasts; the affective cluster tilts toward internalising outcomes, the behavioural and vindictive clusters toward the externalising trajectory that ends in conduct disorder.

MNEMONIC

Mad, Bad and Vengeful

The three clusters in order: **Mad** (angry/irritable mood), **Bad** (argumentative/defiant behaviour) and **Vengeful** (vindictiveness). Holding them as separate axes rather than one undifferentiated pile of misbehaviour is what makes the prognostic split usable at the bedside.

8.4 The frequency rule: telling a symptom from ordinary development

Persistence and frequency, read against the child's age, are what convert a normal behaviour into a symptom. Because the raw behaviours are so common, the criteria supply an age-graded frequency floor. For a child younger than 5 years the behaviour should occur on most days across a period of at least 6 months; for a child of 5 years or older it should occur at least once per week over the same period, with an allowance for the vindictiveness item, which is expected less often. These frequencies encode a developmental truth: daily oppositionality is closer to the norm in the preschool years than later, so a higher bar is set for the younger child and a lower one for the older. The criteria also insist that the judgement be made against the individual's developmental level, sex and culture, which keeps the diagnosis from being read off behaviour in isolation from the child who produces it. Frequency, persistence and context together are what license the move from behaviour to symptom.

RULE **The threshold is set by frequency against age, not by the behaviour alone.** The same tantrum that is developmentally unremarkable on most days in a preschooler is a symptom when it recurs weekly in a school-aged child. The criteria pin the diagnosis to how often the behaviour occurs relative to what is expected at that age, which is precisely the safeguard that stops normal childhood oppositionality being pathologised.

8.5 Grading the disorder: pervasiveness across settings

Severity is read from how many settings the symptoms invade. The disorder is graded not by symptom count but by pervasiveness, on the principle that a child who is oppositional only at home is in a different clinical position from one who is oppositional everywhere. The grade is **mild** when symptoms are confined to a single setting, moderate when some symptoms appear in at least two settings, and severe when they are present in three or more. The clinical logic is sound. Symptoms limited to one relationship or place often say as much about that setting as about the child, and may respond to work targeted there; symptoms that generalise across home,

school and the wider world point to a more ingrained, more disabling disposition. Reading severity from pervasiveness also quietly instructs the assessor to gather information from more than one informant, because a grade cannot be assigned honestly from the parents' account alone.

> **GOOD TO REMEMBER**
>
> Because severity tracks the number of settings, a single-informant assessment can only ever establish the floor. If the parents describe defiance at home but the child has never been observed or reported on at school, the honest grade is provisional, and the next clinical move is to obtain the school's account before the disorder is called moderate or severe.

8.6 Epidemiology and the sex distribution

The frequency of the disorder is one of the reasons the threshold has to be strict. Cross-national estimates put the average prevalence at about **3.3%**, though the figure ranges widely, from roughly 1% to 11% across settings. Before adolescence the disorder is somewhat commoner in boys than girls, at a ratio of about **1.59 to 1**; the male preponderance is real but modest, and it attenuates with age, unlike the sharper and more persistent male excess seen in the frankly conduct-disordered group. The wide prevalence band is itself an examinable point: it is a direct consequence of how much the diagnosis depends on where the line between a difficult child and a disordered one is drawn, which varies between raters and cultures, and it is a standing argument for holding to the frequency and pervasiveness rules rather than to clinical impression.

8.7 The local differential: oppositional defiant disorder against conduct disorder

The two disorders share a family resemblance but part on rights-violation and on mood. The most consequential differential is against **conduct disorder**, whose full criteria are developed in its own right elsewhere in this chapter. Two lines separate them. First, the behaviours of oppositional defiant disorder are typically less severe and, crucially, do *not* include aggression toward people or animals, destruction of property, or a pattern of theft or deceit; those serious rights-violating and norm-violating acts are the province of conduct disorder. Second, oppositional defiant disorder additionally carries a component of emotion dysregulation, the angry and irritable mood, that has no place in the definition of conduct disorder. The two are not mutually exclusive, and when a young person genuinely satisfies the criteria for both, both diagnoses can be made.

- defiance, argument and spite without aggression, destruction, theft or deceit point to oppositional defiant disorder, not conduct disorder;
- aggression to people or animals, property destruction, or a pattern of theft or deceit moves the picture into conduct disorder territory;
- the angry and irritable mood dimension belongs to oppositional defiant disorder and is not part of the conduct disorder definition;
- when the criteria for both are met, both are diagnosed rather than one being forced to displace the other.

TRAP **Oppositional defiant disorder and conduct disorder are not mutually exclusive.** Candidates often treat them as a hierarchy in which the more severe diagnosis cancels the milder, and answer that a child meeting both sets of criteria has "only" conduct disorder. When both are genuinely satisfied, both diagnoses stand; the disorders are related but distinct, and the presence of one does not extinguish the other.

8.8 The classification split: chronic irritability and where it is housed

The two manuals agree on the disorder and disagree on what to do with chronic irritability. Under ICD-11 the entity is **oppositional defiant disorder**, coded 6C90, and the classification adds a decision the other manual makes differently. It allows the disorder to be specified **with chronic irritability-anger** (coded 6C90.0) or without it (coded 6C90.1). The with-specifier identifies a pattern of prevailing, persistent irritable and angry mood, and it is ICD-11's home for the very presentation that the other major classification carves out as a separate disorder, **disruptive mood dysregulation disorder**, which is developed in its own right elsewhere in this chapter. This is a genuine structural disagreement rather than a wording difference: one system treats chronic non-episodic irritability as a specifier hung on the oppositional diagnosis, the other as a distinct entity in its own right. Which manual a case file follows therefore decides whether a chronically irritable child is recorded as an oppositional defiant disorder with a specifier or as a separate mood-dysregulation diagnosis.

AXIS	ICD-11	THE OTHER MAJOR CLASSIFICATION
Base diagnosis	Oppositional defiant disorder (6C90)	Oppositional defiant disorder
Chronic irritable-angry presentation	A specifier: with chronic irritability-anger (6C90.0)	A distinct disorder, disruptive mood dysregulation disorder
Consequence for coding	The irritable child stays within the oppositional diagnosis	The irritable child receives a separate mood diagnosis

The same clinical presentation of chronic, non-episodic irritability placed differently by the two classifications; the load-bearing point is that ICD-11 keeps it inside the oppositional diagnosis as a specifier where the other manual gives it its own name.

IN INDIA

Because Indian services classify under ICD, the operative label in case files, referrals and official reports is oppositional defiant disorder under its ICD code, with the chronic irritability-anger specifier available for the persistently irritable child. A clinician trained on the other manual's categories should not go looking for a separate mood-dysregulation diagnosis in an ICD-coded record: the same child is recorded here as an oppositional defiant disorder with the specifier applied, and treating the two as different disorders rather than the same presentation filed differently is a recurring source of confusion in cross-referenced notes.

8.9 Course and management

Onset is early, the outlook is dimension-dependent, and the first-line treatment is delivered through the parents. The disorder typically declares itself in the preschool and early school

years, often before conduct problems proper, and for a subset it is the earliest link in a chain that runs toward conduct disorder and, beyond it, to antisocial outcomes in adulthood. But this trajectory is neither universal nor fixed, and which way a given child tends is what the cluster profile forecasts: the behavioural and vindictive dimension carries the risk of progression to conduct disorder, the irritable dimension the risk toward mood and anxiety disorders. Comorbidity is the rule rather than the exception, with attention-deficit/hyperactivity disorder the most frequent travelling companion; that disorder, its assessment and its treatment belong to the ADHD and specific learning/communication disorders notes, and its presence materially worsens the oppositional picture and complicates management.

Treatment is built on the parent-child relationship before it is built on medication. The first-line and best-supported intervention is structured **parent management training**, in which caregivers are coached to replace the escalating cycles of command, refusal and capitulation that maintain oppositional behaviour with consistent, contingent responses, clear expectations, and the deliberate reinforcement of prosocial behaviour. For an older child, individual work on problem-solving and anger management is added, and school-based consistency is enlisted so the same contingencies operate across settings, which also addresses the pervasiveness that defines severity. Pharmacotherapy has no primary role in the oppositional syndrome itself and is directed instead at treatable comorbidity, most often the accompanying attention-deficit/hyperactivity disorder, rather than at defiance as such. This is a relational and developmental problem first, so the family, not a prescription, is the main instrument of change; medication earns its place only where a comorbid disorder independently warrants it.

PITFALL

The commonest clinical error runs in both directions around the same axis: over-diagnosing the ordinary defiance of a tired, testing or newly-limit-tested young child as a disorder by ignoring the age-graded frequency floor, and, conversely, dismissing a genuinely disordered older child as "just naughty" because oppositionality is expected in the young. The corrective is the same in both cases: hold the behaviour against what is developmentally expected at that age, and against how often and in how many settings it actually occurs, rather than against the adults' exasperation.

4 of 8	3.3%	1.59:1
SYMPTOMS NEEDED, AT LEAST 6 MONTHS IN DURATION	AVERAGE CROSS-NATIONAL PREVALENCE	BOYS TO GIRLS BEFORE ADOLESCENCE

9 · Intermittent explosive disorder

The disorder is defined by the loss of control, not by the size of the violence. Intermittent explosive disorder is the diagnosis given to recurrent behavioural outbursts that represent a failure to control aggressive impulses. What is disordered is not that a person becomes angry, nor even that they become violent, but that the aggressive impulse is discharged in a sudden, poorly restrained explosion that the person themselves usually regrets. The picture is of a short fuse attached to a response grossly larger than whatever lit it: a trivial provocation, a spilled drink or a delayed reply, met with screaming, threats, a thrown object or a blow. Between the episodes the

person is often unremarkable, which is precisely why families describe someone who is "fine until they snap".

Marks accrue here for a specific reason. Aggression is a final common pathway of many disorders, and the examiner wants to know that a candidate can tell impulsive, anger-driven aggression apart from the cold, instrumental aggression of conduct disorder and antisocial personality, from the chronically irritable child, and from aggression that is merely a symptom of mania, intoxication or a frontal lesion. Intermittent explosive disorder is the residual, positive diagnosis of the impulsive aggressive outburst once those other explanations have been excluded. This topic owns that diagnosis in full: its essential feature, the two thresholds of its recurrence criterion, its qualifying and exclusion rules, its course, epidemiology and differential. The wider family of impulse-control disorders, and the conditions of firesetting and stealing, are developed in their own right and named here only where the differential demands it.

9.1 The essential feature: a failure to control aggressive impulses

The unit of diagnosis is the impulsive aggressive outburst. The core disturbance is an inability to resist aggressive impulses, expressed as recurrent outbursts that are out of proportion and out of the person's control. The aggression is **impulsive** or anger-based; it is not **premeditated**, and it is not committed to secure a tangible objective such as money, power or intimidation. That single distinction carries most of the clinical and examination weight. Aggression used as a tool, to coerce, acquire or dominate, belongs to conduct disorder or antisocial personality and not here, however dramatic it looks. The aggression of this disorder is that of a system that has lost its brakes, discharged in the heat of the moment and typically followed by genuine remorse once the arousal subsides. The outburst is the disease; the person's baseline, and their regret, are part of the picture.

RULE **Impulsive and disproportionate, never instrumental.** The diagnosis requires aggression that is anger-based and unplanned and that is grossly out of proportion to its trigger. The moment the aggression is revealed to be premeditated or committed for gain, the diagnosis is not intermittent explosive disorder, and the assessor should be looking at conduct disorder, antisocial personality or another explanation instead.

9.2 Criterion A: two ways in, frequency or severity

The threshold is a dyad, and either arm alone suffices. The recurrence criterion can be met by one of two mutually alternative patterns, and understanding that they are alternatives is the examinable core of the topic. The first arm captures frequent, low-severity outbursts: **verbal aggression or non-damaging physical aggression** occurring **twice weekly**, on average, over a period of three months. These outbursts, by definition, do not damage or destroy property and do not cause physical injury, the tantrum-like verbal explosion or the shove that harms nothing being the prototype. The second arm captures infrequent but destructive outbursts: **three** outbursts that involve damage or destruction of property, or physical assault causing injury to people or animals, occurring within a 12-month period. A person qualifies on either arm; they need not meet both. The design is deliberate, catching both the individual disrupted by constant low-grade verbal explosions and the one who erupts only rarely but does real harm.

ARM OF CRITERION A	SEVERITY OF THE OUTBURST	REQUIRED FREQUENCY AND WINDOW
High-frequency arm	Verbal or non-damaging physical aggression; no property damage, no injury	Twice weekly on average, for three months
High-severity arm	Property damage or destruction, or assault causing injury	Three outbursts within a 12-month period

The two alternative routes to the recurrence criterion; a person satisfies the requirement through either arm, and the two differ in the severity of the outburst and in the counting window rather than in the nature of the underlying impulse.

9.3 The qualifying and exclusion criteria

Recurrence alone is not the disorder; the qualifiers make it one. Several further conditions must hold before the outbursts count. The aggressiveness must be grossly out of proportion to the provocation or precipitating stressor, so that a measured, if forceful, response to a genuine threat does not qualify. The outbursts must cause the person real cost, whether marked personal distress, impairment of occupational or interpersonal functioning, or financial and legal consequences. There is a developmental floor: the person must be at least **6 years** of chronological age, or the equivalent developmental level, and the diagnosis is not made below that age, where explosive behaviour is developmentally common and non-specific. Finally, the outbursts must not be better explained by another mental disorder and must not be attributable to a substance or a general medical condition. This last exclusion is what makes the condition a diagnosis of careful exclusion rather than of first impression, since aggression is so often secondary.

- the response is grossly disproportionate to its trigger;
- the outbursts cause marked distress, functional impairment, or financial or legal harm;
- the person is developmentally at least six years old;
- the aggression is not better accounted for by another disorder, a substance, or a medical condition.

> Carry this into the exam: impulsive, disproportionate, distressing aggression, either twice weekly and non-damaging for three months or three damaging outbursts in a year, in a person aged at least 6, and not explained by anything else.

9.4 The phenomenology and course of the outburst

The anatomy of the episode is characteristic and worth knowing. The typical outburst has a rapid, almost explosive onset, often with little or no prodrome, and is usually short-lived rather than smouldering for hours. Many patients describe a mounting sense of tension or arousal before the act and a sense of relief during it, followed by fatigue and, characteristically, remorse, embarrassment or guilt once it has passed. It is this remorse, and the ego-dystonic quality of the aggression, that distinguishes the picture from the unrepentant, goal-directed aggression of the antisocial patient. The disorder tends to begin in late childhood or adolescence and to run a chronic course over many years, punctuated by discrete outbursts against a comparatively normal

inter-episode baseline. That episodic structure against a well background is the signature, and it is a large part of why the condition is under-recognised: the person seeking help usually does so between outbursts, when they appear entirely well.

GOOD TO REMEMBER

Ask specifically about the shape of the episodes, not just their occurrence. Rapid onset, short duration, a build-up of tension beforehand, relief during, and remorse afterwards, all against a normal baseline, is a pattern the patient will rarely volunteer but will readily confirm. Documenting that episodic architecture is often what separates this diagnosis from a persistently irritable temperament or a mood disorder.

9.5 Epidemiology

It is commoner than its low profile suggests. Population data put the one-year prevalence in the United States at about **2.6%**, with a lifetime prevalence of around **4.0%**, figures that make it far from a rarity even if it is seldom the presenting complaint. It is more prevalent among younger people, being concentrated in those under about 35 to 40 years, in keeping with its onset in youth and its attenuation with age, and it is somewhat commoner in males. The gap between how often the disorder occurs and how rarely it is formally diagnosed is itself an examination point: patients are labelled as having an anger problem, or seen only through the marital, occupational or forensic consequences of their outbursts, rather than recognised as having a discrete, treatable impulse-control disorder.

9.6 The differential diagnosis: a crowded field

Almost every disorder that produces aggression must be set aside first. Because aggression is nonspecific, the differential is the most demanding part of the topic. The chronically irritable child whose mood is persistently angry between outbursts is better captured by **disruptive mood dysregulation disorder**, developed in its own right elsewhere in this chapter; the diagnostic convention is that where that disorder's criteria are met in a child, the explosive-disorder label is not added on top. Conduct disorder and oppositional defiant disorder, also elsewhere in this chapter, involve a broader pattern of rule-breaking or defiance in which aggression is one element, and the explosive-disorder diagnosis is reserved for impulsive aggression that is in excess of, and not fully explained by, that broader pattern. Antisocial personality is separated by the instrumental, unremorseful quality of its aggression and belongs to the Personality disorders notes. Aggression arising only during manic, depressive, psychotic or intoxicated states is a symptom of those states, and the impulsivity of untreated attention-deficit/hyperactivity disorder, taken up in the ADHD and specific learning/communication disorders notes, must be weighed as well.

CONDITION TO EXCLUDE	WHAT SEPARATES IT FROM INTERMITTENT EXPLOSIVE DISORDER
Disruptive mood dysregulation disorder	Persistent angry or irritable mood *between* the outbursts; where its criteria are met in a child, this disorder takes precedence and the explosive-disorder label is not added
Conduct disorder and oppositional defiant disorder	A broad pattern of rule-violation or defiance; the explosive diagnosis needs impulsive aggression in excess of what that pattern explains
Antisocial personality disorder	Aggression that is premeditated and instrumental, pursued for gain and without remorse
Manic, depressive or psychotic states	Aggression occurs only during the mood or psychotic episode and remits with it
Substance intoxication or withdrawal, and medical or neurological conditions	Aggression is attributable to the substance or the lesion; excluded by Criterion F

The principal competitors for the aggressive presentation; intermittent explosive disorder is what remains once each of these has been considered and set aside, which is why it is best thought of as a positive diagnosis reached through disciplined exclusion.

TRAP **Calling instrumental aggression "explosive".** The classic error is to reach for this diagnosis for any patient with a history of violence. Candidates forget that aggression committed to obtain something, or that is planned, is specifically excluded: it points to conduct disorder or antisocial personality. The disorder is impulsive, disproportionate and regretted, never a calculated means to an end.

9.7 Principles of management

Treatment targets the impulse, not merely the incident. Management combines psychological and pharmacological strategies, with the emphasis on reducing the frequency and intensity of the outbursts rather than managing each crisis after the fact. Cognitive behavioural approaches, including anger management, relaxation and coping-skills training, cognitive restructuring of the appraisals that trigger the arousal, and relapse prevention, are the psychological mainstay and have the best-established evidence. Pharmacologically, serotonergic antidepressants are the most commonly used agents, on the rationale that impulsive aggression is linked to serotonergic dysregulation, with mood stabilisers and certain anticonvulsants where affective instability is prominent; specific agents and dosing lie outside what this topic establishes and should be confirmed against a pharmacology source. Coexisting conditions, particularly depression, substance use and attention-deficit/hyperactivity disorder, must be identified and treated in their own right, since untreated comorbidity both worsens the outbursts and undermines any intervention aimed at them.

PITFALL

The commonest clinical failure is to treat only the aftermath. Clinicians manage the injury, the property damage or the legal fallout of each outburst and never step back to recognise and treat the underlying impulse-control disorder, so the patient cycles through emergency departments, marital breakdowns and forensic contacts without anyone naming the condition that drives them. Screening a patient with recurrent, regretted, disproportionate aggression for the disorder itself is what breaks that cycle.

IN INDIA

Most Indian services classify under ICD rather than DSM, where the condition sits among the impulse-control disorders, and its wider framework is developed in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. The practical reality is that these patients present through their consequences, in casualty after an assault, in the marital clinic, or via a medicolegal referral after a charge, far more often than they ask for help with anger. Holding the diagnosis in mind when assessing recurrent, out-of-proportion, regretted aggression can convert a repeat forensic or emergency presentation into a treatable psychiatric problem, which is the single most useful move the topic offers here.

age 6 DEVELOPMENTAL FLOOR FOR THE DIAGNOSIS	**2.6%** ONE-YEAR PREVALENCE (UNITED STATES)	**4.0%** LIFETIME PREVALENCE

10 · Juvenile delinquency (psychiatric perspective)

The label is a verdict, not a diagnosis. A young person becomes a delinquent the moment a court adjudicates them for an offence, and nothing about that legal event tells you whether a psychiatric disorder is present. This is the first and most important idea in the topic, because the word arrives in the examination looking like a clinical entity and is nothing of the sort. Juvenile delinquency is a **legal and administrative category**, a description of what a young person has done and how the state has responded to it, not a description of a mind. The psychiatrist is called into this world not to confirm the label but to answer a separate question underneath it: what, if anything, is wrong, and is it treatable.

Marks are here for a reasoning move rather than a fact list. The examiner wants to see that a candidate can hold the legal act and the mental-health need apart, and can then say what the child and adolescent psychiatrist actually contributes to a young offender: an understanding of the antisocial behaviour, and a disciplined search for the psychiatric disorders that so often sit behind it. This topic owns that psychiatric perspective in full and names the juvenile-justice framework around it. It does not own the disorders themselves, which are taught in their own right, and it deliberately does not teach the legal machinery in detail, which belongs to the statute and to the child-services notes named at the end.

10.1 A legal category, not a psychiatric diagnosis

Delinquency is defined by adjudication, not by symptoms. The defining feature of the term is administrative: a young person has committed an act that would be an offence, and a justice system has processed them for it. There is no symptom list, no duration criterion, no exclusion clause, because it is not a diagnosis at all. This matters clinically because the same legal label covers utterly different children. One delinquent has no psychiatric disorder and has offended out of circumstance, poverty or a single bad decision; another carries **conduct disorder**, or an untreated attentional disorder, or a substance problem, or the aftermath of trauma, and offends as one expression of it. The legal category flattens all of them into a single administrative fact, and the psychiatrist's task is to reopen it. Treating the label as though it were the diagnosis is the error the whole topic is built to prevent: it leads clinicians and courts alike to assume a disorder where there is none, or, worse, to miss a treatable one because the young person has already been filed under a legal heading that seems to explain everything.

RULE **Delinquency is what the court decides; the diagnosis is what the clinician finds.** These are two independent questions asked by two different systems, and the psychiatric perspective exists to answer the second without letting the first stand in for it. A young offender may have no psychiatric disorder, or may have one that has gone unrecognised precisely because the legal label arrived first.

10.2 The psychiatric perspective: finding the disorder inside the label

The clinician's contribution is comprehension and comorbidity. Child and adolescent psychiatry is asked to do two things with a delinquent young person: to understand the antisocial behaviour in developmental terms, and to assess the psychiatric disorders that are frequently present and that contribute to the offending. This second duty is where the marks concentrate, because rates of unrecognised psychiatric illness in young people who reach the justice system are high, and much of it is treatable. The disorders that recur are a familiar cluster. Conduct disorder is the commonest and most directly relevant, developed on its own terms elsewhere in this chapter; attention-deficit/hyperactivity disorder, taken up in the ADHD and specific learning/communication disorders notes, drives the impulsivity and poor self-regulation that turn a temptation into an offence; substance use both disinhibits behaviour and generates acquisitive crime; specific learning disorders and low scholastic attainment feed the school failure and truancy that precede much delinquency; and a history of maltreatment or trauma, with its post-traumatic sequelae, is disproportionately common. None of these is the legal category, and each changes what should happen next.

CONTRIBUTING DISORDER TO SCREEN FOR	WHY IT MATTERS IN A YOUNG OFFENDER
Conduct disorder	The most direct psychiatric correlate of persistent offending; taught in its own right in this chapter, not re-established here
Attention-deficit/hyperactivity disorder	Impulsivity and poor self-regulation convert opportunity into offence; treatable, and covered in the ADHD and specific learning/communication disorders notes
Substance use	Disinhibits behaviour and generates acquisitive and violent crime; often the reversible driver
Specific learning disorders and scholastic failure	School failure and truancy commonly precede delinquency and are frequently unrecognised
Trauma and its post-traumatic sequelae	Maltreatment histories are over-represented; the offending may be one expression of the aftermath

The psychiatric disorders that recur behind the legal label; the clinical value of the psychiatric perspective lies in detecting and treating these, none of which is the delinquency itself, and several of which are directly modifiable.

GOOD TO REMEMBER

Treat entry into the justice system as a screening opportunity that would otherwise be missed. Many of these young people have never had a psychiatric assessment, and the disorders most worth finding, an attentional disorder, a substance problem, a treatable mood or post-traumatic picture, are exactly the ones that a purely legal response will overlook. The single most useful thing the psychiatric perspective offers is a low threshold for looking, because the disorder that is found is often the one that changes the trajectory.

10.3 The juvenile-justice framework and its rehabilitative orientation

The system that handles young offenders was built to rehabilitate, not to punish. The **juvenile-justice framework** is the specialised court and justice system that deals with young offenders separately from adults, and its founding logic is what a candidate must be able to state. The first juvenile court was created in **1899**, deliberately set apart from the adult criminal process so that the response to a delinquent child could be corrective rather than retributive. That rehabilitative orientation has persisted, and modern practice within the framework increasingly emphasises evidence-based psychosocial treatment over incarceration, and in particular over placements that gather delinquent young people together. The interventions that carry the best evidence are worth knowing by name:

- **multisystemic therapy**, an intensive family- and community-based treatment;
- therapeutic foster care, a structured alternative to group placement;
- diversion away from formal processing where appropriate;
- juvenile mental-health and drug courts, which route treatment needs into the justice response.

The common thread is that each keeps the young person embedded in a corrective relationship, family, foster placement or treatment programme, rather than in a peer group of other offenders.

There is also growing recognition within the framework of how much untreated psychiatric illness this population carries, which is precisely the door through which the psychiatric perspective enters. The full machinery of the framework, its statutory structure and the child-protection services that sit alongside it, is taught in the Child psychiatry: assessment, treatment, services and protection notes, and this topic names it rather than reproducing it.

PITFALL

The intuitive response, gathering delinquent adolescents together in a group placement or programme, can make antisocial behaviour worse rather than better. Placing young offenders among deviant peers tends to reinforce the very behaviour it is meant to correct, which is why the evidence-based interventions deliberately keep the young person in a family or individually structured setting. A clinician who recommends "a place with others like him" may be recommending the one thing the framework has learnt to avoid.

10.4 The Indian statutory frame, named but not quoted

The legal specifics belong to the statute, not to a textbook paraphrase. Everything above describes the general, largely Western juvenile-court model and the psychiatric role within it. The Indian legal machinery is governed by its own statute, the **Juvenile Justice (Care and Protection of Children) Act**, and this is where a candidate must be disciplined. The exact definitions, the age thresholds that determine who is treated as a child, the provisions dealing with serious offences, and the bodies constituted to decide these cases are statutory specifics that must be read from the primary Act itself, not carried over from a Western textbook or a second-hand summary. Quoting an age or a provision from memory or from a paraphrase is precisely how an error enters a candidate's answer, because the numbers differ across jurisdictions and across revisions of the law. The safe and correct move is to name the Act, to state that it governs the Indian juvenile-justice response, and to say that its provisions are read from the statute when a specific is genuinely needed.

IN INDIA

The Indian juvenile-justice response operates under the Juvenile Justice (Care and Protection of Children) Act, which establishes the dedicated bodies that adjudicate and provide for young persons in conflict with the law and children in need of care and protection. The statutory detail, the operative age definitions and the provisions for serious offences, should be read from the current Act rather than reproduced here, because these are the specifics most likely to be misquoted. For the full child-protection and juvenile-justice machinery, and for the child psychiatric services that interface with it, see the Child psychiatry: assessment, treatment, services and protection notes.

A delinquent is a young person a court has adjudicated, not a young person a clinician has diagnosed; the marks are for finding, and treating, the psychiatric disorder that so often hides inside the legal label.

TRAP **Equating delinquency with conduct disorder.** Candidates routinely treat the two as synonyms and lose the point of the topic. Delinquency is a legal status conferred by a court; conduct disorder is a clinical diagnosis conferred by a clinician. Most delinquents are not simply "conduct disorder by another name": some have no psychiatric disorder at all, and others have an attentional, substance-related, learning or post-traumatic disorder that the label conceals. Answering as though every young offender has conduct disorder both over-diagnoses and misses the treatable illness the perspective exists to find.

1899	Legal	Comorbid
FIRST JUVENILE COURT ESTABLISHED, ON A REHABILITATIVE MODEL	DELINQUENCY IS AN ADJUDICATED CATEGORY, NOT A DIAGNOSIS	CONDUCT DISORDER, ADHD, SUBSTANCE USE, TRAUMA COMMONLY PRESENT

11 · Pyromania and kleptomania (impulse-control disorders)

These are diagnoses of a captured will, not of the behaviour it produces. **Pyromania** and **kleptomania** are the classical impulse-control disorders of deliberate fire setting and repeated stealing. What makes each a psychiatric diagnosis is not the act, which is also the stuff of ordinary crime, but the internal machinery driving it: a rising, uncomfortable tension that the act discharges, followed by pleasure or relief, in the absence of any everyday motive that would explain the same behaviour in anyone else. The person does not set fires to collect insurance or steal what they cannot afford; they set fires because the setting relieves something, and they steal objects they neither need nor want.

Marks accrue here because the examiner is testing a discrimination the untrained eye gets wrong almost every time: the difference between a crime and a disorder that happens to be enacted through a criminal behaviour. A candidate who can recite that the fire setting must be purposeless, tension-driven and unexplained by gain or anger has understood the topic; one who labels every arsonist a pyromaniac and every shoplifter a kleptomaniac has missed the point. This section owns both disorders in full: their essential features, exclusion rules, rarity and differential from their criminal mimics. The wider family of impulse-control disorders is developed in the Somatic-symptom, sexual, impulse-control disorders and suicide notes and is named here only as context.

11.1 The shared architecture: tension, act, relief

Both disorders run on the same three-beat cycle, and recognising it is half the topic. Before the act there is a mounting sense of **tension or affective arousal**; the act discharges it; and in its aftermath there is pleasure, gratification or relief. This is the signature of an **impulse-control disorder**: the behaviour is not a means to an external end but a way of managing an internal state, which is why it feels compelling to the person and senseless to the observer. The impulse is difficult to resist, often ego-dystonic, and the relief is short-lived, so the cycle repeats. Holding this architecture in mind is what lets a clinician ask the right questions, because the tension-then-relief pattern is rarely volunteered but readily confirmed once specifically sought.

MNEMONIC

Tension - Act - Relief

The common spine of both disorders: an uncomfortable build-up of arousal before the behaviour, its discharge in the act of fire setting or stealing, and a transient sense of pleasure, gratification or relief afterwards. If that cycle is absent, and the behaviour is fully explained by an external motive, neither diagnosis applies.

RULE **The diagnosis is the impulse, never the act.** Fire setting and stealing are behaviours, not disorders. Pyromania and kleptomania are made only when the behaviour is driven by an irresistible, tension-relieving impulse and is not accounted for by profit, ideology, concealment, anger, need or another psychiatric condition. The moment an ordinary motive is found, the impulse-control diagnosis falls away.

11.2 Pyromania: the core criteria

Four positive features must be present together. The behavioural core is **deliberate and purposeful fire setting** on more than one occasion, so a single episode never suffices. Around it sit three affective features that make it a disorder: the tension or affective arousal that precedes the act; a genuine **fascination with, interest in, curiosity about or attraction to fire** and its contexts, uses and paraphernalia; and the pleasure, gratification or relief experienced when setting fires or witnessing their aftermath. The person is often a familiar face at fires, drawn to alarms, equipment and the fire service. The internal state carries the weight: the fire is set not to destroy a target but because the setting and its spectacle satisfy something in the person.

11.3 Pyromania: the exclusions and the arson differential

The exclusions do most of the diagnostic work, because instrumental fire setting is common and pyromania is not. The fire setting must not be done for a rational or comprehensible external reason: not for monetary gain, not in the service of a sociopolitical ideology, not to conceal a crime, not to express anger or vengeance, not to improve one's living circumstances, not in response to a delusion or a hallucination, and not as a product of impaired judgement such as in a major neurocognitive disorder or intellectual disability. Beyond these motive-based exclusions, the fire setting must not be better explained by a broader disorder in which it is one symptom among many.

- excluded if set for monetary gain, ideology, concealment of crime, anger or vengeance, or to improve living circumstances;
- excluded if set in response to a delusion or hallucination, or as a result of impaired judgement;
- excluded if better explained by **conduct disorder, a manic episode, or antisocial personality disorder**.

These exclusions are precisely what separate the diagnosis from ordinary or **instrumental arson**, and from fire setting that is a symptom of conduct disorder, developed in its own right elsewhere in this chapter. The great majority who set fires do so for a reason, which is itself the disqualifier. Antisocial personality disorder, where fire setting can be one facet of a broader exploitative

pattern, belongs to the Personality disorders notes; fire setting only during a manic episode is a symptom of that episode.

TRAP **Equating fire setting with pyromania.** The classic examination error, and the classic clinical one, is to call any repeated fire setter a pyromaniac. Candidates forget that the diagnosis is one of exclusion: it requires that every ordinary motive be absent and that the behaviour not be part of conduct disorder, mania or antisocial personality. Most fire setting is instrumental or symptomatic, and true pyromania is a small residue left once those are stripped away.

11.4 How rare pyromania really is

The number examiners want is a warning against over-diagnosis. Pyromania as a primary diagnosis appears to be very rare, and its true population prevalence is simply not known. The most quoted figure comes from a forensic study of repeated fire setters, among whom only **3.3%** met full criteria for the disorder; even in the population most enriched for fire setting, the overwhelming majority did not qualify. It is essential to separate this from fire-setting behaviour in general, whose lifetime prevalence is of the order of **1.0% to 1.1%** and which is only one component of the disorder and never sufficient for it. In children and adolescents, fire setting is usually associated with conduct disorder, attention-deficit/hyperactivity disorder or an adjustment disorder rather than pyromania, so the paediatric diagnosis should be made with great caution.

11.5 Kleptomania: the core criteria

The defining feature is theft of the useless. Kleptomania is a recurrent failure to resist impulses to steal objects that are **not needed for personal use or for their monetary value**. As with pyromania, an increasing sense of tension precedes the theft, and pleasure, gratification or relief accompanies the act of committing it. The tell is in what is taken and what becomes of it: the objects are typically of little value to the person, who could usually have afforded them, and who then gives them away, discards, hoards or even returns them. The stealing is not driven by want but by the impulse, and the goods are almost incidental. Between episodes the person is frequently distressed and ashamed, the ego-dystonic quality that marks the impulse-control disorders and separates them from a settled criminal disposition.

11.6 Kleptomania: exclusions and the ordinary-theft differential

The single most important discrimination is from ordinary theft. The stealing must not be committed to express anger or vengeance and must not occur in response to a delusion or a hallucination, and it must not be better explained by conduct disorder, a manic episode or antisocial personality disorder. The pivotal contrast is with **ordinary theft**, which is deliberate and motivated by the usefulness or monetary worth of the object. In kleptomania the object is not wanted; in ordinary theft it is the whole point. Shoplifting driven by need, resale value or peer pressure is not kleptomania; nor is the calculated stealing of the antisocial patient, which belongs to the Personality disorders notes, nor the disinhibited acquisitiveness of a manic episode, which remits with the mood state.

- not committed to express anger or vengeance, and not a response to a delusion or hallucination;
- not better explained by conduct disorder, a manic episode, or antisocial personality disorder;
- distinguished from ordinary theft, where the object is taken for its use or its worth.

PITFALL

The commonest clinical failure is to stop at the label of thief and never look for what travels with kleptomania. These patients carry a heavy burden of comorbid mood, anxiety, eating and substance-use disorders, and present through shame and legal jeopardy rather than a request for help. Treating the person as merely delinquent, without screening for the treatable picture behind the stealing, misses both the diagnosis and its companions.

11.7 Kleptomania: epidemiology and the sex ratio

Rare in the population, over-represented among the caught. Kleptomania is very rare in the general population, with a prevalence of about **0.3% to 0.6%**. It shows a female preponderance, with women outnumbering men by a ratio of about **3 to 1**, one of the few impulse-control disorders that is commoner in women. Its visibility is greatest at the point of apprehension: it is found in roughly 4% to 24% of people arrested for shoplifting, a wide band that reflects how variably it is sought. That combination, genuine rarity in the community but a real minority presence among shoplifters, is the examinable shape of its epidemiology, mirroring pyromania, where the disorder is a small fraction even of fire setters.

AXIS	PYROMANIA	KLEPTOMANIA
The behaviour	Deliberate, purposeful fire setting on more than one occasion	Recurrent stealing of objects not needed for use or value
The internal cycle	Tension before, fascination with fire, relief after	Tension before, pleasure or relief at the theft
Its criminal mimic	Instrumental or ideological arson	Ordinary, need-driven or profit-driven theft
Sex distribution	Not established by an owned figure here	Female preponderance, about 3 to 1
Frequency	Very rare even among fire setters (3.3%)	Very rare in the population (0.3% to 0.6%)

The two disorders side by side; they share an identical internal architecture and differ chiefly in the behaviour through which the impulse is discharged and the criminal act each must be told apart from.

11.8 Assessment and management principles

The task is to find the impulse behind the offence and to treat what surrounds it. Because both present far more often through their consequences than a request for help, assessment begins with a deliberate search for the tension-relief cycle and a careful exclusion of every ordinary motive, followed by a systematic screen for the accompanying comorbidities. Management is not established here by an owned protocol, and specific agents and doses should be confirmed against a pharmacology source; in broad terms it combines psychological work

aimed at the impulse, such as cognitive and behavioural strategies that interrupt the tension-to-act sequence, with treatment of coexisting mood, anxiety and substance-use disorders, which frequently improves the impulse-control behaviour as a byproduct. The evidence base for both is thin, a consequence of their rarity, and treatment is individualised rather than protocolised.

GOOD TO REMEMBER

When a patient reaches you through a charge for fire setting or shoplifting, ask three things first: what they felt in the minutes before the act, what they felt during it, and what they did with what they took or what target they chose. A build-up of tension, relief in the act, and a fire set at nothing in particular or an object neither needed nor kept is what turns a medicolegal referral into a treatable diagnosis. The motive question is the whole assessment in miniature.

IN INDIA

Most Indian services diagnose under ICD, where both conditions sit among the impulse-control disorders and their broader framework is developed in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. In practice these patients almost never present asking for treatment; they arrive through the criminal-justice route, after a fire or a shoplifting charge, often for a medicolegal opinion on responsibility. Holding the diagnosis in mind in that forensic setting, and enquiring carefully into motive and the tension-relief cycle, is what distinguishes a treatable disorder from ordinary crime.

Carry this into the exam: pyromania and kleptomania are diagnoses of a tension-relieving impulse, made only when fire setting or stealing is purposeless and every ordinary motive - gain, anger, ideology, need - and every competing disorder is excluded.

3.3%	0.3-0.6%	3 to 1
OF REPEATED FIRE SETTERS MET FULL PYROMANIA CRITERIA	KLEPTOMANIA PREVALENCE, GENERAL POPULATION	FEMALE-TO-MALE RATIO IN KLEPTOMANIA

Childhood anxiety, OCD and trauma disorders

12 · Separation anxiety disorder (criteria, course, management)

Almost every toddler protests when a parent leaves the room, so the whole clinical art of this diagnosis is knowing where an ordinary developmental protest ends and a disorder begins. **Separation anxiety disorder** is the syndrome in which fear or anxiety about being parted from those to whom the child is attached becomes developmentally inappropriate, excessive and persistent, and starts to cost the child a normal life. It is the most frequent anxiety disorder of early childhood, and it earns its marks not from the symptom list, which candidates memorise easily, but from the two discriminations that sit on either side of it: telling the disorder apart from the heightened separation anxiety that is a normal, even reassuring, feature of early

development, and recognising that the same disorder no longer stops at the nursery door but runs on into adolescence and adult life.

This topic owns the diagnostic architecture of the disorder: the essential feature and its symptom threshold, the eight anxieties the criteria enumerate, the duration and impairment rules, the way the disorder is graded against the child's developmental stage, its epidemiology across the lifespan, its heritable and temperamental roots, the split between the two major classifications over how long symptoms must last, and the screening instrument most used to detect it. School refusal, the childhood anxiety family, selective mutism and the somatisation of distress each belong to their own accounts elsewhere in this chapter and are named here only where the reasoning demands, never reopened.

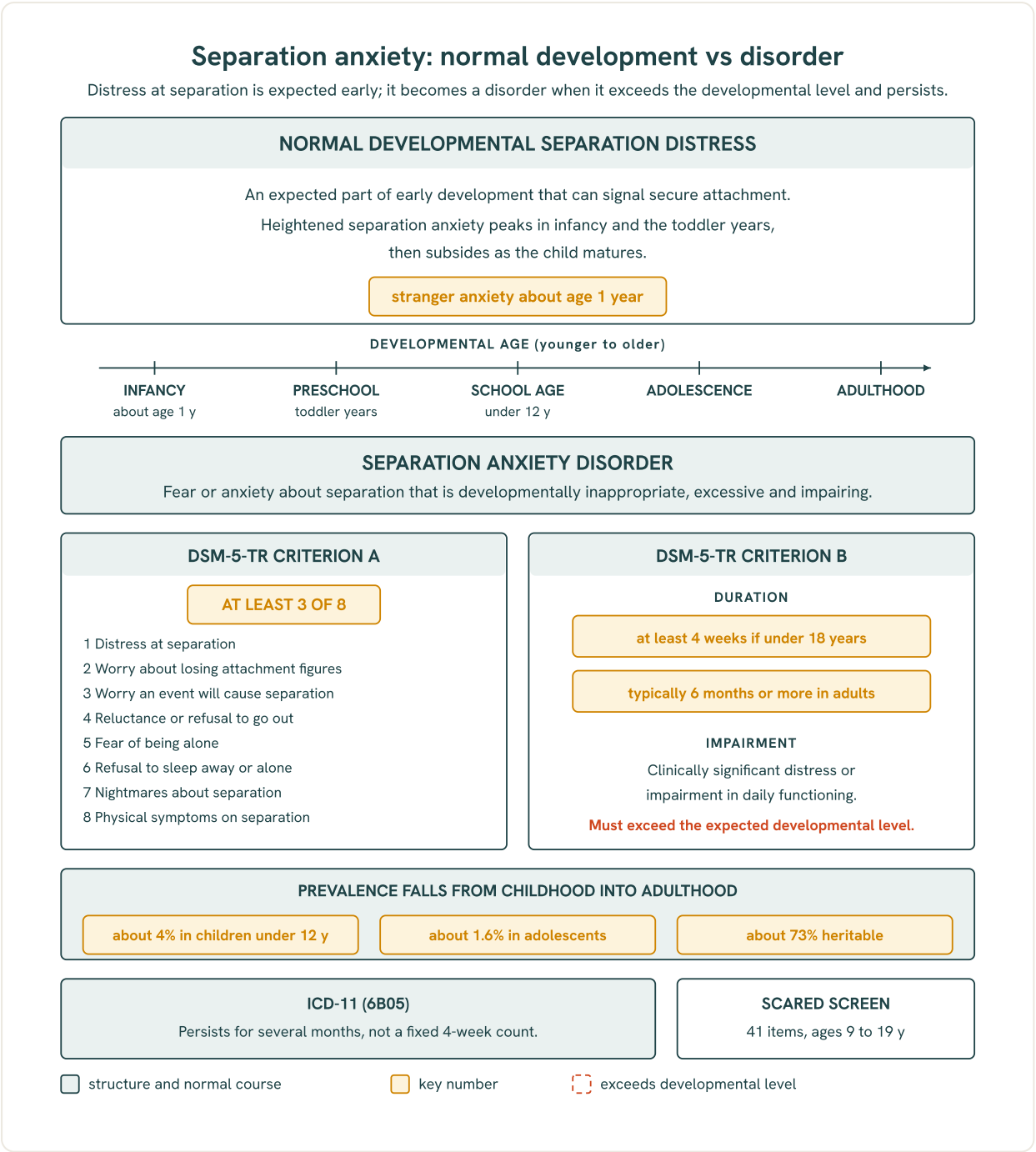


Fig 23.8. Separation anxiety across development: normal early distress that signals secure attachment versus separation anxiety disorder, defined by the DSM-5-TR count and duration thresholds, with prevalence falling from childhood into adulthood.

12.1 Normal separation anxiety and where the disorder begins

Separation fear is a normal developmental achievement before it is ever a disorder. A period of heightened distress on separation is an expected part of early development, appearing as **stranger anxiety** around the age of one year and reflecting the very cognitive and attachment gains that let an infant hold a caregiver in mind and register their absence. Far from being pathological, its presence can signal a securely formed attachment. The disorder is diagnosed only when the anxiety exceeds what is developmentally expected for the child's age and, in addition, meets the duration and impairment thresholds the criteria set. That two-part test - out of proportion to development, and functionally costly - is the safeguard that keeps a normal

phase from being pathologised, and it is the SAD-specific corner of the broader question of when childhood behaviour is within normal limits, which is drawn together as a cross-cutting map in its own right elsewhere in this chapter.

PITFALL

The commonest clinical error runs in both directions around the same axis. A clinging, tearful preschooler at the school gate is over-called a disorder when the distress is age-appropriate and transient; conversely, a genuinely impaired older child is dismissed as merely "attached" or "shy" because separation fear is assumed to belong only to the very young. The corrective is to read the anxiety against the child's developmental level and against how much it actually derails schooling, sleep and family life, rather than against the parents' worry alone.

12.2 Criterion A: the count and the eight anxieties

The diagnosis requires a developmentally excessive fear of separation evidenced by a defined minimum of symptoms. The operational rule is that the fear or anxiety concerning separation from attachment figures be shown by **at least three** of eight enumerated symptoms. Those eight are not a random inventory: they cluster around a small number of themes. Three are forms of anticipatory **worry** - distress at actual or anticipated separation, persistent worry about losing attachment figures or that harm will befall them, and worry that some untoward event will bring about separation. Two are forms of refusal and avoidance - reluctance or refusal to leave home, go to school or go out because of the separation it entails, and reluctance or refusal to be alone. Two concern sleep - reluctance or refusal to sleep away from home or without being near an attachment figure, and repeated nightmares whose theme is separation. The eighth is bodily: repeated **physical complaints** such as headaches, stomachaches, nausea or vomiting when separation occurs or is anticipated. The last of these is easy to miss because it presents to the paediatrician, not the psychiatrist; the recurrent abdominal pain and headache through which anxiety and low mood so often speak in children is developed as a presentation in its own right elsewhere in this chapter, but here the point is narrower - somatic complaints tied specifically to separation are one of the eight diagnostic symptoms and must be counted as such.

THEME	DIAGNOSTIC SYMPTOMS TIED TO SEPARATION
Anticipatory worry	Distress at separation; worry about losing or harm coming to attachment figures; worry about an event causing separation
Refusal and avoidance	Reluctance or refusal to go out or to school; fear of being alone
Sleep	Reluctance or refusal to sleep away or without an attachment figure near; nightmares of separation
Bodily	Physical symptoms - headaches, stomachaches, nausea, vomiting - on separation

The eight Criterion A symptoms grouped by theme; the child needs at least three of the eight, and the bodily symptoms are the ones most likely to be routed to a physician before a psychiatrist.

MNEMONIC

Worry, Won't-go, Won't-sleep, and the body

The eight anxieties fall into four holdable groups: three **worries** about separation and harm, two forms of **won't-go** refusal to leave or be alone, two forms of **won't-sleep** away from an attachment figure, and one **bodily** cluster of physical complaints. Carrying the themes rather than a flat list of eight is what makes the count usable at the bedside.

12.3 Criteria B to D: duration, distress and the differential

Duration is where the criteria are age-graded, and it is the most examinable single rule. The fear, anxiety or avoidance must be persistent, lasting **at least four weeks** in children and adolescents younger than eighteen years, and typically six months or more in adults. The four-week floor is deliberately short because childhood distress on separation can be so intense that a longer wait would leave an impaired child untreated; the longer adult convention reflects that a disorder first surfacing or persisting in adulthood must be distinguished from transient reactions to real life stress. Beyond duration, the disturbance must cause clinically significant distress or impairment in social, academic or other important areas, and it must not be better explained by another disorder. Several conditions mimic it and must be excluded:

- the refusal to leave home in autism, driven by a need for sameness rather than separation fear;
- the diffuse worry of generalised anxiety, which is not anchored to separation;
- a fear driven by delusion in a psychotic illness;
- the reluctance to go out in agoraphobia, where the fear is of the situation, not the parting.

The diagnosis, in other words, is not made from the separation fear alone but from separation fear that persists, disables and is not a better fit somewhere else.

The core rule to carry into the exam: at least three of eight symptoms of developmentally excessive separation fear, persisting at least four weeks in the under-eighteens, with clinically significant impairment.

RULE **The threshold is developmental inappropriateness plus duration plus impairment, never the fear alone.** Separation anxiety is normal; separation anxiety that exceeds the child's developmental level, lasts beyond the criterion period and demonstrably impairs schooling, sleep or family function is the disorder. Each of the three conditions is load-bearing, and dropping any one of them is how normal childhood distress is over-diagnosed.

12.4 A lifespan disorder: epidemiology and course

The single most important shift in how this disorder is now understood is that it does not end with childhood. It is the most common anxiety disorder in children younger than twelve years, with a six-to-twelve-month prevalence of **approximately four per cent**. Prevalence then falls steadily from childhood through adolescence and into adult life; by adolescence the twelve-month figure is down to **about 1.6 per cent**. The older teaching that the condition is purely a

disorder of childhood has been abandoned: it can persist across development, can wax and wane with periods of stress and transition, and can have its first onset in adulthood, which is why the criteria carry a separate adult duration convention at all. The typical childhood course is one of exacerbation around developmental hurdles - starting school, a family move, a parental illness or a bereavement - and the disorder is a recognised antecedent of later anxiety and depressive disorders, so it is worth treating rather than waiting out.

12.5 Etiology: temperament, attachment and a strongly heritable core

The disorder sits at the meeting point of a fearful temperament, the quality of attachment and a substantial genetic loading. Behavioural inhibition - the temperamental tendency to withdraw from, and to react with distress to, the unfamiliar - is the constitutional soil, and an anxious or overprotective parenting style, parental anxiety disorder, and stressful life events involving loss or threat of separation are the environmental accelerants. Onto that clinical picture the genetics map cleanly: in a community sample of six-year-old twins, heritability was **estimated at 73 per cent**, with higher rates in girls. That is a high figure for a childhood emotional disorder: it signals that the condition is not simply a learned response to an anxious home but carries a strong constitutional contribution, and it fits the observed familial aggregation, in which children of parents with anxiety and panic disorders are over-represented. Etiology here is genuinely biopsychosocial: temperament sets the threshold, attachment and parenting shape the expression, and life events involving separation pull the trigger.

12.6 The classification split: a fixed count against a clinical judgement of duration

The two major manuals agree on the disorder and disagree on how much numerical precision to demand. One system fixes an explicit symptom count and an explicit minimum duration, the four-week floor for the under-eighteens being the clearest example. The other, the ICD-11 clinical descriptions and diagnostic requirements, deliberately avoids that kind of artificial precision, asking instead that symptoms persist for at least several months rather than for a fixed four-week count, and leaving the clinician to judge severity and persistence against the whole picture. In ICD-11 the disorder is coded **6B05**, and, unlike its predecessor, it is no longer confined to childhood. Where the individual is under six years of age, the ICD-11 mortality and morbidity statistics map the condition to the older category of separation anxiety disorder of childhood, F93.0. The disagreement is not cosmetic: a count-and-clock system prizes reliability and reproducibility between raters, while the descriptive system prizes clinical validity and warns against reifying an arbitrary threshold, and knowing which philosophy a given case file follows tells the reader why one record insists on four weeks and another speaks of several months.

AXIS	FIXED-CRITERIA SYSTEM	ICD-11 CLINICAL DESCRIPTIONS
Symptom count	An explicit three-of-eight threshold	No fixed count; a clinical judgement
Duration	At least four weeks in the under-eighteens	At least several months, not a fixed count
Code	Separation anxiety disorder	6B05 (mapping to F93.0 under age six)

The same disorder handled by two classificatory philosophies; the load-bearing contrast is the fixed four-week count against a clinical judgement that symptoms have lasted several months.

IN INDIA

Because Indian services classify under ICD, the operative label in case files, referrals and official reports is the ICD entity, and the clinician is not obliged to satisfy an exact four-week count so much as to judge that the separation anxiety has persisted, is developmentally excessive and is impairing. A trainee schooled on the count-and-clock manual should not treat a record that speaks of several months rather than four weeks as incomplete: it is following the classification actually in force here, and the two systems are describing the same child.

12.7 Assessment and the screening instruments

Assessment is multi-informant, developmentally framed and helped, but never replaced, by a rating scale. The history is taken from the child and, separately, from the parents, because a young child's account and a caregiver's account of the same anxiety frequently diverge, and school information anchors the impairment. Among structured aids the most widely used is the **Screen for Child Anxiety Related Emotional Disorders**, the SCARED, developed by Birmaher and colleagues. It is a 41-item questionnaire yielding five factors - panic or somatic symptoms, generalised anxiety, separation anxiety, social phobia and school phobia - so that it screens not only for this disorder but across the childhood anxiety family, whose members are developed in their own account elsewhere in this chapter. It has matched child and parent report versions, is intended for roughly ages nine to nineteen, is freely available, and takes under fifteen minutes to complete; a short five-item version also exists for rapid screening. Its value is precisely that it captures the separation factor within a broader anxiety screen, which suits a disorder that rarely travels alone.

GOOD TO REMEMBER

Use the SCARED as a screen and a way of structuring the interview across the anxiety factors, not as a diagnostic verdict. A scale flags where to look; the diagnosis still turns on the developmental-inappropriateness, duration and impairment judgement made from the history, and a high separation-anxiety factor score in a child whose function is intact is a prompt to reassess, not a diagnosis.

12.8 Management and the borders that matter

Treatment is psychological first, pharmacological second, and always delivered partly through the parents. The best-supported first-line intervention is a structured, exposure-based **cognitive behavioural therapy**, in which the child is helped to face graded separations while the accompanying catastrophic cognitions about harm and loss are tested and revised, and in which caregivers are coached out of the accommodation - the reassurance, the sleeping-in, the staying at home - that inadvertently maintains the fear. For more severe or refractory presentations, pharmacotherapy is added, with the serotonergic antidepressants the usual choice; the specific agents, doses and the youth-specific safety monitoring that any antidepressant in a young person requires are the province of the paediatric mood and antidepressant accounts and are not

reproduced here. The clinically decisive point is that medication supplements, and does not replace, the psychological and family work, because the disorder is sustained by a learned cycle of avoidance and accommodation that only exposure can unwind.

The management borders are as examinable as the treatment itself. Separation anxiety disorder is the single commonest engine of **school refusal**, but the two are not the same thing - school refusal has other causes, from social anxiety and depression to bullying and learning difficulty, and its assessment and management are developed in their own right elsewhere in this chapter. It must also be held apart from selective mutism, another childhood anxiety condition treated separately here, and from the frank school truancy of the conduct-disordered child, who stays away from school without anxiety and usually without the parents' knowledge, rather than clinging to a caregiver in fear. The anxious child who cannot get to school and the defiant child who will not are two different clinical problems, and the exam reliably rewards the distinction.

TRAP **School refusal is not a diagnosis, and separation anxiety disorder is not its only cause.** Candidates conflate the two, answering "separation anxiety disorder" whenever a child will not attend school. The anxious, home-clinging non-attender whose parents know exactly where he is points to this disorder; the child who leaves for school and never arrives, without anxiety and without the parents' knowledge, is truant, which belongs to the disruptive rather than the anxious spectrum.

3 of 8	4%	73%
SYMPTOMS, WITH A FOUR-WEEK MINIMUM DURATION	PREVALENCE IN CHILDREN UNDER 12	HERITABILITY IN A TWIN SAMPLE

13 · School refusal and school phobia (assessment and management)

The single most useful thing this topic teaches is that "not going to school" is a behaviour, not a diagnosis. A child who is repeatedly absent has told you almost nothing about why, and the entire clinical and examination value of the subject lies in taking that one observable fact apart into the very different problems that produce it. Absenteeism sits at the meeting point of psychiatry, paediatrics, the family and the school, and the marks are here because the assessor wants to see a candidate move from the presenting behaviour to the mechanism underneath it, and then to a management plan that follows from the mechanism rather than from the behaviour.

The vocabulary is where candidates lose easy marks, because the words are used loosely in ordinary speech and precisely in the exam. This topic owns the terminology of school non-attendance, the assessment that separates its varieties, and the management that flows from that separation. The individual anxiety disorders that so often lie beneath school refusal are each developed in their own right elsewhere in this chapter and are named here only at the point where the differential needs them, because the skill being tested is not the re-recitation of separation anxiety criteria but the ability to recognise which disorder is driving the child to the door and turning them back.

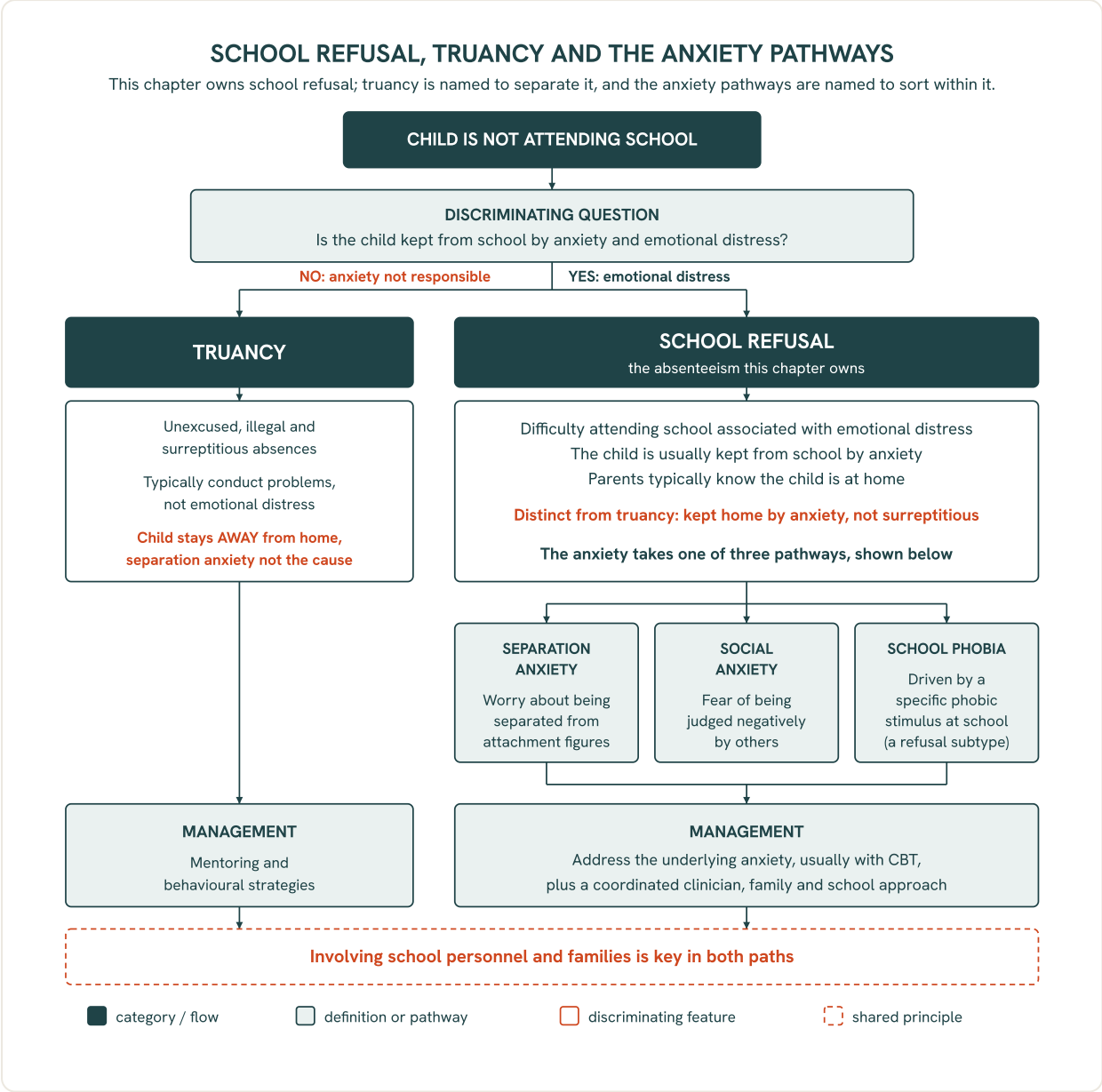


Fig 23.9. School refusal against truancy and the three anxiety pathways: one discriminating question splits anxiety-driven school refusal from surreptitious truancy, school refusal then sorts into separation anxiety, social anxiety or school phobia, and the management path diverges - mentoring and behavioural strategies for truancy, addressing the underlying anxiety for school refusal - while school and family involvement stays key in both.

13.1 Three problems wearing one presentation

The same empty desk has at least three quite different explanations. The first is **truancy**, which is absence that is unexcused, concealed and often against the rules, in a child who characteristically does not want to be in school and shows no particular emotional distress about staying away. Truancy is typically embedded in a wider pattern of conduct problems rather than in anxiety, and the child usually hides the absence from parents. The second is **school refusal**, difficulty attending school that is bound up with emotional distress: the child is not skipping school for something more enjoyable but is being kept from it by fear, dread or misery, and the distress is real and visible. The third and narrowest is **school phobia**, which is difficulty attending because of a specific phobia, a phobic stimulus located in or on the way to the school itself. These three are not points on a single spectrum of severity; they are different problems with different engines, and the first task of assessment is to say which one is in front of you.

RULE **Distress is the pivot on which the differential turns.** The absence that is comfortable, concealed and tied to rule-breaking points to truancy and its conduct-problem context; the absence that is distressing, known to the parents and driven by fear points to school refusal and an anxiety disorder beneath it. Every later decision, assessment and management alike, follows from which side of that line the child falls.

13.2 Why "school refusal" is a symptom and not a disorder

School refusal is a final common pathway, and the diagnosis lives one layer down. No classificatory system carries "school refusal" as a disorder, and that is the conceptual heart of the topic. It is a presenting behaviour produced by any of several anxiety disorders, and the clinical job is to identify which one. Three pathways account for most cases. In the youngest children the driver is most often separation anxiety, the fear not of school itself but of being apart from an attachment figure, so that the child would be equally reluctant to go anywhere that meant separation; separation anxiety disorder is developed in its own section of this chapter and is only named here. In older children and adolescents the driver is frequently social anxiety, where the avoidance is generated by **fear of being judged negatively by others** rather than by worry about leaving home, so that the feared object is the classroom, the corridor and the crowd rather than the parent's absence. The third pathway is the true school phobia, in which a discrete phobic stimulus connected with the school compels avoidance. Social anxiety disorder and specific phobia are themselves taught elsewhere in this chapter; what belongs here is the recognition that each can surface as the identical behaviour of a child at the school gate who cannot go in.

PATHWAY BENEATH THE REFUSAL	WHAT THE CHILD IS ACTUALLY AFRAID OF	WHERE THE FEAR POINTS
Separation anxiety	Being apart from an attachment figure; harm befalling them or the self while apart	Away from the parent, not at the school as such; reluctance to sleep away or be left anywhere
Social anxiety	Being negatively evaluated by others rather than separation from home	The peer group, being watched, performing, the corridor and the classroom
Specific phobia (school phobia)	A discrete phobic stimulus located in or en route to the school	The particular object or situation, avoidance narrowing onto it

The three anxiety routes to the same behaviour. Naming the route is the diagnosis; the behaviour of non-attendance is shared and by itself distinguishes none of them.

13.3 Truancy versus school refusal: the fork that decides everything

The two look alike from the school register and diverge on almost every clinical axis. Distinguishing conduct-driven truancy from anxiety-driven school refusal is the examinable core of assessment, and it is done from a handful of discriminating features rather than from the fact of absence. The most reliable single discriminator concerns where the child is while not in school. In truancy, and in the school avoidance that goes with conduct disorder, the child or adolescent typically stays away from the home rather than returning to it, and separation anxiety is not what is keeping them out; the absence is spent elsewhere, often with a peer group, and is concealed

from the parents. In school refusal the opposite holds: the child is usually at home, and the parents usually know it, because the child cannot bear to leave and the distress is directed at going, not at being caught. Conduct disorder, within which truancy characteristically sits, is developed in its own section of this chapter and is named here only as the context that truancy points towards.

FEATURE	TRUANCY (CONDUCT-LINKED)	SCHOOL REFUSAL (ANXIETY-LINKED)
Emotional state about attending	Little distress; the child prefers not to attend	Marked distress, fear or dread centred on going
Where the child is during absence	Away from home, often with peers	At home, close to the attachment figure
Parental knowledge	Usually concealed from parents	Usually known to the parents
Associated pattern	Broader conduct problems and rule-breaking	An underlying anxiety disorder
Schoolwork attitude	Often accompanied by loss of interest in schoolwork	Often a conscientious child who wants to keep up

The clinical axes that separate the two great categories of absence. No single row is infallible, but the pattern across them is what the assessor is testing.

TRAP **Treating "school phobia" as a synonym for all school refusal.** The older literature used "school phobia" loosely for any anxious non-attendance, and candidates inherit the habit. In precise use it is the narrow subtype in which a specific phobia drives the avoidance; most school refusal is not a true phobia of the school at all but separation or social anxiety wearing the school as its stage. Answering that a young, separation-anxious child has "school phobia" misnames the mechanism and, worse, points management in the wrong direction.

13.4 Assessment: reading the pattern, not just the absence

The history is built to expose the mechanism, and its shape is characteristic. A useful assessment establishes the onset and its triggers, the daily pattern, the somatic accompaniments and the family response. Onset is often tied to a transition or a discrete stressor: starting a new school, moving up a stage, returning after an illness or a holiday, a bereavement, bullying, or a humiliation in class. The daily pattern is a strong clue, with distress and physical symptoms mounting on school mornings, on Sunday evenings and at the start of term, and easing markedly at weekends, in the holidays and once the child is allowed to stay home, a Monday-to-Friday rhythm that anchors the problem to school rather than to a generalised illness. A meticulous account of what the child does during the day, and of whether the parents know where they are, does much of the work of separating refusal from truancy on its own.

The somatic presentation deserves particular emphasis because it is how many of these children first reach a doctor. Recurrent abdominal pain, headache, nausea and non-specific malaise, appearing on school mornings and resolving when attendance is not required, are the common currency of anxious school refusal, and the child is frequently worked up for a physical illness before the pattern is recognised. This somatisation of distress is itself developed elsewhere in this

chapter, and the point to carry here is only that a negative physical work-up in a child whose symptoms keep the timetable of the school week should redirect the assessment towards anxiety rather than prolong the search for organic disease. Corroborating history from the school, and from several informants, is essential, and the fuller apparatus of child psychiatric assessment and the involvement of services is developed in the Child psychiatry: assessment, treatment, services and protection notes.

- onset and its trigger: a school transition, an illness, a bereavement, bullying or a classroom humiliation;
- the weekly rhythm: worse on school mornings and at term's start, better at weekends and in holidays;
- somatic symptoms timed to attendance and clearing when the child stays home;
- where the child spends the day and whether the parents know, the discriminator from truancy;
- the family's response, and whether accommodation has quietly become the pattern.

GOOD TO REMEMBER

Ask the parents to narrate a single school morning in detail, from waking to the point at which the child either leaves or does not. That one concrete account usually reveals the mechanism faster than any checklist: the pleading and the physical complaints, the exact moment the distress peaks, whether it is the parting or the classroom that is dreaded, and how the household has learned to respond. The pattern of who does what at that moment is also the raw material for the behavioural plan that follows.

13.5 Management follows the mechanism

The management splits exactly where the diagnosis split, and the two paths are not interchangeable. Because truancy and school refusal have different engines, they call for different interventions. Truancy is best met with mentoring and behavioural strategies, whereas school refusal is best managed by treating the anxiety underneath it, usually with cognitive behavioural therapy and a coordinated approach across clinician, family and school. In both, the involvement of school personnel and the family is decisive, because the behaviour is enacted in the space between home and school and cannot be shifted from the clinic alone. For the anxious school refuser the therapeutic centre of gravity is a **graded return to school**: a planned, stepwise re-exposure that begins below the point of overwhelming anxiety and advances as tolerance builds, so that avoidance is not reinforced by escape and the child relearns that the feared situation can be survived. The longer a child is out, the harder re-entry becomes, which is why an early, structured, sympathetic push to return generally serves the child better than an open-ended wait for the anxiety to pass on its own.

The work is necessarily done by a triad. The clinician formulates the driving disorder and delivers or directs the anxiety treatment; the family is coached to hold the plan at the difficult morning moment and to stop inadvertently rewarding non-attendance; and the school arranges the graded

timetable, a point of safety within the building and the flexibility that a stepwise return requires. Where the underlying disorder is severe, medication for the anxiety disorder may be added to therapy, but the specific agents and their dosing belong with the pharmacology of the individual anxiety disorders and are not settled by this topic. Comorbid conditions and the family's own difficulties are addressed in parallel, since an unaddressed parental anxiety or an unrecognised depression in the child will quietly undo the best-laid return plan.

PITFALL

The recurring clinical failure is to misread the category and then apply the wrong lever. An anxious school refuser handled as a truant, with sanctions, threats and a purely disciplinary response, is punished for a fear they cannot simply choose to drop, and the anxiety and the avoidance both deepen. The mirror error, treating a conduct-driven truant with gentle, anxiety-focused accommodation, rewards the very absence it means to cure. Naming the mechanism first is not an academic nicety; it is what decides whether the intervention helps or harms.

IN INDIA

Several features of Indian practice sharpen this topic. These children very often present first to a paediatrician or a general practitioner with recurrent abdominal pain or headache, and the psychiatric mechanism is reached only after a physical work-up, so the index of suspicion has to be carried by the first doctor. The intense weight placed on academic performance, tuition and board examinations can both precipitate anxious refusal and make families read it as laziness or defiance, which pushes them towards a punitive response and away from the graded, collaborative plan that actually works. Coordinated clinician, family and school management, straightforward to prescribe, is harder to deliver where schools have little counselling provision and mental-health literacy is low, so a large part of the clinician's task is patient liaison and psychoeducation with parents and teachers who may never have heard the behaviour named as anxiety.

13.6 Course, complications and why the marks are here

Left unaddressed, the problem compounds. School refusal tends to entrench: avoidance is self-reinforcing, each absence makes the next one harder, and prolonged absence brings secondary losses that outlast the original fear. Academic slippage, social withdrawal from a peer group the child no longer sees daily, erosion of confidence and, in the family, a slow accommodation that hardens around the absence are the characteristic complications, and the anxious school refuser who never returns is at risk of carrying anxiety disorders and impaired functioning into adult life. The prognostic levers are the ones assessment and management have already identified: the earlier the recognition and the shorter the time out of school, the better the outlook, while long-standing refusal in an older child with a well-established pattern is harder to reverse. This is why the topic rewards a candidate who can move cleanly from the shared behaviour to the specific mechanism and then to a mechanism-matched plan, because that sequence is exactly what changes the trajectory.

Not-going-to-school is a behaviour, not a diagnosis: separate the concealed, distress-free absence of truancy from the distressing, parent-known absence of school refusal, find the anxiety disorder driving the refusal, and manage each along its own path, with a graded return to school at the centre of the anxious child's plan.

Distress	At home	Graded
THE PIVOT: ITS PRESENCE MARKS REFUSAL, ITS ABSENCE MARKS TRUANCY	WHERE THE REFUSER WAITS AND THE PARENTS KNOW; THE TRUANT IS AWAY	THE STEPWISE RETURN TO SCHOOL AT THE CENTRE OF ANXIOUS-REFUSAL MANAGEMENT

14 · Anxiety disorders in children (generalized, social, specific phobia)

Anxiety is the commonest form of childhood psychopathology, and the marks here reward the candidate who can hold three disorders apart while remembering what binds them. This topic covers the childhood presentations of generalized anxiety disorder, social anxiety disorder and specific phobia. These are ordinary human states of worry and fear that have crossed a threshold: they have become excessive for the child's developmental stage, persistent rather than passing, and costly to functioning at home, at school or among peers. The examinable difficulty is not the existence of these disorders, which every candidate can name, but the child-specific modifications the classifications make to their adult criteria, the developmental content of the fear, and the border between a disorder and the fears and worries that are normal in growing up.

What is owned here is the child-specific criteria and epidemiology of these three disorders. The wider family of childhood anxiety - separation anxiety disorder, selective mutism, and the anxiety that drives school refusal - is developed in its own right elsewhere in this chapter, as are paediatric obsessive-compulsive disorder and childhood post-traumatic stress disorder; here they are named as relatives, not reopened. The general adult anxiety disorders, their neurobiology and their pharmacology are not the business of this chapter. The accompanying figure places these disorders as one anxiety family so that their overlap and comorbidity can be seen at a glance.

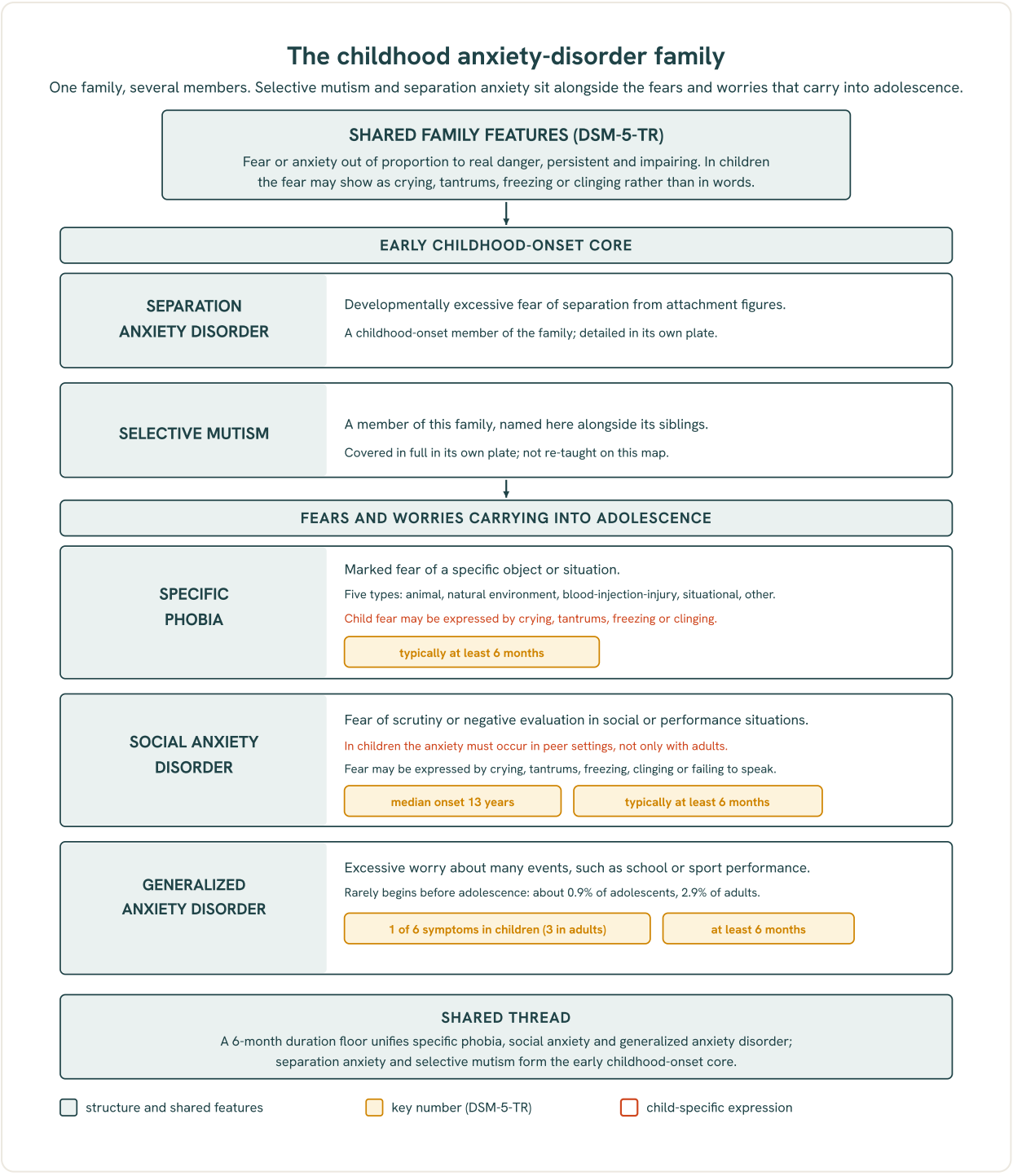


Fig 23.10. The childhood anxiety-disorder family: an early childhood-onset core (separation anxiety disorder and selective mutism, the latter named only) alongside specific phobia, social anxiety disorder and generalized anxiety disorder, unified by a fear out of proportion to danger, a typical 6-month duration floor and a child-specific expression through crying, tantrums, freezing or clinging.

14.1 The shared architecture: what makes childhood fear a disorder

Across all three disorders the diagnosis turns on the same three qualities: the fear is excessive, it is persistent, and it impairs. A young child who is frightened of the dark, shy with strangers or worried before an examination is not thereby ill; fear and worry are adaptive and developmentally expected. The classifications convert these normal states into disorders only when the response is out of proportion to any real danger, endures well beyond the situation that provoked it, and interferes with the child's life. This is why each of the three carries a minimum

duration and an impairment requirement, and why the clinician's first move is always to weigh the presentation against what is normal for that age. The core pathology is not different from the adult form; what differs is how a developing child expresses fear and how the thresholds are set for someone who cannot yet regulate or articulate distress. Holding this shared frame in mind is what stops a candidate from memorising three unconnected symptom lists and losing the reasoning that actually earns the marks.

RULE **Childhood anxiety disorders differ from their adult forms in expression and threshold, not in essence.** The fear is the same fear; the child shows it through behaviour rather than words, and the criteria are modified to fit a developing person. Diagnose when the fear or worry is excessive for the child's stage, persistent rather than transient, and genuinely impairing, and not before.

14.2 Generalized anxiety disorder: the worry and its childhood content

The essential feature is excessive, hard-to-control worry, and in children its content is characteristically about performance. **Generalized anxiety disorder** requires excessive anxiety and worry, occurring more days than not, about a number of events or activities, sustained for at least **6 months**. What marks the childhood form is the subject matter of the worry. Affected children **worry excessively about their own competence and the quality of their performance** at school or in sport, and they do so even when their performance is not being evaluated by anyone. Such children are often overly conforming, perfectionistic and unsure of themselves, and they tend to seek repeated reassurance about their work and their worth. This reassurance-seeking is diagnostically useful and clinically double-edged: it briefly relieves the child but draws the parent into providing it again and again, maintaining the very worry it is meant to settle. The worry is not tied to a single feared object, which separates it from specific phobia, nor to separation or to social scrutiny specifically.

14.3 The associated-symptom criterion and the child modification

The single most tested point in this disorder is that children need far fewer associated somatic-cognitive symptoms than adults. The worry must be accompanied by physical and cognitive symptoms drawn from a fixed set of six. In adults, at least three of the six must be present; in children, however, only **one** of the six is required. This is a deliberate developmental concession: a worried child may not yet report or recognise the full cluster of arousal symptoms an adult can describe, so the bar is set lower to avoid missing genuine cases. The **six associated symptoms** are the familiar mix of arousal and its consequences.

- restlessness or feeling keyed up or on edge;
- being easily fatigued;
- difficulty concentrating or the mind going blank;
- irritability;
- muscle tension;
- sleep disturbance.

MNEMONIC

Restless, Run-down, Distracted, Irritable, Tense, Sleepless

The six associated symptoms in order: **R**estless (restlessness or feeling keyed up), **R**un-down (easily fatigued), **D**istracted (difficulty concentrating or mind going blank), **I**rritable, **T**ense (muscle tension) and **S**leepless (sleep disturbance). In a child, remember that any single one of these, alongside the worry, satisfies the criterion.

14.4 Generalized anxiety disorder: epidemiology and course

The disorder is uncommon before adolescence, and that fact carries clinical weight. Twelve-month prevalence among adolescents is around **0.9%**, and the disorder rarely occurs before adolescence, with rates rising as the child moves through the teenage years toward the higher figures seen in adulthood. The developmental point behind the numbers is that the sustained, future-oriented, self-evaluative worry that defines this disorder depends on cognitive capacities - anticipating, comparing oneself against a standard, projecting consequences forward - that mature through late childhood and adolescence. A genuinely generalised, chronic worry in a very young child is therefore unusual and should prompt a careful look for another explanation: a more circumscribed anxiety disorder such as separation anxiety, a response to an ongoing stressor, or worry anchored to a specific feared situation. The disorder tends to be chronic and to fluctuate, and it is a frequent forerunner of, and companion to, depressive disorders as the young person grows.

14.5 Social anxiety disorder: the fear and its child-specific expression

Two child-specific rules define this disorder in the young: the fear must reach peers, and it may be shown as behaviour rather than spoken as fear. **Social anxiety disorder** is a marked fear of social situations in which the child is exposed to possible scrutiny by others, driven by a fear of acting in a way, or showing anxiety symptoms, that will be negatively evaluated. The first modification is a safeguard against overdiagnosis: in children the anxiety must occur in settings with peers and not only during interactions with adults. Many children are reticent with unfamiliar grown-ups while being entirely comfortable among other children, and that pattern is not this disorder; genuine social anxiety disorder shows itself with age-mates, in the playground and the classroom, not merely in the consulting room. The second modification concerns how the fear surfaces. A young child rarely says that they fear negative evaluation; instead the fear may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations. The clinician must read these behaviours as the child's language of fear rather than as defiance or as a separate problem.

GOOD TO REMEMBER

A child who freezes, clings or falls silent when peers are present is telling you about fear, not staging a protest. Because the same child may speak freely at home, the diagnosis is easily missed if the assessment relies only on the parents' account of a "shy" or "stubborn" child; ask specifically about behaviour in the presence of other children, and gather a report from school before the shyness is dismissed.

14.6 Social anxiety disorder: duration, onset and trajectory

The duration requirement is what separates the disorder from the ordinary and often intense social fears of childhood. The fear, anxiety or avoidance must be persistent, typically lasting 6 months or more. This floor matters more in the young than in adults precisely because transient social fears - a phase of clinginess, a spell of reluctance to perform, a wariness after a change of school - are so common in children and so often self-limiting. The persistence requirement forces the clinician to wait past the passing phase before affixing a diagnosis. In its course, social anxiety disorder has a characteristically early onset: the median age at which it begins is about **13** years, and it frequently emerges out of a childhood history of **behavioural inhibition** or marked shyness, the temperamental tendency to withdraw from the unfamiliar that can be observed from the earliest years. That developmental continuity, from an inhibited temperament in the toddler to a diagnosable disorder in the adolescent, is a favourite theme of examiners and a real target for early intervention.

14.7 Specific phobia: the phenomenon, the childhood expression and the five types

A specific phobia is fear out of proportion to a circumscribed object or situation, and in children it too speaks through behaviour. **Specific phobia** is a marked, disproportionate fear or anxiety about a specific object or situation, which is actively avoided or endured with intense distress, and which is out of keeping with any actual danger. As in social anxiety, the young child's fear may be expressed by crying, tantrums, freezing or clinging rather than described. The phobias are grouped by the nature of the feared stimulus into **five** specifier types.

SPECIFIER TYPE	TYPICAL FEARED STIMULUS
Animal	Dogs, insects, snakes
Natural environment	Heights, storms, water
Blood-injection-injury type	Needles, injections, the sight of blood
Situational	Enclosed spaces, aeroplanes, the dark
Other	Choking, vomiting, costumed figures

The five phobic-stimulus specifiers by which specific phobia is coded. The blood-injection-injury type is set apart by its distinctive physiology.

One type behaves unlike the rest. The blood-injection-injury type is associated with a vasovagal fainting response: rather than the sustained sympathetic arousal of the other phobias, exposure provokes an initial rise and then a sharp fall in heart rate and blood pressure, and the person faints. This is why the child who passes out at the sight of a needle or blood belongs in a

physiological category of their own, and why the applied relaxation used for other phobias is combined here with applied tension to counter the drop in blood pressure.

14.8 Specific phobia: duration and the border with normal childhood fear

Because circumscribed fears are near-universal in childhood, the persistence requirement is the safeguard that keeps a normal fear from being called a disorder. Fear of the dark, of animals, of strangers and of imaginary creatures follows a well-described developmental sequence, each fear appearing and then fading as the child matures; these are part of normal development, not pathology. What converts such a fear into a specific phobia is that it is persistent, typically lasting 6 months or more, disproportionate to real danger, and productive of real impairment or avoidance. The threshold is therefore not the presence of the fear but its persistence and its cost. The normative sequence of childhood fears belongs to the Normal child development and milestones notes; the diagnostic line drawn here is simply that a fear which has outlasted its developmental window, and which is now distorting the child's life, has become a disorder. This is the specific threshold this topic owns; the broader map of normal-versus-disordered childhood behaviour is drawn elsewhere in this chapter.

> **PITFALL**
>
> The error runs both ways. On one side, an anxious parent and clinician pathologise the developmentally ordinary fear of the dark or of dogs in a preschooler, ignoring that the fear is age-appropriate and will pass; on the other, a genuinely impairing, persistent phobia in an older child is waved away as "a phase" long after the phase should have ended. The corrective in both directions is the same: measure the fear against the developmental norm and against the twin tests of persistence and impairment, not against the family's level of alarm.

14.9 Assessment, comorbidity and management

Find one childhood anxiety disorder and look for the others, because they cluster, and treat first with graded exposure. These three disorders are highly comorbid with one another, with the rest of the anxiety family, and with depression as the child grows, so the discovery of one should trigger a screen for the rest. Assessment is necessarily multi-informant: child, parents and school each see a different slice of the anxiety, and the criterion that the fear reach peers, or that worry persist across settings, cannot be judged from one source. Childhood anxiety also hides behind other complaints. It commonly presents through recurrent physical symptoms such as abdominal pain and headaches, and through reluctance or refusal to attend school; those presentations are developed in their own right elsewhere in this chapter and are flagged here only so the anxiety behind them is not missed. The first-line treatment across all three is **exposure**-based cognitive behavioural therapy, in which the child, supported by parents, is helped to approach the feared situation in graded steps while the avoidance that maintains the fear is dismantled; parental accommodation, the well-meaning reassurance and avoidance that families build around an anxious child, is a specific target. Medication is reserved for more severe or refractory presentations and is layered onto the psychological work, never a substitute for it.

IN INDIA

Two realities shape presentation here. First, services classify under ICD, so these disorders appear in case files under their ICD labels rather than the DSM ones, and the clinician reads across the two systems. Second, childhood anxiety is under-detected: it surfaces in paediatric and general clinics as unexplained abdominal pain, headache or school refusal rather than as a complaint of worry, and the intense cultural emphasis on academic performance can both feed the performance-focused worry of generalized anxiety disorder and cause it to be normalised as ordinary diligence. Trained delivery of exposure-based cognitive behavioural therapy remains scarce outside specialist centres, which places a premium on equipping parents and schools to carry the graded-exposure approach.

FEATURE	GENERALIZED ANXIETY	SOCIAL ANXIETY	SPECIFIC PHOBIA
Focus of fear	Diffuse worry about competence and performance	Scrutiny and negative evaluation by others	A single circumscribed object or situation
Child modification	Only one associated symptom required	Must occur in peer settings, not only with adults	Fear shown as crying, tantrums, freezing or clinging
Behavioural expression in the young	Reassurance-seeking, perfectionism, conforming	Crying, freezing, clinging, mutism	Avoidance, distress on exposure
Duration floor	at least 6 months	at least 6 months	at least 6 months

The three disorders on shared axes; the shared six-month persistence floor sits beneath all of them, and each carries its own developmental modification to the adult criteria.

TRAP **Candidates apply the adult criteria to the child and lose the modifications.** The two most frequently missed are that generalized anxiety disorder in a child requires only *one* associated symptom rather than the adult three, and that social anxiety in a child must be present in *peer* settings and not only with adults. Reproducing the adult thresholds verbatim either excludes a genuinely anxious child or counts ordinary adult-directed reticence as a disorder.

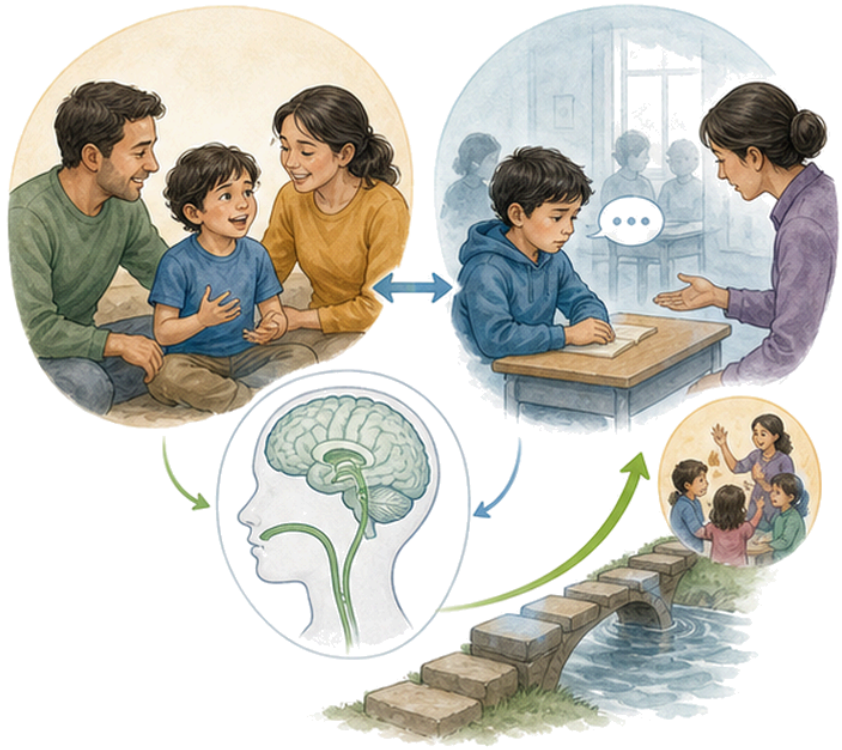
Carry into the exam: all three disorders share a persistence floor of about 6 months plus impairment, and each modifies the adult criteria for the child - generalized anxiety needs only one associated symptom, social anxiety must reach peers, and specific phobia and social anxiety may be shown as crying, freezing or clinging rather than spoken.

6 months SHARED PERSISTENCE FLOOR	**1 of 6** ASSOCIATED SYMPTOMS NEEDED IN A CHILD (GAD)	**0.9%** 12-MONTH PREVALENCE IN ADOLESCENTS (GAD)	**13 yrs** MEDIAN ONSET OF SOCIAL ANXIETY

15 · Selective mutism

The child can speak, and that single fact is the whole diagnosis. **Selective mutism** is the condition of a child who talks fluently and comfortably in the settings where they feel safe, most often at home with immediate family, yet consistently fails to speak in particular social situations

where speech is expected of them, the classroom being the prototype. The speech apparatus is intact, the vocabulary is present, and the child demonstrates both every evening at home; what fails is the ability to produce speech under the specific social pressure of being watched, addressed or expected to answer. This is not shyness that a warm teacher can coax away in a week, nor a refusal that a firm one can command out of the child. It is a persistent, situation-bound silence that the child cannot simply choose to break, and understanding it as an anxiety phenomenon rather than a wilful or a linguistic one is the key to the entire topic.



- Speech is intact
- Speaks in safe settings
- Silent where speech is expected
- Anxiety—not defiance
- Graded participation

Fig 23.11 Selective mutism is persistent, situation-bound failure to speak where speech is expected despite comfortable, fluent speech in safer settings. It is understood as an anxiety phenomenon rather than defiance or absence of language.

The marks here are discriminative. An examiner uses this diagnosis to test whether a candidate can separate an anxiety-driven, situational mutism from the several conditions it superficially resembles: ordinary developmental shyness, the silent settling-in of a child learning a new language of instruction, a primary communication or language disorder, a hearing impairment, and the social muteness that can accompany autism spectrum disorder. This topic owns selective

mutism in full: its defining criterion, its duration and exclusion rules, its standing as an anxiety disorder, its epidemiology, onset and course, and its management. The wider childhood anxiety family of which it is a member is developed in its own right elsewhere in this chapter and named here only where the reasoning needs it.

15.1 The essential feature: a situational, not a global, failure of speech

The diagnosis lives in the contrast between the two settings. The core requirement is a consistent failure to speak in specific social situations in which there is an expectation to speak, present at the same time as normal speech in other situations. It is the coexistence of the two that defines the disorder: a child who is mute everywhere has a different problem, but a child who chatters at home and falls silent at school shows the characteristic split. The failure must be consistent, not the occasional off day, and it must occur where speech is genuinely expected, so that a child who happens to be quiet in a setting that makes no demand on them is not captured. Because the child can and does speak elsewhere, the clinician has direct evidence that the machinery of speech is unimpaired; the deficit is one of performance under a particular kind of social threat, not of competence.

RULE **Speech preserved in one setting, absent in another, is the disorder.** Selective mutism requires demonstrated normal speech in a comfortable setting alongside a consistent failure to speak where speech is expected. If the child is mute in every setting, the diagnosis is not selective mutism, and the assessor should be considering a language disorder, a hearing deficit, autism spectrum disorder or a global mutism instead.

15.2 The duration rule and why the first month of school does not count

The one-month floor exists to exclude normal settling-in. The disturbance must last for **at least one month**, and, importantly, that qualifying month is explicitly not the first month of school. This is not an arbitrary threshold. It is entirely normal for a child to be reticent, subdued or briefly silent in the first weeks of a new class, a new school or a new language environment, and that transient reserve settles on its own as the child habituates. Requiring the mutism to persist beyond that initial settling-in period screens out this benign, self-limiting reticence and reserves the diagnosis for a silence that has proven itself durable. A candidate who forgets the exclusion of that first month will over-diagnose the ordinarily anxious new entrant, which is precisely the error the criterion is written to prevent.

15.3 The exclusion criteria: language, communication and pervasive disorders

The silence must be anxiety, not an artefact of language, speech or a broader disorder. Two exclusions do most of the diagnostic work. First, the failure to speak must not be attributable to a lack of knowledge of, or comfort with, the spoken language the situation demands. A child newly arrived into a school taught in an unfamiliar tongue may pass through a normal **silent period** while they acquire it, and that child does not have the disorder however complete their classroom silence. Second, the mutism must not be better explained by a **communication disorder** such as a childhood-onset fluency disorder, and it must not occur exclusively during the course of autism spectrum disorder or a psychotic disorder. Where the muteness is fully accounted for by one of

those conditions, that condition is the diagnosis. These exclusions are what convert selective mutism from a description of a silent child into a specific, anxiety-based entity.

- not due to a lack of knowledge of, or comfort with, the required spoken language;
- not better explained by a communication disorder such as a fluency disorder;
- not occurring only within autism spectrum disorder or a psychotic disorder;
- separable, clinically, from ordinary shyness and from a hearing impairment.

CONDITION TO DISTINGUISH	WHAT SEPARATES IT FROM SELECTIVE MUTISM
The silent period of a new-language learner	The muteness reflects unfamiliarity with the language of the setting, not anxiety; the language-knowledge exclusion removes it
Communication or fluency disorder	A primary difficulty producing speech itself, present across settings, rather than a setting-bound silence with normal speech elsewhere
Autism spectrum disorder	The muteness sits within a pervasive social-communication deficit and a restricted, repetitive repertoire; selective mutism is not diagnosed if the silence occurs only within autism
Ordinary developmental shyness	Transient, coaxable and not functionally impairing; selective mutism is consistent, durable and disabling

The conditions the situational silence is most often confused with; each is separated by the source of the muteness rather than by its appearance, which is why the exclusion criteria carry the diagnosis.

TRAP **Diagnosing the bilingual child in a silent period.** The classic examination error is to label a recently immigrated or newly enrolled child, silent in a classroom taught in a language they are still acquiring, as having selective mutism. The language-knowledge exclusion exists precisely for this child: until they are comfortable in the language of the setting, their silence is not the disorder, and time and exposure, not treatment, are what they need.

15.4 An anxiety disorder in its own right

The company it keeps settles what kind of disorder it is. Children with selective mutism seen in clinical settings are almost always given an additional anxiety diagnosis, and the one that accompanies it most often is **social anxiety disorder**. That near-constant coincidence is the strongest argument that the mutism is a manifestation of anxiety rather than a communicative or an oppositional problem: the child who cannot speak at school is very often the same child who is intensely frightened of scrutiny and negative evaluation. Both major classifications now place the condition accordingly. It sits among the anxiety disorders in current DSM classification, and ICD-11 lists it as an **anxiety or fear-related disorder** under code **6B06**. This is not a filing detail; it directs treatment, because it tells the clinician to target the anxiety and not to treat the silence as a speech problem or a behaviour to be disciplined.

Carry this into the exam: a child who speaks freely at home but consistently not at school for at least a month, and not explained by language or a communication disorder, is showing an anxiety disorder, almost always alongside social anxiety.

15.5 Epidemiology

A rare disorder, and commoner in the young. Selective mutism is uncommon. Point-prevalence estimates across clinic and school samples fall in the range of **0.03 to 1.9 per cent**, the width of that range reflecting how much the figure depends on the setting sampled and on the age of the children studied. It is more likely to manifest in young children than in adolescents and adults, in keeping with its early onset and its tendency to attenuate with age. The rarity has a practical consequence: because most clinicians see very few cases, the condition is easily missed or misattributed, and the child who is silent at school but never at home is often written off as merely shy long before anyone names the disorder.

15.6 Onset and course

Early to begin, late to be noticed, and it leaves something behind. Onset is usually before **age five**, but the condition frequently goes unrecognised until the child enters school, where the demand to speak in front of others suddenly exposes a silence that at home had looked like nothing more than a quiet temperament. School entry, in other words, does not cause the disorder so much as reveal it. The course is instructive: in many children the mutism itself fades with time, but the underlying social anxiety commonly persists, so that the disorder is better understood as an early, visible expression of an anxiety diathesis than as a self-contained childhood problem that resolves without trace. That residual anxiety is why early, anxiety-directed intervention matters, rather than simply waiting for the child to grow out of the silence.

15.7 Principles of management

Treat the anxiety, lower the pressure, and let speech be shaped, not forced. Because the disorder is anxiety-based, management is built on behavioural and family-and-school interventions that reduce the anxiety around speaking rather than demand speech directly. The mainstay is graded behavioural work: techniques such as stimulus fading, in which a person the child already speaks to slowly brings a new listener into the setting, and shaping, in which any communication is rewarded and successively closer approximations to speech are encouraged, together with graded exposure to the feared speaking situations. Close collaboration with the school is essential, since the classroom is usually where the silence lives and where any gain has to be generalised. Where the disorder is severe or does not respond to behavioural work, a selective serotonin reuptake inhibitor is the pharmacological option most commonly added, on the same anxiety rationale that governs its use across the childhood anxiety disorders; specific agents and dosing lie outside what this topic establishes and should be confirmed against a pharmacology source.

GOOD TO REMEMBER

The single most useful instruction to give the parents and the teacher is to stop asking the child to speak. Direct pressure, coaxing, and rewards made contingent on an immediate spoken answer all raise the very anxiety that produces the silence. Removing the spotlight, accepting non-verbal responses at first, and letting a trusted adult widen the circle gradually does more than any amount of encouragement to talk.

PITFALL

The commonest clinical failure is to read the silence as oppositionality. A child who speaks fluently at home but says nothing to the teacher looks, to an untrained eye, as though they are choosing not to cooperate, and the response, more pressure, discipline or a battle of wills, predictably worsens matters. The child is not refusing; they are unable to speak under that specific anxiety, and treating it as defiance both misses the diagnosis and deepens the problem.

IN INDIA

Two features of Indian practice are worth holding in mind. Most services diagnose under ICD, where the condition now sits among the anxiety or fear-related disorders, which usefully reinforces the anxiety-directed approach. And the multilingual classroom makes the language-knowledge exclusion especially live: a child schooled in English, or in a state language different from the mother tongue spoken at home, may be silent simply because they are still acquiring the language of instruction. Establishing which languages the child speaks freely, and where, is the first step before the diagnosis is even entertained, and it is often what separates a genuine case from a child in a normal silent period.

0.03 to 1.9%	1 month	age 5	6B06
POINT-PREVALENCE RANGE, CLINIC AND SCHOOL SAMPLES	MINIMUM DURATION, BEYOND THE FIRST MONTH OF SCHOOL	ONSET USUALLY BEFORE	ICD-11 ANXIETY OR FEAR-RELATED CODE

16 · Paediatric OCD and PANDAS

Obsessive-compulsive disorder in a child is the same disorder as in an adult, but it wears a developmental disguise. A young child rarely arrives complaining of intrusive thoughts. The family notices the behaviour first: the handwashing that will not stop, the bedtime routine that must be repeated until it feels right, the questions asked again and again for reassurance. Marks accrue here because the examiner wants to know that a candidate can recognise the disorder through that behavioural surface, grade its severity with the standard paediatric instrument, and hold a disciplined, sceptical line on the one piece of this territory that generates more heat than light, the proposed link between streptococcal infection and abrupt-onset childhood OCD. The general adult disorder, its full criteria set and its pharmacology, are developed in the Anxiety, OCD and trauma-related disorders notes; this topic owns the child-specific presentation, the standard rating scale, and the PANDAS and PANS story in full.

The structure to carry into the exam is simple. First, what OCD is and how its two building blocks behave in a child. Then how it is measured and how common it is. Then the post-infectious hypothesis, taught as a named, contested proposal rather than as settled fact, because that scepticism is itself the examinable point.

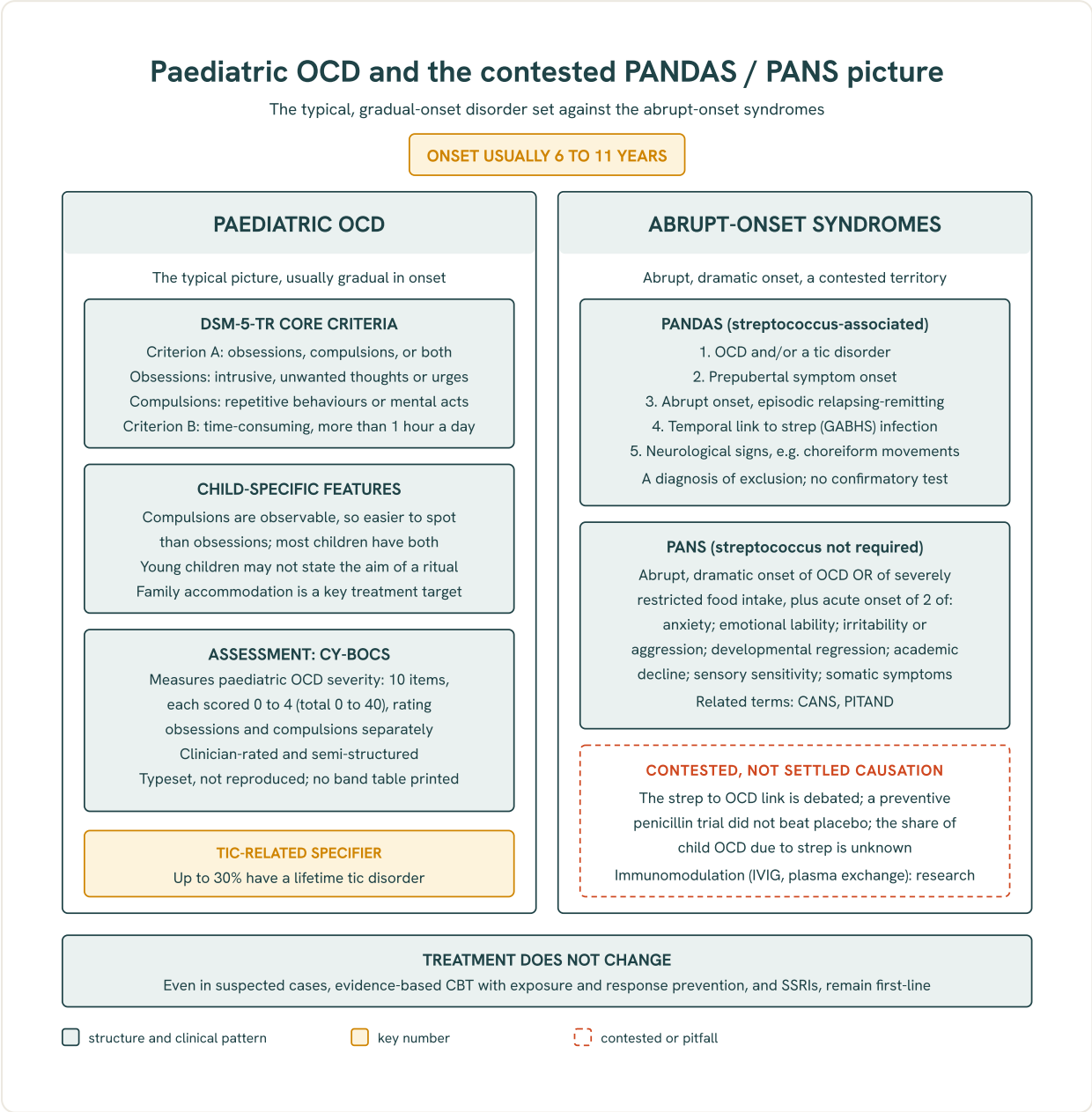


Fig 23.12. Paediatric OCD and the contested PANDAS and PANS abrupt-onset picture: the typical gradual-onset disorder with its DSM-5-TR criteria and its CY-BOCS severity assessment, set against the abrupt-onset syndromes whose streptococcal cause remains contested and whose treatment stays evidence-based CBT with exposure and response prevention, and SSRIs.

16.1 The defining features and how they present in a child

The disorder is built from two elements, and either can stand alone. The core diagnostic requirement is the **presence of obsessions, compulsions, or both**. Obsessions are recurrent, intrusive and unwanted thoughts, urges or images that the person experiences as distressing; compulsions are the repetitive behaviours or mental acts performed in response to an obsession, or according to rigid self-imposed rules, that are meant to reduce that distress or to prevent some feared event. The compulsion is functionally tethered to the obsession even when the child

cannot articulate the link. The second requirement is that these symptoms exact a real cost. They must be time-consuming, taking **more than one hour a day**, or else cause clinically significant distress or impairment of functioning. That threshold is what separates a diagnosable disorder from the ordinary superstitions, rituals and preoccupations of normal childhood, which the reader will find mapped against their pathological counterparts elsewhere in this chapter.

RULE **Obsession drives, compulsion relieves.** The compulsion is not a random tic or habit; it is performed to neutralise the anxiety of an obsession or to satisfy a rigid rule. When you cannot see an obsession, ask what the child fears will happen if the ritual is stopped, and the obsession usually appears.

16.2 Why the child looks different from the textbook adult

In children the compulsion is the visible half of the disorder. Younger children often cannot describe the aims of their compulsions, so the **compulsions**, being observable, are more readily diagnosed than the obsessions that drive them, even though most affected children in fact have both. This inverts the adult stereotype of a patient who can narrate a tormenting thought. A second developmental feature carries genuine clinical weight: **family accommodation**, the involvement of parents or siblings in the child's rituals, providing the reassurance, performing the checks, or reorganising the household around the symptoms. Accommodation feels kind in the moment and is almost universal, but it maintains the disorder by removing every opportunity for the anxiety to fall on its own, and it is therefore an important treatment target, more so in children than in adults.

PITFALL

The commonest management failure is to leave family accommodation untouched. Parents who have spent months answering the same reassurance-seeking question, or supervising a two-hour bedtime ritual to keep the peace, are unwittingly holding the disorder in place. Unless the treatment plan explicitly coaches the family to withdraw accommodation in a graded, agreed way, exposure work with the child alone will keep failing at home.

16.3 Epidemiology, onset and sex

It is neither rare nor a purely adult disease. The most widely accepted six-month prevalence of OCD in the general paediatric population is **0.5 to 1 per cent**. The disorder is strongly developmental in its origins: **up to 80 per cent** of adults with OCD had their onset in childhood or adolescence, so the paediatric presentation is not a minor tributary of the adult disorder but its headwater. Mean age at onset falls between 6 and 11 years, with a bimodal pattern peaking around puberty and again in young adulthood. The prepubertal, early-onset group has a distinctive profile: it shows a male preponderance and a higher rate of family history, whereas the sex ratio tends to even out by adolescence. That early-onset, male-predominant, familial, often tic-associated form is the one to keep in mind when the post-infectious hypothesis is raised.

16.4 The tic-related specifier and OCD-tic comorbidity

Childhood-onset OCD and tics travel together. DSM-5-TR carries a **tic-related specifier**, applied when the individual has a current or past tic disorder, precisely because the overlap is substantial: **up to 30 per cent** of people with OCD have a lifetime tic disorder, an association most common in males with childhood onset. The clinical importance is that tic-related OCD tends to present with a particular symptom flavour, with more just-right, symmetry and touching compulsions than pure contamination-and-washing pictures, and it sits at the crossroads of OCD and Tourette syndrome. The tic disorders themselves, their classification and management, are developed in their own right elsewhere in this chapter; here the specifier matters because it flags the early-onset, familial subtype and because it is the same subtype invoked by the streptococcal hypothesis below.

16.5 Measuring severity: the CY-BOCS

The standard paediatric instrument is worth knowing in structural detail. The **Children's Yale-Brown Obsessive Compulsive Scale** is a ten-item clinician-administered, semi-structured scale, each item anchored on an ordinal scale from 0 to 4. It precedes the rated items with a broad symptom checklist and then rates obsessions and compulsions separately across five dimensions each: the time occupied, the interference with life, the subjective distress, the internal resistance mounted against the symptom, and the degree of control the child retains over it. What it measures is paediatric OCD severity across those two halves, and severity is read off the summed total. No interpretive band table is printed here: the exact cut-offs separating mild from moderate from severe illness could not be confirmed against a primary source, and a wrong cut-off is worse than none, so learn the structure and the dimensions rather than a number line. The instrument is a licensed one, typeset from its published description rather than reproduced as a form. Because it is administered by the clinician rather than self-reported, it sidesteps the very problem that defines paediatric OCD, the child who cannot put the obsession into words, and it is the scale used both to grade severity at intake and to track response over treatment.

> **GOOD TO REMEMBER**
>
> Use the CY-BOCS as a change measure, not a one-off label. A total at intake, repeated at review, converts a vague impression that the child is "a bit better" into a defensible figure that tells you whether exposure therapy and, where used, a serotonergic agent are actually working, and whether family accommodation is falling as it should.

16.6 PANDAS: the proposed post-streptococcal syndrome

PANDAS names a hypothesised subgroup, not an established disease. **PANDAS**, paediatric autoimmune neuropsychiatric disorders associated with streptococcus, denotes OCD-like and tic symptoms proposed to be triggered by group A beta-haemolytic streptococcal infection. The proposed mechanism is **molecular mimicry**: antibodies raised against streptococcal antigens are held to cross-react with, and inflame, the basal ganglia, producing an acute neuropsychiatric picture. The model is deliberately built on Sydenham chorea, the recognised post-streptococcal movement disorder of rheumatic fever, and it was first described by Swedo and colleagues in a

small putative subgroup of children. The concept is attractive because it offers a mechanism and, tantalisingly, a treatable cause; the difficulty, taken up below, is that the evidence has never firmly closed the loop from infection to symptoms.

16.7 The working diagnostic features, and PANS

The clinical description is a checklist of features and a diagnosis of exclusion. The working features proposed for PANDAS are the presence of OCD or a tic disorder; prepubertal onset; an abrupt onset with an episodic, relapsing-remitting course; a temporal association with streptococcal infection; and associated neurological signs such as motoric hyperactivity and choreiform movements. There is no confirmatory test, so the diagnosis rests on this pattern and on excluding other causes.

- OCD or a tic disorder is present;
- onset is prepubertal;
- onset is abrupt and the course is episodic;
- there is a temporal link to streptococcal infection;
- neurological abnormalities, such as choreiform movements, accompany the presentation.

A broader term was later coined to escape the demand for a proven streptococcal cause. **PANS**, paediatric acute-onset neuropsychiatric syndrome, requires an abrupt, dramatic onset either of OCD symptoms or of severely restricted food intake, together with the acute onset of at least two of a wider list, anxiety, emotional lability, irritability or aggression, developmental regression, academic deterioration, sensory sensitivity, or somatic symptoms. The crucial contrast is that PANS, unlike PANDAS, does not require any link with or presumed cause by streptococcal infection; it is defined by the abrupt neuropsychiatric onset alone, and it too has no definitive test.

FEATURE	PANDAS	PANS
Streptococcal link	Required: a temporal association with streptococcal infection	Not required; no presumed streptococcal cause
Core symptom	OCD or a tic disorder	Abrupt OCD, or severely restricted food intake, plus acute onset of at least two further neuropsychiatric symptoms
Onset and course	Prepubertal, abrupt, episodic and relapsing-remitting	Abrupt and dramatic
Confirmatory test	None; diagnosis of exclusion	None; diagnosis of exclusion

PANS is the wider, streptococcus-agnostic term: it keeps the abrupt neuropsychiatric onset of PANDAS but drops the requirement for a streptococcal trigger, which is precisely the requirement that has proved hardest to substantiate.

16.8 The controversy, and why it does not change the treatment

This is the part the examiner is really testing. The causal claim behind PANDAS is **contested and not established**. The association between streptococcal infection and childhood OCD remains debated; efforts to establish a reliable biological marker have been inconclusive; the

proportion of paediatric OCD actually attributable to streptococcus is unknown; and a prophylactic penicillin trial failed to separate from placebo, while several groups could find no dependable temporal association between infection and symptom flares. In the current literature PANDAS is described as one of the most **controversial** conditions in paediatric practice, with epidemiological data still lacking and few randomised studies to anchor any recommendation. The honest position, and the one to write, is that this is a proposed, contested autoimmune mechanism, never settled causation.

The practical consequence is reassuringly clear. Whatever one believes about the trigger, the treatment of a child who presents with OCD or tics does not change: evidence-based cognitive behavioural therapy with exposure and response prevention, together with a serotonergic agent where indicated, remains the mainstay even in suspected post-infectious cases. Immunomodulatory treatments such as intravenous immunoglobulin and plasmapheresis remain experimental and belong to research protocols, not to routine care.

TRAP **Presenting PANDAS as a settled, antibiotic-treatable cause of OCD.** The seductive error is to hear "abrupt-onset OCD after a sore throat" and reach for a streptococcal work-up and antibiotics as if the diagnosis were proven. It is not. Reproduce the contested status, keep the child on exposure-based therapy and, where indicated, a serotonergic agent, and reserve immunomodulation for research settings.

Paediatric OCD is diagnosed through observable compulsions and treated with exposure and response prevention plus an SSRI; PANDAS and PANS are contested, test-free hypotheses that never displace that treatment.

IN INDIA

Two local realities sharpen this topic. First, Indian services classify predominantly under ICD, and the CY-BOCS remains the workhorse severity measure across child psychiatry units. Second, the background rate of streptococcal disease and rheumatic fever is higher here than in the Western data that framed the PANDAS debate, which makes it tempting to over-attribute abrupt childhood OCD to infection. The discipline is the same as everywhere: a positive throat swab or a raised antistreptococcal titre in a child with new OCD proves exposure, not causation, and it must not divert the family from exposure-based therapy and, where indicated, a serotonergic agent.

0.5 to 1%	up to 80%	up to 30%	1 hour/day
SIX-MONTH PAEDIATRIC PREVALENCE	ADULT OCD WITH CHILDHOOD ONSET	LIFETIME TIC DISORDER IN OCD	TIME THRESHOLD, CRITERION B

17 · Post-traumatic stress disorder in children

A child is not a small adult with the same symptoms writ small. Post-traumatic stress disorder after a traumatic event is recognisable in a school-aged child or adolescent along broadly the same lines as in an adult, but in the youngest children it hides. A traumatised two-year-old does not describe a flashback; a traumatised four-year-old does not report emotional

numbing. They repeat the event in their play, wake screaming from dreams whose content no one can trace, lose words they had already learned, and cling to a parent as though the world has become unsafe. Applying the standard adult symptom list to such a child systematically under-diagnoses them, and that under-recognition is the whole reason this topic carries marks.



- Traumatic play
- Non-specific nightmares
- Regression
- Clinging
- Developmentally modified assessment

Fig 23.13 Post-traumatic stress in young children may appear through repetitive traumatic play, frightening dreams without recognisable content, developmental regression and new clinging rather than through an adult verbal account of re-experiencing and numbing.

The general trauma-related disorders, including the adult form of post-traumatic stress disorder, acute stress disorder, adjustment disorders and the underlying neurobiology of the fear circuitry, are developed in the Anxiety, OCD and trauma-related disorders notes; they are named here and not re-taught. What this topic owns is the paediatric problem: how trauma presents developmentally in young children, and the separate, developmentally modified diagnostic set that the current classification provides for them. The examinable core is that a child of a certain age is read against a different rulebook, and knowing which criteria change, and why, is what a candidate must show.

17.1 A separate rulebook for the youngest children

The main criteria are written for anyone older; the very young get their own set. The current classification splits the diagnosis by developmental stage. The principal post-traumatic stress disorder criteria are intended for adults, adolescents and children older than six years, and are read as they would be for an adult. For children who are **six years and younger**, a distinct and developmentally modified **preschool subtype** is applied instead. This is not a mere footnote softening the adult criteria; it is a genuinely separate set, with fewer required symptoms and with several clusters rewritten to match what a preverbal or barely verbal child can actually show. The single most useful thing to carry into the assessment room and the examination hall is the age boundary itself, because it decides which of two different diagnostic templates you are entitled to use.

RULE **Age decides the template.** A child of six years or younger is diagnosed on the preschool subtype, which lowers and re-shapes the symptom requirements to fit developmental expression. Reading such a child against the adult criteria, which demand more symptoms and more verbal reporting, is how a genuinely traumatised toddler is wrongly cleared.

17.2 Criterion A: the exposure, seen through the caregiver

For a young child the caregiver is the centre of the traumatic world. The exposure criterion in the preschool subtype is deliberately narrower and more caregiver-focused than the older-than-six version. A young child qualifies by directly experiencing the event, by witnessing it in person as it happened to others (particularly to primary caregivers), or by learning that the event happened to a parent or other caregiving figure. The logic is developmental: a small child's sense of safety is organised almost entirely around the attachment figure, so a threat to that figure is a threat to the child, whereas the more abstract routes that count for older individuals do not yet have the same force. This differs from the criterion used for anyone older than six, which additionally counts learning of violent or accidental events happening to any close relative or friend, and repeated or extreme exposure to aversive details of trauma. Naming that contrast is often the mark: the young child's exposure is anchored to the people who care for them.

17.3 Criterion B: intrusion expressed as play

Reexperiencing in a young child is enacted, not narrated. The intrusion cluster requires one or more symptoms, but the crucial point is how they show. Intrusive memories in a young child **may appear as repetitive play** that refers, directly or symbolically, to the trauma, and this play need not look distressing to an observer; the child may seem absorbed or even calm while re-enacting a car crash or an assault with toys. Frightening dreams are common, but their content often cannot be tied to the event, so a new pattern of night terrors without an obvious theme still counts. Trauma-specific re-enactment may spill into behaviour and games. Because the child cannot say "I keep seeing it happen", the clinician must infer the intrusion from what the child does, which is why detailed collateral about play, sleep and behaviour is not optional here but is the actual data of the criterion.

17.4 Criterion C: avoidance and negative cognition, merged

Two adult clusters become one, and a single symptom will do. This is the structural heart of the subtype and the point most likely to be tested. In the version for anyone older than six, persistent avoidance and negative alterations in cognitions and mood are two separate clusters, each requiring its own symptoms. In the preschool subtype these are collapsed into a single Criterion C, and only one symptom from the combined list is needed, whether that is avoidance of reminders or a negative change such as social withdrawal, restricted play, or a marked reduction in the expression of positive emotions. The consequence to memorise is arithmetic: the preschool set is built on **three** symptom clusters rather than the four of the older version. The merge exists because a young child cannot reliably report the cognitive content, the persistent distorted blame or the sense of a foreshortened future, that fills out the adult negative-cognition cluster, so the classification asks only for the observable behavioural change.

FEATURE	OLDER THAN SIX YEARS	SIX YEARS AND YOUNGER (PRESCHOOL SUBTYPE)
Exposure (A)	Includes learning of events to any close person, and repeated exposure to aversive details	Direct experience, witnessing in person (especially to caregivers), or learning it happened to a parent or caregiving figure
Intrusion (B)	Reexperiencing, often reportable	One or more; often expressed as play re-enactment, not overt distress
Avoidance and negative cognition	Two separate clusters	Merged into a single Criterion C requiring one symptom
Arousal and reactivity (D)	Full cluster	Two or more symptoms, tantrums count as irritability
Number of symptom clusters	Four	Three
Duration	More than one month	More than one month

The preschool subtype set against the version used for everyone older; the changes all move in one direction, lowering and re-shaping the requirements to fit what a developmentally young child can show.

TRAP **Counting a preschooler against the four-cluster adult set.** Candidates apply the older-than-six structure to a young child, look for two separate avoidance and negative-cognition clusters and the full adult symptom counts, find them absent, and conclude there is no disorder. The preschool child is diagnosed on three clusters with lower thresholds, so the adult arithmetic wrongly excludes a genuine case.

17.5 Criterion D: arousal, and the tantrum as a symptom

Hyperarousal in a young child wears the face of behaviour problems. The **arousal and reactivity** cluster requires two or more symptoms, and here the developmental translation matters as much as the count. Irritable behaviour and angry outbursts may be expressed as extreme temper tantrums, and this is precisely where a traumatised preschooler is misread as merely oppositional or as having a behavioural disorder. Alongside the tantrums the cluster includes hypervigilance, an exaggerated startle response, problems with concentration, and

disturbed sleep. The reason this cluster is a trap in daily practice is that every one of its manifestations, the tantrums, the poor attention, the broken sleep, is nonspecific and common in early childhood, so the arousal cluster is only informative when it is new, when it clusters with the other criteria, and when it dates from an identifiable trauma.

PITFALL

The commonest clinical failure is to stop at the presenting behaviour. A young child brought in for new tantrums, defiance, poor sleep and clinginess is labelled with a behavioural or oppositional problem, medicated or sent for behaviour management, and never asked what happened to them. Because young children do not spontaneously report trauma and may not even have shown fear at the time of the event, the history has to be sought actively from caregivers; without that question, the arousal cluster reads as naughtiness and the diagnosis is missed.

17.6 Duration, delayed expression and the developmental picture

The clock is the same, but the symptoms may take time to declare themselves. The duration requirement does not change with age: symptoms must persist for **more than one month** before the diagnosis is made, which separates the disorder from the expected, self-limiting distress of the first weeks after a frightening event. Where the full criteria are not met until **at least six months** after the event, the delayed-expression specifier applies, a pattern that is clinically real in children whose symptoms crystallise only as development proceeds. The wider developmental picture rounds out the assessment: before the age of six, children more often express reexperiencing through play that refers to the trauma directly or symbolically, may develop new frightening dreams without trauma-specific content, and may show developmental regression such as loss of previously acquired language. Young children may not have shown a fearful reaction at the moment of exposure at all, and their negative alterations tend to be changes in mood rather than the articulated guilt or self-blame of an older patient, simply because the capacity to label and attribute emotion is still forming.

- reexperiencing enacted in repetitive, trauma-referring play rather than described;
- new frightening dreams whose content cannot be tied to the event;
- developmental regression, including loss of language or of toileting skills;
- mood change and withdrawal in place of verbalised negative beliefs.

In a child of six or younger, diagnose on the modified set: three symptom clusters not four, one intrusion symptom, one merged avoidance-or-negative-cognition symptom, two arousal symptoms, persisting for more than one month.

17.7 Assessment, management and the Indian setting

The diagnosis is only useful if it changes what happens next. Assessment leans heavily on caregiver report and on structured observation of the child's play, because the child is not a reliable narrator of internal states. The clinician gathers a clear trauma history, maps the current symptoms onto the developmental criteria, and screens the caregiving environment, since

ongoing threat or a distressed, unavailable caregiver both perpetuates the disorder and limits any treatment. The first-line treatment is a **trauma-focused psychotherapy**, delivered in a developmentally graded and caregiver-inclusive form; the general evidence base and the pharmacological questions for post-traumatic stress disorder belong to the Anxiety, OCD and trauma-related disorders notes and are not restated here. Where the trauma is abuse, neglect or exposure to violence, safeguarding and the statutory child-protection response are inseparable from treatment, and the machinery for that is set out in the Child psychiatry: assessment, treatment, services and protection notes.

GOOD TO REMEMBER

Interview the caregiver as your primary instrument and watch the child's play as your second. Ask specifically about new fears, sleep, tantrums, clinginess, regression and any change dated to a frightening event, because none of these will be offered spontaneously by a young child. A single well-placed question about what happened often converts a vague "behaviour problem" referral into a treatable, developmentally-typed post-traumatic presentation.

IN INDIA

Young children in Indian practice carry a heavy and often unspoken trauma load, from road-traffic and burn injuries, natural disasters, domestic and community violence, and physical or sexual abuse, yet the preschool presentation is routinely read as a phase or a discipline problem and reaches services late, if at all. Most public services classify under ICD rather than DSM, and access to a trained trauma-focused child therapist is scarce outside a few centres, so the practical yield of this topic is recognition: asking the trauma question of a regressed or newly tantrumming young child, and routing genuine cases into whatever child mental-health and protection services exist locally.

6 and younger	3 clusters	over 1 month	6 months
AGE FOR THE PRESCHOOL SUBTYPE	PRESCHOOL SET, NOT FOUR	REQUIRED SYMPTOM DURATION	DELAYED-EXPRESSION SPECIFIER

Childhood mood disorders, disruptive mood dysregulation, early-onset psychosis and paediatric suicidality

18 · Childhood depression (presentation, masked depression, management)

The whole difficulty of the topic is that the illness rarely announces itself the way it does in an adult. **Childhood depression** is the same major depressive syndrome recognised in later life, but its surface presentation is bent by development: a young child cannot always name low mood, is more likely to show it as irritability or bodily complaint, and depends on the adults around to notice that something has changed. This is why the marks cluster where they do. Candidates who can recite the adult symptom list still lose ground on the two questions that actually decide the

diagnosis in a child, which is how the presentation shifts with age, and how a depressive disorder is told apart from the disruptive and behavioural pictures it can hide behind.

This topic owns the developmental presentation of the disorder - the irritable-mood variant, the age-dependent symptom expression, and the older idea of a depression that is masked behind other complaints - together with the assessment instruments used to detect and track it and the shared minimal duties of its management. The general neurobiology of depression, the detailed suicide-risk tools, the paediatric antidepressant-suicidality warning, disruptive mood dysregulation disorder and the somatic presentation of childhood distress are each developed in their own right elsewhere; here they are named where the reasoning demands it, not reopened.



Fig 23.14. Childhood depression, developmental presentation: irritable mood and age-adjusted criteria as the picture shifts toward the adult form with development.

18.1 Why the disorder is missed: development conceals the mood

The core clinical problem is under-recognition, and it is a developmental problem before it is a diagnostic one. Depression in children was for a long time thought not to exist, on the reasoning that an immature personality could not sustain the sense of guilt and hopelessness that defines the adult illness. That view has been abandoned - the disorder is real, impairing and recurrent in the young - but the reason it was ever plausible remains clinically live. A child's capacity to identify and report an internal state is limited, so the depression tends to be inferred

from what the adults around the child observe rather than declared by the child. Pervasive **anhedonia**, a loss of the ordinary pleasure in play, friends and activities, is often the most reliable observable sign, precisely because it does not depend on the child being able to articulate sadness. The practical consequence is that the assessor must actively look for the disorder in a child whose difficulty is showing up as falling grades, withdrawal, somatic complaint or a change in temper, rather than wait for a spontaneous complaint of low mood that a young child may never produce.

18.2 Irritability as the depressed mood

The single most examinable adaptation of the criteria is that irritability can stand in for sadness. The diagnostic rules for a major depressive episode carry an explicit developmental note: **in children and adolescents the depressed-mood criterion can be satisfied by an irritable mood** rather than by a subjectively sad or dejected one. This is not a softening of the threshold but a recognition that the same underlying mood disturbance surfaces differently earlier in life, so that a young person who is persistently cranky, touchy and easily provoked may be depressed even though they never say they are sad. The clinical instruction that follows is a discrimination, not a relabelling: an irritable or cranky mood may develop in place of a sad or dejected one, and it must be differentiated from the ordinary irritability a child shows when frustrated. What converts irritability into a depressive sign is its pervasiveness and persistence, its company with anhedonia, sleep and appetite change and a drop in functioning, and its independence from a specific frustrating trigger. The irritability of the depressed child is a background weather, not a reaction to being told no.

RULE **In a child, an irritable mood can meet the depressed-mood criterion in place of sadness.** The examiner is testing whether the candidate knows that a persistently irritable young person can be experiencing a major depressive episode, and can separate that sustained, pervasive irritability from the situational crossness of a frustrated child. Miss the developmental note and the whole diagnosis is missed with it.

18.3 The age-graded shift in symptoms

The same disorder wears different clothes at different ages. Beyond the mood itself, the neurovegetative criteria are read differently in a growing child. Where an adult is expected to lose weight, the criteria direct that in a child one should instead consider a failure to make the expected weight gain: a still-growing child who is depressed may not lose weight but may fall off their expected growth trajectory, so the clinician reads the growth chart rather than the scale reading alone. More broadly, the presenting complaint tends to track development. Younger children more often present with somatic distress, clinginess, irritability and a flattening of play; adolescents move closer to the adult picture of low mood, hopelessness, guilt and articulated suicidal thinking, but with a heavier loading of irritability, interpersonal sensitivity and behavioural change than an adult would show. The recurrent bodily complaints - the aching stomach, the headache with no organic cause - are a genuine and frequent vehicle for depressive and anxious distress in the young, but that somatic presentation is developed in its own right elsewhere in this chapter and is only named here as one of the forms the disorder can take.

FEATURE	YOUNGER CHILD	ADOLESCENT
Predominant mood surface	Irritability, crankiness	Low mood and irritability, closer to the adult picture
Appetite and weight criterion	Failure to make expected weight gain	Weight loss or gain, as in adults
How distress is voiced	Somatic complaints, clinginess, loss of play	Hopelessness, guilt, articulated suicidal thoughts
Chief route to detection	Adult observation of change	Self-report becomes more available

The developmental presentation set out age against age; the load-bearing points are that irritability can be the mood and that a failure to gain expected weight can replace weight loss in the still-growing child.

Carry two developmental substitutions into the exam: in children and adolescents the depressed-mood criterion can be met by irritable mood, and the appetite criterion by a failure to make expected weight gain.

18.4 Masked depression: the concept and its careful reading

Masked depression is the older name for a depression whose mood is hidden behind a non-mood complaint. The term **masked depression** was coined for presentations in which the depressive affect is not the presenting feature at all, and the disorder instead shows itself through what were called **depressive equivalents**: recurrent somatic complaints, school refusal, a fall in academic performance, aggression, or in older children substance use and antisocial behaviour. In a child, for the developmental reasons already given, the depression is more often masked than in an adult, and the idea earns its keep as a reminder to hold depression in mind when the complaint on the referral letter is behavioural or physical. It should nonetheless be read critically. The concept is imprecise and historically over-extended, and the safer modern position is not that any behavioural disturbance is a hidden depression, but that a depressive disorder must be actively excluded when a child presents with an unexplained change in conduct, function or bodily state. The mask is a prompt to look underneath, not a licence to diagnose depression behind every difficult behaviour.

PITFALL

Diagnosing a child from the child's self-report alone. Depressed children, especially younger ones, under-report their own symptoms and may deny sadness outright, while a parent or teacher sees the irritability, withdrawal and functional decline plainly. A single-informant assessment built on the child's account can therefore return a falsely reassuring picture; the diagnosis in this age group is a multi-informant one, and the account of the adults who see the child across settings is not optional.

18.5 Detecting and tracking it: the rating scales

Because the disorder is inferred rather than declared, a structured instrument earns its place. Rating scales do not make the diagnosis, which remains clinical, but they standardise detection, quantify severity and let the clinician track change over treatment. The best known in

this age group is the **Children's Depression Inventory**, a **27-item** self-report scale built as a downward extension of the adult Beck inventory for younger respondents. The original version resolved into five subscales - dysphoric mood, acting out, loss of personal and social interest, self-deprecation and vegetative symptoms - though the total score is what is generally used, and it is brief enough to complete in a single short sitting. Its structure tells you what a good paediatric depression scale must do: sample mood, the behavioural surface, anhedonia, self-worth and the neurovegetative signs together, because any one of these alone can be the way the disorder shows.

The current second edition is designed as a **multi-informant** instrument, pairing the child's self-report with parent and teacher forms, which is exactly the correction the single-informant pitfall demands. It remains modelled on the Beck Depression Inventory, is a widely used self-report measure that includes an item on suicidality and is sensitive to treatment effects, so it doubles as an outcome measure across a course of care; its limitation is that results are mixed for distinguishing depression from other disorders, so it screens and monitors but does not adjudicate the diagnosis. It is applicable across the school-age and adolescent years, in the region of 7 to 17 years depending on the source consulted, and being a proprietary instrument it must be purchased for use.

> **GOOD TO REMEMBER**
>
> Choose the scale for the job. A self-report inventory with a suicidality item and known sensitivity to change is well suited to tracking a known case across treatment and to prompting a suicide conversation, but a scale that does not reliably separate depression from other disorders cannot be used to confirm the diagnosis. Score it, act on the suicidality item at once, and re-score it to judge response - but let the clinical formulation, not the number, make the diagnosis.

18.6 Management: severity decides the first move

Management is stepped to severity, and the first line for a mild presentation is deliberately not a drug. The organising principle is that treatment intensity should match illness severity, and the sharpest examinable edge is at the mild end. For **mild depression the first-line approach is supportive care or a psychological intervention, and an antidepressant should not be prescribed**. The reasoning is twofold: mild childhood depression has a substantial rate of spontaneous improvement and response to non-drug support, so a period of active watchful support with a psychological therapy captures many recoveries without exposing a child to medication; and the risk-benefit balance of antidepressants in the young is only favourable once the illness is severe enough to warrant it. As the picture moves to moderate or severe, a structured psychological therapy is offered either alone or in combination with an antidepressant. Involving the family and the school is not an optional extra but part of the treatment itself, because the child's environment carries much of the maintenance and much of the recovery.

- mild depression: supportive care and a psychological therapy first-line, with medication actively withheld;
- moderate to severe depression: a psychological therapy alone or combined with an antidepressant;

- family and school engaged throughout as part of the intervention, not as an afterthought;
- severity, suicide risk and comorbidity reviewed at the outset and again as treatment proceeds.

18.7 Pharmacotherapy: which drug, what dose, what evidence

When an antidepressant is indicated, the choice, the dose and the evidence behind it are all examinable. The first-line agent is **fluoxetine**, and the reason it holds that place is specific rather than generic: it is the one antidepressant for which the trial evidence shows benefits outweighing risks in this age group, and it is approved for use from **age 8**, with escitalopram approved from age 12 as the other option. Dosing is cautious and stepwise: start at 10 mg daily, increase after one week to 20 mg daily, with a usual range of 20 to 60 mg daily, the lower end being the minimum therapeutic dose and the higher end reserved for the older or higher-weight child or where an early response is a priority. The general pharmacology of the antidepressants belongs to the Mood disorders: pharmacotherapy notes and is not reopened here; what is childhood-specific is that fluoxetine is chosen first on evidence, and that the youth-specific antidepressant-suicidality question and its monitoring schedule are developed in their own right elsewhere in this chapter.

The evidence that anchors the choice is worth knowing as a figure. The Treatment of Adolescents with Depression Study, which compared fluoxetine, cognitive behavioural therapy, their combination and placebo in adolescents with major depression, found over its acute phase a response of **61 percent** to fluoxetine against 35 percent to placebo, a number needed to treat of 4. That separation is the quantitative backbone of the recommendation, and the trial is also the source most often cited for the combined-treatment finding that adding a psychological therapy to medication does best of all, though the combination figures are not reproduced here.

> **IN INDIA**
>
> Fluoxetine is inexpensive, off-patent and among the most widely available antidepressants in the country, which makes the evidence-based first choice also the pragmatic one in a resource-limited service. The greater Indian constraint is not the drug but access to the psychological therapies that should precede and accompany it: specialist child mental health services are concentrated in a few centres, so much childhood depression is first seen in general adult psychiatry, paediatrics or primary care. The stepped principle still holds - a mild presentation is managed with support and psychological input, not a prescription - but its delivery leans heavily on family work and the school, and on task-shared counselling under the national mental health programme, where a full child psychiatry team is out of reach.

18.8 The safety floor every case carries

Whatever the severity, childhood depression management carries a minimum safety duty. Depression is the commonest diagnosis behind youth suicide, so every assessment of a depressed child carries a baseline screen for suicidality and early, close monitoring, and when an antidepressant is started the risk of harm must be carefully monitored in the early weeks. This is the shared minimal duty owned by the management of the disorder itself. It deliberately stops short of the detailed content that sits elsewhere: the full risk-assessment and safety-planning

tools are developed in their own right elsewhere in this chapter, as is the paediatric antidepressant-suicidality warning with its absolute-risk figures and its structured early-monitoring schedule. The point to hold here is the floor, not the detail - that a suicide screen and early monitoring are not add-ons to be remembered for severe cases but the baseline of every depressed child's care, and that starting a drug raises rather than removes the monitoring obligation.

18.9 Course, comorbidity and the differential that catches candidates

Getting the diagnosis right means getting the boundaries right. Childhood depression is recurrent, carries forward into adult mood disorder in a substantial proportion, and rarely travels alone: anxiety disorders, the disruptive behaviour disorders and attention problems are frequent companions, and comorbidity both worsens the outlook and complicates treatment. The general neurobiology and life-course of mood disorder belong to the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes; what is examinable here is the local differential. The chronic, non-episodic irritability that in a child can look like depression is also the territory of a separate chronic-irritability diagnosis, disruptive mood dysregulation disorder, which is developed in its own right elsewhere in this chapter and must be distinguished from a discrete depressive episode with an irritable mood. The behavioural surface of a masked depression can equally be read as a purely disruptive disorder. The discipline in every case is the same: establish whether a genuine, pervasive and persistent change in mood and functioning underlies the presenting behaviour, because that change is what separates a mood disorder from the conduct and irritability syndromes it can imitate.

TRAP **Reading an irritable, declining child as "just behavioural" and stopping there.** The classic error is to take the irritability, the falling grades or the acting-out at face value as an oppositional or conduct problem and never screen for the depression underneath. The developmental note that irritability can be the depressed mood exists precisely to stop this: a persistent, pervasive irritability with anhedonia and functional decline is a reason to assess for a depressive disorder, not a reason to close the file on a behavioural label.

10 mg	20-60 mg	61% vs 35%	4
FLUOXETINE STARTING DOSE, DAILY	USUAL DAILY RANGE	TADS RESPONSE, FLUOXETINE VS PLACEBO	NUMBER NEEDED TO TREAT

19 · Somatic symptom, conversion and pain disorders in children

A child in distress often has no words for it, so the distress finds a body to speak through. The recurring tummy ache before school, the morning headache that lifts by lunchtime, the exhaustion no blood test explains: these are among the commonest ways emotional trouble reaches a paediatrician, and they are examinable because a candidate must do two quite different things well. The first is to recognise ordinary somatisation, the healthy child whose anxiety or low mood is being felt in the gut rather than named as a feeling. The second is to recognise the two formal disorders that sit beyond it, somatic symptom disorder and conversion disorder, and to grade and reason about them without falling into the traps that have been deliberately built into the modern criteria. The general adult forms of these conditions, their full nosology and their

treatment, are developed in the Somatic-symptom, sexual, impulse-control disorders and suicide notes; this topic owns the child-specific presentation and teaches the two disorders in their own right.

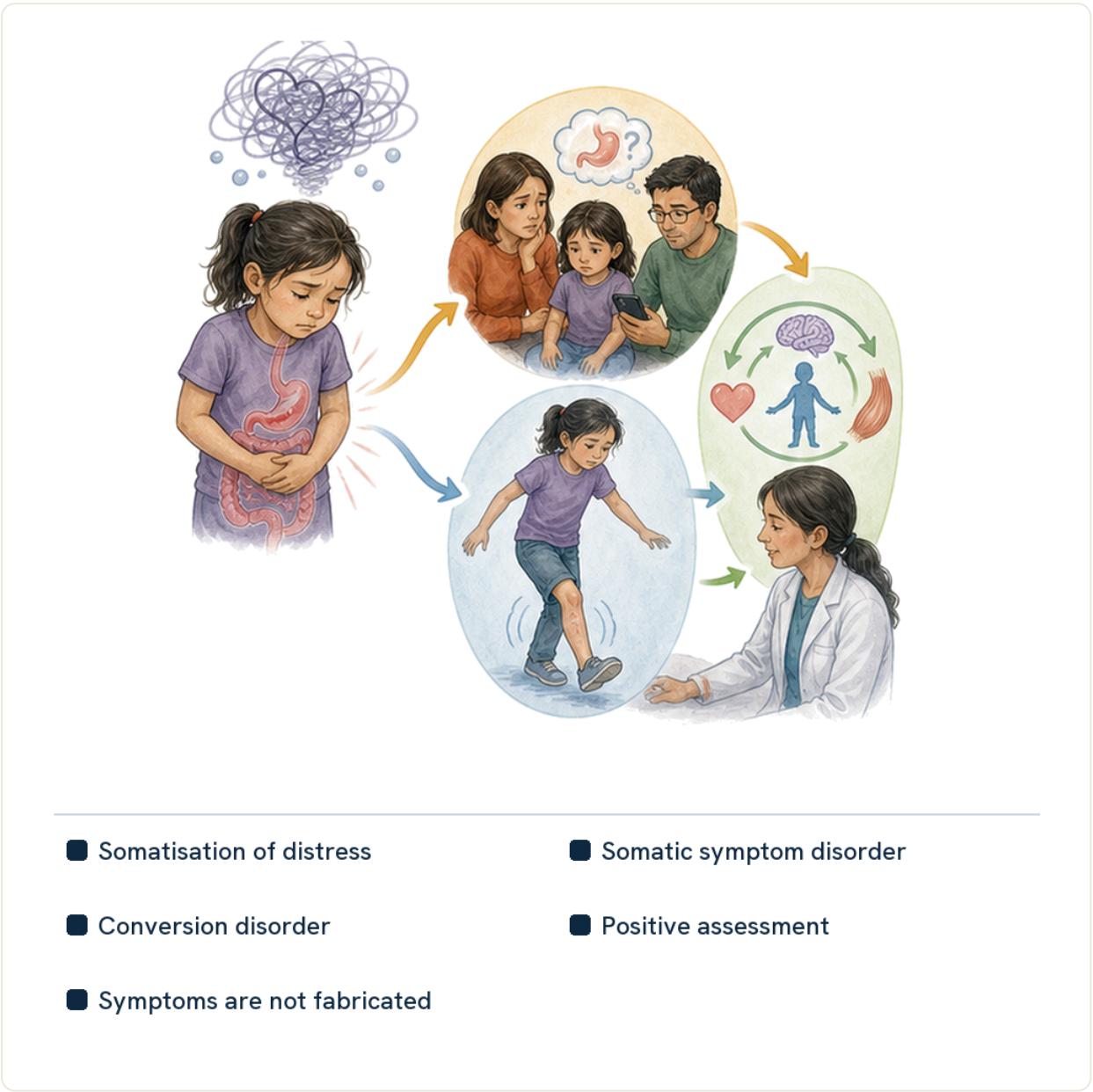


Fig 23.15 Childhood bodily symptoms lie on a clinical sequence from somatisation of distress to formal somatic symptom or conversion disorder. Assessment validates the symptom, looks for positive clinical features and functional impact, and does not equate unexplained symptoms with fabrication.

The order to hold runs from the softest to the hardest edge: first the somatisation of distress, a presentation and not yet a disorder; then somatic symptom disorder, defined by how the child and family respond to symptoms rather than by whether those symptoms are explained; then conversion disorder, which turns on a positive neurological sign and is not a diagnosis reached by exclusion.

19.1 The body as the voice of distress

Before any disorder is diagnosed, know how ordinary childhood distress somatises. When children are anxious or depressed, the complaint that reaches the clinic is frequently physical.

The characteristic symptoms of childhood **somatisation** are recurrent abdominal pain, headache, fatigue and nausea, and a useful developmental point is that a single prominent symptom is commoner in a child than the elaborate multi-system picture more typical of an adult. This is the presentation that separation anxiety, school refusal and childhood depression each borrow when they surface in the body rather than in mood or thought; those conditions are taught in full in their own places in this chapter, and here the point is only that the abdominal pain or the headache is the surface, and the affect underneath it is what the interview must reach.

19.2 Recurrent abdominal pain as the paradigm

One symptom carries most of the marks here. **Recurrent abdominal pain** is one of the most common medical complaints of childhood, and in the majority of children who present with it no organic pathology is ever identified. That single fact does most of the clinical work. It tells you that a careful history and examination, rather than a widening battery of tests, is the right first move, and that in a child with recurrent pain, normal growth and no alarm features, an emotional contributor is statistically the likeliest story. The pain is real, felt exactly where the child points; it is the meaning, not the sensation, that is misattributed. The discipline is to hold two truths together: most such pain is functional, and yet the minority with organic disease must not be missed, which is why red-flag features such as weight loss, nocturnal waking, bleeding or a localising sign always earn investigation regardless of how anxious the child seems.

> **PITFALL**
>
> The repeated normal investigation can itself become the disease. Each fresh scan that comes back clear is meant to reassure, but for an anxious child and a frightened family it often does the opposite: it confirms that something serious is being hunted for and has not yet been found. The result is escalating investigation, school absence and an entrenched sick role. Deciding early that the picture is functional, and saying so with conviction while keeping a light safety net, protects the child better than another test.

19.3 Somatic symptom disorder: the DSM-5 entity

Somatic symptom disorder is a formal diagnosis, distinct from the presentation above. Its architecture is worth carrying exactly. **Somatic symptom disorder** requires one or more somatic symptoms that are distressing or that cause significant disruption of daily life. The defining requirement, however, is not the symptom but the reaction to it: there must be **excessive thoughts, feelings or behaviours** about the symptoms, demonstrated by at least **one** of three features.

- disproportionate and persistent thoughts about the seriousness of the symptoms;
- a persistently high level of anxiety about health or about the symptoms;
- excessive time and energy devoted to the symptoms or to health concerns.

The symptomatic state must be persistent, typically lasting **more than six months**, although any one symptom need not be continuously present across that time. Severity is graded by how many

of the three response features are met, which keeps the grading anchored to the psychological burden rather than to the count of bodily complaints.

MNEMONIC

Symptom, Story, Staying-power

A distressing bodily **symptom** (Criterion A); the excessive **story** the child and family build around it, in thought, health anxiety or time consumed (Criterion B); and the **staying-power** of a persistent symptomatic state (Criterion C). The middle term is the diagnosis.

19.4 The pivot away from medically unexplained symptoms

This is the single most tested conceptual point. The older somatoform category was built on the idea that the symptoms were medically unexplained. DSM-5 abandoned that foundation. Having **medically unexplained symptoms** is no longer sufficient to make the diagnosis; the diagnosis rests on the excessive thoughts, feelings and behaviours, and the somatic symptoms may or may not accompany a diagnosable medical condition. A child with genuine asthma or migraine can also have somatic symptom disorder if the response to those real symptoms is disproportionate and disabling. This reframing stops the diagnosis from being a label of last resort applied when the tests come back normal, and it protects the truth that the child's suffering is authentic whether or not medicine can explain the sensation.

RULE **Somatic symptom disorder is diagnosed by the response, not by the absence of a cause.** Ask not whether the symptom is explained but whether the thoughts, anxiety and behaviour around it are out of proportion and are consuming the child's life. A real diagnosis can sit alongside a real disease.

19.5 Applying the criteria to children

The adult criteria transfer, but the assessment does not. The somatic symptom disorder criteria appear suitable for use in children and adolescents, though the entity is far less studied in the young than in adults. The practical consequence is that a child cannot be assessed alone. Distress in childhood is co-authored: how a parent interprets a stomach ache, whether it is met with alarm or with calm, shapes how the child comes to experience and report it, and the same symptom can be trivial in one household and disabling in another. Assessment therefore gathers the child's account, the family's, and the school's, because the pattern of missed lessons and the child's function among peers reveals disability the consulting room cannot. The full child psychiatric assessment battery and its services are set out in the Child psychiatry: assessment, treatment, services and protection notes.

19.6 Conversion disorder and the incompatibility criterion

Conversion disorder is a different animal, defined by a positive examination. In **functional neurological symptom disorder**, also called conversion disorder, the presenting problem is altered voluntary motor or sensory function: a weak or paralysed limb, an abnormal gait, non-epileptic attacks that resemble seizures, or a sensory loss. The pivotal requirement is that the clinical findings provide evidence of incompatibility between the symptom and recognised

neurological or medical conditions. Incompatibility is a specific and technical idea: it means the signs are internally inconsistent, behaving in a way no organic lesion could produce, rather than simply being unexplained or unusual. That internal inconsistency, demonstrated at the bedside, is what carries the diagnosis, and it is why the neurological examination in a suspected conversion disorder is an active search for positive signs rather than a screen for disease to rule out.

19.7 A rule-in, not a rule-out, diagnosis

Conversion disorder is not made because the scans are clean. This deserves its own place because getting it wrong is the classic failure. The diagnosis is not one of exclusion; it is made on positive clinical signs of incompatibility. The examples worth knowing are **Hoover's sign**, in which apparent leg weakness normalises when the opposite hip is flexed against resistance, and the tremor entrainment test, in which a functional tremor takes on the rhythm the examiner asks the other hand to tap. Because these signs demonstrate the symptom directly, conversion disorder can coexist with genuine neurological disease, and it must never be diagnosed merely because investigations are normal or because a symptom looks bizarre. A symptom that is odd is not thereby functional, and a normal scan proves the absence of the lesions it images, not the presence of conversion.

TRAP **Treating conversion disorder as a diagnosis of exclusion.** The tempting shortcut is to order the investigations, watch them return normal, and conclude by elimination that the paralysis or the non-epileptic attack must be psychological. That reasoning is unsafe in both directions: it misses the organic disease the tests did not cover, and it fails to demonstrate the positive incompatibility the diagnosis actually requires. Show the sign, do not merely fail to find a lesion.

19.8 Telling the three apart

The examinable discrimination is between three near neighbours. The somatisation of distress, somatic symptom disorder and conversion disorder are related but distinct, and a candidate is expected to separate them cleanly. The sharpest line runs between the two formal disorders: in **functional neurological symptom disorder the presenting problem is a loss of function**, of a limb or a sense, whereas in somatic symptom disorder the focus is the distress that the symptoms cause and the disproportionate response to them. The somatisation presentation sits before both, describing how childhood anxiety and depression speak through the body without necessarily reaching the threshold of either disorder. Persistent pain, once carved out as a separate pain disorder, is now captured within somatic symptom disorder when the response to it is excessive. For the general adult versions of all of these, and their management, the general somatic-symptom and conversion disorders are taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

FEATURE	SOMATISATION OF DISTRESS	SOMATIC SYMPTOM DISORDER	CONVERSION DISORDER
Status	A presentation, not a disorder	DSM-5 disorder	DSM-5 disorder
Core focus	Anxiety or low mood felt in the body	The distress and excessive response to the symptoms	A loss of voluntary motor or sensory function
Typical symptom	Recurrent abdominal pain, headache	Any distressing bodily symptom, explained or not	Weakness, abnormal gait, non-epileptic attacks
What secures it	Reaching the affect beneath the complaint	The excessive thoughts, feelings and behaviours	A positive sign of clinical incompatibility
Cardinal trap	Dismissing real suffering as fabrication	Reading it as merely "medically unexplained"	Diagnosing by exclusion

The three run from a presentation towards two disorders defined on opposite grounds: somatic symptom disorder by the response to a symptom, conversion disorder by a positive sign that the symptom is incompatible with disease.

GOOD TO REMEMBER

What changes practice on Monday is the stance, not a new test. Validate the symptom as genuinely felt, name the emotional contributor without implying the child is inventing anything, set a firm ceiling on investigation, and enlist the family and school in a graded return to normal function. For a suspected conversion presentation, gently demonstrate the incompatibility sign to the family, because a diagnosis they can see explained is one they can work with.

IN INDIA

Somatic presentation is arguably the default idiom of distress across much of Indian practice, where emotional vocabulary is often somatic and the first contact is a physician or paediatrician rather than a mental health clinician. Conversion presentations, including non-epileptic attacks framed by families in idioms of possession or spiritual affliction, are seen frequently in Indian child and adolescent services. Two habits follow. Screen for anxiety and depression behind the persistent tummy ache or headache rather than reaching only for another investigation, and, in a country where organic infective and nutritional disease is common, keep the safety net for red-flag features firmly in place even once a functional cause looks likely.

Somatic symptom disorder is diagnosed by the excessive response to symptoms, not by their being unexplained; conversion disorder is ruled in by a positive sign of incompatibility, never ruled in by exclusion.

1 or more DISTRESSING SOMATIC SYMPTOMS, CRITERION A	**at least 1 of 3** EXCESSIVE-RESPONSE FEATURES, CRITERION B	**over 6 months** PERSISTENT SYMPTOMATIC STATE, CRITERION C	**the majority** CHILDHOOD RECURRENT ABDOMINAL PAIN WITH NO ORGANIC CAUSE

20 · Disruptive mood dysregulation disorder

The diagnosis was built to solve a problem the field had created for itself. **Disruptive mood dysregulation disorder** names the child who is chronically, grindingly irritable and who erupts into severe temper outbursts many times a week, every week, for a year or more. It exists because a generation of chronically irritable children had been swept into a diagnosis of paediatric bipolar disorder on the strength of their rages, treated with mood stabilisers and antipsychotics, and followed into an adulthood that turned out to hold not mania but depression and anxiety. The construct was introduced to give that presentation a home of its own, in the depressive rather than the bipolar family, and to stop the reflex that read every explosive child as bipolar. For the examination the marks sit almost entirely on two things: the exact criteria, which are long and easily half-remembered, and the reasoning that separates this chronic, non-episodic irritability from the episodic mood elevation of bipolar disorder.

This topic owns the diagnostic architecture of the disorder and the operational rule that distinguishes it from paediatric bipolar disorder: the temper-outburst criterion, the frequency and inter-outburst mood requirements, the duration, pervasiveness, age-window and onset rules, the manic-exclusion clause, its placement among the depressive disorders, its differential against oppositional defiant disorder, its prevalence, its position in the two major classifications, and its indication-scoped pharmacotherapy. The historical over-diagnosis debate itself, the narrow-phenotype argument and the reasons the category was contested are developed in their own right elsewhere in this chapter; here they are named as the backdrop, not reopened.

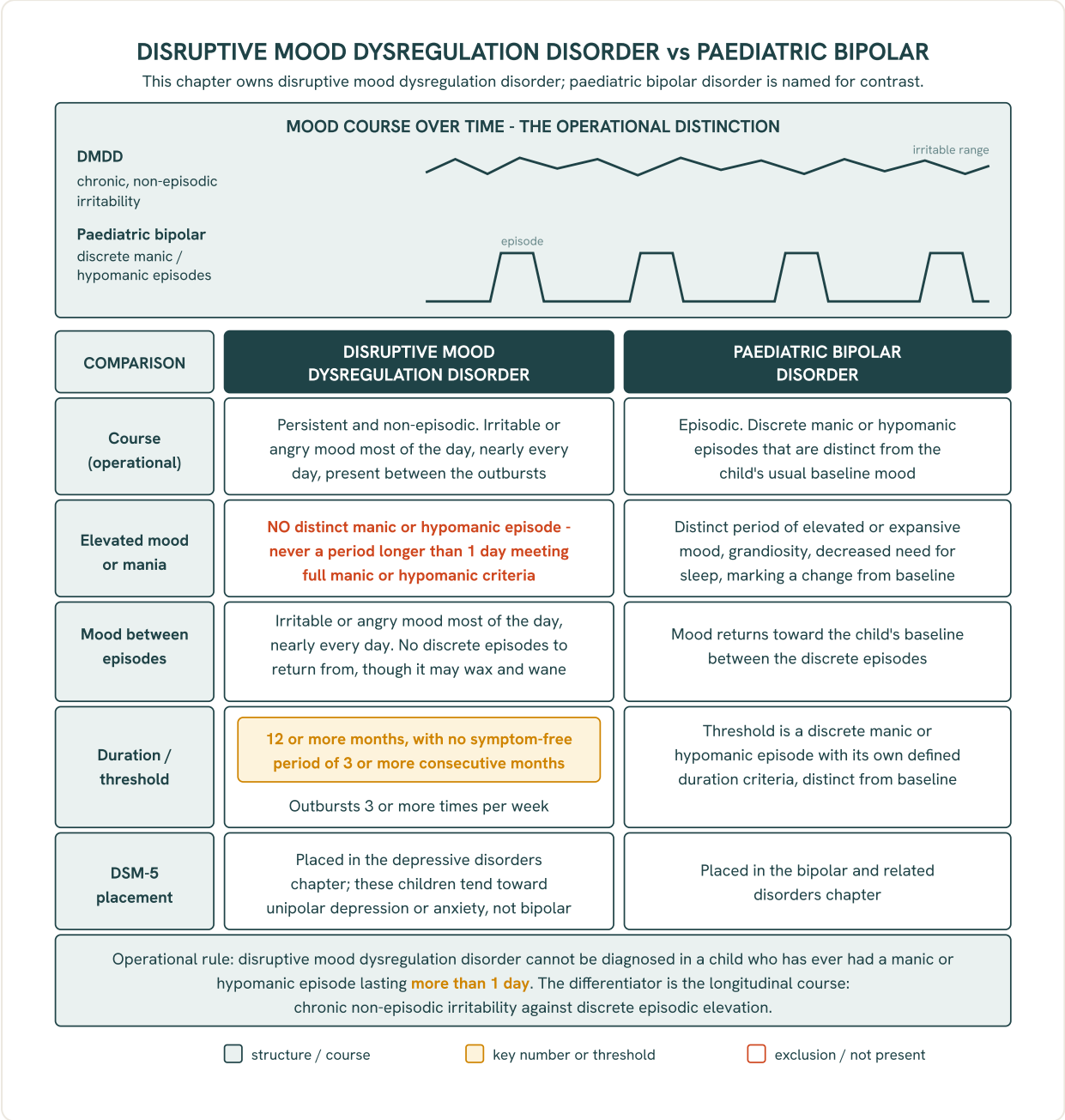


Fig 23.16. Disruptive mood dysregulation disorder against paediatric bipolar disorder: a mood-course timeline and a paired criteria grid showing chronic non-episodic irritability against discrete episodic mania, the 12-month duration floor, the manic-episode exclusion boundary of more than 1 day, and the depressive-chapter placement that carries the operational distinction.

20.1 What the disorder is, and why it sits among the depressive disorders

The placement is the argument in miniature. The classification files this disorder among the **depressive disorders**, and that decision carries the whole rationale for the category. Longitudinal work found that children with chronic, non-episodic irritability do not, as a rule, grow into adults with bipolar disorder; they grow into adults with unipolar depressive and anxiety disorders. The irritability is therefore read as a depressive-spectrum phenomenon expressed in a developmentally immature way, not as a prodrome of mania, and the disorder is housed accordingly. This is worth holding onto because it explains everything downstream: why the manic exclusion is written into the criteria, why lithium is not the answer, and why the differential that matters is not against conduct problems but against bipolar disorder. The name

itself is a compromise, splitting the presentation into two visible components - the **persistently irritable or angry mood** that forms the baseline, and the severe outbursts that punctuate it.

20.2 Criterion A: the temper outburst as the core symptom

The disorder is anchored on outbursts that are grossly disproportionate to their trigger. The core criterion is **severe recurrent temper outbursts**, which may be verbal, behavioural, or both, and which are grossly out of proportion in intensity or duration to the situation or provocation that set them off. In practice this is the verbal rage - screaming, shouting - and the physical aggression toward people or property that families describe as coming out of nowhere and lasting far longer than the small frustration that triggered it. Two qualities do the diagnostic work. The first is disproportion: the reaction is wildly larger than the provocation, so a minor "no" produces a twenty-minute destructive storm. The second is that the outbursts are inconsistent with developmental level; the tantrum of a two-year-old denied a sweet is expected, the same storm in a school-aged child is not. It is the pairing of severity, disproportion and developmental inappropriateness, not the mere fact of a tantrum, that makes an outburst count.

MNEMONIC

Storms on a stormy sky

The whole picture is two components at once: the **storms** are the severe temper outbursts, and the **stormy sky** is the persistently irritable, angry mood that persists between them. A child who has the storms but a calm sky between them does not have this disorder, and neither does the child who is merely irritable without the outbursts. Requiring both is the single feature that keeps the category tight.

20.3 Frequency and the mood between outbursts: the two thresholds that define the syndrome

An outburst threshold and a baseline-mood threshold must both be crossed. The frequency rule requires the outbursts to occur, on average, at least **three** times a week. This is a demanding bar and it is deliberate: it filters out the child who erupts occasionally under stress and captures only the pattern of repeated weekly explosiveness. The second threshold is the mood between the storms. The criteria require that, in the intervals between outbursts, the mood is persistently irritable or angry, present most of the day, nearly every day, and - crucially - observable by others such as parents, teachers and peers. This inter-outburst irritability is what separates the disorder from a simple explosive-behaviour problem. The child is not calm and pleasant between rages; the baseline itself is angry. Requiring the irritability to be observable by others, rather than merely reported, guards against a diagnosis built on a single exhausted parent's account, and it is a frequently examined clause.

RULE **Both the outbursts and the mood between them must be abnormal.** The defining structure of this disorder is a persistently irritable or angry baseline punctuated by severe, frequent temper outbursts. The outbursts alone are not enough, and the irritable baseline alone is not enough; the diagnosis lives precisely in the requirement that both be present, together, over a long stretch of time. This is what makes the irritability chronic rather than episodic, and chronicity is the whole point.

20.4 Duration, pervasiveness and the age rules

Four gating rules turn a cross-sectional picture into a diagnosis. The criteria then wrap the two core thresholds in a set of qualifying rules whose job is to enforce chronicity and to keep the diagnosis inside a defined developmental band. The symptoms must have been present for at least **twelve** months, with no symptom-free stretch of three or more consecutive months, so a transient irritable phase cannot qualify. They must be present in at least two of three settings - home, school and with peers - and be severe in at least one, which enforces the pervasiveness that separates a disorder from a reaction to one difficult environment. The diagnosis must not be made for the first time before age 6 or after age 18, because the outburst-plus-irritability picture is neither reliable nor distinctive at the extremes of that range. And by history or observation the onset of the symptoms must be before **age 10**. Together these rules are what make this a disorder of chronic, pervasive, early-onset irritability rather than a label for any child who is having a bad month.

REQUIREMENT	THE RULE	WHAT IT GUARDS AGAINST
Outbursts	Severe, disproportionate, at least three per week on average	The occasional stress-driven eruption
Baseline mood	Persistently irritable or angry between outbursts, observable by others	Explosive behaviour without a mood disturbance
Duration	Present at least twelve months, no gap of three or more months	A transient irritable phase
Pervasiveness	In at least two of three settings, severe in one	A reaction confined to one setting
Age window	Not diagnosed before age 6 or after age 18	Unreliable diagnosis at the developmental extremes
Onset	Symptoms begin before age 10	An adolescent-onset mood or behavioural disorder in disguise

The gating rules read against the failure mode each one is designed to exclude; the accompanying figure lays the same structure out as the two core thresholds wrapped in the chronicity and age constraints.

20.5 The manic exclusion and the chronic-versus-episodic distinction

This is the reasoning the whole category was built to force. The criteria carry an explicit exclusion: a child who has ever had a manic or hypomanic episode - a distinct period meeting the full symptom criteria, except duration - is, by definition, on the bipolar spectrum and cannot receive this diagnosis. The load-bearing distinction is longitudinal and it is the single most examined point in the topic: the irritability of this disorder is **persistent and non-episodic**, a chronic background state that may wax and wane without ever resolving into episodes, whereas bipolar disorder is **episodic**, defined by discrete manic or hypomanic episodes that stand out clearly from the child's usual baseline. You are not comparing two cross-sectional pictures; you are comparing a flat, chronically irritable course against a course marked by episodes with a beginning and an end. The bipolar controversy in children - the historical over-diagnosis, the

narrow-phenotype debate - is taken up in its own right elsewhere in this chapter; the operational discriminators the clinician actually applies are these:

- a chronic, non-episodic irritable baseline, present most of the day and nearly every day though it may wax and wane, favours this disorder; irritability that arrives and departs in discrete spells favours bipolar disorder;
- any distinct period, longer than one day, that met full manic or hypomanic criteria bars this diagnosis outright;
- a developmentally appropriate surge of high spirits at a genuinely exciting event is not mania and does not count toward it.

TRAP **Chronic severe irritability is not paediatric mania.** The classic error, and the very error the diagnosis was created to correct, is to see a child with frequent explosive rages and a short fuse and reach for bipolar disorder. Irritability is not episode-defining; it is the non-specific affect this disorder makes chronic. The question is never how angry the child is but whether the anger comes in discrete episodes distinct from baseline. If it does not, this is chronic irritability, and the manic-exclusion clause bars the bipolar label outright.

20.6 The differential against oppositional defiant disorder

The two overlap heavily, and the diagnostic-hierarchy rule resolves it. The other disorder this presentation is constantly confused with is **oppositional defiant disorder**, whose diagnostic architecture is developed in its own right elsewhere in this chapter. The overlap is substantial: roughly **15%** of children who meet criteria for oppositional defiant disorder also meet criteria for this disorder. The two share the angry, irritable, easily-provoked child, but this disorder demands more: severe, recurrent temper outbursts and a persistently disturbed inter-outburst mood, at a severity and chronicity that the oppositional diagnosis does not require. Because the presentations nest, the classification imposes a hierarchy: when a child meets criteria for both, only this disorder is diagnosed. That rule is the reverse of the usual instinct to give the "milder" oppositional label, and it reflects a judgement that the chronic mood disturbance is the more clinically significant fact about the child. The practical upshot is that a chronically irritable, explosive child who could be called oppositional is called by this disorder's name instead, once the outburst and mood thresholds are genuinely met.

PITFALL

Clinicians who anchor on the tantrums alone slide toward one of two wrong homes for this child: oppositional defiant disorder, if they read the outbursts as defiance, or bipolar disorder, if they read them as mania. Both misreadings share a single cause - attending to the explosive behaviour and neglecting the shape of the mood over time. The corrective is to characterise the baseline between outbursts and the longitudinal course before choosing a label, because it is the persistent, non-episodic irritability, not the outbursts, that actually discriminates this disorder from its neighbours.

20.7 Epidemiology

The prevalence figures carry a warning about the diagnosis itself. Community estimates vary substantially with the age of the sample and the instrument used, which is itself the

epidemiological headline. A population-based cohort of Brazilian eleven-year-olds, assessed with a dedicated diagnostic module, put the prevalence at about 2.5%, while a United States community sample of six-year-olds returned a figure closer to **8.2%**. Reading the two together, the diagnosis appears commoner in younger children, consistent with the general truth that irritability and tantrums are more prevalent, and less specific, earlier in childhood - which is part of why the criteria refuse the diagnosis below the lower age bound. Unlike several externalising disorders of childhood, a consistent sex difference has not been reported in population samples.

20.8 The two classifications part company

One major system created the disorder; the other declined to. The two international classifications disagree at the level of whether this entity exists at all. One houses it as a standalone diagnosis within the depressive disorders. ICD-11 **has no equivalent category**; the corresponding presentation is coded instead as oppositional defiant disorder with chronic irritability-anger, under the code 6C90.0. In other words, where one manual carves the chronically irritable child out as a separate depressive-spectrum disorder, the other keeps the child inside the oppositional category and attaches a specifier to mark the irritability. That system also holds that irritability-anger on its own is neither necessary nor sufficient for the oppositional diagnosis. This is a genuine structural disagreement, not a difference of wording, and it decides how the same child is recorded depending on which manual a service follows.

> **IN INDIA**
>
> Because Indian services classify under ICD, there is no disruptive mood dysregulation disorder to code in routine case files, referrals or official reports. The chronically irritable, explosive child is recorded as oppositional defiant disorder with the chronic irritability-anger specifier under its ICD code. A clinician trained on the other manual's categories should not go hunting for a separate mood-dysregulation diagnosis in an ICD-coded record: the same presentation lives here inside the oppositional diagnosis, and treating the two systems as describing different children, rather than the same child filed differently, is a recurring source of confusion in cross-referenced notes and in examination answers.

20.9 Management: what is established, and what is not

The honest teaching point is the absence of a specific evidence base. There is, as yet, **no established treatment** for this disorder as such. Two negatives and two provisional positives should be carried. First, lithium is ineffective here - a direct consequence of the disorder not being bipolar, and a useful confirmation that the depressive-spectrum placement is more than a filing decision. Second, SSRIs together with psychological and parenting interventions may be considered, though the supporting data specific to this indication are thin. Beyond that, treatment is genuinely investigational: trials of stimulant and adjunctive SSRI treatment for these children are in progress, and adjunctive SSRIs are in practice used for the irritable child with comorbid attention-deficit/hyperactivity disorder without a firm evidence base behind that use. The comorbid disorder itself, its stimulant and non-stimulant treatment, belongs to the ADHD and specific learning/communication disorders notes; here it is named only as the common travelling companion whose treatment sometimes carries the irritability with it. Benzodiazepines

are disfavoured, because they can increase disinhibition and aggression in this population. The examinable posture is therefore one of therapeutic humility, kept carefully distinct from the pharmacotherapy of aggression in conduct disorder, which is a separate indication with its own evidence and is developed elsewhere in this chapter.

The one line to carry: this is chronic, non-episodic irritability with severe frequent temper outbursts on a persistently angry baseline, placed among the depressive disorders precisely because it is not bipolar.

GOOD TO REMEMBER

Before this label changes anything you prescribe, characterise the course. If the irritability is chronic and non-episodic and the outbursts frequent on an angry baseline, you are in this disorder's territory and lithium and antipsychotics are not the reflex; if the irritability comes in discrete episodes distinct from baseline, you are not, and the assessment turns toward bipolar disorder. The clinical move that protects the child is to map the mood over months, not to weigh the size of the last tantrum.

3+ / week	12 months	before 10	~15%
TEMPER OUTBURSTS, ON AVERAGE	MINIMUM SYMPTOM DURATION	AGE AT SYMPTOM ONSET	OF ODD ALSO MEET CRITERIA

21 · Childhood bipolar disorder controversy

Few debates in child psychiatry have caused as much diagnostic harm as the question of whether young children can have bipolar disorder. The topic earns its marks not because paediatric bipolar disorder is common, but because a generation of children were labelled with it who did not have it, and a candidate is expected to understand exactly how that happened, why a new diagnostic category was created to stop it, and where the honest line now lies. The general bipolar syndrome, its full episode criteria and its neurobiology, belongs to the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes; what this topic owns is the controversy itself, the reasoning behind it, and the discipline it demands at the bedside. The single most examinable idea is that a diagnosis with sharp, episodic boundaries was quietly stretched to cover children whose problem was not episodic at all.

The structure to carry into the exam is a short causal chain. A diagnostic upsurge occurred; it was driven by a specific conceptual move; that move collided with the defining requirement of the disorder; and the classification responded by carving out a separate home for the children who had been swept in. Each link is teachable, and each is where the marks sit.

21.1 The shape of the controversy

A rare disorder became, briefly, a common diagnosis. Over a relatively short span, bipolar disorder came to be applied to large numbers of children, first and most dramatically in the United States and afterwards, more cautiously, in other countries. The concern that grew out of this was not academic hair-splitting: it was that the disorder was being **over-diagnosed and**

over-treated in children, with young patients placed on mood stabilisers and antipsychotics on the strength of a label many of them did not warrant. That worry became formal enough that a new category, **disruptive mood dysregulation disorder**, was written into the classification for the express purpose of giving these children a more accurate diagnostic home. The whole controversy, in other words, is documented inside the classification that resolved it, which is why examiners treat it as settled teaching rather than open opinion.

21.2 How the upsurge happened: two presentations merged into one

The rise did not come from better detection of true mania; it came from a conceptual merger. The mechanism of the upsurge was that clinicians combined **two** genuinely distinct clinical pictures into a single category. On one side sat **episodic mania**, the classic, discrete elevation or expansion of mood that defines the adult disorder. On the other sat **non-episodic severe irritability**, a chronic, grinding crossness punctuated by explosive outbursts, with no discrete episode at all. Once these two were treated as versions of the same illness, the pool of eligible children expanded enormously, because chronic irritability is common and non-specific in the clinic while true episodic mania is not. The classification's answer was to draw the boundary sharply: in **DSM-5** the term bipolar disorder is explicitly reserved for the episodic presentation, so that the mere presence of a chronically irritable, explosive child can no longer be read as a mood-cycling illness.

RULE **Bipolar disorder is defined by episodes, not by irritability.** Irritability is a symptom that appears in mania, in depression, in anxiety and in ordinary childhood distress. What makes a presentation bipolar is a discrete change from baseline with an onset and an offset, not the intensity of a child's temper. Strip the episode away and you have not made a milder bipolar disorder; you have a different condition.

21.3 The crux: is chronic irritability a form of mania?

This is the question the whole debate reduces to. The crux is whether severe, **non-episodic irritability** should count as a paediatric form of mania. The answer written into the diagnostic rules is no, and the reasoning is structural rather than a matter of taste. Both DSM-IV and DSM-5 require distinct **a distinct manic episode** for a diagnosis of bipolar I disorder. A child whose irritability is present most of the day, most days, without ever resolving into and out of a bounded episode does not meet that requirement, however severe the presentation looks. This is why the debate was often framed as a contest between a narrow and a broad reading of the disorder. The **narrow phenotype** holds the episode requirement intact and keeps the diagnosis close to its adult form; the **broad phenotype** loosened it to include persistent irritability, and it was the broad reading that generated the over-diagnosis. The operational criteria for the disruptive mood dysregulation disorder that now houses these children are developed in their own right elsewhere in this chapter; here the point is only that the episode requirement is the fault line the two phenotypes fall on.

AXIS OF CONTRAST	NARROW PHENOTYPE (TRUE BIPOLAR)	BROAD PHENOTYPE (CHRONIC IRRITABILITY)
Mood pattern	Distinct manic episodes with a clear onset and offset	Persistent, non-episodic irritability with no discrete episode
Core disturbance	Episodic elevation or expansion of mood and energy	Chronic crossness with reactive, explosive outbursts
Diagnostic home	Bipolar I and the bipolar spectrum	Disruptive mood dysregulation disorder, placed among the depressive disorders
Longitudinal course	Continuity with adult bipolar disorder	Very low conversion to bipolar; risk of unipolar depression and anxiety

The two columns are not two grades of one illness; they are different conditions that were briefly filed together, and the episode requirement is what separates them.

21.4 Why a new category was created, and where it sits

The classification did not simply forbid the diagnosis; it built somewhere for the children to go. Removing the broad phenotype from bipolar disorder would have left a large group of genuinely impaired, chronically irritable children with no diagnostic label at all, and no clinician will leave such a child unnamed. The purpose of the new category was therefore twofold: to protect the bipolar diagnosis from erosion, and to give chronic paediatric irritability its own honest home. Crucially, that home was placed among the **depressive disorders** rather than in the bipolar section. That placement is not arbitrary filing. It is a claim about the underlying nature of the condition, and it is defended by the longitudinal evidence taken up next: these children do not travel toward bipolar disorder, so housing them beside it would repeat the very error the category was built to correct.

- it preserves the episodic meaning of the bipolar label;
- it gives severe non-episodic irritability a specific diagnosis of its own;
- it signals, by its placement, a depressive rather than a bipolar trajectory;
- it discourages the reflex prescription of mood stabilisers to irritable children.

21.5 What the follow-up data actually show

The longitudinal evidence is the strongest single argument against the broad phenotype. If chronic non-episodic irritability were really an early form of bipolar disorder, then children who show it should convert to bipolar disorder as they grow. They largely do not. The **rates of conversion** from severe non-episodic irritability to bipolar disorder are very low. What these children are at increased risk of, instead, is unipolar depressive and anxiety disorders in adulthood. This is a decisive discrimination for the exam, because it converts a question of definition into a question of prognosis: the two phenotypes do not share an outcome, and an illness is known partly by where it leads. The trajectory data are precisely what justify filing chronic irritability with the depressive disorders and keeping it out of the bipolar section.

GOOD TO REMEMBER

When a chronically irritable, explosive child is in front of you, the useful question is not "how severe is the temper" but "is there a discrete change from baseline". Hunt for a bounded period of elevated, expansive or unusually energised mood, distinct from the child's usual self, with a beginning and an end. If you cannot find one, you are not looking at bipolar disorder, and the treatment that follows a bipolar label does not follow.

21.6 The traps, and the position to defend

The examiner is testing discipline, not knowledge of a rare disorder. The safe position to write is the narrow one: bipolar disorder in children exists but is uncommon, it requires the same discrete episodes demanded in adults, and chronic irritability is not a substitute for those episodes. The candidate who can state that cleanly, name the category built to house the displaced children, and cite the low conversion rate as the reason for its placement has shown the whole reasoning chain the marks reward.

TRAP **Reading chronic irritability, or "very frequent mood swings", as paediatric rapid-cycling bipolar disorder.** The seductive move is to hear that a child is irritable "all the time" and explosive "several times a day" and translate that into ultra-rapid cycling. Frequency within a day is not cycling; cycling means discrete episodes. Label the presentation as chronic irritability, look for a true episode before you invoke bipolar disorder, and do not let severity stand in for episodicity.

PITFALL

The clinical harm of the broad phenotype was pharmacological. A bipolar label on a chronically irritable child leads almost automatically to a mood stabiliser or an antipsychotic, carrying metabolic and neurological burden, to treat a condition the child does not have. Naming the presentation accurately is not a semantic nicety; it is what keeps a child off years of unnecessary medication.

Episodic mania is bipolar disorder; chronic non-episodic irritability is not, and it was the conflation of the two that drove the over-diagnosis a separate diagnostic category was created to end.

IN INDIA

Indian child psychiatry classifies predominantly under ICD, which never carried the broad paediatric-bipolar phenotype the way American practice briefly did, so the over-diagnosis surge was largely a Western phenomenon that Indian trainees read about rather than lived through. The discipline it teaches still applies here. A chronically irritable, explosive child brought to an Indian clinic is common, and the temptation to reach for a bipolar label and a mood stabiliser is real; the correct response is to reserve the bipolar diagnosis for genuine episodic illness and to resist importing the broad reading that the international debate has already discredited.

two	very low	episodic
PRESENTATIONS WRONGLY MERGED INTO ONE	CONVERSION TO BIPOLAR DISORDER	WHAT THE BIPOLAR LABEL REQUIRES

22 · Early-onset schizophrenia and childhood psychosis

Psychosis in a child is not a smaller version of an adult illness; it is the same illness arriving early, on a brain that was already developing atypically. This topic is about schizophrenia and related psychotic states that declare themselves before adulthood, and it carries marks out of all proportion to how often the condition is seen, because it forces a candidate to do three things at once: recognise that true psychosis can begin in childhood, place it correctly on the neurodevelopmental continuum with the adult disorder, and separate it from the far commoner non-psychotic phenomena that mimic it. Get any one of those wrong and a well child is labelled schizophrenic, or a genuinely psychotic child is dismissed as imaginative, and both errors are examined.

The essential message is one of continuity with severity. Early-onset schizophrenia is uncommon, but where it occurs it is a harsher, more neurodevelopmentally saturated expression of the same process that produces adult schizophrenia. This topic owns that account in full: the definitions and the onset-age spectrum, the premorbid picture, the phenomenology, the neurocognition, the course and outcome, and the differential from the psychosis-mimics of childhood. The general neurobiology and pharmacology of schizophrenia belong to the adult chapters and are named here only where the reasoning demands them.

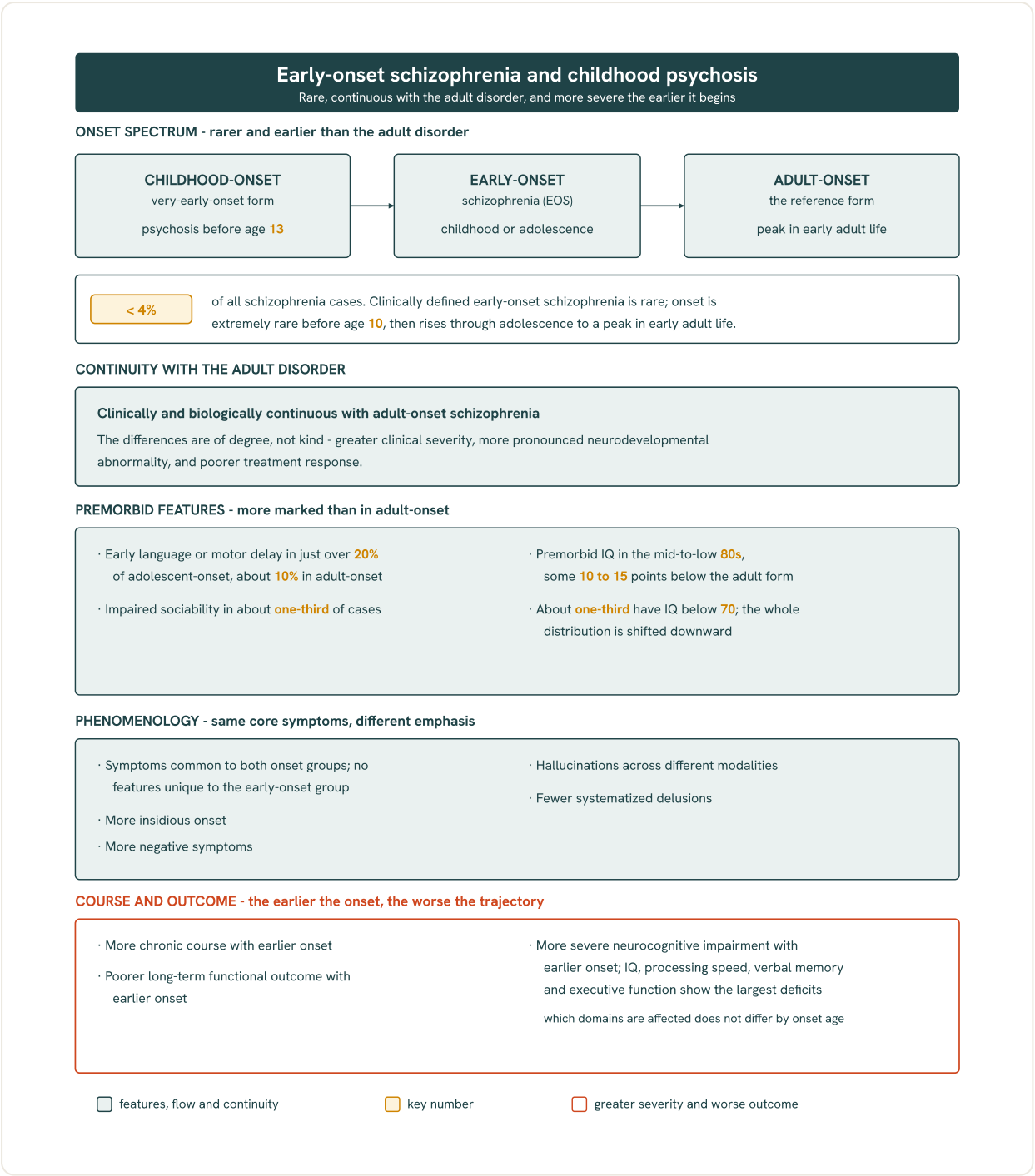


Fig 23.17. Early-onset schizophrenia and childhood psychosis: a rare disorder (under 4% of all cases, extremely rare before age 10) that is continuous with the adult form but more severe - childhood-onset psychosis begins before age 13, premorbid delay and low IQ are more common, phenomenology is broadly shared, and earlier onset predicts a more chronic course, poorer functional outcome and more severe neurocognitive impairment.

22.1 Definitions and the onset-age spectrum

Onset age is not a footnote; it defines the entities. The same diagnostic criteria used for adults are applied, unchanged, at every age, so what distinguishes these conditions is purely the age at which the full syndrome first appears. Two thresholds are worth holding. **Early-onset schizophrenia** refers to onset before adulthood, in the adolescent years, while the rarer **childhood-onset** or very-early-onset form is conventionally defined by onset of psychosis before the age of **13**, the boundary used by the National Institute of Mental Health childhood-onset cohort, which additionally required a near-normal premorbid intelligence and the absence of

significant neurological disease so that a primary psychosis was being studied rather than a secondary one.

Rarity is itself examinable. Clinically defined early-onset schizophrenia is genuinely rare, accounting for fewer than **4%** of all schizophrenia, even though self-reported psychotic-like experiences are far commoner in the general youth population and must not be equated with the disorder. Rarity increases sharply the younger the child: schizophrenia is extremely uncommon before the age of 10, and its incidence then rises steadily through adolescence towards a peak in early adult life. That gradient is why any convincing psychosis in a young child should prompt a careful search for a secondary cause before schizophrenia is accepted.

22.2 Continuity with the adult disorder

The default assumption is one illness across the lifespan, not two diseases. A large body of evidence indicates that early-onset schizophrenia is clinically and biologically **continuous** with the adult-onset disorder: the same diagnostic construct, broadly the same genetic and neuroimaging findings, the same treatment logic. What changes with earlier onset is quantitative, not categorical. Three differences stand out and are the ones to reproduce in an answer: earlier onset carries greater clinical severity, more pronounced neurodevelopmental abnormality, and a poorer response to treatment. The developmental framing follows directly. If schizophrenia is in part a disorder of aberrant brain maturation, then a case that surfaces during childhood or adolescence is one in which that aberration has been more marked, or has expressed itself sooner, and the child accordingly carries more of its developmental fingerprints.

RULE **Earlier onset is a more neurodevelopmental, more severe form of the same disorder, not a different one.** Do not present early-onset schizophrenia as a distinct childhood disease. Present it as adult schizophrenia declaring itself early, on a more compromised developmental substrate, which is precisely why its premorbid impairment is heavier, its symptoms more insidious, its cognition more affected and its outcome worse.

22.3 Premorbid functioning: the developmental fingerprint

The illness is usually visible, in retrospect, long before the first psychotic symptom. This is the single richest examination seam in the topic, because the premorbid abnormalities are more frequent and more severe than in adult-onset disease and they map cleanly onto the neurodevelopmental account. Careful histories find early **premorbid** difficulties across several domains, and they are worth carrying as a set because it is the pattern across all four, rather than any one of them, that points to a neurodevelopmental illness.

- **Language or motor delay.** Significant early delay is present in just over **20%** of adolescent-onset cases, markedly more than in adult-onset schizophrenia.
- **Impaired sociability.** The child who was always solitary, odd or poorly connected to peers: about a third of cases.
- **Premorbid IQ.** The group sits lower than the adult-onset group from the outset, averaging in the **mid-to-low 80s**, some 10 to 15 points below the adult-onset average.

- **Intellectual disability range.** Around a third of early-onset patients have a premorbid IQ below 70, with the whole distribution shifted downward rather than a small tail pulling the mean.

The clinical use of this is diagnostic, not merely descriptive. A convincing premorbid history of language delay, motor clumsiness, social isolation and academic struggle, followed by an insidious decline into psychosis, is far more consistent with a neurodevelopmental early-onset schizophrenia than with an acute reactive or drug-induced state, and it should raise rather than lower the index of suspicion.

> **GOOD TO REMEMBER**
>
> Always reconstruct the premorbid trajectory before you commit to a diagnosis. Ask the parents, and the school, about early speech and motor milestones, friendships, and the timing of any change. A lifelong drift of subtle developmental impairment that then steepens into positive symptoms supports a primary neurodevelopmental psychosis; a previously well child who becomes acutely psychotic over days should push you harder towards an organic, substance-related or mood-driven cause first.

22.4 Clinical phenomenology

The symptoms are the adult symptoms, with a shift in emphasis, not a new set. There are no phenomena unique to the early-onset group; the clinical symptoms are common to both. What differs is the balance and the presentation. Onset tends to be more **insidious** than in adults, creeping in over months of withdrawal, deteriorating function and blunting rather than announcing itself in a sudden florid break. The burden of **negative symptoms**, the avolition, flattening and social retreat, is heavier. Hallucinations tend to occur across different sensory modalities rather than being confined to the auditory, and delusions are typically less **systematized**, more fragmentary and less elaborately constructed than the organised delusional architecture of the older patient, in keeping with the cognitive immaturity and heavier cognitive impairment of the child. That combination, an insidious slide dominated by negative symptoms and disorganisation, is exactly what makes the diagnosis easy to miss early, when the picture can look like depression, oppositionality or simple failure to thrive at school.

22.5 The differential diagnosis of childhood psychosis

Far more children report psychotic-like phenomena than are psychotic, and this is the crux of the topic. The examiner is testing whether a candidate will resist the pull to over-diagnose. The first task is to establish that the phenomena are truly psychotic at all: developmentally normal imaginary companions, vivid fantasy, hypnagogic experiences and the misreported perceptions of a frightened or tired child are not psychosis, and isolated self-reported hallucinatory experiences in youth are common and usually transient. The second task is to exclude secondary and non-schizophrenic causes: delirium, epilepsy, central nervous system infection, substance intoxication, and the psychotic phenomena that can accompany severe mood disorder or trauma. The chronic irritability of disruptive mood dysregulation disorder, the mood-congruent phenomena and episodicity of the childhood bipolar disorder question, and the re-

experiencing and dissociation of childhood post-traumatic stress disorder are each developed elsewhere in this chapter and must be set against a psychotic presentation before schizophrenia is accepted. Distinguishing schizophrenia from autism spectrum disorder rests on the presence of genuine positive psychotic symptoms and a clear deterioration from a previously attained baseline, whereas the social-communication difficulties of autism are lifelong and non-psychotic; the disorder itself is taught in the Intellectual disability and autism spectrum disorder notes and is only named here.

TRAP **Reading normal or non-psychotic childhood experience as schizophrenia.** The classic error is to take a child's imaginary companion, vivid fantasy, or an isolated report of hearing a voice as evidence of psychosis and reach for schizophrenia. Such experiences are common, usually developmentally normal or transient, and clinically defined schizophrenia in childhood is rare. True psychosis requires sustained positive symptoms, disorganisation and functional deterioration, not a single frightening perception in an otherwise well child.

AXIS	EARLY-ONSET SCHIZOPHRENIA	ADULT-ONSET SCHIZOPHRENIA
Frequency	Rare, under 4% of all cases; increasingly rare the younger the child	The great majority of cases; peak incidence in early adult life
Premorbid development	Language and motor delay, impaired sociability and lower IQ far commoner	Premorbid impairment present but less frequent and milder
Onset and symptoms	More insidious onset, more negative symptoms, fewer systematized delusions	Often more acute; more organised, systematized delusions
Neurocognition	Same domains affected, more severe impairment	Same domains affected, less severe on average
Course and outcome	More chronic course, poorer functional outcome	Comparatively better course and outcome

The comparison is one of degree along shared axes rather than of kind; earlier onset shifts every axis in the direction of greater severity, which is the unifying idea of the whole topic.

22.6 Neurocognition

The cognitive deficit is qualitatively the same as in adults but quantitatively worse.

Neurocognitive impairment is a core, not incidental, feature, and it is more severe the earlier the onset. Importantly, which domains are affected does not change between the groups: the largest deficits fall on **neurocognitive** measures of general intelligence, processing speed, verbal memory and executive function in both early- and adult-onset disease. The message for an answer is precise. Early onset does not produce a different cognitive profile, it produces a deeper one, and because it strikes during the years of active learning and skill acquisition, that deeper deficit compounds over development into a heavier functional handicap than the same absolute impairment would cause in a fully matured adult.

22.7 Course, outcome and principles of management

Age of onset is one of the more reliable prognostic markers available. The relationship is consistent and directional: the earlier the onset, the more **chronic** the course tends to be, and the poorer the long-term functional **outcome**. Early-onset schizophrenia thus sits at the more severe end of the schizophrenia spectrum on almost every measure that matters, which is why the poorer treatment response noted earlier is so consequential. Management follows the same principles as in adult schizophrenia, combining antipsychotic pharmacotherapy with family work, educational support and psychosocial rehabilitation, but with heightened attention to developmental needs, schooling and the greater sensitivity of the young to adverse effects; the specific agents, doses and monitoring lie outside what this topic establishes and should be taken from a pharmacology source and the antipsychotics chapter. What the topic does establish is the stance: treat early and adequately, support development actively, and hold realistic expectations shaped by the worse prognosis that early onset confers.

PITFALL

Because the onset is insidious and negative-symptom-dominated, the commonest clinical failure is not over-diagnosis but delay. The gradual withdrawal, falling grades and blunted affect are attributed to depression, laziness or oppositionality, and months pass before the psychosis is recognised and treated. In a young person with an unexplained, sustained decline in function and social contact, actively ask about attenuated psychotic phenomena rather than waiting for a florid presentation to force the diagnosis.

IN INDIA

Most services here classify under ICD, and the same criteria are applied irrespective of age, so the entity is recognised even where a dedicated child psychiatry service is not available. Two realities shape practice. First, specialist child and adolescent psychiatry capacity is thin outside the larger centres, so a psychotic child often reaches an adult general psychiatry clinic, where the developmental history is easy to under-take. Second, secondary and organic psychoses, including those of neuroinfection, epilepsy and metabolic disease, carry a meaningful load in Indian children and must be excluded with particular care before a primary early-onset schizophrenia is diagnosed. The practical rule is to invest in the premorbid and organic history, which is exactly the part that a rushed clinic is tempted to skip.

Carry this into the exam: early-onset schizophrenia is the same disorder as the adult form, arriving before adulthood on a more neurodevelopmentally impaired brain, and it is more premorbidly abnormal, more insidious, more cognitively affected, more chronic and poorer in outcome the earlier it begins.

under 4%	**before 13**	**just over 20%**	**about a third**
OF ALL SCHIZOPHRENIA IS EARLY-ONSET	ONSET DEFINING THE CHILDHOOD-ONSET FORM	WITH EARLY LANGUAGE OR MOTOR DELAY	WITH PREMORBID IQ BELOW 70

23 · Suicide and self-harm in children and adolescents

The act is the alarm, not the intent behind it. The single most useful move a clinician makes when a young person presents after hurting themselves is to stop trying to read their mind about whether they "really meant it" and to treat the act itself as the signal. **Self-harm** in children and adolescents is deliberately defined without reference to motive: it is any nonfatal act of self-poisoning or self-injury, whatever the degree of wish to die, and it is the doorway through which almost every completed youth suicide has first passed. This section owns the youth-specific tools for that presentation - what the act is, how common it is, how young people do it, what raises the danger, how the risk is assessed, and how it is managed once identified.

Marks accrue here because paediatric suicidality is where a candidate's judgement is tested rather than their recall. There is no criteria set to recite; there is a way of thinking. The examiner wants to see that you can define self-harm without collapsing it into "suicide attempt", that you know the risk factors and the structure of a risk assessment, and that you can turn that assessment into a concrete plan rather than a reassuring note. The wider adult framework and the pharmacovigilance question of antidepressants in the young are developed in their own right elsewhere; this topic teaches the child and adolescent detail in full.

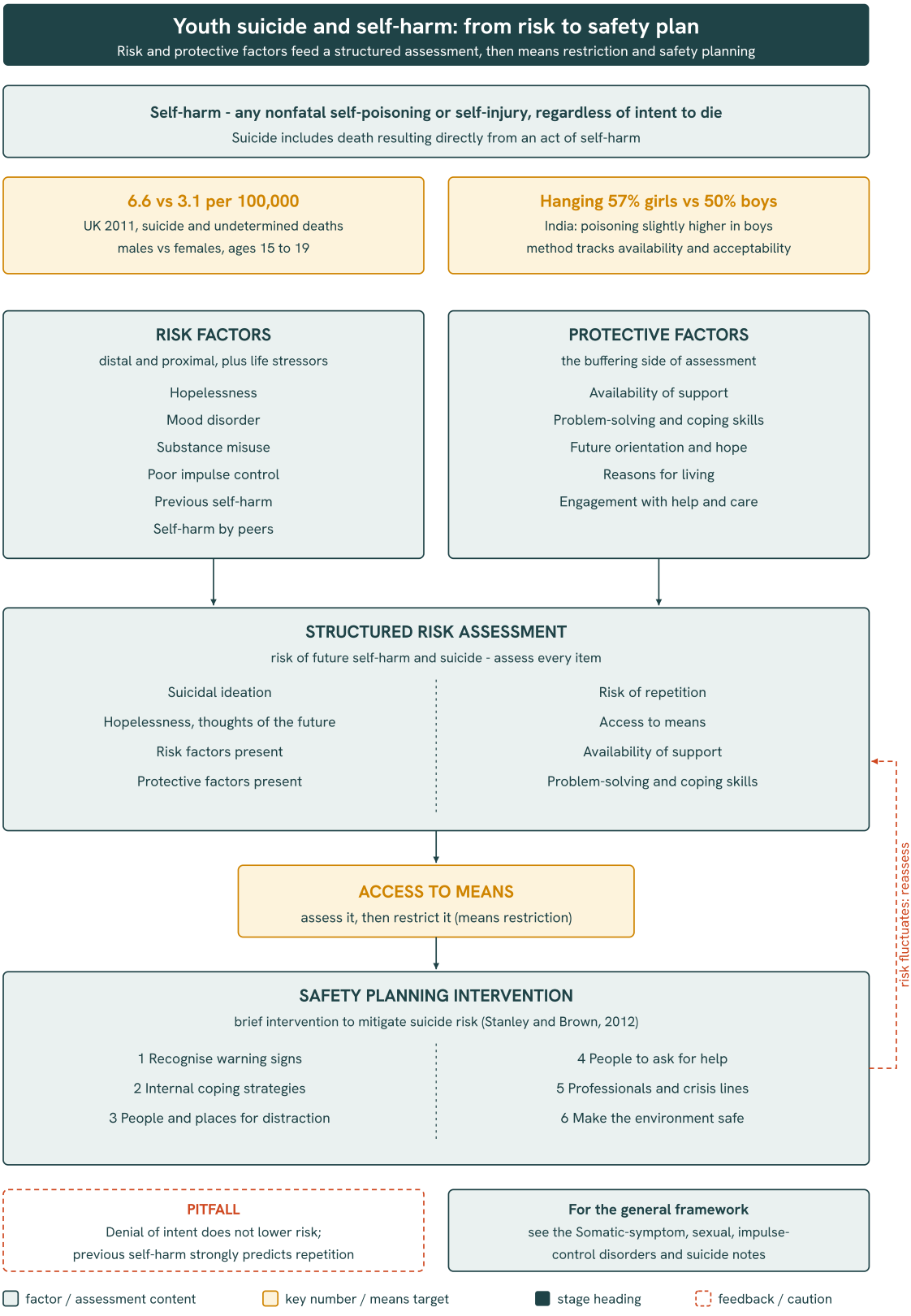


Fig 23.18. Youth suicide and self-harm pathway: risk and protective factors feed a structured risk assessment, then means restriction and a safety plan (Stanley and Brown), with reassessment as risk fluctuates.

23.1 What counts as self-harm, and how it relates to suicide

Self-harm is defined by the act, deliberately divorced from intent. The operational definition is broad on purpose. It takes in any form of nonfatal **self-poisoning or self-injury**, and it does so regardless of the motivation or the degree of intent to die that lay behind it. The cut made in private with no thought of dying, the impulsive overdose taken in front of a parent, and the near-lethal act interrupted by chance all fall under the one term, because the alternative - grading acts by inferred intent at the point of contact - is exactly where clinical assessment fails. Intent in an adolescent is fluid, poorly recalled and easily minimised, and an act that carried little wish to die today is still the strongest single marker of the act that may kill next year. Suicide sits at the fatal end of the same continuum: it is best understood as death resulting directly from an act of self-harm, not as a categorically different behaviour. Holding the definition this wide is what stops a clinician discharging a "minor" cut as unrelated to suicide risk.

- self-cutting and other self-injury;
- self-poisoning and overdose;
- hanging and self-strangulation;
- other dangerous acts such as running into traffic.

RULE **Assess the act, not the story about the act.** Because self-harm is defined without reference to intent, the clinician's job is never to decide whether the young person "meant it" and then act on that verdict. Every nonfatal act of self-poisoning or self-injury is taken as a marker of risk and assessed as such, whatever motive the young person or the family offers for it.

23.2 Epidemiology and the developmental gradient

Rare before puberty, then a sharp adolescent rise, with sexes that diverge. Completed suicide is uncommon before puberty and climbs steeply through adolescence, which is why the condition is a problem of the teenage years rather than of childhood proper. The pattern by sex is the examinable point and it reverses depending on which end of the continuum you count. For completed suicide the male rate runs higher: national figures for the United Kingdom put the rate of suicide and undetermined deaths in those aged 15 to 19 at **6.6 per 100,000** in males against **3.1 per 100,000** in females. Non-fatal self-harm shows the opposite skew, being commoner in girls, so that the same population produces more female acts but more male deaths - a reversal that turns on method and impulsivity rather than on distress. A methodological caution belongs here too: undetermined verdicts are not applied to those aged 10 to 14, so recorded rates in the youngest band understate the true burden and cross-country comparison must allow for how each coroner system counts.

23.3 Methods, and why the method is a clinical fact

Method is not incidental; it is where prevention gets its purchase. How a young person harms themselves is driven by what is culturally acceptable and what is physically available, and it varies by sex and by country in ways that matter at the bedside. The Indian pattern is a standing examination contrast. Where in many countries hanging predominates among males, Indian data show hanging to be somewhat more frequent in girls than in boys, and self-poisoning slightly

commoner in boys, so the Western default cannot simply be transposed. The clinical significance is that method choice is modifiable at the population level: restrict access to the lethal means that are locally common and you reduce deaths, because much youth self-harm is impulsive and a barrier at the moment of crisis buys the time in which the impulse passes.

METHOD	PATTERN BY SEX IN INDIAN YOUTH
Hanging	More frequent in girls (**57%**) than in boys (50%)
Self-poisoning	Slightly commoner in boys (**50%**) than in girls

Method distribution by sex in Indian youth; the contrast with the male-hanging predominance reported in many other countries is itself the teaching point, and it exists because acceptability and availability, not biology, set the method.

IN INDIA

Two locally common methods carry most of the mortality of youth self-harm: hanging and the poisons that sit within reach in Indian homes, above all agricultural pesticides and household chemicals. That makes means restriction a concrete, culturally specific task rather than an abstraction - securing or removing pesticides and medicines, and counselling families on storage, is often the highest-yield intervention available and one that does not depend on a scarce specialist. It also reframes the assessment: asking what is physically accessible to this particular young person in this particular home is not a formality but the part of the interview that most directly changes the odds.

23.4 Risk factors: a distal-proximal pathway

Suicidality is the endpoint of accumulating risk, not a single cause. No one factor explains a suicidal act; the useful model is a pathway in which longstanding vulnerabilities and immediate precipitants combine against a background stressor to push a young person over threshold. The core risk factors an examiner expects, read as one set, are **hopelessness**, an underlying mood disorder, substance misuse, poor impulse control, a history of previous self-harm, and self-harm among the young person's peers. They separate naturally along a time axis. The more distal contributors are the standing conditions - a depressive illness, a substance problem, a temperamentally impulsive style - that raise baseline vulnerability over months and years. The more proximal are the near-term markers, above all a recent act of self-harm or exposure to it in a close friend, and these fire in the setting of an acute life stressor such as a humiliation, a loss, a relationship rupture or a disciplinary crisis. Previous self-harm deserves particular weight as the strongest behavioural predictor of a further act, which is why a history of it reframes the whole assessment. The depressive illness that so often underlies the picture is developed as childhood depression in its own right elsewhere in this chapter, and the separate question of whether starting an antidepressant itself alters suicidality in the young is taken up as a distinct topic; here the mood disorder is named as a risk domain, not re-taught.

23.5 Assessing the risk of future self-harm

Structured content beats prediction. No instrument predicts which individual will die, and a candidate who promises the examiner a risk score has missed the point. What a good assessment does is systematically cover the domains that inform judgement and disposition, so that nothing

decisive is left unasked. The content the young person's assessment must reach is definable and this topic owns it: current suicidal ideation and its intensity; hopelessness and how the young person pictures their future; the risk factors present; the protective factors that pull the other way; the **risk of repetition**; **access to means**; the availability of support around them; and their problem-solving and coping capacity. Two of these do double duty as intervention targets rather than mere descriptors - access to means, because it can be restricted, and support, because it can be mobilised - which is what makes the assessment continuous with the plan rather than a separate exercise that precedes it.

DOMAIN OF THE ASSESSMENT	WHAT IT ESTABLISHES
Suicidal ideation	Whether thoughts are present, and their frequency, intensity and specificity
Hopelessness and view of the future	The affective marker most tied to intent; can the young person imagine things improving
Risk factors	The distal and proximal contributors and the precipitating stressor
Protective factors	Reasons for living, attachments and responsibilities that pull against the act
Risk of repetition	Prior self-harm and the features that predict a further act
Access to means	What lethal means are physically available; an explicit target for restriction
Availability of support	Who can watch, contain and respond; can it be mobilised now
Problem-solving and coping	The young person's capacity to tolerate and resolve the crisis

The content a youth suicide-risk assessment must cover; it is a structure for gathering the information that informs disposition and a plan, not a scale that outputs a probability of death.

TRAP **Reading a denial of ideation as an absence of risk.** The classic error is to accept "I don't want to die" at face value and stand down. A young person may minimise or genuinely fluctuate, and low intent at interview coexists with high danger when the means are lethal and to hand. Risk is judged from the whole assessment - prior acts, hopelessness, access to means and support - never from the single question about current wish to die.

PITFALL

Labelling self-harm of apparently low intent as "attention-seeking" and treating it as a behaviour to be ignored is a recurrent and dangerous clinical failure. The framing licenses the clinician to skip the assessment and the means-restriction conversation, yet low-intent acts are precisely the population from which impulsive deaths emerge. Communicative or interpersonal function and lethal risk are not alternatives; an act can be both a signal to others and a genuine hazard, and it is assessed on its danger regardless of what it also communicates.

23.6 Managing the risk: safety planning and means restriction

The plan is an intervention, not a promise extracted from the patient. Management of the identified risk turns on a small number of high-yield actions taken with the young person and their family. Chief among them is a **safety planning intervention** - the brief, structured safety plan described by **Stanley and Brown** - which works with the young person to recognise their own warning signs, to name internal coping strategies and people and settings that provide distraction, to identify who to contact in a crisis, and to reduce the danger of the immediate environment. It is deliberately distinct from the discredited "no-suicide contract", which asks for a promise and changes nothing. Coupled to it is **means restriction**: because access to means is both an assessment item and a modifiable target, removing or securing the lethal means available to this young person is a direct reduction in risk and a routine, non-negotiable component of the plan. Around these sit the treatment of the underlying mood, substance or impulse-control disorder, the mobilisation of family supervision and support, and clear, explicit arrangements for follow-up and re-assessment, since risk is not a fixed quantity settled at one interview but a state that shifts with circumstance and must be reviewed.

The general suicide-risk framework that applies across the lifespan - the wider theory of assessment and the adult evidence base - is developed in the Somatic-symptom, sexual, impulse-control disorders and suicide notes; what this section adds is the child and adolescent application of it, where developmental fluidity of intent, dependence on the family, and culturally specific means make the youth version its own competence.

GOOD TO REMEMBER

Every young person who has harmed themselves leaves the consultation with two things done, not one: a completed risk assessment and a concrete plan that includes means restriction. The assessment without the plan is an observation; the plan without honest means restriction is a document. Doing both, and arranging who reviews the young person and when, is the deliverable the examiner and the parent are both looking for.

Self-harm is defined by the act and not the intent behind it; take every nonfatal self-poisoning or self-injury as a risk marker, assess it across its full content, and convert that assessment into a safety plan with means restriction.

6.6 per 100,000 SUICIDE AND UNDETERMINED DEATHS, ADOLESCENT MALES (UK)	**3.1 per 100,000** SUICIDE AND UNDETERMINED DEATHS, ADOLESCENT FEMALES (UK)	**57%** HANGING AS A METHOD IN GIRLS (INDIA)	**50%** SELF-POISONING AS A METHOD IN BOYS (INDIA)

24 · Antidepressant use and suicidality warning in youth

This is the most politically charged prescribing decision in child psychiatry, and the examiner knows it. A young person with moderate to severe depression stands to gain from an antidepressant, yet the same drug carries a regulatory warning that it may increase suicidal

thinking in exactly this age group. Marks accrue here because the topic tests something harder than a fact: it tests whether a candidate can hold two true statements at once, that the risk signal is real and that the treatment is still, for the right patient, correct. The general pharmacology of antidepressants, their classes and mechanisms, belongs to the Mood disorders: pharmacotherapy notes; the assessment of suicide risk itself, its structured tools and safety planning, is developed elsewhere in this chapter. What this topic owns is the pharmacovigilance story: where the warning came from, how large the risk actually is, the adverse effects unique to starting these drugs in the young, and how the child must be monitored once the prescription is written.

The reasoning to carry into the exam runs in a fixed order. First the signal and the trials that produced it. Then the single most important move in the whole topic, converting an alarming relative risk into a small absolute one. Then the regulatory response, the youth-specific adverse effects, and the monitoring that the warning demands.

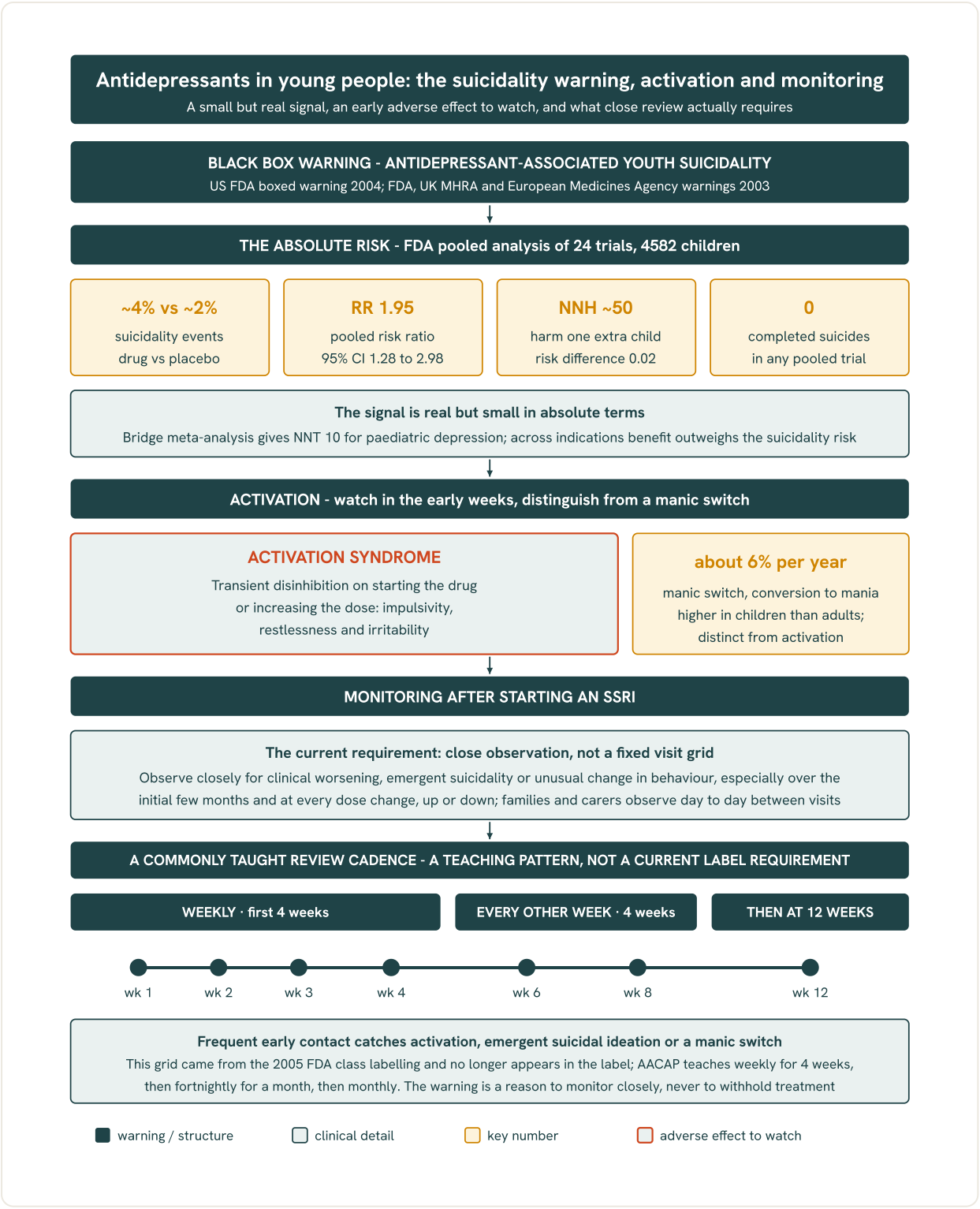


Fig 23.19. Antidepressants in young people: the paediatric suicidality warning quantified (absolute risk, risk ratio and number needed to harm), activation as the early adverse effect to distinguish from a manic switch, and what the label requires after starting an SSRI: close observation through the initial few months and at every dose change, with daily family observation between visits, rather than a fixed visit grid.

24.1 The signal and where it came from

The warning rests on a pooled analysis, not on a stream of deaths. When regulators grew concerned, the United States regulator assembled the paediatric placebo-controlled antidepressant trials and pooled their **suicidality** events, meaning suicidal ideation and suicidal behaviour recorded as adverse events, not completed suicide. Across 24 trials enrolling some 4582 children and adolescents, the pooled risk of a suicidality event on active drug against

placebo gave a risk ratio of **1.95** across all drugs and all indications. Restricted to the selective serotonin reuptake inhibitors used in depression trials, the risk ratio was 1.66. Those numbers are the origin of the entire controversy, and two features of them must be reproduced. They describe emergent suicidal ideation and behaviour, and the crucial fact that anchors every sensible reading of the data is that there were no completed suicides in any of the pooled trials.

24.2 Relative against absolute: the number that actually matters

A doubled relative risk sounds catastrophic until you see the base rate it doubles. A risk ratio near two means the event became about twice as likely, but on a rare event twice a small number is still a small number. The quantity that a clinician and a family can actually use is the **absolute risk difference**, and here it was 0.02, roughly two percentage points. In the regulator's cell rates that appears as approximately **4 per cent on antidepressant versus 2 per cent on placebo**. Inverting that risk difference gives a **number needed to harm** of approximately 50, meaning that for every fifty young people treated, one additional patient reports emergent suicidal thinking or behaviour who would not have on placebo. The teaching point is that the alarming headline and the modest reality are the same finding stated two ways.

The estimate is a range, not a point. Different pooled datasets used slightly different denominators and produced different absolute figures, and the exam rewards a candidate who can bound the signal rather than parrot one number. A meta-analysis cited in the standard formulary gives a lower estimate, roughly 2 per cent versus 1 per cent, with a number needed to harm of 112. A separate meta-analysis of 27 trials found a pooled risk difference of 0.7 per cent and a number needed to harm of 143, with the within-indication differences not reaching statistical significance and, again, no completed suicides. These are not competing truths to be adjudicated; they are the lower and upper bounds of a single small signal.

SOURCE	RELATIVE MEASURE	ABSOLUTE MEASURE	NUMBER NEEDED TO HARM
Regulator's pooled analysis	risk ratio 1.95, all drugs and indications	risk difference 0.02; about 4 per cent versus 2 per cent	approximately 50, derived
Formulary meta-analysis	lower estimate	2 per cent versus 1 per cent	112
27-trial meta-analysis	within-indication differences not significant	risk difference 0.7 per cent	143

The same suicidality signal, expressed by three groups. The relative risk is what alarmed regulators; the absolute risk difference and the number needed to harm are what a clinician weighs against benefit at the bedside.

RULE **Never quote the relative risk without the absolute risk beside it.** A risk ratio near two, stated alone, implies a doubling of deaths and is the single commonest misstatement of this evidence. Stated with its absolute risk difference of two percentage points and its origin in ideation rather than completed suicide, the same finding becomes a manageable, monitorable adverse effect.

24.3 The regulatory response: the boxed warnings

The warning is a class-wide regulatory act, and its dates and wording are examinable. The concern was taken up by regulators on both sides of the Atlantic: warnings on antidepressant-associated youth suicidality were issued by the American regulator, the United Kingdom medicines regulator and the European Medicines Agency in 2003. The American regulator then formalised the strongest label available to it, a **boxed (black box) warning**, in 2004, flagging worsening depression, agitation and suicidal ideation linked to these drugs and drawn from the review of adolescent depression studies. What the warning did NOT say is as important as what it said: it did not withdraw the drugs, did not forbid their use, and did not claim that they cause completed suicide. It mandated informed prescribing and close monitoring, which is the spirit a candidate should convey. Whether the warning was subsequently extended upward to young adults is a separate regulatory question that the sources used here do not settle, and a candidate should not assert an upper age boundary they cannot source.

> **GOOD TO REMEMBER**
>
> The warning changed the conversation with families more than it changed the pharmacology. Before starting an antidepressant in a young person, the modern standard is an explicit, documented discussion: that emergent suicidal thoughts are an uncommon early adverse effect, that they are usually transient, that the family should watch for them in the first weeks and report them immediately, and that this is precisely why review is scheduled early and often. A prescription written without that conversation is the one that gets challenged.

24.4 Why benefit still outweighs risk

The warning is a reason to prescribe carefully, not a reason to withhold. The same body of trials that produced the suicidality signal also demonstrated efficacy: the 27-trial analysis found a **number needed to treat** for paediatric major depressive disorder of **10**, and the authors judged that the benefits outweighed the suicidality risk across indications. Set the two frequencies side by side and the logic is stark: roughly one young person benefits for every ten treated, while the additional suicidality events run at one in fifty to one in a hundred and forty, and none of those events was a death. Against this sits the risk that the warning itself can do harm, because untreated adolescent depression is itself a leading driver of suicidal behaviour, and a chilling effect that reduces prescribing without reducing illness can raise the very outcome everyone fears. The examinable synthesis is therefore not "avoid antidepressants in the young" but "treat the depression that needs treating, and build the monitoring in".

TRAP **Reading the signal as an increase in completed suicide.** Candidates hear "antidepressants increase suicide risk in youth" and picture deaths. The pooled trials recorded emergent suicidal ideation and behaviour as adverse events and contained no completed suicides at all. Stating that antidepressants were shown to increase completed suicide in these trials is factually wrong and marks the answer as unsafe.

24.5 Activation, and its separation from a manic switch

Two early adverse phenomena are constantly confused, and distinguishing them is a favourite station. The first is **activation**, a transient disinhibitory response to starting an antidepressant or increasing its dose, characterised by impulsivity, restlessness and irritability. It is dose-related, it appears early, and it typically settles when the dose is reduced or the drug is withdrawn. Its clinical danger is that in an impulsive, disinhibited adolescent it can be the substrate on which emergent suicidal behaviour is enacted, which is one plausible route from the drug to the suicidality signal above. The second phenomenon is the **manic switch**, a conversion to a manic or hypomanic state, which is reported at approximately **6 per cent per year** in young people taking antidepressants and appears to be commoner in children than in adults, although there is no clear evidence that the antidepressant actually causes the switch rather than unmasking a latent bipolar diathesis. Activation must be differentiated from a manic switch, because the two demand different responses.

FEATURE	ACTIVATION	MANIC SWITCH
Nature	transient disinhibition with impulsivity, restlessness and irritability	sustained elevated or expansive mood, reduced need for sleep, grandiosity, pressured behaviour
Timing and course	early, dose-related, settles on dose reduction or withdrawal	may persist and may herald an underlying bipolar disorder
Frequency	a recognised early effect of initiation and titration	about 6 per cent per year, apparently higher in children
Response	reduce or stop the drug; the phenomenon reverses	reassess the diagnosis; a mood stabiliser may be needed

Activation is a reversible, dose-linked disinhibition; a manic switch is a syndromic mood change that questions the diagnosis. Confusing the two leads either to needless drug withdrawal or to a missed emerging bipolar disorder.

PITFALL

The frequent clinical error is to read early activation as the depression worsening and respond by pushing the dose higher, which amplifies the very disinhibition driving the problem. The mirror error is to see any early agitation as an emerging bipolar switch and stop the antidepressant altogether, abandoning a treatment the child needed. The safe move is to recognise activation as its own transient, dose-related entity, hold or reduce the dose, and reassess, reserving a diagnostic rethink for genuinely sustained, syndromic mood elevation.

24.6 The monitoring the warning demands

The warning converts into a concrete schedule of contact. Because the suicidality signal and activation both cluster in the early weeks, the regulator paired the label with a monitoring schedule following initiation of a serotonergic antidepressant in a child, front-loaded to catch trouble when it is most likely:

- weekly review over the first four weeks;
- then a review every other week for a further four weeks;

- then a review at week twelve.

The academic child psychiatry literature concurs with a schedule of the same shape, weekly for the first month, then fortnightly for a month, then monthly thereafter. Two honesties should accompany this in an exam answer. The schedule is expert consensus rather than a proven intervention, and there is no firm evidence that adhering to this exact calendar changes outcome; and "monitoring" means active enquiry into mood, suicidal ideation, activation and any switch to elevated mood, not a passive repeat prescription. Reproducing the schedule earns the mark; adding that it is consensus and defining what is actually monitored earns the rest.

The youth antidepressant signal is a doubling of emergent suicidal ideation, not of completed suicide, over a base rate of a few per cent; the response is careful prescribing, early front-loaded monitoring, and a family who know what to watch for, not withholding an effective treatment.

IN INDIA

The warning translates awkwardly into Indian practice. Antidepressants in children are largely prescribed off-label, most often fluoxetine, and frequently by non-specialists, because child psychiatry services are scarce and concentrated in a few tertiary centres. The front-loaded monitoring schedule, which assumes weekly face-to-face review through the first month, is difficult to deliver when families travel long distances and follow-up is irregular. The practical adaptation is to make the family the monitor: to explain activation and emergent suicidal thinking in plain language, to give an explicit instruction to return or telephone at once if either appears, and to use telephone or teleconsultation contact to approximate the weekly review the label intends. The signal itself is not Indian or Western; the ability to monitor for it is where the local reality bites.

1.95	~4% vs 2%	10	0
POOLED SUICIDALITY RISK RATIO	ABSOLUTE EVENT RATES, DRUG VS PLACEBO	NUMBER NEEDED TO TREAT, PAEDIATRIC MDD	COMPLETED SUICIDES IN THE TRIALS

Attachment disorders of childhood

25 · Reactive attachment disorder (criteria, etiology)

This is the one childhood diagnosis whose very definition points a finger at the caregiving environment rather than at the child. **Reactive attachment disorder** is the syndrome in which a young child, having been denied the ordinary experience of a responsive caregiver, fails to develop the normal behavioural signs of a **selective attachment**: when frightened, hurt or ill, the child neither turns to an adult for comfort nor takes much comfort when it is offered. What makes the disorder examinable is not the symptom picture of a flat, withdrawn, joyless child, but the demanding structure of its criteria - a specific behavioural pattern, a required history of grossly inadequate care, an explicit causal link between the two, a set of exclusions, and two age gates - all of which must hold together before the label can be used.

Its placement in the classification carries the whole argument. Rather than sitting with the neurodevelopmental disorders, where a naive reader might expect a disorder of early social behaviour to live, it is classified among the **Trauma- and Stressor-Related Disorders**, because the disturbance is understood as a response to an identifiable adverse experience. This topic owns the diagnostic criteria of reactive attachment disorder, its specifiers, its epidemiology, the etiological role of neglect, its associated features and course, and its within-section differentials. Its mirror-image sibling, **disinhibited social engagement disorder**, in which the same deprivation produces an indiscriminately over-familiar rather than a withdrawn child, is taught in its own account here and is named only as the contrasting pattern. The attachment-side comparison with autism, and the effects of institutional care with the management of these disorders, each belong to their own accounts elsewhere in this chapter.

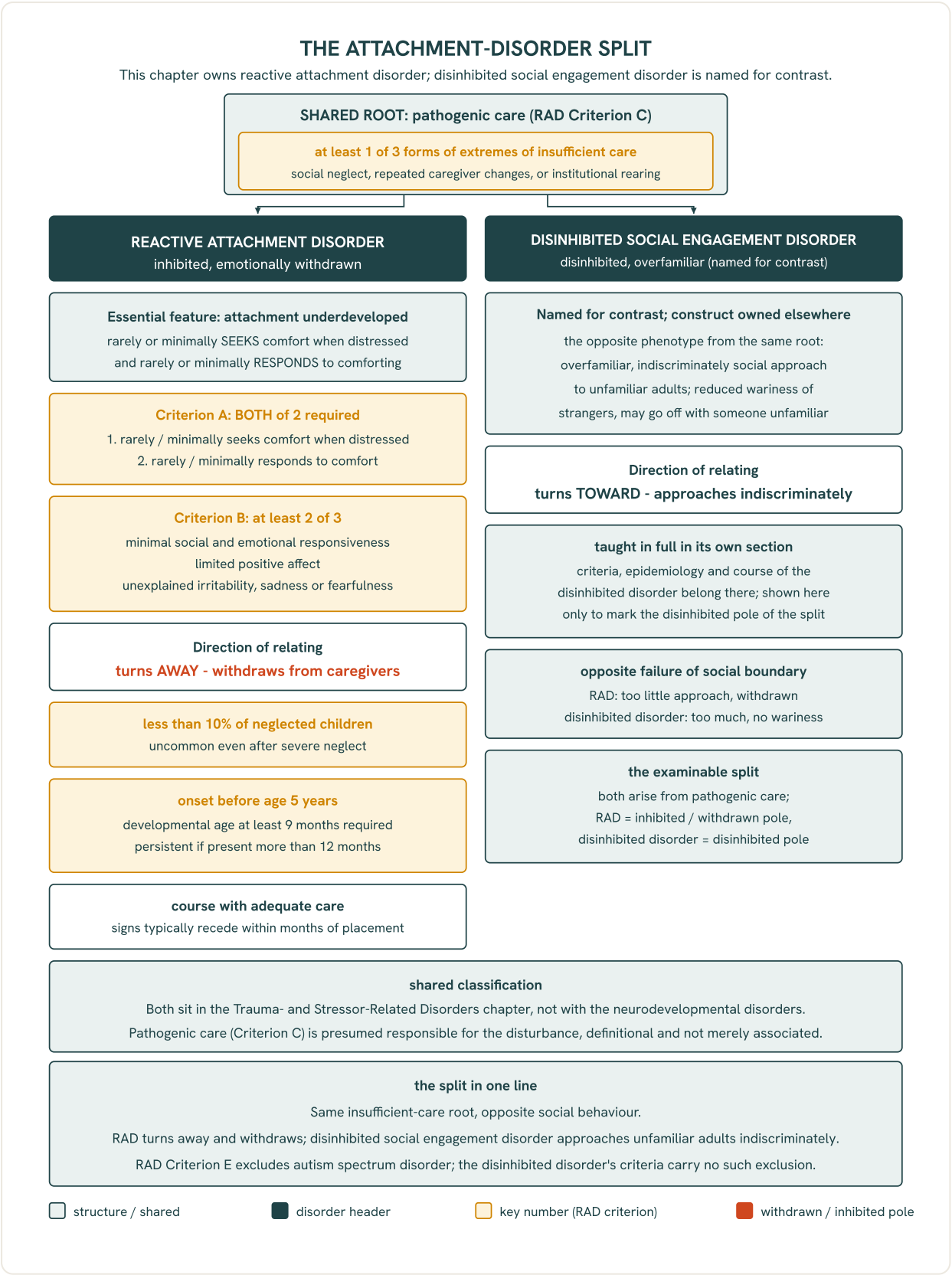


Fig 23.20. The attachment-disorder split: reactive attachment disorder (inhibited, withdrawn) against disinhibited social engagement disorder (disinhibited, overfamiliar, named for contrast), both arising from the same pathogenic care, with RAD turning away from caregivers and the disinhibited disorder turning toward unfamiliar adults.

25.1 The essential feature: an attachment that never took hold

The core of the disorder is an absent or grossly underdeveloped attachment to caregiving adults. A typically developing infant, by the second half of the first year, begins to show a

preferred attachment figure - seeking that person out when distressed and using the caregiver as a secure base. In reactive attachment disorder these behaviours are missing. The prevailing understanding is that these children retain the underlying **capacity to form selective attachments** but, deprived of the early relational opportunity to do so, do not show the behavioural manifestations of one; when distressed they rarely or only minimally seek comfort, and rarely or only minimally respond to comfort when it is given. The clinical impression is of a child who has learned that adults do not reliably answer need, and who has stopped asking. This separates the disorder at its root from a primary disorder of social capacity, and is why better caregiving can change the picture at all.

25.2 Criterion A: the inhibited, emotionally withdrawn pattern

Criterion A defines the behavioural signature, and it is a conjunction, not a menu. The child must show a consistent pattern of inhibited, emotionally withdrawn behaviour toward adult caregivers, evidenced by both of two features: the child rarely or minimally seeks comfort when distressed, and rarely or minimally responds to comfort when distressed. The word "both" is load-bearing. A child who seeks no comfort but is soothable once held, or who cannot be soothed but still turns to the caregiver, does not satisfy Criterion A. The pattern captured is a two-sided failure of the comfort transaction - the child neither initiates the bid for care nor completes it by being reassured - and it is this doubled withdrawal, present consistently rather than in a single frightened moment, that marks the inhibited attachment presentation the disorder is named for.

25.3 Criterion B: the persistent social and emotional disturbance

Criterion B broadens the picture from the attachment relationship to the child's general emotional life. Alongside the withdrawn attachment behaviour there must be a persistent social and emotional disturbance shown by at least two of three features: minimal social and emotional responsiveness to others; limited positive affect; and episodes of unexplained irritability, sadness or fearfulness that are apparent even during non-threatening interactions with caregivers. The third feature is the most clinically telling and the most easily overlooked, because it locates distress where there should be none - the flashes of misery or fear surface in ordinary, safe exchanges, not only under threat, which is what separates this from a child who is simply frightened by a specific stressor. Where Criterion A describes what the child fails to do within the attachment bond, Criterion B describes the pervading flatness and dysregulation that colour every relationship.

25.4 Criteria C and D: the pathogenic care and the causal link

This pair of criteria is what makes reactive attachment disorder unlike almost any other diagnosis in the manual. Criterion C requires that the child has experienced a pattern of extremes of insufficient care, evidenced by at least one of three recognised forms of deprivation:

- social neglect or deprivation, a persistent lack of having basic emotional needs for comfort, stimulation and affection met by caregiving adults;
- repeated changes of primary caregiver that limit the child's opportunity to form a stable attachment, as with recurrent moves through foster placements;

- rearing in unusual settings that severely limit the chance to form selective attachments, such as institutions with high child-to-caregiver ratios.

Criterion D then does the work that no associated risk factor could: it requires that the inadequate care in Criterion C is **presumed responsible** for the disturbed behaviour in Criterion A, as when the disturbance is seen to have followed the onset of neglect. This is what elevates **pathogenic care** from a mere correlate to a definitional requirement: the diagnosis is not "a withdrawn child who happens to have been neglected" but "a withdrawn child whose withdrawal is judged to arise from that neglect".

MNEMONIC

The three N's of Criterion C

The pathogenic care takes three recognised forms, each beginning with an **N**: social **N**eglect of the child's emotional needs, repeatedly **N**ew caregivers whose turnover prevents a stable bond, and iN**N**stitutional or otherwise unusual rearing that starves the child of any selective figure. Only one of the three need be present, but at least one must, and Criterion D then requires that it be judged the cause.

RULE **Pathogenic care is definitional to reactive attachment disorder, not merely associated with it.** A child cannot receive this diagnosis without a documented history of grossly insufficient care, and the criteria go further in demanding that the care be presumed to have caused the disturbance. Remove the neglect and the diagnosis dissolves, which is exactly why the disorder is filed with the trauma- and stressor-related conditions rather than with disorders of innate social development.

25.5 Criteria E to G: the autism exclusion and the two age gates

The final three criteria are exclusions and thresholds that keep the diagnosis honest. Criterion E is an explicit exclusion built into the disorder's own criteria set: the presentation must not meet the criteria for autism spectrum disorder. It is worth noting that this exclusion sits inside reactive attachment disorder but has no counterpart in the criteria of its disinhibited sibling. The fuller attachment-side reasoning for telling these disorders apart from autism, and autism itself, are taught elsewhere; here the point is only that the exclusion exists and must be cleared. Criterion F sets the upper age gate: the disturbance must be evident **before age five years**. Criterion G sets the lower, developmental gate: the child must have a developmental age of **at least nine months**. The rationale for that floor is precise and examinable - around this developmental level the capacity to form a selective attachment normally emerges, so a child who has not reached it cannot be said to have failed at a task they were not yet equipped to attempt. The gate is developmental, not chronological, which matters in a population where developmental delay is common.

GOOD TO REMEMBER

Before diagnosing reactive attachment disorder in a slow-to-develop or neglected infant, establish the child's developmental age, not just the age in months. A child functioning below the nine-month developmental level has not yet reached the stage at which a selective attachment would normally form, so the absence of comfort-seeking cannot be read as the disorder. Screening developmental level first prevents the diagnosis being pinned on a child who is simply not developmentally ready to attach.

25.6 The specifiers: persistence and severity

Two specifiers refine the diagnosis once it is made. The condition is specified as **persistent** when it has been present for **more than twelve months**, marking a presentation that has not resolved with time or with any change of circumstance and that therefore carries a heavier prognostic weight. Current severity is specified as severe when the child exhibits all of the symptoms of the disorder, with each manifesting at relatively high levels. Both specifiers matter because the disorder is, in favourable circumstances, recoverable; a presentation persisting beyond a year despite the chance of better care, or severe across every symptom, marks a child in whom the deprivation has bitten deep and for whom a change of environment alone may not suffice.

25.7 Epidemiology and etiology: neglect necessary, but far from sufficient

The single most important etiological fact is a paradox. Serious social neglect is at once a diagnostic requirement and the only established risk factor for the disorder, and yet the great majority of severely neglected children never develop it. The disorder is seen relatively rarely even in clinical settings; its general-population prevalence is unknown, and even among neglected children it is uncommon, arising in **fewer than one in ten** of them even where the neglect has been severe. That combination - neglect is necessary but not sufficient - is the whole of the etiological teaching a candidate can state with confidence. Pathogenic care sets the stage, but something further, some pattern of individual vulnerability or some specific quality of the neglectful environment, decides which deprived child develops the disorder and which does not, and those vulnerability factors and the critical ingredients of the neglect remain incompletely defined, with no confident biological mechanism assertable beyond the requirement of neglect itself.

25.8 Associated features, comorbidity and course

What travels with the disorder travels with it because of the shared root in neglect. The associated problems are largely those of a deprived early environment: **developmental delays**, particularly in cognition and language, together with stereotypies and the physical stigmata of severe neglect such as malnutrition. Internalising symptoms may co-occur; a relationship with externalising problems or with attention-deficit/hyperactivity disorder has been suggested but is not clearly established, and the reader should hold it loosely. The course is the most hopeful part of the picture and the part most dependent on what happens next. Signs of the disorder typically recede within months once the child is placed in an adequate caregiving environment; in the absence of that enhanced caregiving the signs may persist for several years. Prognosis, in short,

tracks the quality of the post-neglect caregiving far more than any property of the child. The full evidence on institutional deprivation and its remediation, and the interventions themselves, are the province of the attachment-disorder management account elsewhere in this chapter.

PITFALL

When a child's withdrawn signs persist after placement in what looks like a good home, the reflex is to call the treatment a failure or the child untreatable. The more useful reading is that a withdrawn, unrewarding child is genuinely hard to warm to, and can quietly elicit less engaged caregiving even from willing carers - a continuing de facto neglect that keeps the disorder alive. The clinical task then is not to abandon the placement but to support the caregiver's sensitivity, because persistence is often a sign that the child is still not, in practice, receiving the responsive care the diagnosis presumes was missing.

25.9 ICD-11, and telling the disorder apart from its mimics

The two classifications converge, and the differentials are where marks are won or lost. The ICD-11 clinical descriptions mirror the manual approach with closely similar requirements - a history of grossly insufficient care, a persistent and pervasive pattern of inhibited, emotionally withdrawn behaviour toward caregivers with both the minimal comfort-seeking and the minimal response to comfort, and the insufficient care presumed responsible - coding the disorder as **6B44**, its ICD-10 predecessor having been the reactive attachment disorder of childhood, F94.1. Where the neglect has taken the form of repetitive maltreatment such as chronic physical or sexual abuse, the child is additionally at risk of co-occurring post-traumatic stress disorder or complex post-traumatic stress disorder, so the same pathogenic care can generate a frank trauma disorder alongside the attachment disturbance. Two differentials recur in examinations:

CONDITION	ATTACHMENT BEHAVIOUR	THE DISCRIMINATING POINT
Reactive attachment disorder	Comfort neither sought nor accepted	Requires a history of pathogenic care and a developmentally excessive failure of selective attachment
Childhood depression	Comfort still sought and accepted	Reduced positive affect and withdrawal overlap, but the depressed child's attachment is intact; consider this disorder only with significant social neglect and absent comfort-seeking
Intellectual developmental disorder	Selective attachment forms with development	The child with intellectual disability forms selective attachments once a developmental age of about seven to nine months is reached, with social-emotional skills matching cognitive level

The two examination differentials of reactive attachment disorder; in both the pivot is whether attachment behaviour - the seeking and accepting of comfort - is preserved.

The depression differential is genuine because both conditions show blunted positive affect and withdrawal, so the discriminator must be the attachment behaviour itself: the depressed child still turns to a caregiver and is soothed, and the neurovegetative signs and excessive guilt of depression are not features of the attachment disorder. The intellectual disability differential matters because developmental delay so often accompanies neglect; the resolution is that a child whose social-emotional functioning tracks their cognitive level has delay rather than an attachment disorder, and this disorder is diagnosed only when the failure to attach is out of step with the child's developmental level.

Carry into the exam: reactive attachment disorder is the inhibited, withdrawn child who neither seeks nor accepts comfort, arising from a documented history of pathogenic care presumed to be its cause, evident before age five in a child of at least a nine-month developmental age, with autism excluded.

TRAP **The two attachment disorders are mirror images, and candidates reliably swap them.** Reactive attachment disorder is the internalising, inhibited, emotionally withdrawn pattern - the child who will not turn to an adult. Its disinhibited sibling, taught separately here, is the externalising, indiscriminately sociable pattern - the child who wanders off with any stranger. Both spring from the same pathogenic care, but a vignette describing an over-familiar, boundary-less child is not this disorder, and answering "reactive attachment disorder" to it is the classic error.

IN INDIA

Because Indian services classify under ICD, the operative label in case files and referrals is the ICD entity coded 6B44, and the clinician works from its clinical descriptions rather than a separate criteria manual. The pathogenic-care contexts the criteria describe are far from rare here: children reared in institutions with high child-to-caregiver ratios, and children moved repeatedly between placements before adoption, are exactly the settings Criterion C names, so the caregiving history must be documented carefully, because the diagnosis stands or falls on it. The deprivation evidence and the interventions themselves belong to the attachment-disorder management account elsewhere in this chapter.

<10%	Before 5	9 months	>12 months
OF NEGLECTED CHILDREN, EVEN WHEN NEGLECT IS SEVERE	YEARS: THE ONSET GATE	MINIMUM DEVELOPMENTAL AGE TO DIAGNOSE	DEFINES THE PERSISTENT SPECIFIER

26 · Disinhibited social engagement disorder

A child who never learned that a stranger is a stranger. **Disinhibited social engagement disorder** turns on one arresting behaviour: the child walks up to adults they have never met, engages them with warmth and physical closeness, and will wander off with them showing none of the wariness a securely reared child of the same age keeps in reserve for the unfamiliar. Its essential feature is a manner of **culturally inappropriate, overly familiar** conduct with relative strangers that violates the social boundaries the child's own culture sets for that age. It is the

outward, sociable, boundary-crossing face of early adversity, and it is the mirror image of the withdrawn, comfort-refusing picture of the other attachment disorder of childhood, **reactive attachment disorder**, which is developed in its own right elsewhere in this chapter.

The examiner's interest here is discriminative and conceptual. This is a disorder that looks, to an untrained eye, like nothing worse than a friendly temperament, and the marks reward the candidate who can explain why an approach that charms an adult is in fact a marker of disturbed early development, who can hold the picture apart from the general impulsivity of attention-deficit/hyperactivity disorder, and who can name the specific ways it parts company from its sibling attachment disorder. This topic teaches disinhibited social engagement disorder in full: its phenomenology, its diagnostic criteria, the caregiving history it requires, its epidemiology, its comorbidity and differential, its course and its place in the two classifications. Reactive attachment disorder itself, the comparison of both attachment disorders with autism spectrum disorder, and the management of attachment disorders and the effects of institutional care are each owned elsewhere and are named here only where the reasoning needs them.

26.1 The essential feature: indiscriminate sociability that crosses boundaries

The abnormality is not that the child is friendly, but that the friendliness has no discrimination in it. The healthy toddler is sociable too, but their sociability is calibrated: warmth for the familiar, a checking wariness for the stranger, and a caregiver used as a secure base from which to venture and to which to return. In this disorder that calibration is absent. The child treats the unfamiliar adult as though they were a trusted figure, with a lack of the reticence that age and culture would ordinarily impose. Crucially, and unlike its withdrawn sibling, this pattern does not require or imply a failure of attachment. It can appear in children whose attachments range from clearly disturbed to apparently secure, which is the single most counter-intuitive fact about the condition and the one an examiner most likes to test. The behaviour is a marker of a particular kind of early experience rather than a direct readout of the child's bond with any one caregiver, and the sign frequently persists even after other, more obvious markers of neglect have resolved.

GOOD TO REMEMBER

Because the disinhibited approach can coexist with a formed and even secure attachment, the fact that a fostered or adopted child is visibly bonded to the new caregiver does not exclude the diagnosis. Clinicians who reason "but the child is attached to the parents, so this cannot be an attachment disorder" miss it routinely. Watch how the child behaves toward the unfamiliar adult in the room, not only toward the parent.

PITFALL

The most consequential clinical error is to read the overfamiliarity as endearing charm and to reassure the family that the child is simply outgoing. The willingness to go off with an unknown adult is a genuine safeguarding concern, not a personality quirk, and framing it as sociability both misses the disorder and leaves a vulnerable child unprotected.

26.2 Criterion A: the behavioural signature

The diagnosis is built on a pattern of actively approaching and engaging unfamiliar adults. The child must show at least **two** of four characteristic behaviours, so that no single incident carries the diagnosis and the requirement is for a genuine pattern. The four are drawn from the same underlying failure of stranger-wariness expressed at different moments of an encounter.

- Reduced or absent reticence in approaching and interacting with unfamiliar adults;
- Overly familiar verbal or physical behaviour, out of keeping with culturally sanctioned, age-appropriate social boundaries;
- Diminished or absent checking back with the caregiver after venturing away, even in unfamiliar settings;
- Willingness to go off with an unfamiliar adult with minimal or no hesitation.

MNEMONIC

Approaches, over-Familiar, no Checking-back, goes Off willingly

The four behaviours track a single encounter with a stranger from start to finish: the child moves in without hesitation, is too familiar too fast, does not glance back to the caregiver for reassurance, and will leave with the stranger. Any two of the four, sustained as a pattern, satisfy this criterion.

26.3 Criterion B: the disinhibition is social, not merely impulsive

This criterion is what keeps the diagnosis from collapsing into general impulsivity. The behaviours must reflect **socially disinhibited** conduct and not be limited to the impulsivity seen in attention-deficit/hyperactivity disorder. A child who blurts, interrupts and acts without forethought across every domain is showing a broad behavioural impulsivity; the child captured by this disorder shows a specific loss of the social brake that governs approach to unfamiliar people. The distinction is drawn inside the criteria set itself precisely because the two can look alike at a glance and because they genuinely co-occur. Attention-deficit/hyperactivity disorder is developed as its own entity in the ADHD and specific learning/communication disorders notes; the point of Criterion B is only to insist that the disinhibition on display is of the social, stranger-directed kind rather than a general failure of impulse control.

26.4 Criteria C and D: the required history of pathogenic care

No amount of overfamiliar behaviour makes the diagnosis without the caregiving history behind it. The child must have experienced a pattern of **extremes of insufficient care**, evidenced by at least one of three circumstances: social neglect or deprivation, in the form of a persistent lack of having basic emotional needs met by caregiving adults; repeated changes of primary caregiver that prevent stable attachments from forming, as with successive foster placements; or rearing in unusual settings that severely limit the opportunity to form selective attachments, the institutional nursery being the archetype. The accompanying criterion requires that this care is presumed responsible for the disturbance, so that the abnormal behaviour is tied causally to the deprivation and not merely coincident with it. This pathogenic-care requirement is shared, word for word, with the sibling attachment disorder, and the effects of deprivation and

institutional rearing are themselves the subject of a separate topic in this chapter; here the history is named as the necessary etiological gate through which the diagnosis must pass.

26.5 Criterion E, and the two things this disorder does not require that its sibling does

Here the two attachment disorders separate on the page of criteria, not just in clinical feel. The developmental requirement is modest: the child must have a **developmental age** of at least **9 months**, which simply ensures the child is developmentally capable of the selective attachment whose failure the disorder describes. What is far more testable is what the criteria do NOT contain. This disorder carries no criterion demanding onset before a particular age, and it carries no exclusion for autism spectrum disorder, whereas the sibling attachment disorder's criteria include both an onset requirement and an autism exclusion. A candidate who imports those two conditions into this diagnosis from the neighbouring one is making the error the examiners write the question to catch.

TRAP **Importing the sibling disorder's onset and autism rules.** Because the two attachment disorders share their pathogenic-care requirement, candidates assume the rest of the criteria match too, and wrongly demand an onset-before-age-five and rule the diagnosis out in a child with autism. Neither belongs here: this disorder has no onset-age criterion and no autism-spectrum exclusion. The attachment-versus-autism discrimination itself is owned by a separate topic in this chapter.

26.6 The specifiers: persistent and severe

Two specifiers record chronicity and intensity. The disorder is designated **persistent** when it has been present for more than **12 months**, marking the presentation as an entrenched rather than a transient one, which matters because a durable course carries different prognostic weight. It is designated severe when the child exhibits all of the criterion behaviours, each expressed at relatively high levels, rather than the minimum two that satisfy the diagnosis. The specifiers are not idle bookkeeping: an examiner may use them to check that a candidate grasps that this is a dimensional, persisting phenomenon and not a one-off observation, and the persistence specifier in particular foreshadows the disorder's tendency to endure.

26.7 Epidemiology

Rare in the population, and uncommon even among the deprived children in whom it is sought. The general-population prevalence is unknown, and the disorder appears genuinely rare; it develops in only a minority even of children who have suffered severe deprivation, which tells us that pathogenic care is necessary but far from sufficient and that other, still poorly understood factors decide which deprived child goes on to show the syndrome. Where a figure exists it comes from high-risk sampling: in low-income community populations in the United Kingdom the prevalence reaches **up to 2 per cent**. That single anchoring number should be read for what it is, an estimate from an enriched, deprived sample rather than a base rate for children at large, and its very scarcity is part of the teaching, because the clinician who expects to see the disorder often will over-diagnose ordinary sociability.

26.8 Comorbidity

The company it keeps points back to a shared failure of inhibition. In younger children and through middle childhood the disorder often co-occurs with attention-deficit/hyperactivity disorder and with the externalising disorders more broadly, a pattern that has been read as evidence of a shared deficit in **cognitive inhibitory control**: the same weak brake that fails to hold back the socially disinhibited approach may also underlie the broader disruptive picture. Autism spectrum disorder may also co-occur, which is one reason the criteria deliberately omit an autism exclusion. Alongside these, the conditions that travel with early neglect, cognitive and language delays and stereotypies, may be present as well, reflecting the deprivation the child has lived through rather than the attachment disorder as such. The co-occurring conditions are named here, not taught; each is owned by its own topic.

26.9 Differential diagnosis: distinguishing it from ADHD with social impulsivity

The local differential that the criteria themselves anticipate is with attention-deficit/hyperactivity disorder. A child with that disorder and prominent social impulsivity can approach strangers and act without the usual social caution, superficially resembling the disinhibited attachment picture. The separating principle is that this attachment disorder does not, of itself, involve difficulties with attention or hyperactivity: its abnormality is confined to the social, stranger-directed disinhibition, whereas the impulsive child's approach sits within a pervasive inattentive and overactive syndrome. When the full requirements for both are met, both may be diagnosed, and comorbidity is common rather than exceptional. The broader comparison of the attachment disorders with autism spectrum disorder is a distinct discrimination, owned by another topic in this chapter and cross-referring the Intellectual disability and autism spectrum disorder notes for autism itself.

> Carry this into the exam: a friendly, boundary-crossing child who will go off with a stranger, in the setting of a history of extremes of insufficient care, has the externalising attachment disorder, and unlike its withdrawn sibling it may persist even in a markedly improved home.

26.10 Course and prognosis: the persistence that defines the disorder

The prognostic signature is a stubborn independence from the quality of later care. Where the sibling attachment disorder tends to recede once a child is placed with an adequate, responsive caregiver, this disorder does not reliably follow the caregiving environment. Its outcome is only modestly associated with the quality of the post-neglect home, and in many cases the behaviour persists even after that environment has become markedly improved. A further dissociation sharpens the picture: the disorder has not been identified in children who first experience social neglect only after the age of 2 years, which points to a sensitive early window and suggests that the core deficit is not simply the current absence of an attachment relationship but something laid down early and carried forward. This is why the diagnosis is not merely a description of a child's present home but a statement about an enduring trait.

RULE **Good caregiving reliably rescues the withdrawn sibling; it does not reliably rescue this one.** The single most examined contrast between the two attachment disorders is prognostic. Reactive attachment disorder's signs typically fade with adequate care, whereas the disinhibited pattern frequently persists despite a markedly improved caregiving environment. Treat the persistence as the diagnostic and prognostic fingerprint of the disinhibited disorder.

AXIS OF CONTRAST	REACTIVE ATTACHMENT DISORDER (NAMED FOR COMPARISON)	DISINHIBITED SOCIAL ENGAGEMENT DISORDER (THIS TOPIC)
Core behaviour toward others	Emotionally withdrawn, rarely seeks or responds to comfort	Indiscriminately sociable, over-familiar with unfamiliar adults
Emotional direction	Internalising	Externalising, disinhibited
Relation to the attachment bond	Reflects an absent or grossly underdeveloped attachment	Can occur across attachments from disturbed to secure
Response to improved caregiving	Signs typically recede with adequate care	Often persists despite markedly improved care
Onset-age and autism-exclusion criteria	Both present in its criteria set	Neither present

The two attachment disorders share their pathogenic-care requirement but diverge on direction, on the role of the attachment bond, and above all on whether adequate care resolves them; the disinhibited disorder is named for comparison here and taught in full only in its own right.

26.11 Classification: ICD-11, and a material difference over onset

Both major systems recognise the disorder, but they do not define it identically. In ICD-11 it is coded **6B45** and requires, as its essential features, a history of grossly insufficient care together with a persistent, pervasive pattern of reduced or absent reticence in approaching unfamiliar adults. The examinable divergence lies in onset: the ICD-11 description states that the symptoms are evident before the age of 5 years, whereas the DSM criteria impose no onset-age requirement at all and set only the modest developmental-age floor discussed above. It is held apart from autism by the indiscriminately social, over-familiar approach, the opposite of autism's social withdrawal, and by the absence of autism's restricted and repetitive behaviours. The predecessor category in ICD-10 was Disinhibited Attachment Disorder of Childhood, coded F94.2, a label a candidate will still meet in older Indian records.

IN INDIA

Two things anchor the topic to Indian practice. First, most services still diagnose and code under ICD, so the operative labels are the current 6B45 and the legacy F94.2 that persists in older files, and the onset-before-five wording of the ICD description becomes clinically live for a child who presents late out of long institutional care. Second, the population in whom this disorder is realistically sought, children reared with severely limited opportunity to form selective attachments, maps directly onto childcare institutions and orphanage settings, which makes the pathogenic-care history the first thing to establish. The deprivation evidence and the management response, including the primacy of a stable and sensitive caregiver, are developed in the attachment-disorder management topic in this chapter and are not reproduced here.

9 months	up to 2%	12 months	6B45
MINIMUM DEVELOPMENTAL AGE	PREVALENCE, LOW-INCOME UK COMMUNITY SAMPLE	THRESHOLD FOR THE PERSISTENT SPECIFIER	ICD-11 CODE

27 · Differentiation of RAD and DSED from ASD

A severely neglected child and an autistic child can look strikingly alike across a clinic room, and telling them apart is the whole of these marks. A young child brought from an institution or a grossly depriving home may be socially odd, emotionally flat, poorly related and slow to speak, and the first diagnosis that comes to an inexperienced mind is autism. The task this topic sets is the disciplined separation of the two attachment disorders of childhood, **reactive attachment disorder** and **disinhibited social engagement disorder**, from **autism spectrum disorder**. The examiner is not testing whether you can define each condition; the criteria of the two attachment disorders are developed in their own right elsewhere in this chapter, and autism spectrum disorder is taught in full in the Intellectual disability and autism spectrum disorder notes. What is tested here is the reasoning that keeps a deprived child from being mislabelled autistic, and, just as importantly, that keeps a genuinely autistic child from having every deficit written off as the effect of a difficult early life.

The comparison runs along a small number of axes, and each of them cuts cleanly if it is asked properly: the history of care, the presence or near-absence of selective attachment, the quality of social communication, the presence or absence of a restricted and repetitive repertoire, and, decisively, what happens when the child is placed in a good environment. Hold those five questions in mind and the differential resolves; miss the history and it does not. This fragment teaches only the attachment-side view of the boundary. It names reactive attachment disorder and disinhibited social engagement disorder without re-teaching them, and it points to the Intellectual disability and autism spectrum disorder notes for autism spectrum disorder itself.

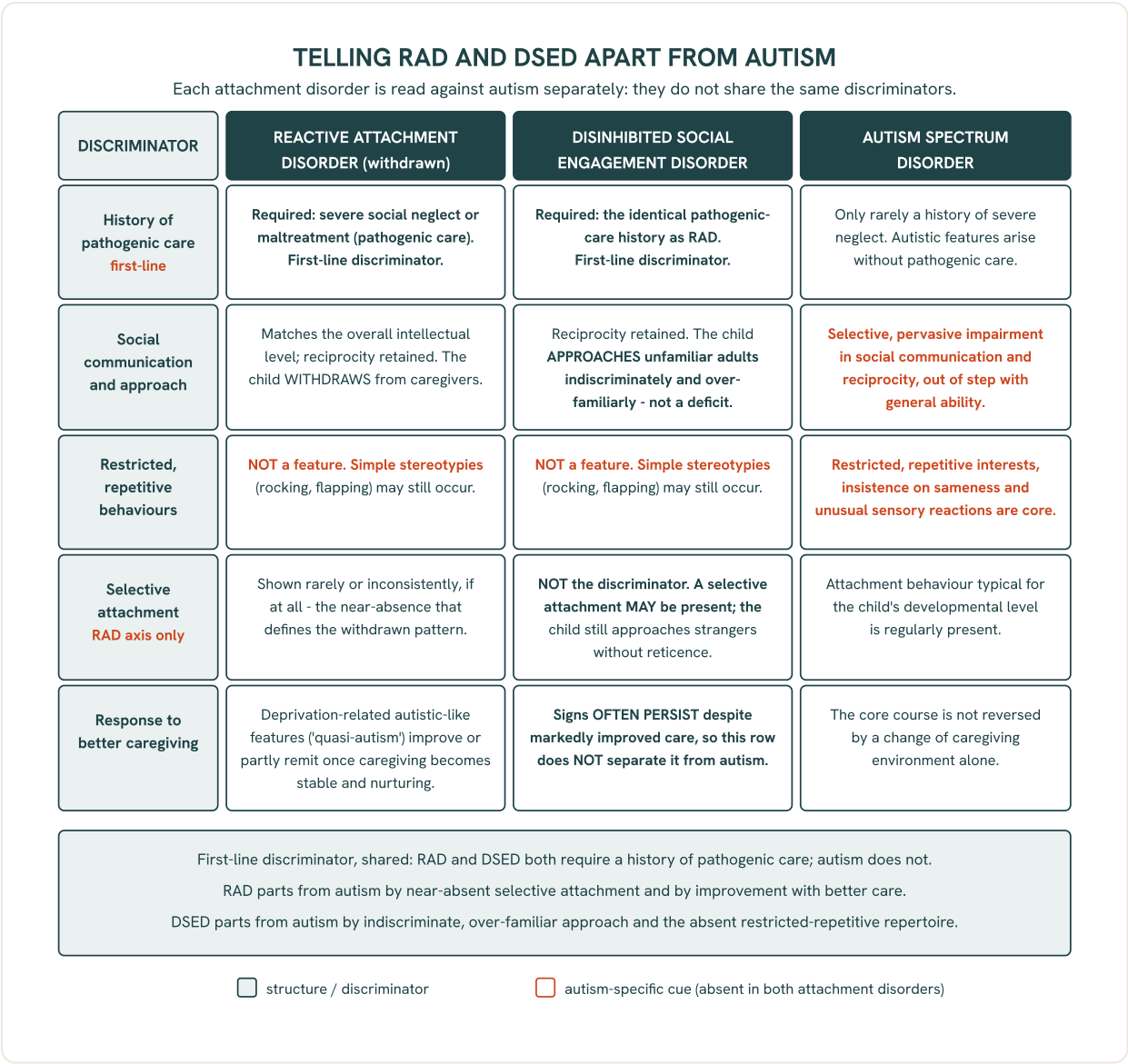


Fig 23.21. Telling reactive attachment disorder and disinhibited social engagement disorder apart from autism spectrum disorder, the attachment-side view, read separately for each disorder: the required history of pathogenic care is the first-line discriminator for both, while near-absent selective attachment and improvement of quasi-autistic features with better caregiving carry reactive attachment disorder, and indiscriminate, over-familiar social approach with preserved reciprocity carries the disinhibited disorder; the restricted-repetitive repertoire is absent in both; for autism spectrum disorder itself, see the Intellectual disability and autism spectrum disorder notes.

27.1 The required history of pathogenic care is the first-line discriminator

Begin with the history, because it is where the whole differential turns. The two attachment disorders are not free-standing behavioural pictures; each requires, as a diagnostic precondition, a documented **history of severe social neglect or maltreatment** - repeated changes of caregiver, institutional rearing, or a pattern of care that failed to meet the child's basic emotional needs. Autism spectrum disorder carries no such requirement and only rarely arrives with such a history. This asymmetry makes the care history the single most efficient opening question in the differential: an aberrant social presentation on a background of grossly inadequate care points first towards an attachment disorder, whereas the same presentation in a child whose early caregiving was adequate points away from it. The history does not, on its own, settle the diagnosis, because a maltreated child can also be autistic, but it sets the prior, and a candidate

who reaches for autism before taking the developmental and placement history has already made the classic mistake.

RULE **No pathogenic care, no attachment disorder; abundant pathogenic care, think of it first.** Reactive attachment disorder and disinhibited social engagement disorder both demand a history of grossly insufficient care as a precondition, while autism spectrum disorder does not. The care history is therefore the discriminator to establish before any other, and it reframes every social sign that follows.

27.2 Selective attachment behaviour: present in autism, scarce in reactive attachment disorder, beside the point in the disinhibited disorder

Autistic children do form attachments; the emotionally withdrawn attachment-disordered child largely does not. This is the point most candidates get backwards. Contrary to the old caricature of the autistic child as unattached, children with autism spectrum disorder regularly show **attachment behaviour typical for their developmental level** - they seek their parent when distressed, prefer familiar caregivers, and show the ordinary preferences of a bonded child, even if the social style around that bond is atypical. The child with reactive attachment disorder shows this selective, preferential attachment only rarely and inconsistently, if at all; the emotionally withdrawn pattern that defines that disorder is precisely a failure to turn to a discriminated attachment figure for comfort. Observing the child across separation and reunion, or simply watching whom the child goes to when hurt or frightened, is a practical way to elicit this contrast. The presence of developmentally expectable attachment is evidence for autism over reactive attachment disorder; its near-absence in a neglected child is evidence for the attachment disorder. Disinhibited social engagement disorder does not sit on this axis at all, and assuming that it does is the second reversal to avoid. The disinhibited child's difficulty is not a missing selective attachment but an indiscriminate, over-familiar approach to unfamiliar adults; such a child may hold an ordinary selective attachment to a caregiver and still go off with a stranger without reticence. Against autism, the disinhibited disorder is therefore separated by the direction and indiscriminateness of social approach, not by absent attachment.

27.3 Reciprocal social communication is selectively impaired only in autism

This is the axis that separates a delayed child from a deviant one. Autism is defined by a pervasive, selective deficit in **social-communicative behaviour** - impaired social reciprocity, deficits in non-verbal communication, and difficulty with relationships - that stands out against, and is disproportionate to, the child's general level of functioning. The child with reactive attachment disorder shows social communication that is broadly commensurate with their overall intellectual level: their language may be delayed by the deprivation itself, and their affect may be muted, but the capacity for reciprocal social interaction is retained rather than qualitatively deviant. In other words, the neglected child is often behind across the board, whereas the autistic child is specifically and disproportionately impaired in the social-communicative domain. The clinical move, therefore, is to ask whether the social deficit is out of step with the rest of development. If it is a selective peak of impairment, that favours autism; if the child's social relatedness tracks their general delay, that favours the attachment disorder. The disinhibited

disorder leaves reciprocal social communication intact in a way that is, if anything, more obvious: the disinhibited child approaches, talks to and engages unfamiliar adults readily and without reticence, which is the mirror image of the autistic child's reduced social approach and impaired reciprocity. Excessive, undiscriminating sociability is not a social-communication deficit, and it is the axis on which the disinhibited disorder parts from autism most cleanly.

27.4 The restricted, repetitive repertoire belongs to autism

The second pillar of autism is simply absent in the attachment disorders. Autism requires not only the social-communication deficit but a restricted, repetitive and inflexible repertoire. The **restricted interests and repetitive behaviours** that characterise autism are not a feature of reactive attachment disorder or disinhibited social engagement disorder. Concretely, what you look for and do not find in the pure attachment disorder is:

- excessive adherence to rituals and routines, with distress at small changes;
- restricted, fixated interests of abnormal intensity or focus;
- unusual sensory reactions - hyper- or hypo-reactivity to sounds, textures or lights.

A caveat prevents this axis from being used naively. Both attachment-disordered and institutionally reared children may show simple motor stereotypies such as body-rocking or hand-flapping, especially where stimulation has been sparse, and these can superficially mimic autistic mannerisms. A single stereotypy is not the restricted-repetitive-inflexible repertoire. What is specific to autism is the whole inflexible pattern - the insistence on sameness, the circumscribed interests and the sensory features together - not an isolated self-soothing movement that a barren environment has shaped.

27.5 Quasi-autism and the test of a nurturing environment

The clearest natural experiment in this whole differential is what a good home does to the picture. Some children reared under severe institutional deprivation develop a cluster of autistic-like features - difficulties in social reciprocity alongside restricted and repetitive behaviours - that is close enough to autism to be called **quasi-autism**. Here the static cross-sectional signs may genuinely overlap with autism, and the axes above can leave real doubt. The discriminator that does the work in these children is longitudinal, not cross-sectional: the deprivation-related picture shows significant improvement, or at least partial remission, when the child is moved into a stable, sensitive and nurturing environment, and that trajectory is what differentiates it from autism, in which the core features persist despite good caregiving. This is why placement in a good home is not only the treatment but part of the diagnostic test. A picture that lifts substantially with better care was never true autism; a picture that holds firm despite it is the real thing.

PITFALL

Overshadowing runs in both directions, and both are errors. The first is to see a socially odd, deprived child and diagnose autism at the first appointment, before the care history and before any period of stable placement has had a chance to reveal a reversible, quasi-autistic picture. The second, subtler, error is to assume that because a child was maltreated every deficit must be attachment-related, and so to miss a genuinely co-occurring autism that will not remit with a good home and needs autism-specific support in its own right. Neglect and autism can coexist; a maltreatment history does not exclude the neurodevelopmental diagnosis.

27.6 Bringing the axes together at the bedside

No single sign is pathognomonic; the diagnosis is the convergence of the axes plus the history plus the course. The efficient examination answer moves through the discriminators in order - the care history first, then attachment behaviour, then whether the social deficit is selective or part of a global delay, then the presence or absence of the restricted-repetitive repertoire, and finally the response to enhanced caregiving over time - and reads them together rather than trusting any one in isolation. Note which axes carry which disorder. The care history carries both attachment disorders. Absent selective attachment carries only reactive attachment disorder. The course axis carries reactive attachment disorder and quasi-autism, and it does not separate the disinhibited disorder from autism, because the signs of the disinhibited disorder often persist despite markedly improved care. What separates the disinhibited disorder from autism is the phenotype itself: an indiscriminate, over-familiar approach to strangers is the opposite of an autistic deficit in social approach and reciprocity, and the restricted, repetitive repertoire is absent. The accompanying figure lays out the same contrast so it can be recalled at a glance.

DISCRIMINATING AXIS	REACTIVE ATTACHMENT DISORDER	DISINHIBITED SOCIAL ENGAGEMENT DISORDER	AUTISM SPECTRUM DISORDER
History of care	Severe neglect or maltreatment required as a precondition	The same pathogenic-care history required	Only rarely a history of pathogenic care
Selective attachment	Rare, inconsistent or absent	Not the discriminator; a selective attachment may be present	Present and typical for developmental level
Social communication	Commensurate with overall intellectual level; capacity for reciprocity retained	Reciprocity retained; social approach is indiscriminate and overfamiliar rather than deficient	Selectively and disproportionately impaired
Restricted, repetitive repertoire	Not a feature; isolated stereotypies may occur	Not a feature; isolated stereotypies may occur	Present - rituals, fixated interests, sensory features
Course with a nurturing environment	Improves; deprivation-related features can remit	Signs often persist despite improved care; this axis does not discriminate it from autism	Core features persist despite good caregiving

The attachment-side comparison across the five axes that carry the differential, read separately for each attachment disorder; the care history discriminates both from autism, the attachment and course rows carry reactive attachment disorder, and the disinhibited disorder is separated from autism by indiscriminate social approach and the absent restricted-repetitive repertoire.

TRAP **Reversing the attachment axis.** The examination favourite is the belief that the autistic child is the one who cannot attach. It is the reactive attachment disorder child who fails to show selective attachment; the autistic child usually attaches to caregivers in a developmentally typical way. State the direction correctly and this half of the question is won.

Carry this into the exam: a required history of pathogenic care, plus improvement of autistic-like features once the child is in a stable and nurturing home, points to an attachment disorder or quasi-autism, not to autism spectrum disorder.

GOOD TO REMEMBER

Do not force the diagnosis at a single visit for the deprived, socially atypical young child. Establish the care history, observe selective attachment directly through separation and reunion, judge whether the social deficit is selective or part of a global delay, and then let time in a stable placement do its diagnostic work. If the picture lifts with good care, it was on the attachment-and-deprivation side; if it holds firm, take the autism diagnosis seriously and arrange autism-specific assessment and support.

IN INDIA

The differential is unusually live in Indian practice because institutional and multiply-disrupted care is not rare: children present from orphanages, children's homes and severely deprived family settings, and many are seen first around adoption or foster placement. Two practical points follow. Most services diagnose under ICD, which frames both the attachment disorders and the quasi-autism boundary, and this favours a longitudinal view - reassessing after the child has spent time in a settled home rather than fixing an autism label at intake. And because language delay in these children so often reflects deprivation and a multilingual environment rather than a communication disorder, the social-communication axis must be judged against the child's whole developmental level, not against a single clinic-room silence. The full assessment battery and the services and protection pathways for such children sit in the Child psychiatry: assessment, treatment, services and protection notes.

History	Attachment	Repertoire	Course
SEVERE NEGLECT REQUIRED IN THE ATTACHMENT DISORDERS, ONLY RARELY PRESENT IN AUTISM	DEVELOPMENTALLY TYPICAL IN AUTISM, SCARCE IN REACTIVE ATTACHMENT DISORDER	RESTRICTED AND REPETITIVE ONLY IN AUTISM, NOT IN THE ATTACHMENT DISORDERS	QUASI-AUTISM IMPROVES WITH A NURTURING HOME; AUTISM PERSISTS

28 · Management of attachment disorders and effects of institutional care

This is the one childhood disorder whose treatment is a person, not a prescription. The two attachment disorders of early childhood, the emotionally withdrawn reactive attachment disorder and the indiscriminately sociable disinhibited social engagement disorder, both arise from the same soil: grossly insufficient care in the years when a child should be forming a selective attachment to one or two committed adults. Those two syndromes are described in full in their own right elsewhere in this chapter; what this topic owns is the ground beneath them - the effects of institutional rearing and early deprivation - and the management that follows from it. The marks here are conceptual and safety-critical at once. An examiner is checking that you understand the intervention is psychosocial and relational rather than pharmacological, that the two disorders respond differently to a good caregiver, and that the coercive "attachment therapies" sometimes marketed to desperate families are not merely unproven but have killed children.

The etiological premise is a form of **pathogenic care**: care so deficient, or so repeatedly interrupted, that the child never has the stable, responsive adult a secure attachment requires. Institutional rearing is the purest natural model of this, and it is why the entire evidence base rests on children raised in institutions and then placed in families. The requirement that pathogenic care precede the diagnosis is the etiological context the two disorder sections depend on; here it is the starting point for everything that follows.

28.1 The rearing that produces the two patterns

Two divergent behaviour sets emerge from the same deprivation. The observational basis for the modern classification is old and instructive. In **Barbara Tizard**'s study of institution-reared children whose caregivers had been explicitly instructed not to form attachments with them, of

26 such children, 8 nonetheless formed secure attachments, 8 were emotionally withdrawn and unresponsive in the pattern we now call reactive attachment disorder, and 10 were indiscriminately social with unfamiliar adults in the pattern we now call disinhibited social engagement disorder. Earlier still, Rene Spitz's descriptions of anaclitic depression in institutionalised infants foreshadowed the withdrawn phenotype. The lesson embedded in those numbers is that deprivation is a probabilistic exposure, not a deterministic one: even under an instruction not to bond, roughly a third of the children found an attachment anyway, which is the first clue that resilience and the availability of even one responsive adult matter enormously.

28.2 Timing and dose: the developmental window

The longer and the earlier the deprivation, the greater the harm. Risk is graded by both the duration of deprivation and the age at which it occurs. Attachment disorders are very rare in children adopted **before 6 months** of age, and signs of disinhibited social engagement have not been reported in children whose deprivation began only after the age of two years, marking a sensitive early period during which the developing attachment system is most vulnerable. Brief institutional care leaves children resembling their never-institutionalised comparison groups on most measures, and the neurophysiological differences seen in deprived children are no longer detectable at age eight if the child is placed with a family before twenty-four months. Yet the potency of prolonged deprivation is sobering: only **about 15%** of children adopted after at least six months of institutional rearing in Romania were free of any diagnosable disorder at any point into their mid-twenties.

- duration of deprivation - the longer the child lives in it, the more likely the disorders;
- age at onset - the early months carry a sensitive window, and disinhibited signs are tied to deprivation that begins early;
- age at placement - earlier rescue is associated with greater reversibility of the measurable deficits.

28.3 The natural experiment: the two disorders diverge under a good caregiver

Foster care turned into a randomised trial is what proves the point. The strongest evidence comes from the **Bucharest Early Intervention Project**, a prospective randomised controlled trial of high-quality foster care as an alternative to continued institutional care. Children with reactive attachment disorder randomised to foster families showed a reduction in symptoms within months of placement, falling to the levels of a community sample of never-institutionalised children. Children with disinhibited social engagement disorder in the same trial continued to show behaviours consistent with the diagnosis after placement, typically improving but not fully resolving. The **English and Romanian Adoptees study** converges on the same split: Romanian children adopted into English families no longer manifest reactive attachment disorder but continue to show persistent signs of disinhibited social engagement. The interpretation is the heart of the topic. Reactive attachment disorder behaves like a condition of missing attachment, so it lifts once a real attachment forms; disinhibited social engagement

behaves like something more enduring, whose core deficit is not simply the absence of an attachment relationship.

AXIS	REACTIVE ATTACHMENT DISORDER	DISINHIBITED SOCIAL ENGAGEMENT DISORDER
Response to a stable, sensitive caregiver	Symptoms reduce toward those of never-institutionalised community children	Signs reduce but commonly persist rather than resolve
Persistence after adoption	Does not continue once an attachment forms	Can persist in a minority even after attachments to the new family form
What this implies about the deficit	Essentially a lack-of-attachment state, remediable by the relationship	Not reducible to a missing attachment; a more enduring social-behavioural disturbance

The two disorders share a cause but not a prognosis under treatment; the differential response to a good caregiver is itself diagnostic teaching.

TRAP **Assuming both disorders remit fully once the child is placed in a loving home.** They do not. Reactive attachment disorder largely resolves with a positive caregiving environment, but disinhibited social engagement signs frequently persist even after the child has clearly formed attachments to the new caregivers. A candidate who writes that placement cures both has missed the single most examined discrimination in this topic.

28.4 The long reach of early deprivation

The effects outlast childhood and broaden well beyond attachment. Follow-up of the English and Romanian adoptees into **early adulthood, at ages 22 to 25**, found that those with longer institutional care before adoption had lower educational achievement, higher unemployment, and greater use of mental-health services. Prolonged deprivation was also associated with high rates of attention-deficit and autistic-type features and of callous-unemotional traits, and self-reported emotional symptoms actually rose from adolescence into adulthood rather than fading. This tells the clinician that institutional deprivation is not a narrow attachment problem but a broad neurodevelopmental and psychiatric risk exposure, and that some of its consequences declare themselves only years after the child is safe and settled. Where a deprived child later carries attention or behavioural difficulties, those are treated on their own terms; the treatment of the general attention-deficit disorder and its medication is the ADHD and specific learning/communication disorders notes'.

PITFALL

The recurring clinical error is to attribute every later difficulty in a post-institutional child to "attachment", and so to miss a comorbid, treatable disorder. A previously deprived child with genuine attention-deficit hyperactivity or autistic features needs that condition assessed and managed directly, not reframed as an attachment wound. Over-psychologising the history leaves an eminently treatable comorbidity untreated.

28.5 Management, first principle: secure the child's safety

Nothing else begins until the child is safe. Because these disorders arise from maltreatment or grossly deficient care, the first step of management is to assess and secure the child's safety, which includes medical referral for the consequences of neglect, involvement of child protective services where warranted, and an assessment of parental fitness. This is not bureaucratic sequencing: child maltreatment carries significant morbidity and non-trivial mortality, particularly in the youngest children, so establishing safety is genuinely the intervention that comes before all others. Only once safety is established does full attention turn to the psychosocial work of building an attachment.

IN INDIA

Institutional rearing remains a live reality here, with large numbers of children in child-care institutions, and national policy increasingly favours family-based alternatives - kinship care, foster care and adoption - over long-term institutionalisation. The statutory machinery for protection and placement is not taught here; that framework belongs to the Child psychiatry: assessment, treatment, services and protection notes. Two cautions for the exam. First, no Indian general-population prevalence figure for either attachment disorder is established, so quote none: the evidence base is Western institutional and adoption cohorts. Second, the same policy shift the evidence supports, moving children out of institutions and into responsive families, is exactly what the Romanian and English data would predict helps most.

28.6 The core intervention: a stable, sensitive caregiver

Everything effective in this topic reduces to one relationship. The central, evidence-informed intervention for both disorders is to provide and support a primary attachment figure who is sensitively responsive, who values the child as an individual, and who places the child's needs ahead of their own. For reactive attachment disorder this is frequently sufficient in itself: the symptoms generally resolve once the child is in a family that offers a genuinely positive caregiving environment. For disinhibited social engagement disorder, clinical consensus adds a further, face-valid but formally unevaluated measure - limiting the child's unnecessary contact with unfamiliar adults for several months so that a selective attachment to the new caregivers has room to consolidate before the child's sociability is diffused across everyone they meet.

RULE **The treatment is a committed, sensitive caregiver, and the relationship itself is the active ingredient.** Interventions work to the extent that they install and support one responsive adult who consistently reads and meets the child's needs; techniques that do not serve that end do not treat the disorder. This is why placement quality, not any specific therapy, is the strongest lever available.

GOOD TO REMEMBER

Once the child is safe, the most powerful thing a clinician can arrange is stability of caregiving - one committed adult, protected from disruption and repeated moves, over a long horizon. Placement breakdown and a revolving door of carers reproduce the original injury. Supporting the caregiver so the placement holds is itself the treatment, not a preliminary to it.

28.7 Dyadic therapies, medication, and the interventions to refuse

Add structured dyadic work, keep medication in its lane, and never coerce. Where more than placement is needed, the attachment-specific treatments focus on the **adult-child dyad** and include the Circle of Security, Attachment and Biobehavioral Catch-Up, and child-parent psychotherapy. These combine developmental guidance with review of videotaped parent-child interaction and attend to instrumental problems such as housing and medical care; long-term intervention is often necessary. Pharmacotherapy has no role in the core attachment disorder itself: the standard account describes management as entirely psychosocial, and no medication is directed at reactive attachment disorder or disinhibited social engagement disorder as such, with any drug treatment reserved for a co-occurring condition rather than the attachment disorder. Finally, the discriminating clinician must actively refuse a category of harm: the **coercive "attachment therapies"** - holding and restraint procedures, "rebirthing" and the like - are discredited by the 2016 practice parameters of the American Academy of Child and Adolescent Psychiatry and have caused the deaths of children. Management is the sensitive-caregiver and dyadic model, never coercion.

MNEMONIC

Secure, Attach, Support, Refuse

Secure the child's safety first; build the primary **A**ttachment through one sensitive caregiver; **S**upport that dyad with manualised therapy and treat comorbidity only; **R**efuse coercive holding and restraint "therapies" outright.

The active treatment is a stable, sensitively responsive caregiver: reactive attachment disorder largely resolves with it, disinhibited social engagement disorder only partly, medication treats only comorbidity, and coercive holding therapies are never used and have killed children.

about 15%	before 6 months	22 to 25	26
OF LONG-INSTITUTIONALISED ROMANIAN ADOPTEES FREE OF ANY DISORDER INTO MID-TWENTIES	ADOPTION AGE BELOW WHICH ATTACHMENT DISORDERS ARE VERY RARE	AGE AT WHICH ADULT ADOPTEE OUTCOMES WERE ASSESSED	INSTITUTION-REARED CHILDREN IN THE FOUNDING BEHAVIOURAL OBSERVATION

Tic disorders and Tourette syndrome

29 · Classification of tic disorders (transient, chronic, Tourette)

Classification here is made almost entirely by the clock. A child brought in for repetitive blinking, sniffing or throat-clearing does not arrive with a diagnosis attached; what turns a description of movements into one of several named disorders is a small set of rules about how long the tics have lasted, whether they are motor, vocal or both, and whether an earlier tic diagnosis has already been made. Those rules are worth a disproportionate share of the marks,

because they are simple to state, easy to half-remember, and endlessly examinable: a single-word change, "and" to "or" or "less than" to "more than", moves the child from one diagnosis to another.

This section owns the classificatory scaffold: what counts as a tic at all, how simple tics are separated from complex ones, the full set of diagnostic categories, the duration and modality rules that divide them, the type specifier, and the hierarchy that governs which label a child may hold. The full diagnostic criteria and phenomenology of Tourette's disorder, the neurobiology, the comorbidity pattern with attention-deficit/hyperactivity disorder and obsessive-compulsive disorder, the management of tics, and the differentiation of tics from other abnormal movements are each developed in their own right elsewhere in this chapter; here they are named where the classification touches them, not reopened.

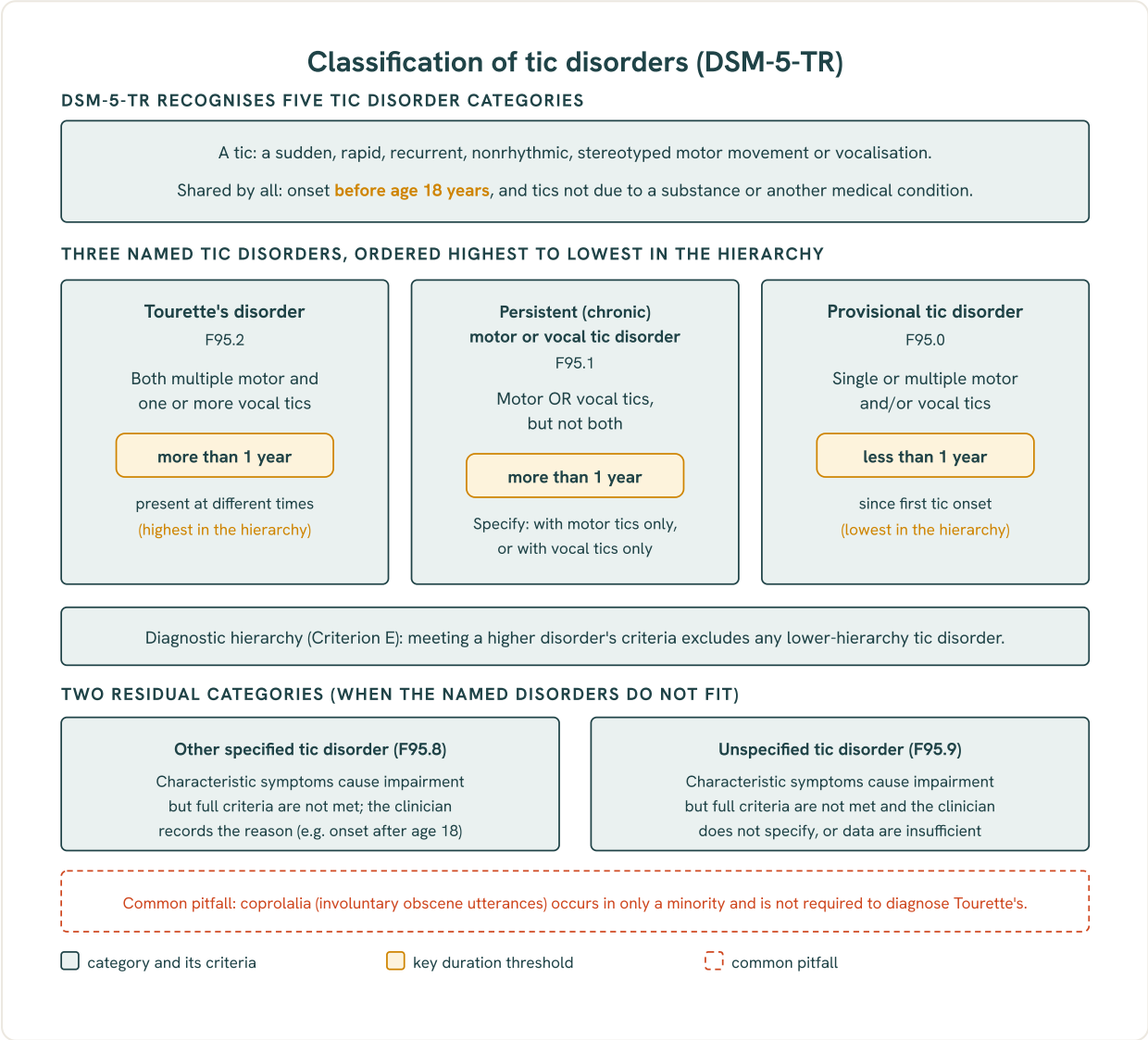


Fig 23.22. Classification of tic disorders: the three named DSM-5-TR disorders ordered by hierarchy - Tourette's disorder (both motor and vocal tics), persistent (chronic) motor or vocal tic disorder, and provisional tic disorder (less than 1 year) - together with the two residual categories and the coprolalia pitfall.

29.1 What counts as a tic

Everything downstream rests on one definition. A **tic** is a sudden, rapid, recurrent, nonrhythmic, stereotyped motor movement or vocalisation. Each word does work. *Sudden* and *rapid* mark the tic as fast and abrupt, unlike the slow writhing of a dystonic movement; *recurrent*

and *stereotyped* capture that the same movement repeats in a fixed form; *nonrhythmic* separates it from tremor, which is regular and oscillatory. The same definition covers both the motor and the vocal forms: a vocal tic is simply a tic whose effector is the respiratory and laryngeal apparatus, which is why a sniff, a grunt or a throat-clear is classified alongside a blink or a shrug rather than treated as something categorically different. Two further features, which sit in the phenomenology rather than the bare definition, make tics recognisable at the bedside and are developed with the Tourette phenomenology elsewhere in this chapter: tics are typically preceded by an uncomfortable premonitory urge and are, for a time, voluntarily suppressible. Naming them here is enough; the classification does not turn on them.

29.2 Simple and complex tics, and the taboo phenomena

Within both the motor and vocal channels, tics run from the fragmentary to the orchestrated. **Simple tics** are brief and meaningless: simple motor tics such as eye-blinks, facial grimaces and shoulder shrugs, and simple vocal tics such as throat-clearing, sniffing and grunting. **Complex tics** are longer, more elaborate and can look purposeful, which is exactly what makes them hard to read: complex motor tics include echopraxia (imitating another's movements) and copropraxia (obscene gestures), and complex vocal tics include palilalia, echolalia and coprolalia. The three "-lalia" terms are constantly confused and constantly examined, so fix them: **echolalia** is repeating the last word or sound one has just heard, **palilalia** is repeating one's own sounds or words, and **coprolalia** is the involuntary uttering of obscene or taboo words. Coprolalia is the feature the public most associates with Tourette's, and that association is the source of the single most common misconception in the topic, because it is present in only a minority and is required for no tic diagnosis at all.

TRAP **Coprolalia is neither necessary nor common.** The examination reflex, and the lay assumption, is that a diagnosis of Tourette's requires the patient to swear involuntarily. It does not. Coprolalia appears in only a minority of those affected and is a feature of no tic disorder's criteria. A candidate who makes coprolalia a requirement, or who withholds a tic diagnosis because it is absent, has mistaken a striking piece of phenomenology for the definition.

29.3 The diagnostic categories, and the logic that orders them

One organising idea makes the whole scheme memorable. The current DSM-5-TR classification recognises **five** tic-disorder categories: Tourette's disorder; persistent (chronic) motor or vocal tic disorder; provisional tic disorder; and the two residual categories, other specified and unspecified tic disorder. Which of the first three a child receives is decided by three things: the duration of the tics, their modality (motor, vocal or both), and whether an earlier tic diagnosis has already been made. Duration draws the line between the short-lived and the persistent; modality draws the line between the single-channel disorder and Tourette's; and the diagnostic history, through the hierarchy rule, prevents a child from sliding down into a lesser label. Hold that trio and the categories almost derive themselves; memorise the boxes without the logic and they blur together in exactly the way examiners rely on.

MNEMONIC

Time, then modality, then history

Read the three deciding questions in order. **Time:** have the tics lasted under a year or beyond it? Under a year and the label is provisional; beyond it and the disorder is one of the persistent forms. **Modality:** among the persistent forms, is only one channel involved, or are both? One channel is persistent (chronic) motor or vocal tic disorder; both is Tourette's. **History:** the hierarchy then forbids demoting a child who already qualifies for a higher category. Three questions, in that order, and every case lands in exactly one box.

29.4 Provisional tic disorder: the transient category

This is the diagnosis for tics that have not yet earned a chronic label. Provisional tic disorder is diagnosed when a child has single or multiple motor and/or vocal tics that have been present for **less than a year** since the first tic appeared, with onset in childhood, not attributable to a substance or another medical condition, and in a child who has never met criteria for Tourette's or a persistent tic disorder. The word "provisional" is deliberately provisional: at diagnosis one cannot know whether the tics will fade in a few months, as most childhood tics do, or persist past the year and convert the diagnosis into a chronic one. The older literature, and current Indian practice, call this same picture *transient tic disorder*, and the change of name matters: "transient" pre-judged an outcome knowable only in retrospect, whereas "provisional" states honestly that the diagnosis is held pending the passage of time. The motor-only or vocal-only specifier is not applied here; that distinction belongs only to the persistent disorder.

29.5 Persistent (chronic) motor or vocal tic disorder, and its specifier

The defining move here is the exclusive "or". Persistent (chronic) motor or vocal tic disorder is diagnosed when a child has had tics of one modality only, motor tics or vocal tics but not both, which may wax and wane in severity yet have persisted for **more than a year** since the first tic, again with childhood onset, not due to a substance or medical condition, and in a child who has never met criteria for Tourette's. The most consequential words in the whole classification are that "not both": the presence of even one vocal tic in a child who also has motor tics, once the year has passed, moves the diagnosis out of this category and into Tourette's. Because the disorder is restricted to one channel, it carries a required **type specifier**, either "with motor tics only" or "with vocal tics only", recording which channel is involved. That specifier exists only here; it is meaningless for Tourette's, where both channels are present by definition, and for the provisional disorder, where the picture is still unsettled.

29.6 Tourette's disorder at the apex

Tourette's is the category defined by the presence of both channels. Tourette's disorder sits at the top of the tic-disorder classification, and the feature that places it there is the requirement for both multiple motor tics and at least one vocal tic over the course of the illness, though the two need not be present at the same time. That both-modalities rule is the whole of what the classification needs from Tourette's; the full criteria, the characteristic waxing-and-waning course, the premonitory urge and the rest of the phenomenology are developed in their own right

elsewhere in this chapter and are not restated here. What matters for classification is the contrast with the category beneath it: where the persistent motor or vocal tic disorder is single-channel by rule, Tourette's is dual-channel by rule, and a child accrues the Tourette's label the moment both a motor and a vocal tic have been present over the required span of time. The coprolalia the public expects plays no part in this; a child with only simple motor and vocal tics and no obscene utterance whatsoever still has Tourette's once both channels and the duration are satisfied.

29.7 The diagnostic hierarchy and the one-way rule

The categories are not a menu; they are a ladder. The tic-disorder diagnoses are **hierarchical**, running from Tourette's at the top, through persistent (chronic) motor or vocal tic disorder, to provisional tic disorder, with the two residual categories beneath. The operative rule, written into each disorder's criteria as its exclusion clause, is that once a child has ever met criteria for a disorder higher in the hierarchy, a lower diagnosis can no longer be made. A child who has qualified for Tourette's cannot later be re-labelled with a persistent single-channel disorder simply because, at one review, only motor tics happen to be active; the higher diagnosis, once earned, holds. This is why the diagnostic history is the third deciding question and not an afterthought: the classification is cumulative and one-directional, and it deliberately resists the temptation to downgrade a child to a milder-sounding label during a quiet spell.

RULE **Duration and modality assign the category; the hierarchy protects it.** Under a year of tics is provisional; beyond a year it is one of the persistent forms; one channel among those is persistent motor or vocal tic disorder and both channels is Tourette's. The hierarchy then adds a one-way lock: a diagnosis once met at a higher level cannot be exchanged for a lower one. Every genuinely difficult classification question in this topic is testing one of those two mechanisms.

29.8 The residual categories, the whole scheme in one view, and the boundaries

The two residual categories catch what the specific ones cannot. Other specified tic disorder is used when a tic presentation causes clinically significant distress or impairment but does not meet the full criteria for any specific tic disorder, and the clinician chooses to record the particular reason (for example an onset after the childhood window). Unspecified tic disorder is used for the same sub-threshold situation when the clinician does not state the reason, or when there is insufficient information to do so. Both exist so that a real, impairing tic problem that sits outside the neat boxes still has a home in the record rather than being forced into a category it does not fit.

CATEGORY	TICS REQUIRED	DURATION	TYPE SPECIFIER
Provisional tic disorder	Motor and/or vocal	Less than a year	Not applied
Persistent (chronic) motor or vocal tic disorder	Motor *or* vocal, not both	More than a year	Motor only / vocal only
Tourette's disorder	Both motor and vocal	Long-standing	Not applied
Other specified / unspecified	Sub-threshold or atypical	Any	Not applied

The three specific categories read across duration and modality, with the residual pair holding the sub-threshold and atypical presentations; the accompanying figure lays the same decision out as its three ordered questions.

Two boundaries complete the picture without belonging to the classification proper. The first is with the other abnormal movements a tic must be told apart from before it even enters this scheme, because only a genuine tic is classified at all. The discriminating features are developed in their own right elsewhere in this chapter; here they are simply named:

- the stereotypies of stereotypic movement disorder and of autism spectrum disorder;
- chorea and the other hyperkinetic movement disorders;
- dystonia; and
- the compulsions of obsessive-compulsive disorder.

The second boundary is with normal childhood. Transient tics are common in school-age children and frequently resolve without ever crossing into a disorder, so the categories describe the impairing or persistent minority, not every child who blinks or clears the throat.

PITFALL

The commonest clinical error is to reach for a chronic-sounding label too early. A child seen a few weeks into a bout of blinking has, by definition, a provisional picture, and naming it Tourette's or a persistent disorder before the year has elapsed both overstates the prognosis to an anxious family and, because of the one-way hierarchy, is hard to walk back. The opposite error is to treat every fleeting tic as pathological, when brief tics are a common and usually self-limiting part of childhood. The clock, not the severity of a single clinic snapshot, decides the category.

IN INDIA

Routine Indian services classify under ICD rather than the manual these criteria are drawn from, and candidates should move comfortably between the two. The ICD scheme carries the same three-part structure under its own headings: a transient category for short-lived tics, a chronic motor or vocal category for the single-channel persistent form, and a combined category corresponding to Tourette's, so the logic of duration and modality transfers directly. The chief translation to remember is that the "provisional" label maps onto the older, and still widely used, term "transient tic disorder"; a child recorded as provisional under one system and transient under the other is the same child, filed by two manuals that agree on the substance.

GOOD TO REMEMBER

The category you assign changes the conversation you have. A provisional diagnosis is an occasion for measured reassurance, because most such tics remit; a persistent or Tourette's diagnosis reframes the problem as a longer-term condition whose burden usually comes less from the tics themselves than from the co-occurring attention and obsessional problems taken up elsewhere in this chapter. Assign the category by the rules, but let it, and not the alarming look of a bad spell of tics, set the tone of what you tell the family.

The one line to carry: duration sets provisional (under a year) against the persistent forms (over a year), modality sets single-channel persistent tic disorder against dual-channel Tourette's, and the hierarchy locks a higher diagnosis in place once it has been met.

Five	Under 1 year	Over 1 year	Both channels
TIC-DISORDER CATEGORIES	PROVISIONAL TIC DISORDER	PERSISTENT (CHRONIC) FORM	REQUIRED FOR TOURETTE'S

30 · Tourette syndrome diagnostic criteria and phenomenology

Tourette syndrome is the most recognisable and, in the public imagination, the most caricatured of the tic disorders, which is exactly why the exam tests whether a candidate can strip the caricature away and diagnose it on its actual rules. **Tourette's disorder** is a childhood-onset neurodevelopmental condition defined by the coexistence, at some point in the illness, of multiple motor tics and at least one vocal tic. A **tic** is a sudden, rapid, recurrent, non-rhythmic motor movement or vocalisation, and the whole diagnosis turns on recognising these movements for what they are and then applying four spare criteria that are almost entirely about pattern and time rather than about any single dramatic symptom. The marks here are not won by knowing that the condition exists; they are won by the discriminations - both tic types against one, the duration clock, the age ceiling - and by the phenomenology of the tic itself, which is what separates a tic disorder from every other movement disorder a child can present with.

This account owns the diagnostic criteria of Tourette's disorder and the phenomenology of tics: the criteria in full, the anatomy of simple and complex tics, the premonitory urge, the waxing-and-waning course, suppressibility and the factors that modify tics, the epidemiology across childhood, the trajectory into adult life and its suicide risk, and the standardised measurement of tic severity. The taxonomy of the tic disorders as a family - provisional, persistent and Tourette's - is set out in the classification account elsewhere in this chapter; the etiology and neurobiology, the pattern of comorbidity with attention-deficit/hyperactivity disorder and obsessive-compulsive disorder, the management of tics, and the formal differentiation of tics from stereotypies, chorea, dystonia and compulsions each belong to their own accounts here and are named only where the reasoning demands.

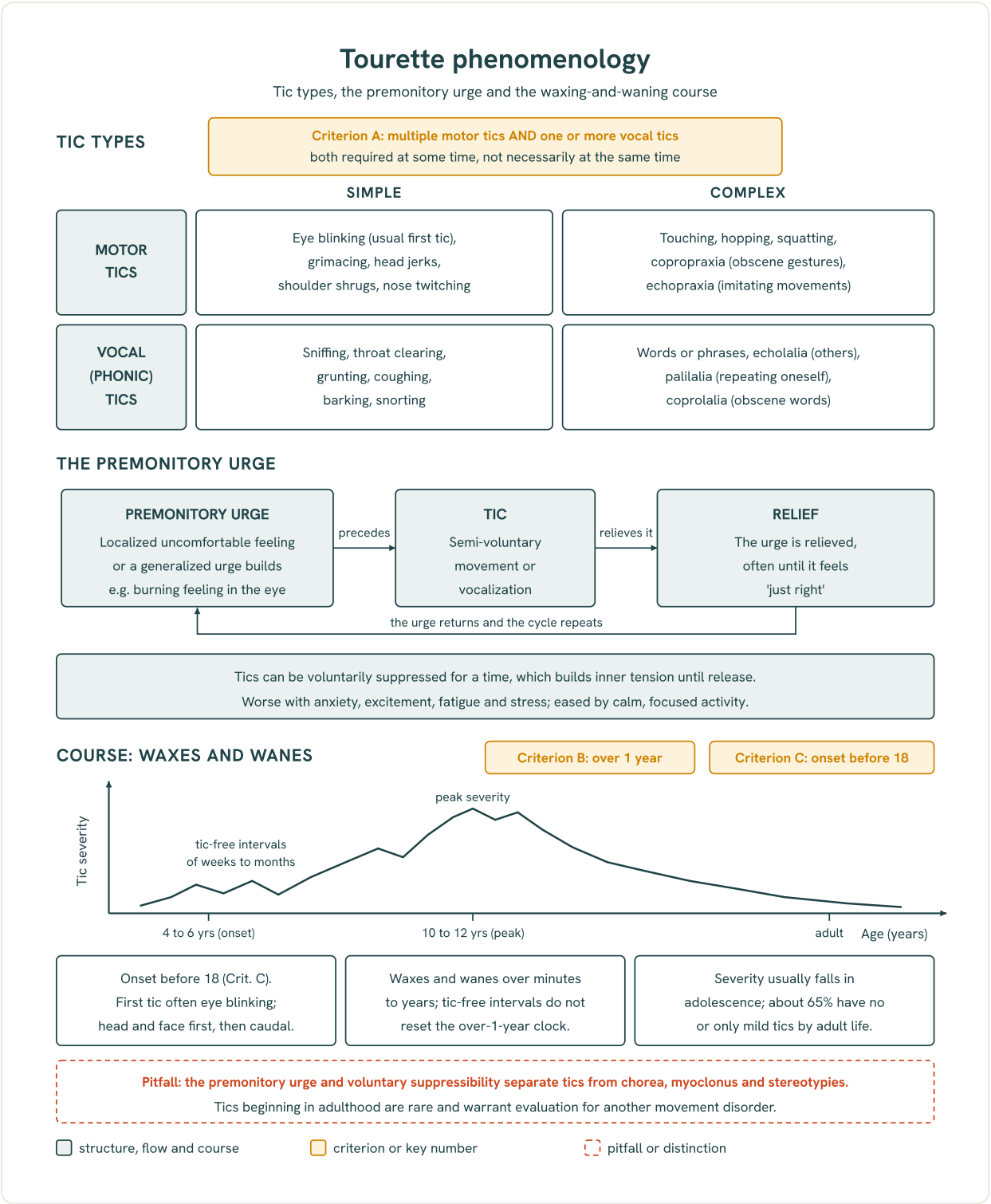


Fig 23.23. Tourette phenomenology: motor and vocal tics in simple and complex forms, the premonitory-urge-to-relief cycle, and the waxing-and-waning course from onset through peak severity to adult life.

30.1 Criterion A: both motor and vocal tics, and why that is the whole game

The single fact that makes a tic disorder Tourette's is the presence of both kinds of tic. Criterion A requires multiple motor tics and one or more vocal tics, and the crucial rider is that they must have been present at some time during the illness, though not necessarily concurrently. This is the discriminator that separates Tourette's from persistent (chronic) tic disorder, in which a child has motor tics only or vocal tics only but never both. A child may have had years of motor tics and only later develop a single throat-clearing or sniffing vocal tic; the moment both types

have been present, even if they never appeared in the same week, the diagnostic threshold for Tourette's is crossed. The corollary matters clinically: a boy currently showing only motor tics may still warrant the Tourette's label if a vocal tic featured earlier in his history, which is why the criterion is written around the whole course of the illness and not the cross-section in front of you. It is also why a careful longitudinal history, not just the present examination, is diagnostic.

RULE **Tourette's disorder is the tic disorder with both motor and vocal tics; the two types need never have coincided in time.** Persistent tic disorder carries one type only. The examiner is testing whether you read Criterion A across the lifetime of the illness rather than across the day of assessment, so a history of an earlier vocal tic in a currently motor-only child still satisfies it.

30.2 Criteria B, C and D: the duration clock, the age ceiling and the exclusions

The remaining three criteria are about time and attribution, and each is a discrete examinable rule. Criterion B is the duration requirement: the tics must have persisted for **more than one year** since the first tic appeared. The subtlety that catches candidates is that this clock is measured from the onset of the first tic and is *not* reset by tic-free intervals; the tics may wax and wane, and may even disappear for weeks, yet the year is counted from that first onset. Criterion C sets the age ceiling: onset of tics must be **before age 18**. A genuinely new tic disorder beginning in adult life is exceedingly rare and should prompt a search for another movement disorder or a secondary cause rather than a first diagnosis of Tourette's. Criterion D is the exclusion: the disturbance must be not attributable to the physiological effects of a substance or another medical condition, the classic offenders being a stimulant such as cocaine, and medical conditions such as Huntington's disease or a post-viral encephalitis. Together the four criteria form a pattern-and-time definition in which no single symptom is pathognomonic.

CRITERION	REQUIREMENT
A	Multiple motor tics and one or more vocal tics, at some time in the illness, not necessarily together
B	Tics have persisted more than one year from first onset, though they may wax and wane
C	Onset before age 18
D	Not attributable to a substance or another medical condition

The four diagnostic criteria of Tourette's disorder; A is the discriminator from persistent tic disorder, and B, C and D are the time-and-attribution rules that surround it.

MNEMONIC

Two types, one year, under eighteen, nothing else

Two types of tic, motor and vocal, at some time in the illness (A); persisting more than **one year** from first onset (B); onset **under eighteen** (C); and **nothing else** - not a substance and not another medical condition - accounting for it (D). Four spare rules, no single dramatic symptom, is the whole definition.

Carry into the exam: both multiple motor and one or more vocal tics at some time in the illness, persisting more than one year from first onset, with onset before age 18, and not due to a substance or medical condition.

30.3 The phenomenology of tics: simple, complex, and the first tic

Before the criteria can be applied, the movements have to be correctly identified as tics, and that is a phenomenological skill. Tics are conventionally sorted along two axes: motor against vocal, and simple against complex. **Simple tics** are brief and meaningless - an eye blink, a facial grimace, a head jerk or a shoulder shrug on the motor side; a sniff, a throat-clear, a grunt or a cough on the vocal side. **Complex tics** are longer, appear more purposeful and can look almost voluntary: touching, tapping, jumping or a coordinated sequence of movements on the motor side, and syllables, words or phrases on the vocal side. The complex vocal tics include the phenomena the condition is unfairly famous for - the involuntary utterance of obscenities, and the repetition of others' or one's own words - and it is worth stating plainly that these dramatic symptoms are uncommon and are in no way required for the diagnosis. Most patients never show them. The typical developmental sequence is characteristic: simple motor tics are the most common initial presentation, and eye blinking is the most common initial tic, with the tics tending to begin in the head and face and to progress caudally down the body as the child grows, complexity generally increasing with age.

	MOTOR	VOCAL (PHONIC)
Simple	Eye blink, grimace, head jerk, shoulder shrug	Sniff, throat-clear, grunt, cough
Complex	Touching, tapping, jumping, co-ordinated sequences	Syllables, words, phrases; ob-scene utterances and word repe-tition (uncommon)

Tics classified on the two axes; note that the socially notorious complex vocal tics sit in one cell only, are uncommon and are never a requirement for diagnosis.

TRAP **The involuntary utterance of obscenities is neither necessary nor common in Tourette's disorder.** Candidates, primed by the public image, treat it as the defining or even a required feature. It is a complex vocal tic seen in only a minority; a patient can have unmistakable Tourette's without ever producing it, and its absence never excludes the diagnosis.

30.4 The premonitory urge and the semi-voluntary quality of tics

The feature that most reliably tells a tic apart from another movement disorder is the sensation that precedes it. Older children and adults commonly describe a **premonitory urge** - a localised uncomfortable sensation or a more generalised inner tension that builds before the tic and is momentarily relieved by performing it. A patient may report a burning feeling in the eye that eases only on blinking, or a tension in the neck that resolves on jerking the head. The tic is often repeated until the sensation resolves and it feels just right, an experience that overlaps phenomenologically with the "just right" perceptions of obsessive-compulsive disorder and helps explain why the two conditions travel together so often. This urge-relief cycle is what gives tics

their peculiar *semi-voluntary* quality: the movement is experienced as neither wholly involuntary, like a chorea, nor wholly deliberate, but as a response to an internal pressure the patient can feel and partly control. Because young children may not yet be able to articulate the urge, its absence in a small child does not count against the diagnosis, but its presence in an older patient is strong confirmatory evidence that the movements are tics.

PITFALL

The semi-voluntary quality is regularly misread. Because a child can suppress the tics briefly and describes an urge behind them, teachers, parents and even clinicians conclude the movements are "a habit", "for attention" or "put on", and the child is disciplined rather than assessed. The urge and the partial control are intrinsic features of a neurological disorder, not evidence of volition or manipulation; reframing them for the family is often the first therapeutic act.

30.5 Course over time: waxing, waning and suppressibility

Tics are fundamentally fluctuating, and their fluctuation is a diagnostic feature rather than noise. Over the natural history the tics **wax and wane** in frequency, anatomical location, number, complexity and severity, changing over intervals as short as minutes and as long as years, and some individuals experience tic-free intervals of weeks to months. This waxing and waning is so characteristic that a movement disorder with a rigidly fixed, unvarying pattern should raise doubt about the diagnosis. Superimposed on this fluctuation is **suppressibility**: tics can be voluntarily held back for varying periods, usually at the cost of mounting inner tension that is then discharged in a flurry once the effort relaxes, which is why a child may appear tic-free in the clinic and then tic heavily on reaching the car. Tics are also state-dependent, increased by anxiety, excitement, fatigue and stress and reduced during calm, absorbing, focused activity. The examinable consequence bears repeating from the duration criterion: because the year is counted from the first tic, these tic-free stretches do *not* reset the one-year clock, and a child with three months of tics, two tic-free months and then further tics can still meet Criterion B.

- Fluctuation over minutes to years, with possible remissions of weeks to months, is expected and supports the diagnosis;
- brief voluntary suppression at the price of rising tension distinguishes tics from chorea and myoclonus, which cannot be held back;
- anxiety, excitement, fatigue and stress worsen tics, while calm focused engagement lessens them.

30.6 Epidemiology: how common, in whom, and when it starts

The epidemiology answers the two questions the exam asks around every childhood disorder - how rare is it really, and who gets it. Isolated tics are extremely common in childhood while Tourette's itself is uncommon, and holding those two facts together is the point. Transient tics affect a large minority of children - of the order of 5 to 20 per cent - and are usually self-limiting, whereas Tourette syndrome is far rarer, at around 0.7 per cent of children and adolescents. A meta-analysis of studies of children put the pooled prevalence at about 0.77 per cent, and a national survey estimate gave 3 per 1,000 clinically identified cases, with a school-age estimate of

3 to 9 per 1,000 children. The concordance of these independent figures around roughly three to eight per thousand is reassuring, and the takeaway is a rare disorder sitting under a very common symptom. The condition shows a consistent male predominance, with a male-to-female ratio of **2:1 to 4:1**. As for timing, the average age at onset is **4 to 6 years**, with tic severity typically greatest at 10 to 12 years before the usual adolescent decline, so a child most often presents in early school years and is at his worst around the transition to secondary school.

IN INDIA

Indian services classify under the ICD rather than the DSM, so the operative label in case files and referrals is the ICD tic-disorder entity, though the diagnostic logic - both tic types, more than a year, onset in childhood - is the same. In practice Tourette's is under-recognised here: mild tics are frequently dismissed as a "nervous habit" or as naughtiness by families and schools, the flamboyant complex vocal tics that would trigger referral are the exception rather than the rule, and children commonly reach a psychiatrist late, often only when a comorbid attention or obsessive-compulsive problem forces the issue. A low index of suspicion for the quiet, motor-tic-predominant child is the main corrective.

30.7 Prognosis into adulthood and the suicide risk

The natural history is, for most, genuinely encouraging, and that reassurance is part of good management. Tic severity most often declines through adolescence, and by early adulthood the majority have shed the bulk of their tics: 20 per cent or fewer continue to have significant functional impairment by the age of twenty, and about 65 per cent have no or only very mild tics by adult life. This favourable trajectory justifies a conservative, watchful stance in many children and a frank, hopeful conversation with families who arrive fearing a lifelong sentence. That optimism, however, must be balanced against a real and under-appreciated risk at the severe end of the spectrum. Among young people with a persistent tic disorder, about one in ten has suicidal thoughts or behaviours, and the disorder carries an increased risk of both suicide attempt (odds ratio 3.86) and death by suicide (odds ratio 4.39). This elevation persists after adjusting for psychiatric comorbidity, and the strongest predictors are persistence of tics beyond young adulthood and a previous attempt, so the very patients whose tics do not remit are the ones who most need active screening for suicidality rather than reassurance alone.

GOOD TO REMEMBER

Hold both messages at once. The default forecast you give a family of a newly diagnosed child is optimistic, because most tics fade by adult life. But the minority whose tics persist into and beyond adolescence, and anyone with a prior attempt, sit in a higher-risk group for suicide and deserve explicit, repeated safety screening. Do not let the good general prognosis lull you into skipping the risk assessment in the severe, persistent case.

30.8 Measuring severity: the standardised rating of tics

Diagnosis is clinical, but quantifying severity and tracking change calls for a structured instrument. The best-established is the **Yale Global Tic Severity Scale**, a clinician-rated instrument that scores motor and vocal tics separately across five dimensions - number,

frequency, intensity, complexity and interference - and adds a global impairment rating. Rating the two tic types on the same five axes captures the fact that a child may have many mild motor tics but a single highly disabling vocal one, or the reverse, and the separate impairment score records how much the tics actually cost the child in daily life, which need not track their raw frequency. Such standardised scales improve the reliability of diagnosis and give quantifiable baseline data - frequency and intensity - against which the response to any later intervention can be judged. They are tools for measurement and monitoring, not substitutes for the criteria: a high severity score confirms how bad the tics are, but the diagnosis itself still rests on the four-criterion pattern applied to the history. Comorbidity, chiefly with attention-deficit/hyperactivity disorder and obsessive-compulsive disorder, is usually what drives impairment beyond the tics themselves and is developed as a pattern in its own right elsewhere in this chapter; a severity rating is therefore read alongside, not instead of, an assessment of the comorbid load.

>1 year	2:1 to 4:1	4 to 6 yr	~65%
TIC DURATION FROM FIRST ONSET (CRITERION B)	MALE-TO-FEMALE RATIO	AVERAGE AGE AT ONSET	NO OR MINIMAL TICS BY ADULT LIFE

31 · Etiology and neurobiology of Tourette syndrome

Tourette syndrome is one of the few child psychiatric disorders whose story can be told at the level of a circuit, a neurotransmitter and a gene, and that is exactly why it is examined. A tic is a sudden, recurrent, non-rhythmic movement or vocalisation, and the question this topic answers is where in the nervous system such a fragment of movement is generated, why it is felt as almost-but-not-quite voluntary, and why it clusters so tightly in families. The honest summary a candidate must be able to give is that the disorder is understood as a developmental disturbance of the motor control loops that link the cortex to the deep grey matter, running on an abnormal dopaminergic tone, on a genetic substrate that is among the strongest in child psychiatry.

What makes the neurobiology worth teaching, rather than reciting, is that each strand of evidence carries a clinical corollary. The circuit model explains why tics are patterned and suppressible; the dopamine model explains why one class of drug calms tics and another provokes them; the genetic model explains why tics, obsessive-compulsive symptoms and inattention travel together in the same families. This account owns the etiology and neurobiology. The classification of the tic disorders, the diagnostic criteria and phenomenology, the comorbidity pattern, and the management of tics are each taught in their own accounts within this chapter and are named here only where the mechanism points to them.

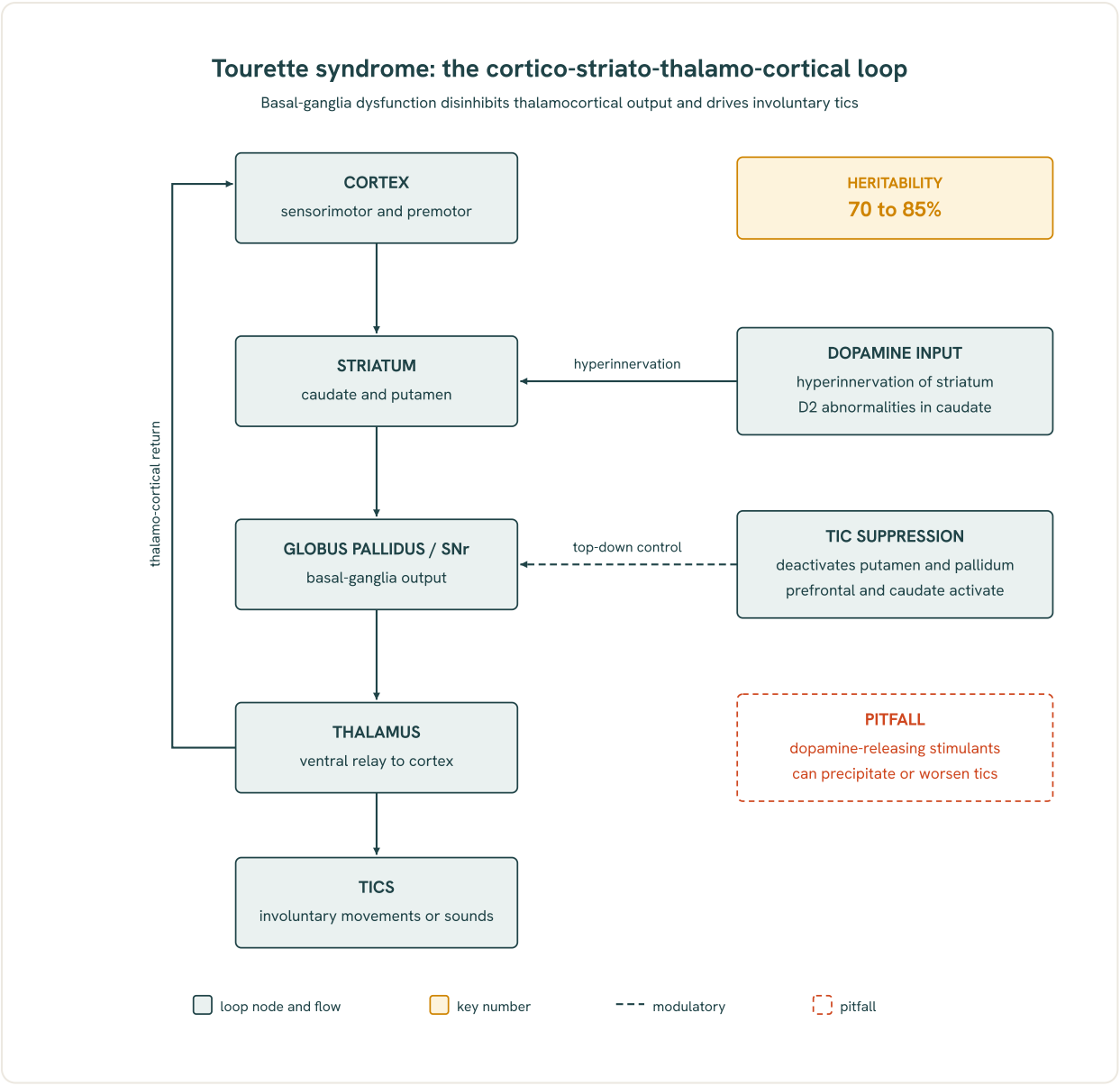


Fig 23.24. The cortico-striato-thalamo-cortical circuit in Tourette syndrome: dopaminergic hyperinnervation of the striatum dysregulates the basal-ganglia loop, disinhibiting thalamocortical output to produce tics.

31.1 A disorder of a motor circuit, not of a single brain region

The organising idea is that tics arise from dysfunction of the loops connecting cortex and basal ganglia, not from damage to one isolated structure. The prevailing model locates the disorder in the **cortico-striato-thalamo-cortical (CSTC) circuit**, the set of parallel loops through which the cortex projects to the striatum, the striatum to the pallidum and thalamus, and the thalamus back to the cortex, gating which motor programmes are released and which are held back. In Tourette syndrome this gating is faulty: fragments of movement that should be suppressed escape into action as tics. Volumetric and functional imaging support the model from several directions at once, implicating cortical thinning in the sensorimotor cortex, striatal structural anomalies and disruption of temporolimbic pathways. The last of these matters because it links the pure motor phenomenon to the affective and urge-laden quality that patients describe, and it is why the disorder sits with the neurodevelopmental conditions rather than with the movement disorders of later life.

MNEMONIC

Cortex - Striatum - Thalamus - Cortex

The name of the circuit is its own map, read in the direction the signal travels: the **C**ortex drives the **S**triatum, the striatum gates the pallidum and **T**halamus, and the thalamus closes the loop back to the **C**ortex. A tic is what happens when this loop fails to hold an unwanted motor programme in check, so every anatomical finding in this topic can be pinned to one station on the ring.

31.2 The basal ganglia as the hub of tic generation

Within that circuit, the weight of evidence falls on the basal ganglia. The **basal ganglia** - the striatum, comprising the caudate and putamen, together with the globus pallidus - are held to be central both to the generation of tics and to their suppression. Two findings anchor this. Structurally, a smaller **caudate** volume in childhood has been linked to worse tic severity in later life, which makes the caudate not merely a site of the lesion but a prognostic marker, one of the few in the disorder. Functionally, a greater capacity of the basal ganglia to suppress cortical activity is associated with lower tic severity, so the same structure that generates the intrusive movement also carries the machinery that damps it down. This is the anatomical reason the disorder is not static: the balance between generation and suppression can shift with maturation, which is part of why tics so often wax through childhood and settle in adolescence.

RULE **Tourette syndrome is a disorder of the cortico-striato-thalamo-cortical circuit with the basal ganglia at its hub, not a disorder of a damaged focal lesion.** The tic is a failure of the normal gating that decides which motor programmes reach the muscles. Every neurobiological finding worth memorising - the striatal anomalies, the caudate-severity link, the dopaminergic abnormality, even the response to medication - is a statement about this loop and its neurochemical tone, which is why the model unifies the imaging, the pharmacology and the natural history into one picture.

31.3 The neurology of voluntary tic suppression

The one feature that separates a tic from a chorea or a myoclonus is that a patient can hold it back, and the imaging of that effort is examinable. Tics are only partially involuntary: most patients can suppress them briefly, at the cost of a mounting inner tension that is relieved when the tic is finally released. When patients suppress tics voluntarily, imaging shows deactivation of the putamen and globus pallidus alongside activation of the prefrontal cortex and caudate. The reading is intuitive once the circuit is in mind: the prefrontal cortex and caudate exert top-down control that quietens the pallidal output driving the tic. This is not an academic detail. It is the neurobiological basis for the behavioural treatment of tics, in which patients are trained to deploy exactly this top-down control against the premonitory urge; that treatment is taught in the account of tic management in this chapter, and the mechanism here is what makes it rational rather than merely empirical.

31.4 The dopaminergic hypothesis

The best-supported neurochemical account is of an abnormal dopaminergic tone within these same striatal circuits. The **dopaminergic hypothesis** holds that tics arise from abnormal

dopamine neurotransmission, specifically an increased dopaminergic innervation, or hyperinnervation, of the striatum together with D2-receptor abnormalities in the caudate. Two independent lines of evidence converge on it:

- functional imaging with **SPECT** shows increased dopaminergic innervation of the striatum in affected individuals;
- studies of **monozygotic twins** discordant for severity show the D2-receptor abnormality to be greater in the more severely affected twin, tying the receptor finding directly to how ill the child is.

The twin observation is the more powerful of the two, because monozygotic co-twins share their entire genome: a difference between them in receptor binding that tracks their difference in severity points to something acting on the dopaminergic system beyond the inherited sequence, and it locates the abnormality in the caudate, the very structure the circuit model already implicated. Dopamine is the best-supported system but not the only one proposed; serotonergic, noradrenergic, glutamatergic and GABAergic contributions have all been suggested, though the evidence for them is weaker and none can be asserted here with the same confidence.

31.5 Pharmacological convergence: the drugs that prove the point

The strongest clinical argument for the dopamine model does not come from a scanner at all - it comes from watching what medicines do. The pharmacology converges on the hypothesis from both ends. **Dopamine-releasing drugs such as amphetamine precipitate or exacerbate tics, whereas dopamine D2-receptor-blocking neuroleptics suppress them**, and patients with the disorder release more dopamine in response to amphetamine than controls do. That double dissociation - worsen with a releaser, improve with a blocker - is difficult to explain on any model other than an overactive or oversensitive striatal dopamine system, and it is the reason the D2-blocking antipsychotics became the mainstay of pharmacological tic control, an application developed in the tic-management account of this chapter. The mechanism is owned here; the drugs, doses and titration belong there.

> **PITFALL**
>
> When a child with attention problems is started on a stimulant and tics appear or worsen, the reflex is to conclude the drug caused a new disorder. The mechanism argues otherwise: a dopamine-releasing agent unmasks or amplifies a tic diathesis that the CSTC and dopaminergic abnormality had already set up, rather than manufacturing Tourette syndrome from nothing. Reading the exacerbation as pharmacological proof of an underlying dopaminergic sensitivity, not as iatrogenic causation, keeps the clinician from both over-alarming the family and missing the co-occurring tic disorder; what to do about the stimulant itself is a decision for the comorbidity and management accounts.

31.6 A strongly heritable, polygenic disorder

Tourette syndrome and the tic disorders are among the most heritable conditions in child psychiatry, and the shape of that heritability is as examinable as its size. The **heritability** of tic disorders is estimated at roughly **70 to 85 per cent**, meaning that most of the variation in

whether and how severely tics appear is attributable to genetic factors. Two qualifications matter. First, there is no sex difference in the familial or heritable risk: although the disorder is expressed more often in boys, the underlying genetic liability is carried equally by both sexes, so a family history counts the same whether the affected relative is male or female. Second, the inheritance is **polygenic**: the liability is built from many genes of small effect rather than a single dominant locus, and the tic disorders most likely lie along a continuous developmental spectrum rather than forming a discrete category cut cleanly from the unaffected. This is why the search for a single Tourette gene failed and why the modern account is of accumulated common variation crossing a threshold.

31.7 A genetic architecture shared with OCD, ADHD and other neurodevelopmental disorders

The genetics do not stop at the tic - they reach across into the disorders that so reliably accompany it. Chronic tic disorders **share genetic variance** with obsessive-compulsive disorder, attention-deficit/hyperactivity disorder and other neurodevelopmental disorders including autism spectrum disorder. The common variants are shared in a graded fashion that correlates with severity, so the more heavily loaded a child is genetically, the broader and heavier the phenotype tends to be. This is the deep reason that tics rarely arrive alone: the same inherited liability that raises the risk of tics raises, in overlapping measure, the risk of obsessions, compulsions and inattention, which is why the clinically dominant problem is so often a comorbidity rather than the tic itself. The comorbidity pattern and the impairment it drives are taught in the dedicated account of Tourette comorbidities in this chapter; obsessive-compulsive disorder and attention-deficit/hyperactivity disorder as disorders in their own right belong elsewhere, the latter to the ADHD and specific learning/communication disorders notes. What this topic owns is the mechanism beneath the association: shared, graded, polygenic liability, not coincidence.

STRAND OF EVIDENCE	CORE FINDING	NATURE OF THE EVIDENCE	WHAT IT EXPLAINS
The circuit	CSTC dysfunction with sensorimotor cortical thinning and temporolimbic disruption	Volumetric and functional imaging	Why tics are patterned, gated movements with an urge quality
The hub	Striatum and pallidum central to tic generation and suppression; smaller childhood caudate tracks worse later severity	Structural and longitudinal imaging	The anatomical seat and a prognostic marker
The chemistry	Striatal dopaminergic hyperinnervation and caudate D2 abnormality	SPECT and monozygotic-twin studies	The neurochemical lesion and the drug response
The pharmacology	Releasers worsen tics, D2-blockers suppress them	Clinical and pharmacological convergence	Why antipsychotics calm tics and stimulants can provoke them
The genes	Strongly heritable and polygenic, with variance shared with OCD, ADHD and other neurodevelopmental disorders	Twin, family and molecular genetics	Familial clustering and the comorbidity pattern

The five convergent strands of the neurobiology of Tourette syndrome; each carries a clinical corollary, which is what makes the mechanism examinable rather than ornamental.

GOOD TO REMEMBER

Two things the neurobiology should change on Monday. Take a genuine family history in every child with tics, because the liability is strongly heritable and carried equally by both sexes, so an affected mother counts as much as an affected father. And when you counsel a family, frame the accompanying obsessive-compulsive or attentional symptoms not as separate misfortunes but as expressions of the same shared, graded genetic liability, which both normalises the pattern and prepares them for the comorbidity being the part that most needs treating.

31.8 Contested and environmental contributions

Genes set the liability, but they do not act in a vacuum, and the environmental side of the story is where confident teaching gives way to careful hedging. A polygenic liability expressed along a developmental spectrum implies that non-genetic factors help decide who crosses the threshold and how severely, and perinatal and other early influences have long been proposed as such modifiers; none, however, can be stated here as an established quantitative risk. The most examined and most contested environmental hypothesis is the post-infectious one, in which group A streptococcal infection is proposed to trigger tics through an autoimmune mechanism, described under the label PANDAS. That proposal is taught, with its evidence and its controversy, in the account of paediatric obsessive-compulsive disorder and PANDAS in this

chapter. It belongs in an etiology topic only as what it is: a proposed and genuinely contested infection-associated trigger, on limited evidence, and not an established cause of Tourette syndrome.

TRAP **Presenting PANDAS as a settled cause of Tourette syndrome is the classic examination error.** Candidates who have read about the autoimmune hypothesis reach for it as though a preceding sore throat closed the case, but the causal claim is contested and the evidence limited, and no examiner rewards stating it as established fact. The safe answer names PANDAS as a proposed, disputed infection-associated trigger and returns the weight of the etiology to where the evidence actually is: the heritable, polygenic disturbance of the cortico-striato-thalamo-cortical circuit and its dopaminergic tone.

IN INDIA

The neurobiology described here is built from imaging and molecular studies that a routine Indian clinic will never run: SPECT and volumetric MRI are research tools, not part of the diagnostic work-up, and the diagnosis of a tic disorder remains wholly clinical under the ICD framework used in Indian services. What the mechanism does change in practice is counselling. Because the disorder is strongly heritable and polygenic, a careful family history is the single most useful piece of the etiological assessment available at the bedside, and families - who often arrive fearing they caused the tics through parenting - can be told accurately that the liability is largely constitutional and inherited, not a product of upbringing or of any single event.

Carry into the exam: Tourette syndrome is a **70 to 85 per cent** heritable, polygenic neurodevelopmental disorder of the cortico-striato-thalamo-cortical circuit, with the basal ganglia at its hub and abnormal striatal dopaminergic tone, sharing its genetic liability with OCD and ADHD; dopamine releasers worsen tics and D2-blockers suppress them, and PANDAS is a contested trigger, never an established cause.

70-85% HERITABILITY OF TIC DISORDERS	**CSTC** THE IMPLICATED CORTICO-STRIATO-THALAMO-CORTICAL CIRCUIT	**Dopamine** STRIATAL HYPERINNERVATION AND CAUDATE D2 ABNORMALITY	**OCD, ADHD** DISORDERS SHARING TIC GENETIC VARIANCE

32 · Comorbidities (ADHD, OCD) in Tourette syndrome

Tourette's is almost never a disorder of tics alone. The great majority of people who reach a clinic with Tourette's carry at least one other psychiatric condition, and for most of them it is that accompanying condition, and not the movements, that drives them to seek help and that shapes the school years, the working life and the family's distress. Of all the conditions that keep Tourette's company, two stand out so consistently that they are best thought of as part of the syndrome's clinical identity rather than as chance neighbours. Attention-deficit/hyperactivity disorder and obsessive-compulsive disorder are the two **defining comorbidities** of Tourette's disorder, and their prominence holds in both clinical and community samples, which tells you that this is not simply a referral artefact of the most complicated patients reaching specialist care.

A candidate who pictures Tourette's as an isolated movement problem has the wrong mental model, and the exam is built to expose exactly that misconception.

This topic owns the comorbidity pattern in Tourette's: which conditions cluster with it, why that clustering matters more than the tics for outcome, and how that fact reorders the clinical priorities. It does not own, and must not re-teach, the disorders themselves. The full criteria, subtyping and treatment of **attention-deficit/hyperactivity disorder**, including its stimulant, non-stimulant and alpha-adrenergic agonist options, belong to the ADHD and specific learning/communication disorders notes; the criteria and management of **obsessive-compulsive disorder** belong to the Anxiety, OCD and trauma-related disorders notes. What is taught here is the overlap and its consequences, which is where the marks in this area actually sit.

32.1 Comorbidity is the rule, not the exception

The isolated tic patient is the unusual one. The single most important reframing in this topic is that a person presenting with Tourette's and nothing else is the minority case. Co-occurring psychiatric disorder is so common that a clinician who fails to look for it will miss the larger part of the patient's difficulty. That the same two conditions, ADHD and OCD, dominate the comorbidity profile in community samples as well as in clinics matters for a precise reason: if the association held only in specialist series it could be dismissed as referral bias, the sickest and most tangled patients being the ones who reach tertiary care. Because it holds in the community too, the link is a property of the syndrome itself and not of who happens to be referred. This is why the modern account of Tourette's treats it as a neurodevelopmental condition whose psychiatric comorbidity is intrinsic, and why screening for that comorbidity is a mandatory part of every assessment rather than an optional extra.

32.2 ADHD: the earliest and often the most disabling companion

The inattention and impulsivity usually arrive before the tics and outlast the clinic's attention to them. Of the two defining comorbidities, ADHD is typically the one that declares itself first, its inattention, restlessness and impulsivity commonly evident in the years before the tics emerge and are recognised. For the child, this ordering has a cruel consequence: the academic and social damage of untreated attention and impulse difficulties is often well established by the time anyone notices the tics and attaches the Tourette label. The impairment of comorbid ADHD in this population lands where impairment always does with ADHD - on learning, on the ability to hold a place in the classroom, on peer relationships and on family life - and it frequently exceeds anything the tics themselves are doing. The natural clinical error is to let the visible, dramatic movements monopolise the consultation while the quieter but more corrosive attentional problem goes unaddressed. The specific pharmacology of ADHD, and the long-standing question of using stimulants in a child who also tics, are matters for the ADHD and specific learning/communication disorders notes; the point that belongs here is simply that ADHD is usually present, usually early, and usually the heavier burden.

32.3 OCD: the obsessive-compulsive phenomena that shade into the tics

The obsessive-compulsive side of Tourette's has a texture of its own. Obsessive-compulsive disorder is the second defining comorbidity, and in the Tourette context it tends to wear a characteristic face. What many patients describe is a **tic-related OCD**: compulsions driven less by a fear of catastrophe and more by an intolerable sense that something is not yet complete or symmetrical, an urge to touch, tap, order, count or repeat until an internal feeling of "just right" is reached. This blurs, at its edges, into the tics themselves, because the more complex tics and the simpler compulsions can be hard to tell apart, both being preceded by an uncomfortable inner urge that the act discharges. That overlap is diagnostically important and is developed where the phenomenology of tics is taught in this chapter; here the essential message is that OCD is a defining companion of Tourette's and that its presentation in this group leans towards the symmetry-and-completion phenotype rather than the contamination-and-checking picture. The criteria, the full symptom dimensions and the treatment of OCD are the province of the Anxiety, OCD and trauma-related disorders notes, and nothing about them is re-taught here.

32.4 The overlap seen from the OCD side: tics within OCD and the triad

Look at the same relationship from the obsessive-compulsive end and it points straight back to tics. The comorbidity is genuinely bidirectional, and the exam likes to test it from the OCD direction because that is where a clean, quotable figure exists. Among people whose primary diagnosis is OCD, **up to 30%** carry a lifetime tic disorder, and this comorbid tic disorder is most common in men whose OCD began in **childhood-onset OCD**. In children in particular the three conditions cluster together often enough to be named as a unit: a **triad of OCD, tic disorder and ADHD** that can be seen presenting together. Recognising the triad matters clinically because encountering any one of its members should prompt a deliberate search for the other two; the child referred for compulsions may have unrecognised tics and untreated inattention sitting behind them, and the whole picture, not the presenting fragment, is what has to be managed. This is the overlap that the older literature gathered under the loose heading of a Tourette-associated or "Tourette-plus" pattern, and it is the reason the tic disorders and the obsessive-compulsive disorders are read together rather than in separate silos.

32.5 The Tourette-plus phenotype and where the impairment actually sits

Add the comorbidities to the tics and you have described most real patients. Pure Tourette's, tics and nothing more, is the textbook simplification; the common clinical reality is the **Tourette-plus** picture, in which the tics are accompanied by ADHD, or by OCD, or by both, frequently alongside further difficulties such as co-occurring mood and anxiety disturbance. The reason this composite label earns its keep is not tidiness but prognosis. In these patients the condition that most damages daily functioning is usually not the tics but the accompanying disorder: the inattention that sinks the school report, the compulsions that consume hours of the day, the anxiety or low mood that closes the world down. The tics may be what an observer notices first and what the family finds most socially exposing, yet when you total up the lost function, the comorbidity is generally the larger contributor. Holding that ranking in mind is

what separates a clinician who treats the noisiest symptom from one who treats the most disabling one.

RULE **In Tourette's, the comorbidity usually decides how disabled the patient is, not the tics.** Tic frequency and tic severity are a poor guide to overall functioning, because the co-occurring ADHD, OCD, anxiety or mood disorder typically carries more of the impairment. Assess the whole comorbidity load before you judge how ill the patient is, and never let the visibility of the movements stand in for a measure of the disability.

32.6 The clinical logic: treat the comorbidity, often before the tics

The order of treatment follows the order of impairment. If the comorbid condition is usually the greater source of disability, then the sequencing of management follows almost automatically: in most Tourette-plus patients the comorbidity is identified and treated first, and in a good number the tics need no direct drug treatment at all once the ADHD or the OCD is under control and the associated distress has eased. This is not a rule that the tics are ignored, but a rule of priorities - you address what is doing the most harm before you turn to what is most conspicuous. It also reframes the whole assessment: a proper Tourette's evaluation is as much an inventory of the accompanying conditions and their relative impact as it is a characterisation of the tics. The behavioural and pharmacological treatment of the tics themselves is developed elsewhere in this chapter; what this topic establishes is the reasoning that so often places that tic treatment second in the queue.

DEFINING COMORBIDITY	HOW IT RELATES TO THE TOURETTE PICTURE	WHERE ITS IMPAIRMENT PRINCIPALLY LANDS
ADHD	Usually the earliest problem, often evident before the tics are recognised; the commonest companion of Tourette's	Learning and academic attainment, classroom conduct, peer relationships and family strain
OCD	Frequently a symmetry-and-completion, tic-related pattern that blurs at its edge into the more complex tics	Time lost to compulsions, internal distress from the "not just right" urge, and rigidity of routine
Mood and anxiety disorders	Common further companions in the Tourette-plus picture rather than defining ones; named, not the focus here	Withdrawal, avoidance and lowered mood that constrict daily life beyond what the tics do

The comorbidity pattern of Tourette's read as a whole: the two defining companions and the further conditions that complete the Tourette-plus picture, set against the domain each one chiefly disables. The tics are frequently the least of it.

- ADHD and OCD are the two defining comorbidities, present in clinical and community samples alike;
- the overlap is bidirectional - a substantial share of OCD patients carry a lifetime tic disorder;
- in children the three may cluster as an OCD, tic disorder and ADHD triad;
- the comorbidity usually causes more functional impairment than the tics;

- so assessment inventories the comorbid load, and treatment commonly addresses it first.

32.7 The wider company Tourette's keeps

Beyond the defining pair, a broader psychiatric load is the norm. Naming ADHD and OCD as the defining comorbidities does not mean they are the only ones. Mood and anxiety disorders co-occur with Tourette's frequently enough to belong in every assessment, the anxiety spectrum running from separation anxiety in the younger child to generalised anxiety, both of which are taught in their own right elsewhere in this chapter and are only named here as members of the comorbid picture. The practical implication is cumulative: because several conditions may stack on top of the tics, the disability a Tourette's patient carries is often the sum of a number of partly independent problems, each needing its own recognition. A clinician who screens only for the two headline comorbidities and stops there will still under-count the burden. The discipline the topic asks for is a systematic sweep across attention, obsessive-compulsive phenomena, mood and anxiety in every patient who presents with tics, rather than a search confined to whichever symptom happens to be loudest on the day.

In Tourette's, screen every patient for ADHD and OCD, and remember the comorbid condition usually disables more than the tics do.

TRAP **Assuming that tic severity tracks overall impairment.** The classic examination error is to grade a Tourette's patient's illness by how frequent or forceful the tics are. Candidates make it because the tics are the visible, nameable feature and feel like the measure of the disorder. In fact the co-occurring ADHD, OCD, anxiety or mood disorder is usually the heavier burden, so a patient with modest tics and severe untreated ADHD may be far more disabled than one with florid tics and nothing else.

PITFALL

The commonest management failure is to pour the consultation into suppressing the tics while the comorbid ADHD or OCD goes untreated. The movements are what the family points to and what draws the eye, so effort and medication get spent on them, and meanwhile the child's schooling collapses under unmanaged inattention or their waking hours are eaten by compulsions. The corrective is to rank the sources of impairment before reaching for a tic drug, and to treat the condition that is doing the most harm first.

GOOD TO REMEMBER

What changes on Monday is the shape of the assessment. Every patient who presents with tics is screened deliberately for attention and impulse problems and for obsessive-compulsive phenomena, and the relative impairment of each is weighed before any treatment plan is drawn. If the comorbidity is the greater burden, it is named as the priority in the plan and addressed first; the tics can very often wait, and sometimes need no direct drug treatment once the comorbidity is controlled.

IN INDIA

Two realities of Indian practice sharpen this topic. First, tics are frequently dismissed by families and even by non-specialists as mere habits or naughtiness, so the child often reaches services not for the movements but for the school failure of comorbid ADHD or the puzzling rituals of comorbid OCD; the comorbidity is the presenting complaint far more often than the tics are. Second, specialist tic services are scarce and unevenly distributed, which makes the impairment-first logic doubly useful: a general psychiatrist or paediatrician who cannot offer sophisticated tic-directed therapy can still transform a child's life by recognising and treating the accompanying ADHD or OCD, which is usually where the real disability sits anyway.

up to 30%	ADHD + OCD	Tourette-plus
OF OCD PATIENTS HAVE A LIFETIME TIC DISORDER	THE TWO DEFINING COMORBIDITIES OF TOURETTE'S	COMORBIDITY USUALLY OUTWEIGHS THE TICS

33 · Management of tics (habit reversal, CBIT, pharmacotherapy)

Most people with tics never need a drug, and knowing when not to prescribe is the larger part of the skill. Tics wax and wane, peak in the early school years and often settle through adolescence, so the management question is rarely "which medication" and much more often "does this child need any active treatment at all, and if so, what is the least intervention that restores function". The marks go to the candidate who holds that restraint and then doses each agent to its tic indication rather than to a number learned for a different one.

This section owns the treatment of tics in full: the decision to treat, the behavioural first line of habit reversal and its parent programme, the stepped sequence of drugs, and every tic-indication dose with its monitoring. The phenomenology of tics, the diagnostic criteria of Tourette syndrome and the comorbidity pattern of attention-deficit/hyperactivity disorder and obsessive-compulsive disorder are developed elsewhere in this chapter and named here only where a treatment decision turns on them.



Fig 23.25. Tic management ladder: habit reversal training within CBIT first for mild to moderate tics, then an alpha-2 agonist (clonidine or guanfacine), then an antipsychotic (aripiprazole or risperidone). Aripiprazole is the tic-licensed choice at the antipsychotic step, and its dose is given by weight band rather than as a single range because the upper end of that range is licensed only for patients of 50 kg or more. Clonidine, guanfacine and risperidone are used off-label and have no licensed tic dose, so no dose is printed for them: what is shown instead is the labelled absence itself, and for risperidone a named trial's mean, labelled as a trial mean and not a regimen. Haloperidol and pimozide are also tic-licensed but are held in reserve on tolerability and cardiac grounds.

33.1 Deciding to treat, and the order of treatment

Treatment is aimed at impairment, not at the tic count. A child whose tics are noticed but not distressing, not painful and not disrupting learning or relationships usually needs psychoeducation, reassurance and school liaison, and nothing more. Active treatment is reserved for tics that hurt, that draw bullying, that interrupt schooling or that the young person themselves wants reduced. When treatment is warranted it follows a deliberate sequence rather

than a menu: educational and behavioural treatment first, then an **alpha-2 agonist** if a drug is needed, then an antipsychotic, and only then the older or experimental agents. An alpha-2 agonist is generally tried before an antipsychotic because the adverse-effect cost of an antipsychotic can outweigh its benefit in a fluctuating, often self-limiting condition.

Comorbidity reorders the whole plan. Where attention-deficit/hyperactivity disorder or obsessive-compulsive disorder coexists, the comorbid disorder is frequently the greater source of impairment and is usually treated first, because controlling it can make the tics feel manageable without a tic-specific drug. This is also why the alpha-2 agonists are attractive: they address tics and the comorbid hyperactivity together.

Stimulants are not contraindicated in tic disorders, and believing that they are withholds the treatment most likely to help. Current labelling for methylphenidate and for amphetamine places tics and Tourette's under warnings and precautions only, never under contraindications, which list nothing but hypersensitivity and recent or concurrent monoamine oxidase inhibitor use; what the label actually requires is that the family history be taken and the patient clinically evaluated for tics before starting, that treatment be monitored regularly for the emergence or worsening of tics, and that it be discontinued if that becomes clinically appropriate. The group-level evidence is flat: a meta-analysis of 22 randomised placebo-controlled trials in 2,385 children found new-onset or worsening tics in 5.7% on psychostimulant against 6.5% on placebo, a risk ratio of 0.99 (95% CI 0.78 to 1.27), with no moderating effect of stimulant type, dose, duration of treatment, recorder or age. Because tics wax and wane on their own, a worsening that follows a stimulant start is much more likely coincidence than cause, and rechallenge may be considered. Where a child has both tics and ADHD, methylphenidate, clonidine, clonidine with methylphenidate, and guanfacine are each probably more likely than placebo to reduce tic severity as well as ADHD symptoms, and the clinician should ensure that functionally impairing ADHD is treated.

RULE **Behavioural treatment leads, an alpha-2 agonist comes before an antipsychotic, and most tics need no drug at all.** Escalation is stepwise and impairment-driven, and comorbidity is usually treated first. Opening with an antipsychotic skips the two steps before it and inverts the safety logic of the ladder.

Carry this into the exam: treat the impairment not the tic, lead with education and habit reversal, use an alpha-2 agonist before an antipsychotic, and treat the comorbidity first, stimulant and all.

33.2 Habit reversal training and CBIT: the behavioural first line

The first-line active treatment is behavioural, and it is more than distraction. **Habit reversal training** is the core of Comprehensive Behavioural Intervention for Tics, the first-line treatment when a child with mild to moderate tics needs active intervention. Its power rests on a physiological fact: most tics are preceded by a **premonitory urge**, an uncomfortable building

sensation that the tic momentarily discharges. Because the urge precedes the movement, the movement can be intercepted. The programme layers components onto that:

- awareness training, teaching the young person to detect the urge and the earliest signs of the tic;
- **competing response** training, in which they perform a voluntary movement incompatible with the tic and hold it until the urge subsides;
- relaxation training, contingency management and social support, with parents coached to prompt and reward home practice;
- relapse prevention, so gains survive the next natural worsening of the tics.

The mechanism is a controlled extinction of the urge-to-tic loop: repeatedly meeting the premonitory urge with a competing response rather than the tic weakens the urge over time, so the behaviour is not merely suppressed by willpower but progressively unlearned. This is a tic-specific technique and should not be confused with the exposure and response prevention used for paediatric obsessive-compulsive disorder; the competing response is a motor substitution against an urge, not a graded exposure to a feared thought. Behavioural treatment is well supported, with effect sizes broadly comparable to antipsychotic medication for tic reduction, which is precisely why it, and not a drug, sits at the head of the active-treatment ladder. Its practical limits are access and effort: it needs a trained therapist, a child old enough to report the urge and monitor themselves, and sustained home practice.

MNEMONIC

Aware, Compete, Relax, Reward, Sustain

The working parts in order: **aware**ness of the premonitory urge, a **compet**ing response against it, **relax**ation to lower baseline arousal, **reward** for practice through contingency management and social support, and relapse prevention to **sustain** the gains.

33.3 The alpha-2 agonists: clonidine and guanfacine

When a drug is needed, the alpha-2 agonists are the first rung and the safest place to start. The thing most sources leave out: in none of the labelling this chapter has read, that of the United Kingdom, the European Union, Australia and the United States, is either agent licensed for tics, so neither has a licensed tic dose. **Clonidine** is used off-label; every clonidine product this chapter has checked is licensed for something else: hypertension, ADHD in its extended-release form, or, in United Kingdom labelling, migraine prophylaxis and menopausal flushing. Current labelling supplies no starting dose, no frequency, no titration interval and no maximum for the tic indication, precisely because no clonidine product carries a tic indication, and no ceiling licensed for another indication may be imported as the tic ceiling. That absence is the teaching, not a gap in it: the weight-based figure circulating in the textbooks is an order-of-magnitude target, not a regimen, so it cannot be prescribed from and has no business on a dosing page. The American Academy of Neurology's 2019 practice guideline recommends clonidine for tics where the benefits outweigh the risks, and directs counselling about sedation, monitoring of heart rate

and blood pressure, and gradual tapering, but it publishes no dose at all. The United Kingdom position is blunter still: both UK oral clonidine labels state that there is insufficient evidence for its use in children and adolescents under 18 and that clonidine is therefore not recommended in them, and both record that its efficacy in Tourette syndrome has not been demonstrated. Its adverse effects are the reason to go slowly: sedation, postural hypotension and low mood. On the evidence, people with tics given clonidine are probably more likely than placebo to have reduced tic severity, and the effect is larger where ADHD is comorbid.

Guanfacine is the more selective alpha-2A agonist and tends to sedate and lower blood pressure less. It too is used off-label for tics and has no licensed tic dose; its licensed indications are hypertension and ADHD, and people with tics given guanfacine are only possibly more likely than placebo to have reduced tic severity, a weaker grade of evidence than clonidine's, with the effect again larger where ADHD is comorbid. The milligram figures most trainees recite for guanfacine are the ADHD figures, so any milligram number offered for guanfacine in tics must be traceable to a named tic trial and labelled as that trial's dose, never lifted from a monograph range. There is a tic-specific efficacy anchor: in an 8-week double-blind randomised trial of children who had both a tic disorder and ADHD, guanfacine reduced tic severity by **31%** against no change on placebo.

The monitoring for this class is mandatory, and it is not only about sedation. For either alpha-2 agonist in tics, the physician must counsel the patient about common adverse effects including sedation, must monitor heart rate and blood pressure, and must taper the drug gradually on discontinuation to avoid rebound hypertension; the class should be prescribed when the benefits of treatment outweigh the risks. Those are level A requirements, not counsels of perfection. Guanfacine also carries a cardiac requirement: a physician prescribing extended-release guanfacine must monitor the QTc interval in a patient with a history of cardiac conditions, in a patient taking other QT-prolonging agents, and in a patient with a family history of long QT syndrome, also a level A requirement. The cardiac warning does not begin at the classical agents; it begins on the second rung.

The alpha-2 agonists are also used in ADHD, where they do have a licence and a licensed dose, and for that alpha-2 dose the reader should cross-refer the ADHD and specific learning/communication disorders notes. Those numbers belong to that indication, and there is no tic-indication counterpart to which they could be transferred.

TRAP **Reciting the ADHD-indication alpha-2 dose as if it were the tic dose.** The same two drugs, clonidine and guanfacine, are prescribed for ADHD and for tics, and a candidate who has memorised one milligram figure will offer it for the other indication. This trap is sprung more often than any other on this topic, and printed sources spring it too: the guanfacine range in general circulation fuses the hypertension dose of the immediate-release form with the ADHD dose of the extended-release form, and neither has anything to do with tics. Neither agent has a tic-indication dose at all, which is the answer the examiner is listening for. Naming the drug is not enough; the examiner wants the dose scoped to the indication in front of you, and wants you to say so when no such dose exists.

PITFALL

Stopping clonidine suddenly. Because it is sedating and sometimes only modestly effective, a frustrated family may simply discontinue it, and an abrupt stop of a central alpha-2 agonist risks rebound hypertension. Whenever clonidine or guanfacine is prescribed for tics, the taper and the instruction never to stop it suddenly are part of the prescription, not an afterthought.

33.4 The antipsychotics for tics: aripiprazole and risperidone

When tics are severe or the alpha-2 step has failed, a dopamine blocker is the most reliable suppressor, at a price. Tics respond to dopamine D2 blockade, which is why antipsychotics work and why their metabolic and motor costs are the reason they are not first. **Aripiprazole** is the usual modern choice and the only one of the two antipsychotics taught at this step that carries a tic licence: it is FDA-approved for Tourette's disorder in children and adolescents aged 6 to 18, with a recommended range of **5 to 20 mg/day**. That range is a whole-population envelope, not a prescribable instruction, and it must never be quoted or printed without the weight bands beside it, because its upper end is licensed only for the heavier band. Three agents here hold a United States tic licence: aripiprazole, haloperidol and pimozide. A licence is not a place in the sequence: both classical agents are licensed and sit low anyway, on tolerability and cardiac grounds, and pimozide's licence is itself written only for patients who have failed to respond satisfactorily to standard treatment. What separates aripiprazole is not freedom from cost, but that its cost is not the sedation, extrapyramidal burden and QTc surveillance the classical agents bring.

The bands are these, of a tablet taken once a day: the labelled formulation here is the oral tablet, administered once daily without regard to meals. A patient weighing less than 50 kg is started at 2 mg/day, with a target of 5 mg/day after 2 days, which may be increased to 10 mg/day if optimal tic control is not achieved; 10 mg/day is that patient's maximum. A patient weighing 50 kg or more is started at 2 mg/day for 2 days, then 5 mg/day for 5 days, with a target of 10 mg/day on the eighth day; only where optimal tic control is not achieved may the dose rise in increments of 5 mg/day to a maximum of 20 mg/day. In either band, dosage adjustments are made gradually, at intervals of no less than one week. The one-week rule and the two-day step are not in conflict: the staged schedule above is the label's own initial titration, and the one-week interval governs the discretionary adjustments made after it. The staged steps are the schedule; everything after them is an adjustment, and adjustments wait a week. Two distinctions carry the marks and the safety. The first is the band boundary itself: less than 50 kg against 50 kg or more, so that a child of exactly 50 kg is not left between two regimens. The second is target against ceiling: for the heavier band 10 mg/day is the recommended dose and 20 mg/day is a ceiling for those who do not respond, not a destination. A bare "5 to 20 mg/day", carried into a viva or printed on a plate without its bands, licenses double the labelled maximum in a patient under 50 kg. The trial evidence supports both the drug and the low starting doses: in a placebo-controlled trial of children and adolescents with Tourette's, both a low-dose and a high-dose aripiprazole arm reduced tics, with roughly 69% much or very much improved on low dose and 74% on high dose against 38% on placebo, at a modest average weight gain.

Risperidone is also effective for tics, but off-label and with no licensed tic dose. Its licensed indications are schizophrenia in adolescents from 13 to 17 and in adults, acute manic or mixed episodes of bipolar I disorder from 10 to 17 and in adults, and irritability associated with autistic disorder from 5 to 16; tics are nowhere among them, and each of those indications carries its own separate dose. So the only risperidone figure that may honestly be quoted for tics is a trial's descriptive number, answering a question about the evidence, not about how to prescribe: in the landmark tic trial the mean effective dose settled at about **2.5 mg/day** over 8 weeks and cut the **Yale Global Tic Severity Scale** Total Tic score by about 32%, with a mean weight gain of 2.8 kg that captures the class liability in a single number. That Total Tic score is the standard primary endpoint against which tic treatments are judged. Risperidone is probably more likely than placebo to reduce tic severity, at a higher risk of drug-induced movement disorders, weight gain and somnolence. Say "the trial mean was about 2.5 mg/day, a trial mean rather than a regimen" and you have answered honestly. The figure carries no starting dose, no titration increment, no dosing interval and no maximum, which is what separates a descriptive number from a prescribable one. Offer instead the low paediatric range that circulates for risperidone and you have quoted a general envelope belonging to the autism and mania indications, sitting below the anchoring tic trial's own mean effective dose, which is the tell that it was never a tic dose.

GOOD TO REMEMBER

With any antipsychotic used for tics, the dosing method is start low, titrate slowly and monitor deliberately, because the tic dose is often lower than the antipsychotic dose you would reach for psychosis and because a growing child pays the metabolic bill. Track weight and metabolic parameters from the outset; the full adverse-effect and monitoring profile of these agents is developed with the antipsychotics themselves, but the weighing starts on the first prescription.

33.5 The classical agents: haloperidol and pimozide, and the ECG

The older high-potency agents still suppress tics powerfully, but tolerability and cardiac safety have moved them down the ladder. Haloperidol is FDA-approved for the control of tics and vocal utterances of Tourette's disorder in children and adults, and its labelled paediatric regimen is narrow: it is written for children between 3 and 12 years of age, in the weight range 15 to 40 kg, and is not intended for a child under 3. Within that band, therapy begins at the lowest dose possible, 0.5 mg/day, and is raised by increments of 0.5 mg at 5 to 7 day intervals until the desired therapeutic effect is obtained, with the total daily dose divided and given twice or three times a day, working toward a target of 0.05 to 0.075 mg/kg per day for Tourette's and the other nonpsychotic behaviour disorders, a deliberately lower target than the 0.05 to 0.15 mg/kg per day used for psychotic disorders. The maximum is an honest absence rather than a number: no maximum effective dosage has been established, and there is little evidence that improvement is further enhanced beyond 6 mg/day. That is a ceiling on expected benefit, not a licence to climb toward it. Haloperidol is often poorly tolerated, with sedation and extrapyramidal effects.

Pimozide, a classical D2 antagonist reserved for patients who have failed standard treatment, is used to suppress motor and phonic tics at a usual range kept under **10 mg/day**. Reliable dose-

response data for its effect on tics below the age of twelve are not available, which is itself worth saying aloud before prescribing it to a younger child. In children it is started at 0.05 mg/kg per day, preferably taken once at bedtime, and may be increased every third day to a maximum of 0.2 mg/kg per day, not to exceed 10 mg/day.

Those dose mechanics are governed by a pharmacogenomic gate, the part candidates omit. At doses above 0.05 mg/kg per day, CYP2D6 genotyping should be performed; in a poor CYP2D6 metaboliser the dose should not exceed 0.05 mg/kg per day and should not be increased earlier than 14 days. Roughly 5 to 10% of the population are poor CYP2D6 metabolisers, and they reach pimozide concentrations similar to those seen with a strong CYP2D6 inhibitor such as paroxetine; because their half-life is prolonged, steady state takes about 2 weeks to arrive, so alternative dosing strategies are recommended for them. The standard titration, moving every third day, therefore outruns the drug in exactly the patients who accumulate it, which is why the interval stretches to a fortnight rather than the dose merely being capped.

The safety-critical point is cardiac. ECG monitoring is essential for both haloperidol and pimozide when they are used for tics. Pimozide in particular causes dose-dependent QTc prolongation with a real risk of ventricular arrhythmia and sudden death, so before and during treatment one must obtain a baseline ECG and serum potassium and monitor periodically, especially during titration. Sudden unexpected deaths have occurred at high doses and patients must not exceed the prescribed dose. The interactions must be filed under the right enzyme and at the right severity. Pimozide is metabolised mainly by CYP3A4 and, to a lesser extent, by CYP1A2 and CYP2D6. Inhibitors of CYP3A4, including macrolides, azole antifungals and grapefruit juice, raise pimozide levels and arrhythmia risk. Strong CYP2D6 inhibitors are a different matter: paroxetine and the other strong CYP2D6 inhibitors are contraindicated with pimozide outright, pimozide 2 mg given with paroxetine 60 mg having raised pimozide AUC by 151% and Cmax by 62%. Filing paroxetine under CYP3A4 as a mere caution gets both the enzyme and the severity wrong, and the pairing is a live one: a child with tics and comorbid obsessive-compulsive disorder is exactly the patient in whom an SSRI and pimozide might otherwise meet.

33.6 Measuring response and assembling the plan

A defensible answer sets out the whole staged plan and says how response is judged. Response is tracked against a validated tic-severity endpoint rather than a clinician's impression, which is what lets a service tell genuine improvement from the natural waning of the tics. Put together: assessment and psychoeducation, comorbidity treated, habit reversal as the active first line, an alpha-2 agonist when a drug is needed, an antipsychotic for severe or refractory tics, and the classical high-potency agents held in reserve under cardiac monitoring. The figure and the table below set the agents against their line and their tic-indication dose. Read both with the same question in hand: for this agent, is there a licensed tic dose at all, and if not, what exactly am I quoting?

AGENT	PLACE IN THE LADDER	TICS: THE LICENSED DOSE, OR WHAT THE FIGURE ACTUALLY IS	CHIEF CAVEAT
Clonidine	Alpha-2 agonist; first drug step	Off-label; no licensed tic dose. No licensed start, interval or maximum for tics; UK labelling does not recommend clonidine under 18 at all	Sedation, postural hypotension; monitor heart rate and blood pressure; taper, never stop abruptly
Guanfacine	Alpha-2A agonist; first drug step	Off-label; no licensed tic dose and no tic-scoped milligram figure	Less sedating than clonidine, but extended release requires QTc monitoring where there is cardiac history, other QT-prolonging drugs or a family history of long QT; taper
Aripiprazole	Antipsychotic; for severe or refractory tics; the tic-licensed choice at this step	Under 50 kg: 2 mg/day, then 5 mg/day, maximum 10 mg/day. 50 kg or more: 2 mg/day, then 5 mg/day, target 10 mg/day, maximum 20 mg/day; steps no closer than a week apart	Metabolic effects, weight gain; the 5 to 20 mg/day envelope is never quoted without its bands
Risperidone	Antipsychotic; off-label for tics	Off-label; no licensed tic dose. The only figure is one trial's mean daily dose over 8 weeks, about 2.5 mg/day, and that figure carries no start, no titration and no maximum	Weight gain, hyperprolactinaemia, drug-induced movement disorders
Haloperidol	Classical agent; second-line; FDA-approved for tics	Children 3 to 12 years, 15 to 40 kg: start 0.5 mg/day, increments of 0.5 mg at 5 to 7 day intervals, divided twice or three times daily; target 0.05 to 0.075 mg/kg per day; no established maximum effective dose	Poorly tolerated; ECG monitoring essential
Pimozide	Classical agent; refractory only; FDA-approved for tics in patients who have failed standard treatment	Usual range under 10 mg per day; children start 0.05 mg/kg per day at night, raise every third day, maximum 0.2 mg/kg per day or 10 mg/day	Dose-dependent QTc prolongation; baseline ECG and potassium; CYP2D6 genotyping above 0.05 mg/kg per day; paroxetine contraindicated

Each agent's place in the sequence, its tic-indication dose where a licensed one exists and the caveat that governs its use; the behavioural first line precedes every row.

IN INDIA

The behavioural first line is the hardest part of this ladder to deliver here. Therapists trained in habit reversal and Comprehensive Behavioural Intervention for Tics are scarce outside a few academic centres, so in routine practice the active first line is often pragmatic psychoeducation, urge-awareness coaching and parent guidance built on the same principles rather than a manualised programme. One caution about the approvals named above: they are United States labelling, and the Indian licensing position for these agents was not verified for this chapter and must not be inferred from them. Where an Indian insert differs, it is the insert that governs the prescription written in India. What does travel is the order of the ladder. Reaching for a familiar antipsychotic first trades a fluctuating, often self-limiting condition for the metabolic and, with pimozide, the cardiac liabilities of a dopamine blocker, the inversion the evidence warns against.

Under 18 CLONIDINE IS NOT RECOMMENDED IN UK LABELLING	**31%** TIC REDUCTION, GUANFACINE TRIAL	**10 and 20 mg/day** ARIPIPRAZOLE TIC MAXIMUM, UNDER 50 KG AND 50 KG OR MORE	**under 10 mg/day** PIMOZIDE USUAL RANGE

34 · Differentiation of tics from stereotypies, chorea, dystonia and compulsions

A tic almost never announces itself with a label, and the child in front of you has simply been brought in for "abnormal movements", which is why the whole of this topic is a bedside discrimination and not a piece of knowledge. Tics belong to the wider family of childhood hyperkinetic movements, and the movements they are confused with - motor stereotypies, chorea, dystonia, myoclonus and, at the complex end, obsessive-compulsive rituals - each carry a treatable and prognostically different cause. Getting the movement wrong sends the child down the wrong pathway: a stereotypy worked up as a tic, a chorea missed as a habit, a dystonia treated as a quirk. The marks here are won not by naming the disorders but by knowing the single feature that pulls each one apart from a tic at the bedside.

This account owns the formal differentiation of tics from stereotypies, chorea, dystonia, myoclonus and compulsions. The diagnostic criteria of Tourette's disorder, the phenomenology of the premonitory urge and suppressibility, the classification of the tic disorders, and the management of tics each belong to their own accounts elsewhere in this chapter and are named here only as far as the discrimination needs them. Obsessive-compulsive disorder in its own right is developed in the paediatric obsessive-compulsive account; the general disorder is the Anxiety, OCD and trauma-related disorders notes'.

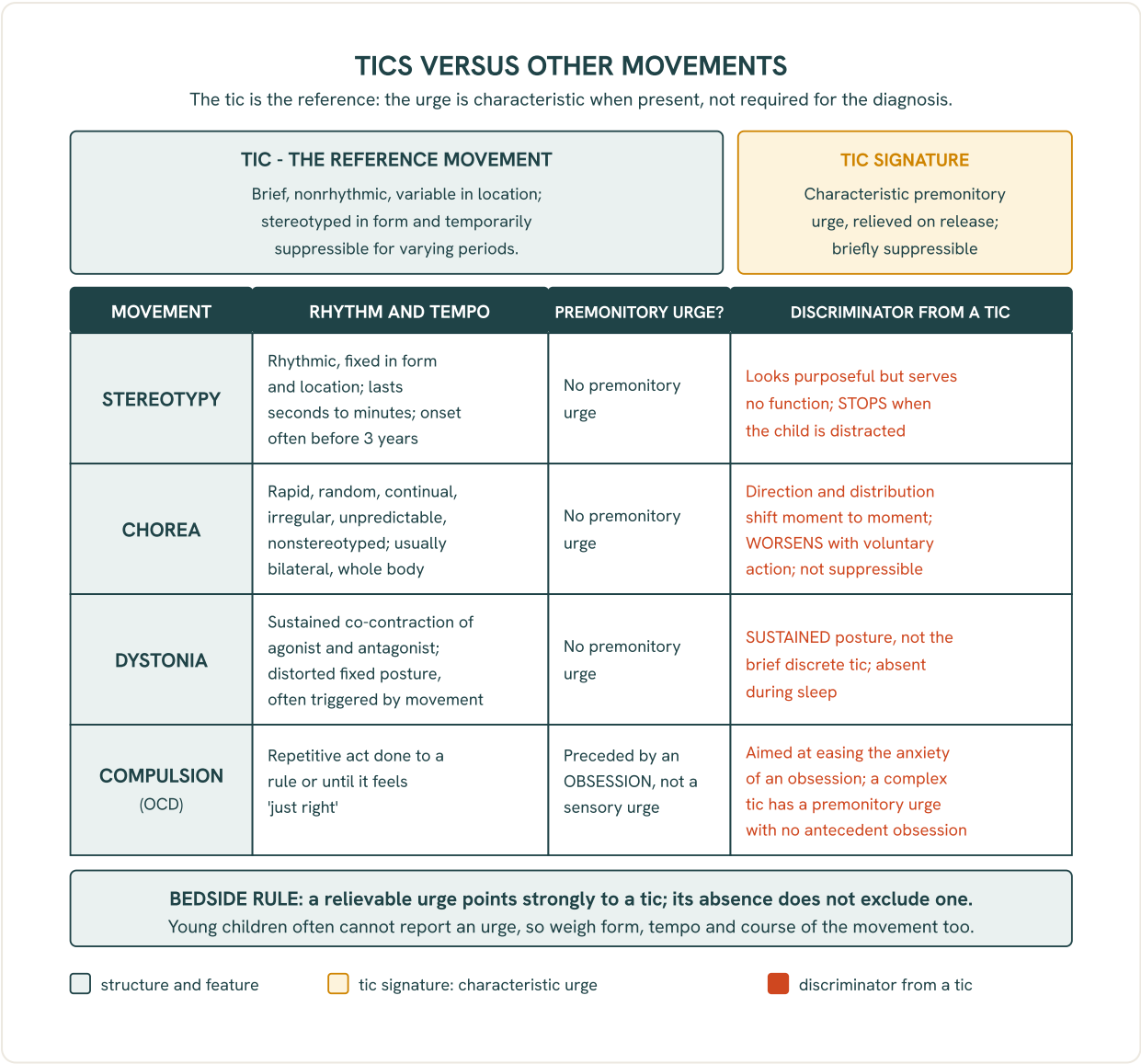


Fig 23.26. Tics versus other movements: the premonitory urge, characteristic of a tic when the patient can report it, and the brief suppressibility that goes with it, set against the discriminating feature of motor stereotypy, chorea, dystonia and obsessive-compulsive compulsion.

34.1 The signature of a tic: the reference frame for every comparison

Every discrimination below is really the same question asked six ways - does this movement carry the signature of a tic? A **tic** is a sudden, brief, non-rhythmic movement or vocalisation, and three linked features together form its signature. First, many tics are preceded by a **premonitory urge**, an uncomfortable localised sensation or inner tension that builds and is momentarily relieved by the movement; most patients old enough to describe one do, but younger children often cannot report it and not every tic carries it. Second, a tic shows partial **suppressibility**: the patient can hold it back for varying periods, at the cost of rising tension. Third, its form is stereotyped and recognisable yet its location and frequency vary over time. No other movement disorder in this differential carries all three, and a reported urge marks a movement as a tic more reliably than anything else, because it is a subjective report of an internal drive the involuntary hyperkinesias do not generate. An absent urge, though, never excludes a tic. The full teaching of the urge sits in the Tourette phenomenology account; what matters here is that you carry it as the yardstick against which each mimic is measured.

- Is there a premonitory urge, relieved by the movement? A reported urge points to a tic; the involuntary movement disorders generate none.
- Can the movement be briefly suppressed on request? A tic can; chorea and myoclonus cannot.
- Is the movement brief and non-sustained? A tic is; a dystonic posture is held.

RULE **The premonitory urge and brief suppressibility are the signature of a tic, and a positive report of them all but settles this differential.** A movement preceded by a relievable inner urge and capable of temporary suppression is a tic until proven otherwise; a movement that is purely involuntary, cannot be held back at all and carries no antecedent sensation is one of its mimics. Their absence carries far less weight: a young child may be unable to report an urge, so a negative answer sends you to form, tempo and course rather than out of the diagnosis.

MNEMONIC

Urge before, suppress on demand, brief by nature

The three-part signature in order: an **urge before** the movement that it relieves, where the patient can report one; the capacity to **suppress on demand** for a time; and a **brief, non-sustained** form. Test any suspicious movement against these three and the mimics fall away.

34.2 Tics versus motor stereotypies

This is the commonest and most examinable confusion, because both look patterned and both occur in children. **Motor stereotypies** are repetitive movements such as hand flapping, body rocking or finger wiggling that appear purposeful but serve no adaptive function. Several features separate them cleanly from tics. Stereotypies have an earlier onset, often younger than **three years**, whereas tics typically begin later in childhood. A single bout runs **seconds to minutes**, far longer than the flick of a tic. Crucially, a stereotypy is rhythmic and fixed in form and location, repeating the same movement in the same place, while a tic is brief, non-rhythmic and variable. And a stereotypy lacks any premonitory urge. The bedside discriminator that settles it is response to distraction: calling the child's name or touching them stops a stereotypy, because the child is typically absorbed and unbothered, whereas a tic is not abolished this way. Stereotypies are common in typically developing young children and more so in those with intellectual disability or autism; a child engrossed in a rhythmic, fixed pattern that a call to attention interrupts is showing a stereotypy, not a tic.

PITFALL

The costly error is to read a young child's rhythmic hand flapping or rocking as a tic and reach for a tic medication, or conversely to dismiss genuine tics as "just a stereotypy" and withhold assessment. Stereotypies rarely need pharmacotherapy and often settle with reassurance and behavioural strategies; misclassifying them exposes a child to antipsychotic or alpha-adrenergic agonist treatment they do not need. When form is fixed, onset is early and a call of the name interrupts the movement, think stereotypy before tic.

34.3 Tics versus chorea

Chorea is separated from a tic by its randomness and its relationship to movement. Chorea consists of movements that are rapid, random, continual, abrupt, irregular, unpredictable and non-stereotyped, usually bilateral and affecting all body parts, and that worsen during attempted voluntary action. Set that against the tic's signature and the contrast is sharp: a tic is stereotyped and can usually be held back for a time, and most patients able to report one describe a premonitory urge, whereas chorea has no fixed pattern, is not stereotyped, is usually bilateral across face, trunk and limbs, and its timing, direction and distribution shift from one moment to the next. The urge is asymmetric evidence and is worth using as such: a reported urge argues strongly for a tic, because the classification explicitly records the ABSENT urge for the two mimics where it states a position, stereotypies and myoclonus. It states no position on a premonitory sensation in chorea at all, so the absence of an urge argues nothing here in either direction, and against chorea the discriminators to lean on are the ones just given, its randomness, its lack of stereotypy and its worsening during attempted voluntary action. The dance-like flow of chorea across the body, flitting from limb to face to trunk without repeating itself, is nothing like the discrete, repeatable jerk of a tic. The most useful positive sign is that chorea disrupts voluntary movement, so attempts to hold a posture or perform a task fragment into extra involuntary flourishes - an active worsening rather than the tension-and-release cycle of a tic.

IN INDIA

Chorea is not an academic differential here. Sydenham chorea, the neurological manifestation of acute rheumatic fever following streptococcal infection, remains common in Indian children because rheumatic fever and rheumatic heart disease are still endemic, and it presents in the same paediatric age group in which tics appear. A new choreiform movement in an Indian child therefore mandates a search for a treatable systemic cause - a history of sore throat or migratory arthritis, examination for carditis, and the relevant work-up - rather than being logged as a tic. Missing it means missing rheumatic carditis, which is why the tic-versus-chorea distinction carries more weight here than the Western default suggests.

34.4 Tics versus dystonia

Dystonia is separated from a tic by duration and by the simultaneous pull of opposing muscles. Dystonia is the simultaneous sustained contraction of both agonist and antagonist muscles, producing a distorted posture or movement, often triggered by voluntary movement and not seen during sleep. The word to hold onto is *sustained*: where a tic is brief and non-sustained, a dystonic contraction locks the body part into an abnormal posture that is held. The co-contraction of agonist against antagonist generates that twisting, cramped quality and is mechanically the opposite of the clean single-direction flick of a simple motor tic. Two contextual features help: dystonia is frequently brought on by a particular voluntary movement, and it typically disappears in sleep. A movement that produces a held, distorted posture from opposing muscle pull is dystonia; one that is over almost as soon as it begins is a tic.

34.5 Tics versus myoclonus

Myoclonus is the supplementary movement-disorder differential, and it turns on the same two anchors. **Myoclonus** is a sudden, unidirectional, often non-rhythmic movement that may occur during sleep. It resembles a tic in being abrupt and shock-like, which is why it earns a place in the differential, but it is distinguished by its rapidity, its lack of suppressibility and the absence of a premonitory sensation or urge. Apply the signature: myoclonus cannot be voluntarily held back and carries no relievable inner urge, so both of the tic's defining subjective and volitional features are missing. That it may appear during sleep is a further pointer, locating it outside the semi-voluntary domain. When an abrupt jerk has neither an antecedent urge nor any capacity for suppression, and especially if it occurs in sleep, it is myoclonus and not a tic.

34.6 Complex tics versus obsessive-compulsive compulsions

This is the hardest separation, because a complex tic and a compulsion can look identical and the answer lies not in the movement but in what drives it. A **compulsion** in obsessive-compulsive disorder is aimed at preventing or reducing anxiety or distress and is performed in response to an obsession, for instance a washing ritual driven by a fear of contamination. A complex tic, by contrast, is driven by a premonitory urge and a need to perform the action until it feels "just right", without any antecedent obsession. The discriminating question is therefore about the antecedent: ask why the movement is done. If it neutralises a specific frightening thought, it is a compulsion; if it discharges a rising physical urge to reach a "just right" resolution with no idea being warded off, it is a complex tic. The difficulty is real, because complex tics and compulsions frequently co-occur and can be genuinely hard to separate, and many patients with a tic disorder also meet criteria for obsessive-compulsive disorder. The clinical resolution is to characterise each repetitive behaviour by its antecedent rather than by its appearance.

TRAP **Candidates try to separate a complex tic from a compulsion by how the movement looks; the discriminator is the antecedent.** Both can be elaborate, repeated and semi-purposeful, so appearance settles nothing. A compulsion answers an *obsession* and is done to reduce anxiety; a complex tic answers a *premonitory sensory urge* and is done until it feels "just right", with no frightening thought behind it. Examine the driver, not the choreography.

34.7 Putting the differential together at the bedside

Laid side by side on shared axes, the six movements separate cleanly on the two anchors and on a single cardinal feature each. The discrimination is made from a careful description of the movement and, where possible, direct observation or a home video, watching the child's response to distraction, to a request to suppress, and to attempted voluntary action.

MOVEMENT	DEFINING QUALITY	CARDINAL CONTRAST WITH A TIC
Tic	Sudden, rapid, recurrent, non-rhythmic and stereotyped, variable in location	The reference movement: urge-preceded when reportable, briefly suppressible
Motor stereotypy	Rhythmic, fixed in form and location, no urge, stops with distraction	Earlier onset and fixed pattern; interrupted by a call of the name
Chorea	Rapid, random, irregular, unpredictable, non-stereotyped; worsens with voluntary action	No fixed pattern and no urge; disrupts voluntary movement
Dystonia	Sustained co-contraction of agonist and antagonist; distorted held posture; absent in sleep	Sustained, not brief; a held abnormal posture
Myoclonus	Sudden, unidirectional, often non-rhythmic; may occur in sleep	Not suppressible and no premonitory urge
Compulsion	Performed in response to an obsession to reduce anxiety or distress	Antecedent is an obsession, not a sensory urge

The six movements of the differential on shared axes; the premonitory urge and suppressibility resolve most cases, and the final column gives the one feature that clinches each mimic.

GOOD TO REMEMBER

When a description alone leaves the movement ambiguous, do three things. Ask the older child whether a feeling builds before the movement and eases after it, since a positive report of a relievable urge is strong evidence for a tic, while a younger child unable to answer tells you nothing either way. Ask them to hold the movement back and watch for the tension-and-release of suppressibility. And observe it during an absorbing task and during a call to attention, since chorea worsens with voluntary action while a stereotypy stops when the child is addressed. A short home video often shows more than a clinic encounter.

Carry into the exam: a tic is defined by its form, sudden, rapid, recurrent, non-rhythmic and stereotyped, while the premonitory urge and partial suppressibility are its characteristic accompaniments, reported by most individuals but never required for the diagnosis - stereotypies are fixed, early-onset and stop with distraction; chorea is random and worsens with voluntary action; dystonia is a sustained held posture; myoclonus is unsuppressible; a compulsion answers an obsession while a complex tic answers a sensory urge.

Urge
CHARACTERISTIC OF A TIC, NOT REQUIRED FOR IT; RECORDED AS ABSENT IN STEREOTYPIES AND MYOCLONUS

Suppress
A TIC CAN BE BRIEFLY HELD BACK; CHOREA AND MYOCLONUS CANNOT

Brief
A TIC IS NON-SUSTAINED, UNLIKE THE HELD POSTURE OF DYSTONIA

< 3 yr
TYPICAL STEREOTYPY ONSET, EARLIER THAN MOST TICS

Elimination and feeding disorders

35 · Enuresis (types, etiology, assessment)

Bedwetting is the point at which normal development, organic disease and psychological disturbance all converge on a single symptom, and the marks are here because the candidate has to separate them. **Enuresis** is the repeated voiding of urine into inappropriate places - the bed or the clothing - in a child old enough that continence should by now have been achieved and in whom no medical cause accounts for the wetting. What makes it examinable is not the symptom, which any parent can describe, but the scaffolding around it: an age threshold below which the same wetting is developmentally normal, a frequency-or-distress requirement, a mandatory exclusion of organic disease, and a set of subtype and course distinctions that decide how the child is investigated and, later, treated.

This account owns the definition and diagnostic criteria of enuresis, its classification into subtypes, the pathophysiology that drives it, and the assessment that flows from the criteria. It does not teach the treatment: the behavioural measures, the enuresis alarm and the pharmacotherapy are taken up in their own account within this chapter, and the drug doses in particular are set out there and deliberately not restated here. Toilet-training norms and the ordinary timetable of continence belong to the Normal child development and milestones notes; what follows marks only the point at which the child has crossed from lateness into disorder.

35.1 The essential feature: Criterion A and the voiding itself

Criterion A defines the act, and it is written broadly on purpose. The requirement is the repeated voiding of urine into the bed or into clothes, and the manual is explicit that this may be either involuntary or, occasionally, intentional. The great majority of enuretic wetting is involuntary, and that is the default picture; but by admitting the rare intentional case the definition avoids excluding a child who, out of anger or protest, wets deliberately. The point behind the wording is that enuresis is defined by the event, not by the child's motive: the diagnosis turns on misplaced voiding at an age when it should not occur, and whether it was willed is a matter for formulation, not for the diagnostic threshold.

35.2 Criteria B and C: how often, for how long, and from what age

Criterion B sets the bar the wetting must clear, and it has two routes to satisfaction that candidates routinely collapse into one. The first route is one of frequency and persistence: the voiding must occur at least **twice a week** for a minimum of three consecutive months. The second route dispenses with the count altogether: even below that frequency, the diagnosis is met if the wetting produces clinically significant distress or impairment in social, academic or other important areas of functioning. A once-weekly wetter who is refusing school trips and sleepovers and is being shamed at home meets Criterion B by this second limb even though the frequency route is not reached.

The age criterion is where the diagnosis is separated from normal development. Criterion C requires that the child has reached a chronological age of at least **five years**, or, where

development is delayed, an equivalent developmental (mental) age of the same level. The floor is set at the point by which the ordinary child has established daytime and night-time control, so that wetting below it is lateness rather than disorder. Anchoring the threshold to developmental rather than chronological age matters in any child with global delay, in whom continence tracks developmental level and not birthdays: a chronologically seven-year-old functioning well below the five-year level has not failed at a task they were equipped to master, and should not be labelled.

TRAP **Reciting only "at least twice a week for three months" and forgetting the distress route.** Criterion B is satisfied by the frequency-and-duration standard OR by clinically significant distress or impairment at a lower frequency. Candidates who memorise the numeric limb alone will wrongly exclude the distressed, low-frequency wetter, who is precisely the child who reaches the clinic. The threshold is a disjunction, not a single rule.

35.3 Criterion D: the exclusion that becomes the assessment

Criterion D is a single clause that generates almost the whole of the medical work-up. The wetting must **not be attributable to the physiological effect of a substance or to another medical condition**. The substances named are the diuretics and the antipsychotics; the medical conditions span the endocrine, the structural and the neurological. Because enuresis is reached only after organic disease is cleared, the criterion is really an instruction to investigate, and the differentials it forces are the ones a careless clinician misses:

- endocrine causes of a genuine polyuria - diabetes mellitus and diabetes insipidus - in which the bladder is wet because urine output is genuinely high;
- urinary tract infection, the commonest reversible medical cause of new wetting, especially where there are daytime symptoms;
- structural anomalies of the lower urinary tract - an ectopic ureter, posterior urethral valves - which produce continuous or unusual wetting;
- neurological lesions of the spinal cord - spina bifida and a tethered cord - that disturb bladder innervation;
- a seizure disorder, where nocturnal incontinence is a manifestation of the seizure rather than of enuresis;
- an iatrogenic effect of a prescribed diuretic or antipsychotic.

RULE **Enuresis is a clinical diagnosis of exclusion made only from a defined age.** Two gates must both be passed: the child must be at least five years old chronologically or developmentally, and an organic cause - endocrine, infective, structural, neurological or drug-induced - must have been excluded. Skip either and the diagnosis is unsafe: below the age gate it pathologises normal development, and without the exclusion it renames a treatable medical illness as a behavioural one.

35.4 The subtypes by timing

The primary classification is by the time of day the wetting occurs. The condition is specified into three subtypes according to timing. The **nocturnal-only** form, in which urine is passed only

during night-time sleep, is much the commonest and is the classic monosymptomatic bedwetting of childhood. The **diurnal-only** form occurs during waking hours and, being daytime wetting, more often signals bladder dysfunction or a psychological problem. The third form combines both.

SUBTYPE	WHEN WETTING OCCURS	CLINICAL SIGNIFICANCE
Nocturnal only	Only during night-time sleep	Commonest form; typically the isolated bedwetting driven by the polyuria, bladder-capacity and arousal factors
Diurnal only	During waking hours	Daytime wetting; more likely to reflect bladder overactivity, voiding habit or emotional disturbance
Nocturnal and diurnal	Both daytime and night-time	The combined presentation, also termed the non-monosympto-matic form

The three timing-based subtypes of enuresis; the nocturnal-only form dominates in frequency, while daytime wetting shifts the differential toward bladder and psychological factors.

35.5 Monosymptomatic and non-monosymptomatic: the distinction that guides investigation

Cutting across the timing subtypes is a distinction the urological literature considers more useful still. **Monosymptomatic** enuresis is isolated night-time wetting with no daytime lower-urinary-tract symptoms - no urgency, frequency or daytime incontinence. **Non-monosymptomatic** enuresis is wetting accompanied by such daytime symptoms, and the combined nocturnal-and-diurnal subtype is the presentation this term describes. The distinction steers the work-up: the monosymptomatic child is usually the straightforward bedwetter, whereas daytime symptoms raise the suspicion of bladder pathology or infection. Within the daytime picture the manual recognises two mechanisms: **urge incontinence**, from an overactive, unstable detrusor that contracts before the child reaches a toilet, and **voiding postponement**, the habitual deferral of micturition until the bladder overflows, often in a child absorbed in play. They look alike at the moment of wetting and are told apart by the history of what precedes it.

35.6 Primary and secondary enuresis

A second course-based axis asks whether continence was ever attained. **Primary enuresis** is the form in which urinary continence has never been established, so that the wetting continues unbroken from infancy; by definition it can first be diagnosed at the age of five, the point at which the failure becomes a disorder. **Secondary enuresis** is the reappearance of wetting after a period of established dryness, its onset falling most commonly between the ages of five and eight but possible at any point in childhood. The clinically important fact is a negative one: there is no difference between the two in the prevalence of associated mental disorders, so the older teaching that secondary enuresis is the psychologically loaded form and primary the benign one is not supported. Secondary onset does, however, direct attention to what changed - a urinary

infection, a new medical illness, or a psychosocial stressor such as the birth of a sibling - because the return of wetting in a previously dry child asks for an explanation.

PITFALL

Treating new-onset secondary wetting as a behavioural relapse without asking what precipitated it. Because the child was previously dry, a fresh medical cause - a urinary tract infection, newly manifest diabetes with its polyuria - or an acute psychosocial stressor is likelier than in the never-dry child. Reaching for a behavioural programme skips the step that matters most in the secondary case: looking for the treatable thing that ended the child's dryness.

35.7 Epidemiology: common, male-predominant, and self-limiting

Enuresis is one of the commonest disorders of childhood, and its epidemiology is defined by a steady fall with age. Community prevalence of night-time wetting runs at around **5 to 10% at age five**, declining to 3 to 5% by age ten and to about 1% by age fifteen and beyond. The trajectory is the teaching point: prevalence falls year on year because the condition remits spontaneously in most children, so what is near-normal at four becomes, in the adolescent, uncommon and clinically weighty. Across these figures boys carry the higher prevalence, one of the more reliable features of the disorder.

5 to 10%	3 to 5%	about 1%	5 to 10%
PREVALENCE AT AGE FIVE	PREVALENCE AT AGE TEN	AT AGE FIFTEEN AND OLDER	REMIT SPONTANEOUSLY EACH YEAR AFTER FIVE

35.8 Etiology: three pathophysiological strands

The modern understanding of nocturnal enuresis is not one cause but the convergence of three, and a given child may sit on any one or a combination of them. The first is a mismatch between how much urine the kidney makes at night and how much the bladder can hold: a blunted nocturnal rise in arginine vasopressin, the antidiuretic hormone whose secretion normally climbs overnight to concentrate the urine, allows an overnight nocturnal polyuria that overwhelms the sleeping bladder. That this pathway is real is shown by vasopressin-deficient children becoming dry when the hormone is replaced, and by responders and non-responders differing in their vasopressin profile. The second strand is the bladder itself: a low **functional bladder capacity** with an unstable, overactive detrusor means the bladder signals fullness and empties at a smaller volume than it should, and a low functional capacity is a recognised predictor of failure to respond to the enuresis alarm.

The third strand frames enuresis as a **disorder of arousal**: the enuretic episode characteristically arises out of deep, delta-wave sleep, and the child fails to wake to the signal of a full or contracting bladder. Sleep studies bear this out - enuretic children received the arousal signal yet did not respond by waking - which reframes the wetting as a failure of arousal rather than of bladder or kidney alone. Voiding occasionally occurs in rapid-eye-movement sleep, when the child may later recall a dream of micturition, but the core deficit is the failure to arouse. The three strands are not rivals: a single child may carry mild polyuria, a modest reduction in bladder

capacity and a high arousal threshold together, and it is their combination that produces the wet bed.

MNEMONIC

Too much water, too small a bladder, too deep a sleep

The three etiological strands of nocturnal enuresis in a line. **Too much water**: the blunted overnight vasopressin rise and its polyuria. **Too small a bladder**: low functional bladder capacity with detrusor overactivity. **Too deep a sleep**: the failure to arouse from delta sleep to the bladder's signal. Any one may dominate, and most children carry a mixture.

35.9 The genetic contribution

Enuresis runs in families, and the familial loading is one of the strongest of any childhood disorder. A child's risk is substantially raised by a parental history: it is about **7.1 times** greater where the father was himself enuretic beyond early childhood, and about 5.2 times greater with a corresponding maternal history, and enuresis is correspondingly commoner in children with an affected parent. The heritability is high enough that a positive family history is both a useful diagnostic pointer - it reassures the family that the mechanism is constitutional rather than wilful - and a fair predictor that the child, like the parent before them, will in time grow out of it. The inherited component is best understood as acting through the mechanisms already described, shaping the overnight hormone rhythm, the bladder's functional capacity and the depth of sleep, rather than as a separate cause standing apart from them.

35.10 Assessment: history and examination first, investigation guided

The assessment is driven entirely by the criteria, and its architecture follows Criterion D. The history establishes the pattern - night, day or both; monosymptomatic or carrying daytime urgency, frequency and incontinence; primary or secondary, since a previously dry child who has begun to wet again is investigated differently from one who was never dry. It quantifies frequency and the distress caused, both of which the diagnosis needs, and takes the informative family history. The examination looks for the structural and neurological signs the exclusion criterion demands, the lumbosacral spine and perineal neurology especially. Investigation is then targeted rather than routine: a urinalysis for the glycosuria of diabetes and the pyuria of infection, with imaging or specialist referral reserved for the child whose daytime symptoms, abnormal stream or examination findings point to structural or neurological disease. A frequency-volume record of daytime voids and overnight wetting is the single most informative bedside tool, exposing both the true nocturnal urine output and the functional bladder capacity, and so pointing to which strand is operating.

GOOD TO REMEMBER

Two cheap steps carry most of the assessment. A urine dipstick excludes the two organic causes that must never be missed - the glycosuria of new diabetes and the leucocytes and nitrites of infection - and a few days of a home frequency-volume chart distinguishes the small-capacity bladder from the polyuric night and flags the daytime symptoms of non-monosymptomatic disease. Both precede any referral and turn a vague complaint of bedwetting into a mechanism you can act on.

35.11 Course, prognosis, and the line with normal development

The natural history is favourable and is itself part of the teaching. After the age of five the condition remits without treatment in a substantial share of children each year - on the order of 5 to 10% annually - so the pool shrinks steadily through childhood, and only about 1% of cases persist into adulthood. This high spontaneous remission is why treatment is weighed against watchful waiting, and why the alarm and drug measures are held for the child in whom wetting is causing real distress or failing to resolve. It also fixes the boundary with normal development: below the age of five, or below the equivalent developmental level, night-time wetting is a normal stage of a not-yet-complete process and is not enuresis at all. The disorder begins where the developmental grace period ends, which is why the age criterion, not the wetting, is the true threshold.

Enuresis is diagnosed only from a chronological or developmental age of five years, requires wetting at least twice a week for three months or else clinically significant distress, and is a diagnosis of exclusion made only once organic causes are ruled out.

35.12 ICD-11 and how the two systems differ

The two classifications agree on the concept but differ sharply in how they quantify it. Where the manual sets a numeric threshold, ICD-11 describes the frequency in words: enuresis is the repeated and persistent voiding of urine into the bed or clothes, occurring, in its wording, several times per week over several months, rather than the quantified twice-weekly-for-three-months standard of the manual. The age concept is expressed developmentally - continence is expected at a developmental age approximately equivalent to a chronological age of five years - and the same three timing subtypes are retained. The practical consequence is that the diagnosis rests on the descriptive "persistent and repeated" wording and on clinical judgement of what counts as developmentally overdue, rather than on a hard count, while the concept, the subtypes and the exclusion of organic disease are held in common with the manual.

IN INDIA

Because services here classify under ICD, the operative entity in the case file and the referral is the ICD one, coded 6C00, and the clinician diagnoses from its descriptive frequency and developmental-age wording rather than from a numeric manual threshold. The presentation is shaped by local realities: bedwetting is frequently normalised or, conversely, punished within the family, help-seeking is often delayed until an older child faces the shame of shared sleeping arrangements or a school trip, and the first port of call is usually the paediatrician rather than the psychiatrist. The clinician's early task is often as much to relieve the blame heaped on a constitutionally predisposed child, whose parent likely wet the bed too, as to investigate.

36 · Management of enuresis (behavioural, bell-and-pad alarm, desmopressin, imipramine)

The marks here sit on a sequence and a safety trap, not on a catalogue of drugs. What follows assumes the child has already been worked up, an organic and a daytime-symptom cause excluded, and the diagnosis of primary nocturnal enuresis secured. From that point the whole of management turns on two ideas. The first is that the least medical option is also the most durable, so the child who can wait is better served by conditioning than by a tablet. The second is that the one genuinely dangerous drug on the ladder is dangerous because the dose that works is so small.

Stated as a single sentence, the rational sequence is **behavioural intervention** first, with the enuresis alarm as its most durable member; then **desmopressin** as the drug reached for most often when a rapid pharmacological effect is needed; and **imipramine**, the **tricyclic antidepressant**, held back for refractory individuals. The classification and causal story upstream belong to the companion account of enuresis.

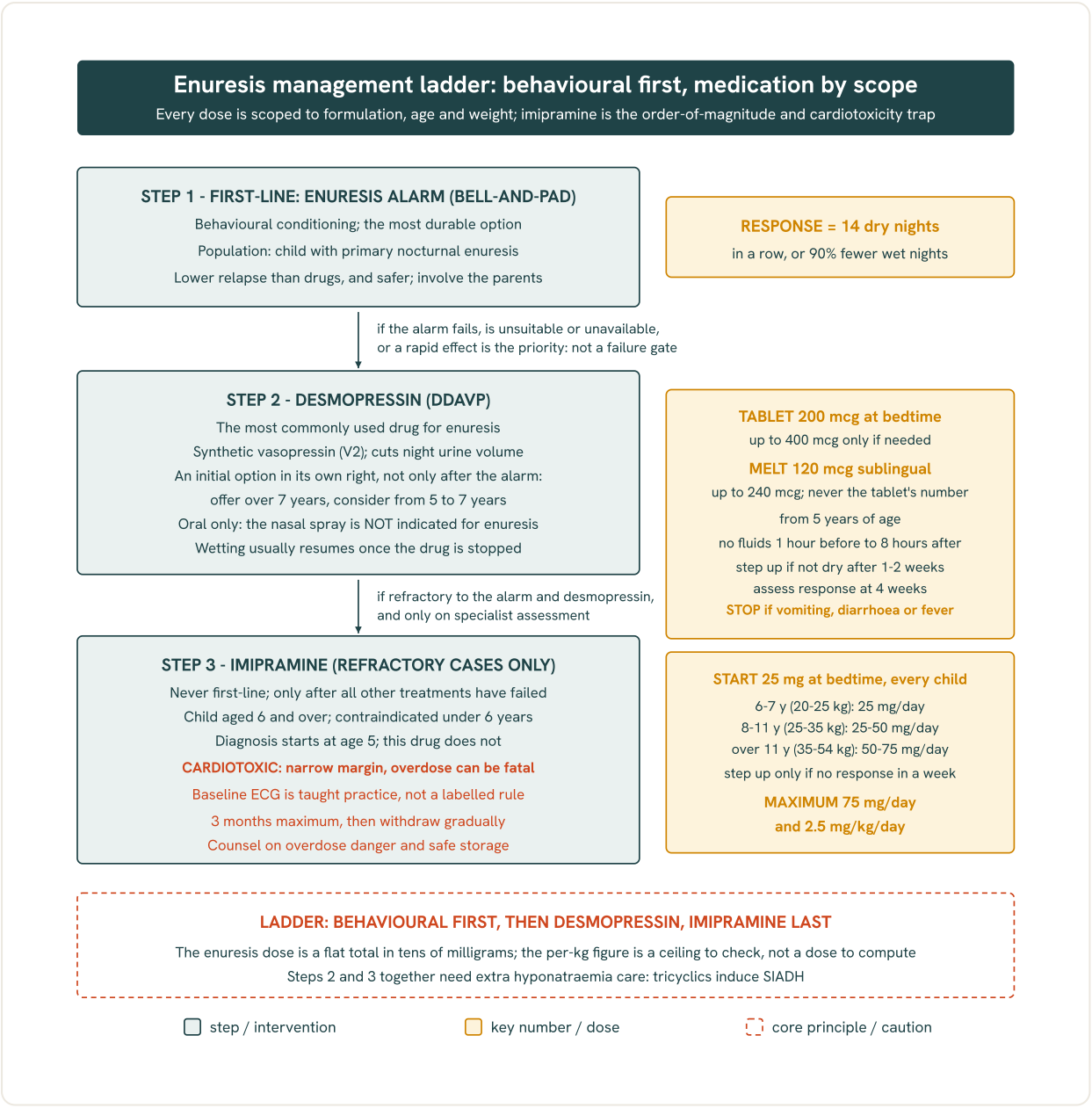


Fig 23.27. Enuresis management ladder: the bell-and-pad alarm is first-line and the most durable option, its benefit outlasting treatment where the drugs' does not, and a response is 14 consecutive dry nights or a 90 percent reduction in wet nights per week; desmopressin is the most-used drug and an initial option in its own right when a rapid effect is the priority or an alarm is unsuitable, given from 5 years of age as a 200 to 400 microgram tablet or a 120 to 240 microgram sublingual melt at bedtime, with fluids withheld from 1 hour before the dose until 8 hours after it, the dose stepped up in the child not completely dry after 1 to 2 weeks and the response assessed at 4 weeks, and the drug stopped during vomiting, diarrhoea or any acute illness upsetting fluid or electrolyte balance until the child is well again; and imipramine is reserved for the refractory child of 6 and over, started at 25 milligrams at bedtime, banded by age and weight, and never taken above 75 milligrams a day or 2.5 milligrams per kilogram per day, for no more than 3 months.

36.1 The ladder, and why its order is the answer

The order encodes a judgement about durability, safety and speed, in that priority. A graded approach begins with the recognition that many children become dry without any active treatment as they grow, so the first duty is to do no harm, to demystify the problem for a family that is often frightened and blaming, and to lift the shame that surrounds it. Against that background the least invasive effective option is preferred, and only when it fails or cannot be used does the clinician step up. A drug is added when the family needs a result faster than

conditioning can deliver it, for instance to get a child through a school trip or a family stay, and here desmopressin is the usual choice. The ladder is a priority order, though, not a queue in which each rung must fail before the next may be touched: desmopressin is an initial treatment in its own right, offered to the child over 7 years, and considered from 5 to 7 years, whenever a rapid or short-term improvement is the priority or an alarm is inappropriate or undesirable. The tricyclic is the one rung that genuinely is gated: it sits at the bottom, not because it does not work, but because it is no longer a first-line pharmacological choice and is reserved for refractory cases, and it is considered only for the child who has not responded to all other treatments and who has been assessed by a clinician with expertise in bedwetting, its cardiotoxicity making it the wrong drug to reach for early.

RULE **Conditioning teaches, drugs only suppress.** The alarm changes what the sleeping bladder does with a full-bladder signal, so its benefit can outlast the treatment; desmopressin and imipramine act only while they are being taken, and wetting characteristically returns once they are stopped. This single distinction is why the alarm leads the ladder and why a drug alone is a holding measure rather than a cure. When a family wants the wetting to end for good, the answer bends toward conditioning; when they want it to pause for a fixed occasion, the answer bends toward a drug.

MNEMONIC

First the bell, then the hormone, last the amine

The **bell** is the bell-and-pad alarm at the head of the ladder; the **hormone** is desmopressin, the vasopressin analogue, as the commonest drug; the **amine** is the tricyclic imipramine, kept last for the refractory child. The order of the phrase is the order of escalation, and it also tracks safety.

36.2 The behavioural foundation before any device or drug

Simple measures resolve a meaningful share of cases and make every later step work better. Before an alarm is fitted or a prescription written, a set of general behavioural measures is put in place, and in the milder or younger child they may be all that is needed.

- Motivational and educational work with the child and family, reframing the wetting as an involuntary developmental lag rather than laziness or defiance, which removes the punishment that entrenches it.
- Fluid and voiding scheduling: adequate daytime drinking, tapering intake in the evening, and a reliable bladder emptying at bedtime.
- Simple positive reinforcement of dry nights, the star-chart family of methods, in which the child records and is rewarded for success rather than blamed for failure.
- Bladder-training and lifting or scheduled-waking strategies in selected children, layered on when the basic measures are insufficient.

This is the substrate on which the alarm succeeds: a child who is engaged, unpunished and motivated will persist with a demanding conditioning programme, and a punished, ashamed

child will abandon it. It carries no risk at all, which is why it is never skipped even when a drug is going to be used.

36.3 The bell-and-pad alarm: the most durable single treatment

The alarm is a conditioning device, and its case rests on durability rather than on a headline success rate. The **bell-and-pad, or enuresis alarm**, works by classical conditioning: a moisture-sensitive sensor triggers a loud alarm at the very start of voiding, the child wakes and completes the void in the toilet, and over repeated pairings the sensation of a full bladder comes to substitute for the alarm as the waking or inhibiting signal. It is the first-line treatment once advice on fluids, toileting and an appropriate reward system has not worked, and its standing on the ladder rests on three comparative facts.

The first is that it gives up nothing while it is running: set against desmopressin, there is little or no difference in the number of children reaching a response by the end of treatment. The second is where the difference actually lies. Once treatment stops, the alarm may leave more children dry at follow-up than desmopressin does, and against imipramine the contrast is starker still, because the tricyclic's effect is not sustained after withdrawal and most children relapse. That persistence is the durability the drugs cannot match. The third is safety, and it is mechanical rather than statistical: a conditioning device cannot cause a hyponatraemic convulsion and cannot be taken in overdose.

One honest caution about the figures. The success percentages that older textbooks still print for the alarm come from reviews that the current Cochrane updates have replaced, and they move a great deal with how success was defined in the first place. The current reviews report relative effects on low-quality evidence and name no single success rate, and NICE says only that alarms have a high long-term success rate. What NICE does give is a definition rather than an effect estimate: a response is **14 consecutive dry nights**, or a **90 percent** improvement in the number of wet nights per week. The response to an alarm is assessed by 4 weeks, and treatment is stopped only if there are no early signs of response at all.

The alarm's chief limitation is that it demands sustained effort over weeks from an already tired family. Two features predict that it will fail: a low **functional bladder capacity**, and an inability to be aroused from sleep.

> **PITFALL**
>
> The commonest way the alarm fails in practice is not that it does not work but that it is abandoned too soon. Families expect a quick result, hear the alarm wake the whole household for several nights running with no dry mornings, and give up before the conditioning has had time to consolidate. Counselling that the method takes weeks of consistent use, and that early alarms without dry nights are the process working rather than failing, is what makes the device work.

36.4 Desmopressin: what it is and what it does

Desmopressin is a hormone analogue, not a sedative or a bladder drug. Desmopressin acetate, or DDAVP, is the most commonly used pharmacological intervention for primary nocturnal

enuresis. It is a synthetic vasopressin V2-receptor analogue that acts on the renal collecting duct to concentrate the urine and so reduce the volume of urine produced overnight. Because the drug corrects the water-handling rather than teaching the bladder anything, its effect is entirely dependent on continued administration. Wetting typically resumes once the drug is stopped, and the durable benefit off treatment is correspondingly low: on current evidence the alarm may leave more children dry at follow-up than desmopressin does. Against placebo the drug may reduce wet nights by roughly one to two a week, on low-certainty evidence, and probably increases the chance of achieving 14 consecutive dry nights, RR 3.18 (95% CI 1.75 to 5.80), on moderate-certainty evidence, and a raised chance of an endpoint is not a dry night promised to a particular child on a particular night. Guidance requires the family to be told, in these terms, that many children but not all will experience a reduction in wetness, and that many but not all will relapse when the drug is withdrawn.

36.5 Desmopressin: route, formulation and dose

Route is now a safety decision, and the oral route has won it. Desmopressin can be given intranasally or orally, and the modern position is that the oral route is preferred. The nasal spray is not a deprecated option but a withdrawn one: it is not an indicated formulation for primary nocturnal enuresis at all, because postmarketing reports showed a higher risk of hyponatraemia and hyponatraemic convulsions with the nasal spray than with desmopressin tablets. There is therefore no current bedtime nasal dose to carry for this indication.

The tablet and the melt are different strengths, and giving one the other's number is the error to avoid. Oral desmopressin is for the child from 5 years of age with normal urine-concentrating ability. The plain tablet is started at **200 micrograms at bedtime and increased to 400 micrograms** only if the lower dose proves insufficient, and the timing of that step matters: **the increase is considered in the child who is not completely dry after 1 to 2 weeks of the initial dose**, and **the response is assessed at 4 weeks**, **treatment being continued for 3 months** where there are signs of one and stopping considered where there are none. The sublingual melt is a different preparation at a different strength: it is started at **120 micrograms sublingually at bedtime and increased to 240 micrograms**, because 120 micrograms of melt is bioequivalent to 200 micrograms of tablet. Write the tablet's number on a melt prescription and the child receives about one and two-thirds of the intended exposure of the drug whose signature harm is a dose-dependent hyponatraemic convulsion. One jurisdictional divergence matters: United Kingdom labelling caps the tablet at 400 micrograms, while United States labelling permits titration to a higher maximum at bedtime. The lower ceiling is the one carried here. Continued treatment is not open-ended either: the need for it is reassessed after 3 months by means of a period of at least a week without the drug.

36.6 Desmopressin: the hyponatraemia caution that governs its use

The whole safety profile of desmopressin reduces to one preventable event. The most serious, if rare, adverse effect is **hyponatraemia**, and it can progress to seizures. It is the direct pharmacological consequence of the drug's action: a V2-mediated water retention that, if the child then drinks freely, dilutes the serum sodium into a dangerous water intoxication. The

management follows from the mechanism, and the rule is a window of time rather than an allowance of volume: **fluid intake must be limited to a minimum from 1 hour before the dose until the next morning, at least 8 hours after it**. Treatment without that reduction in fluid may lead to water retention and hyponatraemia, with or without the warning signs of headache, nausea and vomiting, weight gain and, in severe cases, convulsions; if they appear, treatment is interrupted until the child has fully recovered and the fluid restriction is enforced strictly on restarting. That symptom-triggered stop is the later of two stop rules. The tablet's labelling requires it to be discontinued during an episode of vomiting or diarrhoea until the child's fluid balance is once again normal, and the melt's labelling requires treatment to be interrupted during any acute intercurrent illness characterised by fluid or electrolyte imbalance, systemic infection, fever and gastroenteritis being the named examples. The fluid window and the warning signs both assume a well child drinking to a rule. The sick child has already lost control of his fluid and electrolyte balance, is being rehydrated by an anxious parent, and is on a drug that holds that water in, so waiting for the headache or the weight gain is waiting too long. The sick-day rule is therefore a second instruction of equal rank, not a footnote to the window. In a country where childhood gastroenteritis is common it is the more frequently needed of the two rules, and it is the one families are least often given. The same labelled warning tells the child to avoid swallowing water while swimming. Desmopressin must not be used in a child with primary or psychogenic polydipsia, in whom the compulsion to drink removes the one safeguard the treatment depends on; the polydipsia and any alcohol misuse are excluded before the drug is prescribed, not after. Desmopressin is a safe and useful drug whose single real hazard is entirely avoidable by a rule the family can follow.

Two further points belong to the rule rather than to the laboratory. Routine measurement of weight, serum electrolytes, blood pressure or urine osmolality is not recommended in the child treated with desmopressin for bedwetting, which puts the whole weight of safety on two spoken rules and no blood test: the fluid window on a well night, and the sick-day stop on any night that is not one. And there is one interaction: drugs that induce inappropriate antidiuretic hormone secretion, tricyclic antidepressants expressly among them, demand extra precautions against hyponatraemia when given with desmopressin, including careful attention to the fluid restriction and more frequent monitoring of the serum sodium.

GOOD TO REMEMBER

The instructions that actually prevent harm are not written on the prescription, they are spoken to the parent, and there are two of them. The first is a clock rather than a cup: drinks stop an hour before the tablet and do not resume until the morning. Teaching an allowed volume instead invites the family to give that allowance at two in the morning, deep inside the antidiuretic window. The second is the sick day: no dose on a night the child is vomiting, has diarrhoea or is febrile, and none again until he is well and his fluid balance is normal. Pair every prescription with both, instruct the parents explicitly to keep to them, and withhold the drug entirely from the compulsive drinker.

36.7 Imipramine: the tricyclic, and the order-of-magnitude dose

The imipramine enuresis dose is measured in tens of milligrams total, and this is the single most examined trap in the topic. Imipramine has a long history in this indication, and Indian pharmacology teaching lists enuresis among its uses. The age floor is the first thing to get right, because it is not the diagnostic floor: **the drug is for the child of 6 years and over, and it is contraindicated below 6**, whereas the diagnosis may be made from a chronological or developmental age of 5. The five-year-old who meets criteria is a child you may diagnose and must not give this drug to.

Every child starts at the same place, 25 milligrams at bedtime, whatever the age, and the dose is then set by age and weight band: **25 milligrams a day at 6 to 7 years and 20 to 25 kilograms, 25 to 50 milligrams a day at 8 to 11 years and 25 to 35 kilograms, and 50 to 75 milligrams a day over 11 years and 35 to 54 kilograms**. If a satisfactory response has not come within a week, the dose is stepped up, and it is stepped up slowly, because starting low catches the child who responds low. Two ceilings bound the indication: **75 milligrams a day in total, and 2.5 milligrams per kilogram per day**, whichever is reached first. The labelling is explicit that a daily dose above 75 milligrams does not enhance efficacy and tends only to increase side effects.

The rule is this: the enuresis dose is tens of milligrams as a total daily amount, and it is never converted into, nor borrowed from, a per-kilogram antidepressant figure. Outside nocturnal enuresis, imipramine has no established paediatric safety or efficacy at all; enuresis is the only childhood indication the drug holds. The enuresis dose is small on purpose.

TRAP **Do not read the enuresis dose as milligrams per kilogram.** The classic error writes the imipramine enuresis dose as a per-kilogram quantity, or imports a per-kilogram antidepressant envelope from elsewhere. The enuresis dose is a flat total of tens of milligrams, and the per-kilogram figure that exists in this indication is a cap of 2.5 milligrams per kilogram per day, not a target. A thirty-kilogram nine-year-old dosed to a per-kilogram misreading reaches a three-figure daily dose in a child whose labelled maximum is 75 milligrams.

36.8 Imipramine: cardiotoxicity, overdose and the safeguards

The reason imipramine is held back is a narrow margin between the effective and the fatal. The tricyclic has a **narrow therapeutic index**, and children, the poorly hydrated and those with cardiac disease are more susceptible to its cardiotoxicity than healthy adults. It prolongs the QTc interval and slows cardiac conduction, and in overdose it may be fatal, producing convulsions, cardiac dysrhythmias, severe hypotension, central nervous system depression, coma and characteristic ECG changes. The danger is compounded by the small effective quantity: the tablets a family holds are a plausible instrument of accidental poisoning by a younger sibling, or of a school-aged child's magical belief that swallowing the whole bottle will cure the bedwetting faster. For these reasons the drug must be dispensed and stored under control.

The monitoring follows the cardiac risk. A baseline electrocardiogram before starting is a widely taught practice point rather than a labelled requirement; neither the United Kingdom nor the United States labelling mandates one. What the labelling does record is the reason the ceiling sits where it does: electrocardiographic changes of unknown significance have been reported in

children given twice the maximum of 2.5 milligrams per kilogram per day. There is no per-kilogram threshold above which monitoring is switched on, and any such trigger set above the maximum would only ever fire outside the dose range the drug is allowed to occupy. The cap is the control, not the monitor.

Exposure is capped in time as well as in dose: the maximum treatment period is 3 months, including a gradual withdrawal, and the drug is never stopped abruptly. If the child relapses, a further course is not begun until a full physical examination has been made, and the child who needs repeated courses is reviewed medically every 3 months. The counselling is part of the safety: the family is told that the course lasts 3 months, that the dose is raised gradually, that it is taken at bedtime, that more than two out of three children relapse afterwards, and, in terms, about the particular dangers of overdose and the importance of giving only the prescribed amount and storing the tablets safely. A time-limited course is the control that stops an indefinite exposure to a cardiotoxic drug in a condition that most children grow out of anyway. Imipramine's toxicity is the whole reason it has fallen to the foot of the ladder even though it is an effective drug. It earns its place only in the refractory child in whom the safer options have genuinely been tried and have failed.

36.9 Choosing and combining, and the Indian reality

The three modalities are not interchangeable; each answers a different clinical question.

MODALITY	MECHANISM	DURABILITY OFF TREATMENT	CHIEF HAZARD	PLACE ON THE LADDER
Behavioural measures and the bell-and-pad alarm	Classical conditioning of the full-bladder signal	Highest: the benefit can outlast the treatment	None of consequence; demands weeks of effort	First-line; the most durable single treatment
Desmopressin	Vasopressin V2 analogue reducing nocturnal urine volume	Low: wetting typically resumes on withdrawal	Hyponatraemia and water intoxication; needs the fluid window	The commonest drug; for a rapid or occasion-limited effect, and an initial option when an alarm is unsuitable
Imipramine	Tricyclic; anticholinergic and other actions on the bladder	Low; relapses on withdrawal	Cardiotoxicity, lethal in overdose; dose and duration both capped	Reserved for refractory cases after specialist assessment; no longer first-line

The three treatments compared; the accompanying figure sets out the same escalation from behavioural methods through desmopressin to the reserved tricyclic.

The alarm and desmopressin are not mutually exclusive and are deliberately combined, the drug giving the family early dry nights that sustain their motivation to persist with the conditioning. Where bedwetting has not responded to an initial course of the alarm, the combination of alarm and desmopressin is offered, or desmopressin alone if continuing with the alarm is no longer acceptable to the family. The combination to think twice about is the other one: because tricyclic

antidepressants are among the drugs that induce inappropriate antidiuretic hormone secretion and so demand extra hyponatraemia precautions alongside desmopressin, the second and third rungs of this ladder interact. An anticholinergic is not offered in combination with imipramine.

IN INDIA

The ladder as taught is Western in its ordering, but the Indian reality tilts practice toward the drugs. Enuresis alarms are not widely available or affordable in most settings, so the behavioural first line, though correct, is often not a real option. That is not a licence to skip to the tricyclic. An alarm that cannot be obtained is exactly the case the guidance already anticipates: where an alarm is inappropriate or undesirable, desmopressin is offered as an initial treatment in its own right. Desmopressin as a bedtime oral tablet is therefore the pragmatic pharmacological choice, paired always with the fluid window. Imipramine, by contrast, is inexpensive, familiar and long-established in Indian teaching, where the standard pharmacology texts list enuresis among its uses, and that reachability is precisely why the cardiotoxicity caution matters more here, not less: the safeguards of a controlled supply, a capped dose and a time-limited course are easiest to neglect where the drug is easiest to get.

The doses in this account are taken from United Kingdom and United States labelling, read directly. The Indian regulatory position was not verified: no CDSCO-approved package insert for imipramine or desmopressin was consulted, and no claim is made here about what an Indian insert licenses, at what age, or at what ceiling. Where an Indian insert differs from the figures above, it is the insert that governs the prescription written in India.

The one line to carry: behavioural methods and the alarm are first-line and most durable, desmopressin is the commonest drug and an initial option in its own right when speed matters or an alarm is unsuitable but it relapses on withdrawal, and imipramine is a reserved, cardiotoxic drug for the child of 6 and over whose enuresis dose is a flat tens of milligrams capped at 75 a day, never calculated per kilogram. The per-kilogram figure is a ceiling, not a dose to compute from, and both caps bind and the first one reached is the one that governs.

14 dry nights	**200 to 400 mcg**	**120 to 240 mcg**	**75 mg/day**
IN A ROW, OR A 90% DROP IN WET NIGHTS: THE NICE RESPONSE	DESMOPRESSIN TABLET, AT BEDTIME	DESMOPRESSIN MELT, SUBLINGUAL	IMIPRAMINE MAXIMUM, AND NEVER ABOVE 2.5 MG/KG/DAY

37 · Encopresis (types, etiology, management)

The soiling that brings a child to the clinic is almost never the wilful act it is first taken to be, and the whole of this topic turns on that correction. **Encopresis** is the repeated passage of faeces into places where it does not belong, into the clothing or onto the floor, whether the child intends it or not. It is coded in the manual as F98.1, and it is examinable less for the wording of its criteria than for the physiology hidden beneath them: in most affected children the soiling is the visible end of a long chain that begins with one painful stool and ends with liquid faeces leaking helplessly around a hard, retained mass. Read that way, encopresis stops being a

behavioural problem and becomes a disorder of retention with a behavioural surface, and its whole management follows from that reframing.

This account owns the diagnostic criteria of encopresis, its subtypes, its epidemiology, the retention-constipation mechanism that generates the common form, and the staged treatment that flows from that mechanism. The parallel elimination disorder of the bladder, and the drug treatment of that disorder, are taught in their own accounts elsewhere in this chapter and are named here only where the contrast teaches something; the full paediatric assessment framework belongs to the Child psychiatry: assessment, treatment, services and protection notes.

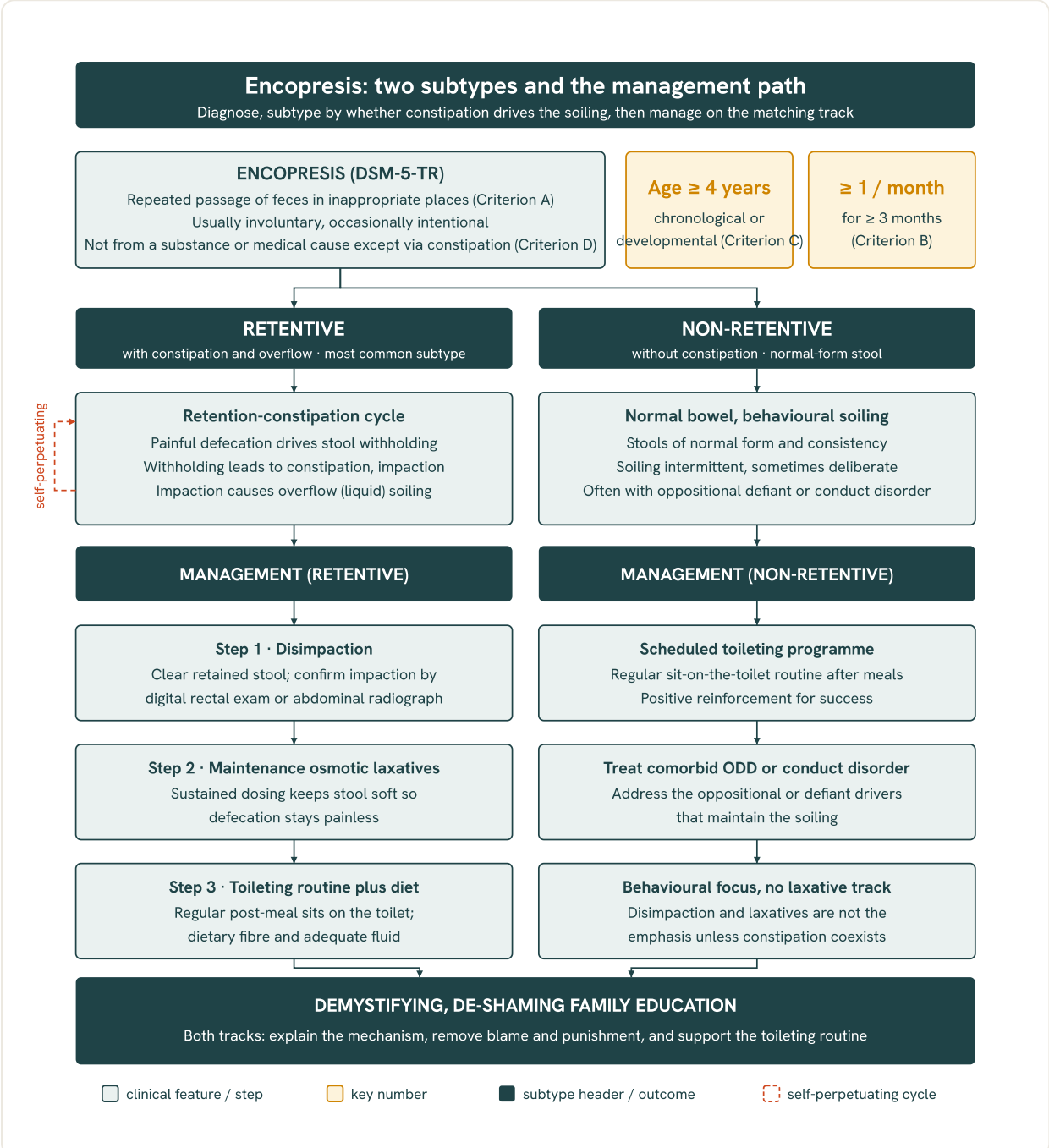


Fig 23.28. Encopresis subtypes and management: a shared DSM-5-TR diagnosis splits into a retentive track (constipation with overflow, managed by disimpaction, maintenance osmotic laxatives, and a toileting routine) and a non-retentive track (normal-form intermittent soiling, managed behaviourally and by treating comorbid oppositional defiant or conduct disorder), converging on demystifying family education.

37.1 Criterion A: the act, and why intent is beside the point

The defining feature is the repeated passage of faeces into inappropriate places, and the criterion is written to be neutral about whether the child meant it. The manual specifies that the passage is most often involuntary and only occasionally intentional, and this ordering is the clinically important part. A tired parent, and sometimes a hurried clinician, reads soiling as defiance, laziness or a bid for attention, because a school-aged child who fouls their clothes surely could stop if they wished. The criterion refuses that reading. In the great majority the child does not feel the stool coming and cannot hold it back, because a retained mass has blunted the normal call to stool and the liquid overflow slips past without warning. Occasionally the passage is deliberate, and that minority carries its own diagnostic weight, discussed with the subtypes below, but the default assumption in front of a soiling child is that the act is involuntary, and getting that starting assumption right is what separates a clinician who treats the bowel from one who punishes the child.

37.2 Criteria B and C: the frequency threshold and the age gate

Two criteria convert a symptom into a disorder: a minimum frequency and duration, and a minimum age. Criterion B sets the count. There must be **at least one such event each month**, sustained for **at least three months**. The threshold is deliberately low, because even monthly soiling in a school-aged child is not a variant of normal, and the three-month floor keeps a single episode of illness-related soiling from being over-labelled. Criterion C is the developmental gate, and it is the one candidates most often state loosely. The child must have reached a chronological age, or an equivalent developmental level, of **at least four years**. The gate is developmental, not merely chronological: continence is a milestone, and a child whose global development sits below the four-year level has not yet reached the stage at which reliable bowel control is normally expected, so the label cannot be applied to them however old they are in calendar years. This matters acutely in a population where intellectual disability and global delay are common, and it is the reason the developmental age, not the birth certificate, decides eligibility.

RULE **Encopresis is a diagnosis of the child who has, developmentally, arrived at continence and then lost or never consolidated it.** The age criterion is a floor set at the point where bowel control is normally achieved, and it is expressed as a developmental level rather than a birthday precisely so that a delayed child is not mislabelled for failing a task their nervous system has not yet reached. Establish the developmental age first; the chronological age alone can never make or exclude the diagnosis.

37.3 Criterion D: the exclusion with a deliberate carve-out

This is the cleverest criterion in the set, and the one most worth a mark. Criterion D states that the soiling must not be attributable to the physiological effect of a substance such as a laxative, or to another medical condition except through a mechanism that involves constipation. The exclusion clause is doing something unusual. Ordinarily a medical cause for a symptom rules a psychiatric label out. Here the manual carves an explicit exception: a medical condition is compatible with the diagnosis when, and only when, it produces the soiling by way of **constipation**. So a child with a low-fibre diet, or hypothyroidism, or coeliac disease, who

becomes constipated and then soils, still has encopresis, because constipation is the accepted final common pathway. By contrast, faecal incontinence arising through a mechanism that is not constipation - the chronic diarrhoea of a gut disease, or the neurogenic bowel of spina bifida, or an anal stenosis that leaks - does not warrant the diagnosis. The clause is not a loophole but the manual recognising that constipation-driven overflow is the disorder's own machinery, and that soiling produced by a different mechanism is a different problem wearing the same outward sign.

37.4 The two subtypes: retentive and non-retentive

The single most useful discrimination in the topic is between the constipated child and the unconstipated one, because they have opposite mechanisms, opposite associations and opposite treatments. The classification recognises exactly two forms, distinguished by whether constipation and overflow are present. The **retentive** form, with constipation and overflow incontinence, is much the commoner; the majority of children older than four who soil have this subtype. Here the stool is retained, the rectum is loaded, and what escapes is liquid overflow. The **non-retentive** form, without constipation and without overflow, is the smaller group: the stools are of normal form and are passed, intermittently, in the wrong place, and this pattern is more often linked with an oppositional or conduct disturbance than with a loaded bowel. The distinction is not academic. A child passing formed stools in inappropriate places without any constipation will not be helped by laxatives, and the clinical attention rightly shifts toward the emotional and behavioural picture, whereas the retentive child needs the bowel cleared before anything behavioural can work.

FEATURE	RETENTIVE (WITH CONSTIPATION AND OVERFLOW)	NON-RETENTIVE (WITHOUT CONSTIPATION)
Relative frequency	The majority of soiling children over four	The smaller group
Stool that soils	Liquid overflow leaking past a retained mass	Stools of normal form, passed intermittently
Constipation and impaction	Present and central	Absent
Typical association	The retention-pain cycle	Oppositional defiant or conduct disturbance
First move in treatment	Clear the impaction, then keep the stool soft	Address the behavioural and emotional picture

The two subtypes of encopresis run on opposite mechanisms; whether the bowel is loaded decides both the associations and the first step of treatment.

37.5 Epidemiology

The numbers are modest, age-dependent and sex-skewed, and each of those three shapes fits the mechanism. The prevalence runs at **one to four per cent** of children in high-income countries, with figures of two to eight per cent reported in some Asian countries. The disorder is far commoner in the younger school-aged child than the older: it is above four per cent between ages four and six and falls to below two per cent between ages ten and twelve, tracking the natural resolution of childhood constipation as the child grows, eats a fuller diet and consolidates

a toileting routine. It is more common in boys than in girls among older children. The age curve is the fact worth carrying: because most cases resolve with growth, persistence into later childhood marks the minority in whom the retention cycle has entrenched and warrants more determined treatment.

37.6 Etiology: the retention-constipation-overflow cycle

Everything about the retentive subtype makes sense once the cycle is drawn. The core mechanism is a self-perpetuating loop of painful defecation and withholding. A painful stool leads the child to withhold, withholding produces constipation, the retained stool becomes impacted, and liquid faeces then overflow around the impaction as incontinence. Once begun, the loop feeds itself: the longer the mass sits, the larger and harder it grows, the more painful its eventual passage, and the stronger the child's learned avoidance of the toilet. This is why **stool withholding** is the pivot of the whole disorder, a rational avoidance of pain that has catastrophic downstream consequences. The constipation that starts the loop may arise on either of two tracks:

- psychological, when the child withholds out of anxiety about defecating, a frightening earlier experience of a painful or hard stool, or oppositional refusal of the toilet;
- physiological, when the stool is hard and difficult to begin with, through ineffectual straining, a paradoxical contraction of the sphincter when the child bears down, a low-fibre and low-fluid diet, or an underlying condition such as hypothyroidism or coeliac disease.

An **anal fissure** closes the loop especially tightly, making the next stool acutely painful and so driving harder withholding still. Whichever track starts it, the destination is the same loaded rectum, and it is the loaded rectum, not the child's will, that produces the soiling.

37.7 Assessment: confirming the impaction

The assessment is short, physical and decisive, because it answers the one question that sorts the subtypes: is the bowel loaded. A careful history establishes the pattern of soiling, the stool form, the presence of pain or withholding behaviour, and the dietary and psychosocial context, and it screens for the red flags that would point away from simple constipation. The physical step that settles the subtype is the demonstration of retained stool: a **digital rectal examination** palpating a loaded rectum, or where that is not feasible or is equivocal, an abdominal radiograph showing faecal loading, confirms the impaction that defines the retentive form. This is not a formality: it converts a vague complaint of soiling into a mechanical diagnosis with an obvious first move, and it lets the clinician show the family that the problem is a full bowel and not a naughty child. The broader psychiatric and developmental workup, where the picture calls for it, follows the framework of the Child psychiatry: assessment, treatment, services and protection notes.

37.8 Management: clear, keep soft, retrain, de-shame

The treatment of the retentive form is a staged programme, and the order of the stages is the examinable core. The sequence is to first clear the retained stool by **disimpaction**, then to hold the bowel empty and the stool soft with **maintenance osmotic laxatives**, and to run alongside

these a **scheduled toileting programme** with dietary fibre, adequate fluid, and family education that demystifies and de-shames the problem. The order is not cosmetic. Disimpaction comes first because maintenance laxatives poured onto an impacted rectum simply add to the overflow; the mass must be gone before anything else can hold. Maintenance is then sustained deliberately over a long period, because the stretched, insensitive rectum needs an extended run of soft, easy, regular stools to recover its tone and sensation, and stopping the moment the soiling clears is the commonest route back to a loaded bowel. The behavioural programme, a regular unhurried sit on the toilet after meals to exploit the gastrocolic reflex, rebuilds the toileting habit the withholding destroyed. The family education carries as much weight as the drugs: a household managing the soiling as misbehaviour has to be brought round to seeing it as a bowel that overflowed, or the punitive dynamic will undo the regimen. This is behavioural-plus-laxative management, and it stands apart from the drug treatment of the bladder disorder taught elsewhere in this chapter, whose agents and doses do not belong here.

MNEMONIC

Clear, Keep, Sit, Teach

Clear the impaction by disimpaction; **Keep** the stool soft with sustained maintenance laxatives; **Sit** the child on a scheduled post-meal toileting routine with fibre and fluid; **Teach** the family that the soiling is overflow from a loaded bowel, not defiance. The order is not interchangeable: keeping, sitting and teaching all fail on a rectum that has not first been cleared.

PITFALL

The relapse trap is stopping the maintenance laxative too early. Soiling often clears within days of disimpaction and a few soft stools, and the natural instinct of family and clinician alike is to stop the medicine now that the child is clean. But the rectum is still stretched and under-sensing, and a bowel allowed to load again reproduces the whole cycle within weeks. Maintenance is continued well beyond symptom resolution and withdrawn slowly, not at the first clean week.

37.9 ICD-11, differentials and the examination traps

The two classifications agree, and the differentials are decided by mechanism rather than by the appearance of the soiling. The ICD-11 essential features mirror the manual, coding the disorder as 6C01 and setting the same approximate age-four developmental threshold. The differentials that earn marks all turn on the carve-out in Criterion D: soiling from chronic diarrhoea, from the neurogenic bowel of spina bifida, or from an anal stenosis is faecal incontinence, not encopresis, because the mechanism is not constipation. Within the diagnosis, the retentive and non-retentive forms are themselves a differential, resolved by whether the bowel is loaded. Two errors recur under examination pressure.

TRAP **Candidates read "except through a mechanism involving constipation" backwards.** The instinct is that any medical cause excludes the diagnosis, so a constipated child with hypothyroidism or coeliac disease gets marked as not having encopresis. The criterion says the opposite: a medical condition is compatible with encopresis precisely when it works through constipation. The exclusion removes only the non-constipation mechanisms, chronic diarrhoea and structural or neurogenic incontinence among them.

GOOD TO REMEMBER

When a school-aged child presents with what the family calls diarrhoea in the pants, think overflow before you think gastroenteritis. Frequent small leaks of foul liquid stool in an otherwise well child, especially with a history of hard or painful stools and toilet avoidance, is the retentive form declaring itself, and the abdomen or the rectal examination will usually find the loaded bowel that explains it. Treating that as an infective diarrhoea, or worse with a constipating agent, deepens the impaction it should be relieving.

Carry into the exam: encopresis is repeated faecal soiling from a developmental age of at least four years, at least monthly for three months, most often the involuntary overflow of a retentive, constipated bowel, managed by disimpaction, then sustained maintenance laxatives, a scheduled toileting routine and family education.

IN INDIA

Because services here classify under ICD, the operative label in case files is the entity coded 6C01, worked from its clinical descriptions. The disorder is genuinely common: prevalence figures in the region of two to eight per cent have been reported in some Asian countries, and low-fibre, low-fluid diets, cramped or shared and unhygienic toilets that a young child dreads, and the frank shame and punishment that soiling attracts in many households all feed the withholding that starts the cycle. Osmotic laxatives for disimpaction and maintenance are widely available and inexpensive, so the mechanical part of treatment is achievable; the harder work is the family education that reframes a shamed, punished child as a child with a loaded bowel, and it is that reframing that decides whether the routine holds.

1-4%	Age 4	≥1/month	3 months
PREVALENCE IN HIGH-INCOME COUNTRIES	MINIMUM CHRONOLOGICAL OR DEVELOPMENTAL AGE	SOILING EVENTS, THE FREQUENCY FLOOR	MINIMUM DURATION

38 · Pica

A child who eats what is not food, and keeps doing it. **Pica** is the persistent eating of **nonnutritive, nonfood substances** continued for **at least one month**. The substances vary with the child's age and with whatever is at hand: paper, soap, cloth, hair, string, chalk, paint, soil, clay, starch, ice, charcoal, pebbles. The defining oddity is that the child is not turning away from food. There is typically no aversion to nourishing food in general; the ingestion of nonfood matter sits alongside an otherwise ordinary appetite, which is exactly what marks pica out from

the disorders in which a child eats too little. Because the behaviour looks trivial to a lay eye and is easy to hide, the diagnosis rests on a clinician thinking to ask, and on separating a genuine disorder from a great deal of developmentally normal or culturally sanctioned mouthing and eating.

The marks here are discriminative and safety-driven. An examiner uses pica to test three things: whether a candidate can apply the developmental and cultural qualifiers that keep the diagnosis from swallowing normal behaviour, whether they know the company pica keeps, and whether they remember that this is a behaviour with hard medical consequences and not merely a curiosity. This topic owns pica in full: its criteria, the age floor, its substances and complications, its comorbidity, its differential and its management. The neighbouring feeding disorders of childhood are named here only where the reasoning needs them and are taught in their own right elsewhere in this chapter.

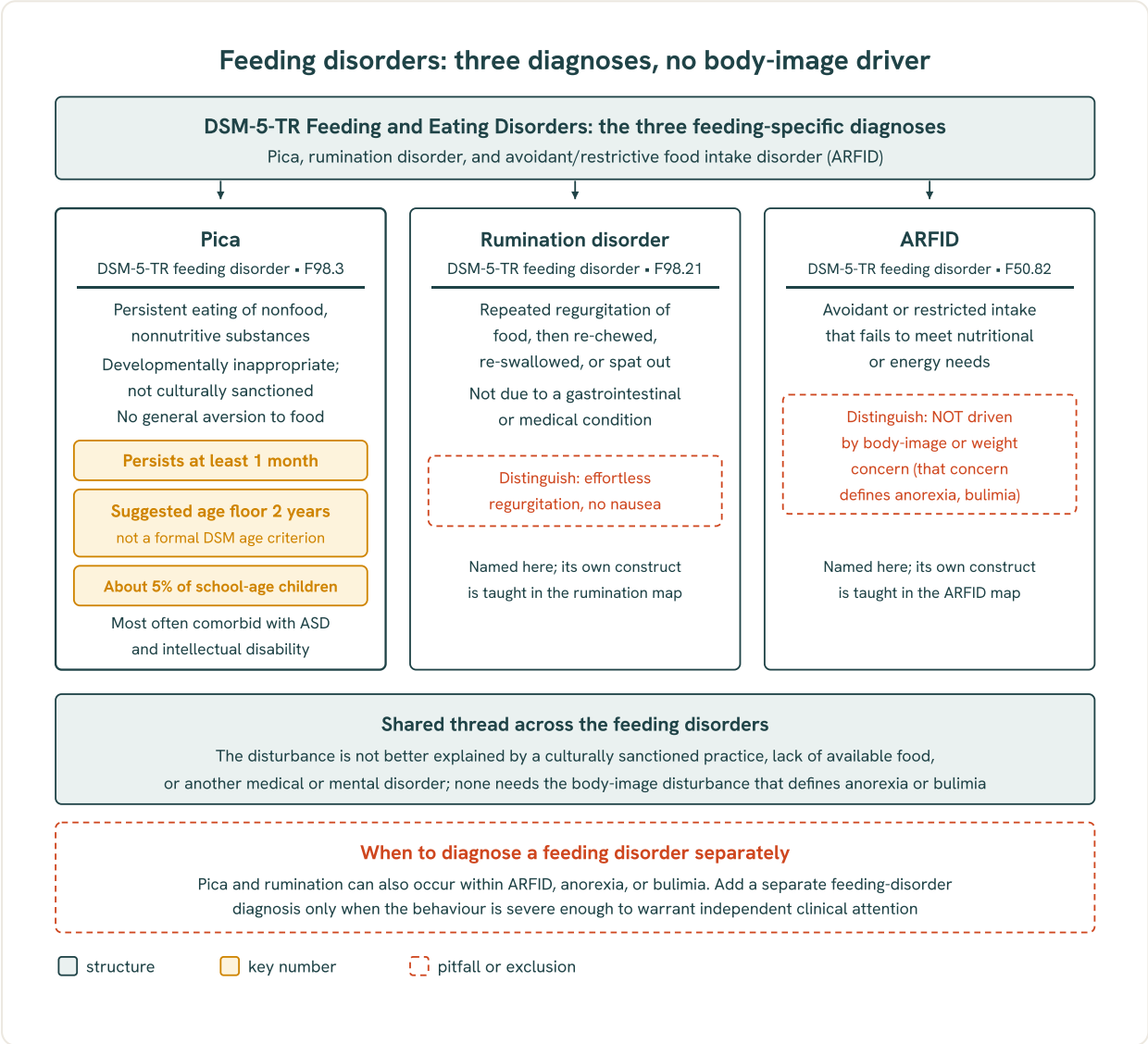


Fig 23.29. Feeding disorders map: pica taught in full, with rumination disorder and ARFID named as the sibling feeding diagnoses that share the absence of a body-image driver.

38.1 The essential feature: nonfood eating, persistent, with appetite intact

The behaviour is an addition to eating, not a subtraction from it. The core requirement is the repeated ingestion of substances that carry no nutritional purpose, sustained rather than a single curious episode, and present for a defined minimum period rather than a passing phase. What a candidate must hold is the qualitative shape of the behaviour. First, it is persistent: an isolated instance of a toddler swallowing a button is not the disorder. Second, the substances are genuinely nonnutritive, so the deliberate eating of low-calorie diet products, which do have some nutritional content, does not qualify. Third, and most usefully in the clinic, the child usually eats food normally as well; pica coexists with an ordinary appetite rather than replacing it. That last point is the fastest way to separate pica at the bedside from a restrictive feeding problem, where the whole difficulty is a narrowed or diminished intake of food itself.

38.2 The qualifiers that keep the diagnosis honest: development, culture and the age floor

Three gates stand between the behaviour and the diagnosis. Not every child who eats nonfood matter has a disorder, and the criteria are built to say so. The eating must be **developmentally inappropriate**, which excludes the universal hand-to-mouth exploration of infancy, when putting objects in the mouth and occasionally swallowing them is a normal stage rather than pathology. It must not be a **culturally supported or socially normative practice**, because in some communities the eating of particular earths or clays is a sanctioned custom and not a sign of illness. And where the eating occurs in the context of another disorder such as autism spectrum disorder, intellectual disability or schizophrenia, a separate diagnosis of pica is made only when the behaviour is severe enough to warrant clinical attention in its own right. To operationalise the developmental gate, a minimum age of **two years** is suggested before the diagnosis is entertained, so that the normal mouthing of the very young is not relabelled as a disorder.

- persistent nonfood eating for the required minimum period, with food eaten normally;
- developmentally inappropriate for the child's age and stage;
- not a culturally sanctioned or socially normative practice;
- if within another disorder, severe enough to deserve independent clinical attention.

RULE **Pica is nonfood eating that is developmentally inappropriate, not culturally sanctioned, and old enough to count.** The behaviour alone is never sufficient. It becomes a diagnosis only once it has cleared the developmental gate, the cultural gate and, where it rides on another disorder, the severity gate. Strip any one of these away and the criteria would capture the exploring infant and the observant clinician alike.

38.3 The substances, and why they are dangerous

What is eaten decides the harm. The preferred substances cluster into recognisable patterns that have acquired their own descriptive names, of which the eating of earth or soil, or **geophagia**, is the classic, alongside the eating of ice and of raw starch. The choice is shaped by age and by availability, which is why the substance changes as the child grows and why environment matters so much. The clinical weight of pica lies not in the strangeness of the

behaviour but in its consequences. Ingested nonfood matter can cause gastrointestinal obstruction, perforation and the formation of concretions in the gut; contaminated soil carries a risk of parasitic infestation; and the swallowing of paint or dust in older housing is a recognised route to lead exposure and its neurotoxicity. These are the reasons an examiner treats pica as a medical problem wearing a behavioural coat, and the reasons the assessment cannot stop at naming the behaviour.

38.4 Comorbidity: the developmental company pica keeps

Where you find pica, look for a developmental disorder. Pica is most commonly seen alongside **autism spectrum disorder** and **intellectual disability**, and the risk tends to rise with the severity of the intellectual impairment. To a lesser degree it is associated with schizophrenia and with obsessive-compulsive disorder. There is a further, characteristic pairing worth carrying into the exam: where a child is pulling out and then eating their own hair, or picking at and ingesting their skin, pica may accompany trichotillomania and excoriation disorder, and the swallowed hair can itself produce a gastric mass. Both autism spectrum disorder and intellectual disability are developed in their own right in the Intellectual disability and autism spectrum disorder notes; here they matter as the settings that should raise suspicion of pica and, conversely, as conditions the clinician must weigh when a child presents eating nonfood substances. The general point is that pica is rarely a lone finding in an otherwise typically developing older child, and its appearance should prompt a look at the wider developmental picture.

38.5 Differential diagnosis

The task is to separate pica from the behaviours it resembles. The accompanying figure maps the feeding and eating disorders of childhood and places pica alongside its neighbours, each of which is separated from it by a single clear feature. The commonest confusions are with normal infant mouthing, with the two other feeding disorders of childhood, and with the hair-and-skin conditions in which ingestion is secondary.

CONDITION TO DISTINGUISH	WHAT SEPARATES IT FROM PICA
Developmentally normal mouthing of infancy	Ingestion follows the ordinary oral exploration of the very young; the suggested age floor of two years and the developmental-appropriateness gate exclude it
Rumination disorder	Repeated regurgitation and re-chewing of already-swallowed food, not the eating of nonfood matter; a disorder of what comes back up rather than what goes down
Avoidant/restrictive food intake disorder	Avoidance or restriction of food leading to inadequate intake, with no ingestion of nonfood substances; the opposite failure of the feeding repertoire, and taught separately in this chapter
Trichotillomania or excoriation with ingestion	The hair-pulling or skin-picking is primary; pica is added only when the eating of the hair or skin is itself a clinical focus
Nonfood eating within another disorder	A separate pica diagnosis is warranted only if the behaviour is severe enough to merit independent attention, not whenever it appears in autism, intellectual disability or schizophrenia

The behaviours pica is most often confused with; each is separated by a single feature rather than by appearance, which is why the qualifiers and the age floor carry the differential.

38.6 Assessment and management

Investigate the body, then modify the behaviour. Because the danger of pica is physical, the assessment is as much medical as psychiatric. A clinician evaluates for the complications the ingested material can cause and for the deficiency states, iron and zinc among them, that are associated with the behaviour, screens for lead exposure where the history or housing suggests it, and looks for gastrointestinal obstruction or a concretion where symptoms point that way. Correcting an identified nutritional deficiency can itself reduce the behaviour, which is why the workup is not optional. Beyond the medical arm, management rests on behavioural strategies and on securing the environment: removing access to the preferred substances, close supervision, and where the child has a developmental disorder, structured behavioural interventions to reduce the ingestion and to build safer alternatives. In many young children the behaviour remits with maturation and with attention to the setting, but the coexisting developmental or nutritional problem often needs its own continuing care. There is no specific medication that treats pica as such; where drugs are used they target a comorbid condition, and any pharmacological choice should be confirmed against a pharmacology source rather than assumed.

Carry this into the exam: persistent eating of nonnutritive, nonfood substances for a month or more, developmentally inappropriate, not culturally sanctioned, in a child of at least two years, most often alongside autism spectrum disorder or intellectual disability.

TRAP **Diagnosing pica in the mouthing infant.** The classic examination error is to label the very young child who explores by mouth and swallows the occasional object as having pica. The suggested minimum age of two years and the requirement that the eating be developmentally inappropriate exist precisely for this child: below that stage the behaviour is a normal part of development, not a disorder.

PITFALL

The commonest clinical failure is to treat pica as a purely behavioural quirk and to skip the medical workup. A child eating soil, paint flakes or hair can arrive with iron-deficiency anaemia, lead exposure, worm infestation, a gut obstruction or a swallowed-hair mass, and none of these is found unless it is looked for. Naming the behaviour and stopping there misses the very harms that make pica worth diagnosing.

GOOD TO REMEMBER

When a child presents with pica, two reflexes change what you do that day: check iron status, because deficiency both drives and is driven by the behaviour and correcting it may resolve it; and take an exposure and access history, because what the child can reach and what the housing contains determine both the medical risk and the first line of management, which is simply removing access.

IN INDIA

Two realities shape pica in Indian practice. Geophagia, the eating of earth or clay, is in some communities a sanctioned custom, at times during pregnancy, and the cultural-exclusion criterion is written for exactly this: a socially normative practice is not a disorder, and the clinician must establish the community norm before reaching for the diagnosis. At the same time, the same soil-eating carries a real burden of iron-deficiency anaemia and of soil-transmitted helminth infestation, so a behaviour that may be culturally ordinary can still demand a medical response. Holding both truths at once, respecting the custom while treating the anaemia and deworming where indicated, is the practical skill this topic tests.

1 month	2 years	ASD, ID
MINIMUM DURATION OF THE BEHAVIOUR	SUGGESTED MINIMUM AGE FOR DIAGNOSIS	COMMONEST DEVELOPMENTAL COMORBIDITIES

39 · Rumination disorder

The child is not sick, and the food comes back up anyway. **Rumination disorder** is the repeated, effortless bringing back up of food that has already been swallowed, so that it can be re-chewed and then re-swallowed or spat out. The defining quality is that it happens without the child appearing ill: there is no nausea beforehand, no retching, no visible disgust, and often no obvious distress at all. Partially digested food simply reappears in the mouth minutes after a meal, is worked over again, and is either swallowed back down or ejected. To an observer who does not know the condition it can look like an odd habit, a digestive complaint, or a mild illness; to the clinician who does, that very absence of the machinery of ordinary vomiting is the diagnosis.

The marks here are about discrimination and about not medicalising the wrong thing. An examiner uses this topic to test whether a candidate can separate an effortless, behaviourally maintained regurgitation from true vomiting, from acid reflux, and from the several structural and neurological conditions that also send food back up. This topic owns rumination disorder in full: its core criterion, its phenomenology, its frequency and duration requirements, the medical and psychiatric conditions it must be told apart from, and its reach across the lifespan. The neighbouring feeding disorders are developed in their own right elsewhere in this chapter and are named here only where the reasoning needs the contrast.

39.1 The essential feature: effortless regurgitation and re-chewing

The whole diagnosis is a repeated, effortless return of already-swallowed food. The core requirement is a repeated **regurgitation** of food, in which previously swallowed, partially digested material is brought back up into the mouth and is then re-chewed, re-swallowed, or spat out. The word regurgitation is doing precise work: this is not the forceful expulsion of vomiting driven by a reflex arc, but a gentle, almost passive reappearance of a bolus that the child then processes again. Because the child produced the swallow in the first place and can carry the food back down afterwards, the act sits closer to a self-generated behaviour than to a symptom happening to the child, and it is this behavioural quality, more than any single feature, that the rest of the topic hangs on.

RULE **Effortless regurgitation without nausea, retching or disgust is rumination; forceful, distressed expulsion is not.** The presence of premonitory nausea, retching, autonomic distress or evident disgust points away from rumination and towards true vomiting or an organic cause. Rumination is quiet, repetitive and post-prandial, and the child frequently seems untroubled by it, which is exactly why it is missed.

39.2 The phenomenology that separates it from vomiting

Read the seconds after the meal, not the vomit bowl. The regurgitated material is characteristically food that was swallowed only minutes earlier and is still recognisable and only partially digested, brought up without the sour, fully acidified quality of gastric vomit and without the preceding wave of nausea. The episode typically begins soon after eating and can recur through the post-prandial period. Many affected children can be observed to initiate the return of food, for instance by particular movements of the tongue, jaw or abdominal wall or by posturing, and the whole sequence tends to be repetitive and stereotyped across meals. None of this resembles the single, effortful, distressing event of true vomiting. The clinical skill the examiner is probing is the willingness to watch a meal and the period straight after it, rather than to reach for an antiemetic or an endoscopy on the assumption that returning food must be a gut disease.

- the material is recently swallowed and only partially digested, not fully acidified gastric content;
- there is no premonitory nausea and no retching;
- the episodes are post-prandial, repetitive and often self-initiated;

- the child commonly appears indifferent rather than distressed.

39.3 How often and for how long: the frequency and duration thresholds

Occasional posseting is not the disorder; a sustained, frequent pattern is. For the diagnosis the regurgitation must have been present for **at least one month**, and it should be a frequent behaviour rather than a rare event, occurring on the order of **several times a week** and often daily. These thresholds do two things. The duration floor screens out the transient regurgitation that many infants show and grow out of, reserving the label for a pattern that has proven itself durable. The frequency expectation stops a very occasional episode from being over-read as a disorder. Together they mark rumination as an established, repeating behaviour, which matters because it is the persistence and the repetition, not the mere fact of food returning once, that carry the nutritional and developmental risk.

39.4 Excluding the medical mimics

Rumination is a diagnosis of a behaviour, made only once organic causes are excluded. The regurgitation must not be attributable to an associated gastrointestinal or other medical condition, and this exclusion is the heart of the differential. The obvious mimic is **gastroesophageal reflux**, in which acidic stomach content passes back up the oesophagus; the returning material there is sour and refluxed rather than re-chewed, and the mechanism is a failure of the lower oesophageal sphincter, not a learned behaviour. Structural obstruction such as **pyloric stenosis** produces true, often forceful vomiting from a mechanical block to gastric emptying, and delayed emptying from **gastroparesis** or an anatomical hiatal hernia can each mimic the picture. A particular neurological trap is **Sandifer syndrome**, in which reflux drives paroxysmal dystonic posturing of the head and trunk that can be mistaken for a movement disorder or for the posturing of rumination itself. Only when these have been considered and do not account for the picture is the behavioural diagnosis made.

CONDITION	WHAT SEPARATES IT FROM RUMINATION
Gastroesophageal reflux	Sour, acidified content refluxed passively through an incompetent sphincter; not re-chewed and re-swallowed, and typically with acid symptoms
Pyloric stenosis	Mechanical gastric outlet obstruction producing true, often projectile vomiting rather than effortless return of chewable food
Gastroparesis / hiatal hernia	Delayed emptying or an anatomical defect causing regurgitation or vomiting on a structural, not behavioural, basis
Sandifer syndrome	Reflux-associated dystonic posturing of the neck and trunk, a neurological mimic that must not be read as the disorder

The organic conditions rumination must be told apart from; each is separated by its mechanism rather than by the mere appearance of returning food, which is why the medical exclusion is done before the behavioural label is applied.

TRAP **Calling refluxed acid rumination, or calling rumination reflux.** The classic examination error is to collapse the two. Reflux brings up sour gastric content through a passive mechanism and is not re-chewed; rumination brings up recently swallowed, still-chewable food that the child works over again, with no nausea and no acid burn. Mistaking one for the other leads either to fruitless anti-reflux treatment or to a missed behavioural diagnosis.

39.5 The eating-disorder exclusion and the additional-attention rule

Two further exclusions keep rumination a distinct entity. The behaviour must not occur exclusively during the course of an eating disorder. If the regurgitation happens only within anorexia nervosa, bulimia nervosa, binge-eating disorder or **avoidant restrictive food intake disorder**, then that condition, not rumination, is the diagnosis; those disorders are taught in their own right, with ARFID developed elsewhere in this chapter and the classical eating disorders in the Eating and sleep-wake disorders notes. The final rule addresses the common situation in which rumination arises alongside another mental disorder, most often an intellectual or neurodevelopmental one: here the regurgitation is diagnosed as an additional condition only when it is severe enough to warrant independent clinical attention in its own right, rather than being folded into the background disorder. This prevents both the over-diagnosis of a minor behaviour and the neglect of a genuinely dangerous one.

39.6 Across the lifespan, and the association with intellectual disability

It is not only an infant's problem. Although rumination is classically described in infancy, it can be diagnosed across the lifespan, in older children, adolescents and adults, and it is seen with particular frequency in people with **intellectual disability**. In infants the behaviour is often understood as self-stimulating and self-soothing, emerging where the ordinary regulation and stimulation provided through feeding interactions is lacking; in individuals with significant intellectual disability it can become an entrenched, self-reinforcing habit. The practical importance of remembering the lifespan reach is that a non-verbal adolescent or adult with intellectual disability who repeatedly brings food back up is easily assumed to have a gastrointestinal problem, and the behavioural nature of the regurgitation is overlooked precisely in the group most likely to have it.

PITFALL

The commonest clinical failure is to subject a ruminating child to an escalating series of invasive gastrointestinal investigations and empirical anti-reflux treatments while never watching a meal. Because the returning food looks like a gut symptom, the workup runs down the organic track for months, when a period of direct observation after eating would have shown the effortless, self-initiated, re-chewed regurgitation and made the diagnosis at the bedside.

IN INDIA

Two realities shape recognition here. Rumination is most often encountered in children and adults with intellectual disability, many of whom are in family or institutional care with limited access to specialist feeding assessment, so the behaviour is frequently attributed to physical illness and worked up repeatedly before anyone names it. And because most services diagnose under ICD, the clinician should hold the same behavioural picture in mind under that framework and resist the pull towards a purely gastroenterological formulation, particularly in a non-verbal patient who cannot report the absence of nausea themselves.

39.7 Why it matters and the principles of management

Left unrecognised it costs weight, nutrition and, sometimes, life. The repeated loss of ingested food can produce weight loss, failure to thrive or malnutrition, dental erosion from the returned material, halitosis and social rejection, and in the most severe cases the nutritional compromise is dangerous. Because the disorder is behavioural, management is directed at the behaviour and its context rather than at the gut. The mainstay in infants and in those with intellectual disability is a behavioural and interactional approach: enriching the feeding relationship and the child's stimulation, and, where a specific technique is used, teaching an action incompatible with regurgitation such as diaphragmatic breathing after meals. The details of specific behavioural protocols and of any pharmacological adjunct lie outside what this topic establishes and should be confirmed against a dedicated source. What the candidate must carry is the logic: identify the effortless, re-chewed, post-prandial regurgitation, exclude the organic mimics, and treat it as a behaviour, not as a disease of the stomach.

GOOD TO REMEMBER

The single most useful investigation is often free: observe the patient during and for the half hour after a meal. Watching the recently swallowed food return effortlessly, be re-chewed and re-swallowed, with no nausea and no retching, settles the diagnosis more cheaply and more certainly than any imaging, and it also reframes the family's understanding of the problem from an illness to be cured to a behaviour to be reshaped.

Carry this into the exam: effortless, post-prandial regurgitation of recently swallowed food that is re-chewed, without nausea or retching, for at least a month and not explained by reflux or another medical condition, is rumination disorder.

1 month	several/week	daily
MINIMUM DURATION OF THE REGURGITATION	MINIMUM FREQUENCY EXPECTED	TYPICAL FREQUENCY AT PRESENTATION

40 · Avoidant restrictive food intake disorder (ARFID)

A child can starve without ever having a thought about weight or shape, and that is the whole point of this diagnosis. **Avoidant/restrictive food intake disorder** describes a persistent disturbance of eating or feeding in which the intake of food, in amount or in variety or in both, is

so restricted that the body or the life suffers for it, yet the restriction is driven by something other than a wish to be thin. The child eats too little, or too narrow a range, because food does not interest them, or because its look, smell or texture repels them, or because they are frightened of what eating might do to them. What is absent is any concern about becoming fat and any distortion in how their weight or shape is experienced. Holding those two facts together, real physical or functional harm on one side and a complete absence of body-image pathology on the other, is the entire topic.

The marks here are almost entirely discriminative. An examiner is testing whether a candidate can recognise a restrictive eating disorder that is not an eating disorder in the classical, weight-and-shape sense, and can therefore avoid the reflex of calling every underweight child who refuses food an anorexia case. This topic owns the criteria of the disorder and, above all, the boundary that separates it from the weight-driven eating disorders; anorexia nervosa and bulimia nervosa themselves belong to the Eating and sleep-wake disorders notes and are only named and cross-referred here, never taught.

40.1 Criterion A: a feeding disturbance that must cause real harm

The eating disturbance is only a disorder when it produces a consequence. The diagnosis is not made on fussy eating alone. There must be an eating or feeding disturbance that fails to meet the child's nutritional or energy needs, and that failure must show itself through at least one of **four** possible consequences. The restriction may cause significant weight loss, or in a growing child a failure to gain expected weight and **faltering growth**; it may produce a significant nutritional deficiency; it may force a dependence on enteral tube feeding or on oral nutritional supplements to keep the child fed; or it may cause a marked interference with psychosocial functioning, so that mealtimes, school trips, family meals and social life are disrupted by the eating problem. Any one of these clears the bar. The last of them matters more than candidates expect, because it means a child of entirely normal weight can still qualify: the harm can be to the life rather than to the body mass.

- significant weight loss, or faltering growth and failure to gain expected weight in a child;
- a significant nutritional deficiency;
- dependence on enteral feeding or oral nutritional supplements to meet needs;
- marked interference with psychosocial functioning.

PITFALL

Waiting for the child to be underweight before considering the diagnosis. Because one of the qualifying consequences is functional and social rather than nutritional, a normal-weight child whose extreme selectivity has made every meal a battle and every outing impossible can meet Criterion A in full. Anchoring on the scale alone will make the clinician miss exactly these children, who are often the ones causing the most family distress.

40.2 The three drivers of the restriction

Why the child is not eating tells you which ARFID you are looking at. The restriction is understood through **three** characteristic drivers, and a given child may sit on one or on more than one of them. The first is an apparent **lack of interest** in eating or in food, a low drive to eat in which the child simply does not seem hungry, forgets to eat, or tires of a meal after a few mouthfuls. The second is avoidance based on the sensory characteristics of food, the intense, selective refusal of foods by texture, smell, colour, temperature or appearance that produces the classic child who will eat only a handful of beige, dry, predictable items. The third is a concern about the aversive consequences of eating, a conditioned fear that follows a frightening experience such as choking, a traumatic gastrointestinal procedure or an episode of vomiting, and that then generalises into avoidance of the foods or the act of eating that the child associates with it, sometimes called functional dysphagia.

DRIVER	WHAT THE CHILD SHOWS	WHAT IT IS NOT
Apparent lack of interest in eating or food	Low appetite drive, early satiety, forgetting to eat, no pleasure in food	Not a wish to lose weight; the child is indifferent to food, not restricting it deliberately
Sensory-based avoidance	Refusal by texture, smell, colour or appearance; a narrow, fixed repertoire of accepted foods	Not calorie avoidance; the same food would be eaten if its sensory qualities were tolerable
Concern about aversive consequences	Fear of choking, vomiting or pain after a frightening event; avoidance of feared foods or of eating itself	Not fear of weight gain; the dread is of a bodily catastrophe while eating, not of fatness

The three drivers of avoidant and restrictive intake. Each explains the restriction by a mechanism that has nothing to do with weight or shape, which is what keeps the whole disorder distinct from the weight-driven eating disorders.

GOOD TO REMEMBER

The sensory-avoidant presentation overlaps heavily with autism spectrum presentations, where narrow, texture-bound eating is common. When you meet the child with an extremely restricted food repertoire, screen deliberately for the wider neurodevelopmental picture, and remember that the eating problem still needs its own nutritional and feeding-focused management rather than being written off as just part of the autism.

40.3 Criterion C: the absence of body-image disturbance is the whole diagnosis

ARFID is the restrictive eating disorder without the weight-and-shape motive. The single most important criterion is the one that draws the boundary with the classical eating disorders. The eating disturbance must not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there must be **no disturbance in the way the person's body weight or shape is experienced**. This is the crux. In anorexia and bulimia the restriction is powered by a fear of fatness and a distorted perception of the body; in ARFID it is powered by lack of interest, sensory aversion or fear of an aversive consequence, and the person has no drive for thinness and no distorted body image at all. Where genuine weight or shape concern is present and driving the restriction, the diagnosis is not ARFID. Anorexia nervosa and bulimia nervosa are developed in

their own right in **the Eating and sleep-wake disorders notes**; here they are the comparators against which ARFID is defined.

RULE **No weight or shape concern, no distorted body image: that absence is what makes it ARFID.** The restriction in ARFID is driven by disinterest, sensory aversion or fear of aversive consequences, never by a wish to be thin. The moment a distorted experience of body weight or shape is driving the eating, the clinician has left ARFID and is in the territory of anorexia or bulimia.

TRAP **Labelling every underweight, food-refusing child as anorexia nervosa.** The classic error is to reason from low weight and restricted intake straight to anorexia, without asking why the child is restricting. If there is no fear of weight gain and no body-image distortion, and the avoidance is sensory or a conditioned fear of choking or vomiting, the diagnosis is ARFID, and treating it as anorexia will target a motive the child does not have.

40.4 Criteria B and D, and where ARFID came from

Two exclusions keep the diagnosis honest. Criterion B requires that the disturbance is **not better explained by a lack of available food** or by a culturally sanctioned practice, so that a child who is undernourished because the family cannot afford food, or who eats little during a religious fast, is not captured. Criterion D requires that the eating disturbance is not attributable to a concurrent medical condition and is not better explained by another mental disorder; where an eating problem is fully accounted for by a physical illness or by another psychiatric condition, that condition is the diagnosis. ARFID is a positive entity, not a residual bin, and these two exclusions are what stop it swallowing every cause of low intake in childhood. Historically, the category was created to replace and extend the older DSM-IV feeding disorder of infancy or early childhood, carrying that clinical reality forward and widening it to older children, adolescents and adults, who were previously left without a home for a restrictive eating problem that was not anorexia.

40.5 Assessment and the company ARFID keeps

The assessment is built to answer one question before all others. Because the diagnosis turns on the motive for restriction and on the presence of harm, the assessment is directed at establishing both. The clinician documents the pattern and the range of foods eaten and refused, elicits which of the three drivers is operating, and actively probes for any weight or shape concern, since its presence or absence decides the diagnosis. In parallel the clinician establishes harm: the growth trajectory and any faltering, nutritional adequacy and specific deficiencies, any reliance on supplements or tube feeding, and the degree of psychosocial and family disruption. The differential is wide and must be worked through with care, because low intake in a child can arise from a medical cause of poor appetite or dysphagia, from a depressive disorder, from an anxiety or obsessive presentation, and, in the sensory-avoidant child, from an autism spectrum disorder whose restricted eating is part of a broader pattern. ARFID is diagnosed when the eating disturbance stands as a problem in its own right rather than being fully explained by one of these.

Carry this into the exam: restricted intake plus real harm, driven by disinterest, sensory aversion or fear of an aversive consequence, and with no fear of fatness and no distorted body image, is ARFID, not anorexia.

40.6 Principles of management

Feed the child, treat the driver, and do not import an eating-disorder model that does not fit. Management follows from the mechanism rather than from a single protocol. The first duty is the physical one: correcting undernutrition, restoring growth, replacing specific deficiencies and, where the child depends on tube feeding or supplements, working deliberately towards oral intake. Beyond that, the psychological work is matched to the driver. Sensory-based avoidance is approached with graded, patient exposure to new textures and foods and a widening of the repertoire, usually with close involvement of the family and often a feeding or occupational-therapy input. The conditioned fear of an aversive consequence is treated on an anxiety model, with graded exposure to the feared foods and to the act of eating, undoing the association that a choking or vomiting episode laid down. The child with a low drive to eat needs structure, appetite-supporting routines and attention to any contributing medical cause. Crucially, because there is no body-image pathology to address, the cognitive work aimed at weight and shape concern that anchors anorexia and bulimia treatment has no target here and should not be transplanted across; specific pharmacological agents and dosing lie outside what this topic establishes and should be confirmed against a pharmacology source.

IN INDIA

ARFID is under-recognised in Indian practice, partly because extreme faddiness is culturally read as ordinary childhood behaviour and met with coaxing or force-feeding rather than assessment. Two discriminations become especially live here. First, Criterion B does real work: in a setting where undernutrition from food insecurity is common, the clinician must establish that food was available and the child restricted it, not that the family could not provide it. Second, the very common paediatric complaint that "my child does not eat" hides a small number of genuine ARFID cases among a large majority of normal variation, so the useful clinical move is to ask specifically about harm, growth faltering, nutritional deficiency and the collapse of family and social life around meals, which is what separates the disorder from the ordinary fussy eater.

3	4	No
DRIVER PRESENTATIONS: DISINTEREST, SENSORY AVERSION, FEAR OF CONSEQUENCE	POSSIBLE CRITERION A CONSEQUENCES, ANY ONE SUFFICIENT	BODY-IMAGE DISTURBANCE, THE FEATURE SEPARATING ARFID FROM ANOREXIA AND BULIMIA

41 · Breath-holding spells and other transient childhood behavioural phenomena

A frightening event with a benign heart. Few things alarm a parent more than watching a toddler cry, stop breathing, change colour and go limp, and few things reassure a clinician more once the pattern is recognised for what it is. **Breath-holding spells** are involuntary, reflexive episodes in which a young child, provoked by a sudden emotional or physical stimulus, stops breathing in expiration long enough to lose colour, tone and consciousness, and then recovers

completely and spontaneously. The whole event is dramatic, stereotyped and self-terminating, and the single most important thing a candidate can say about it is that it is neither an act of will nor a form of epilepsy. The marks in this topic are earned by holding that reframe steady against the two intuitions that mislead everyone in the room, the parent who is sure the child is doing it deliberately, and the clinician who reaches for an anticonvulsant.

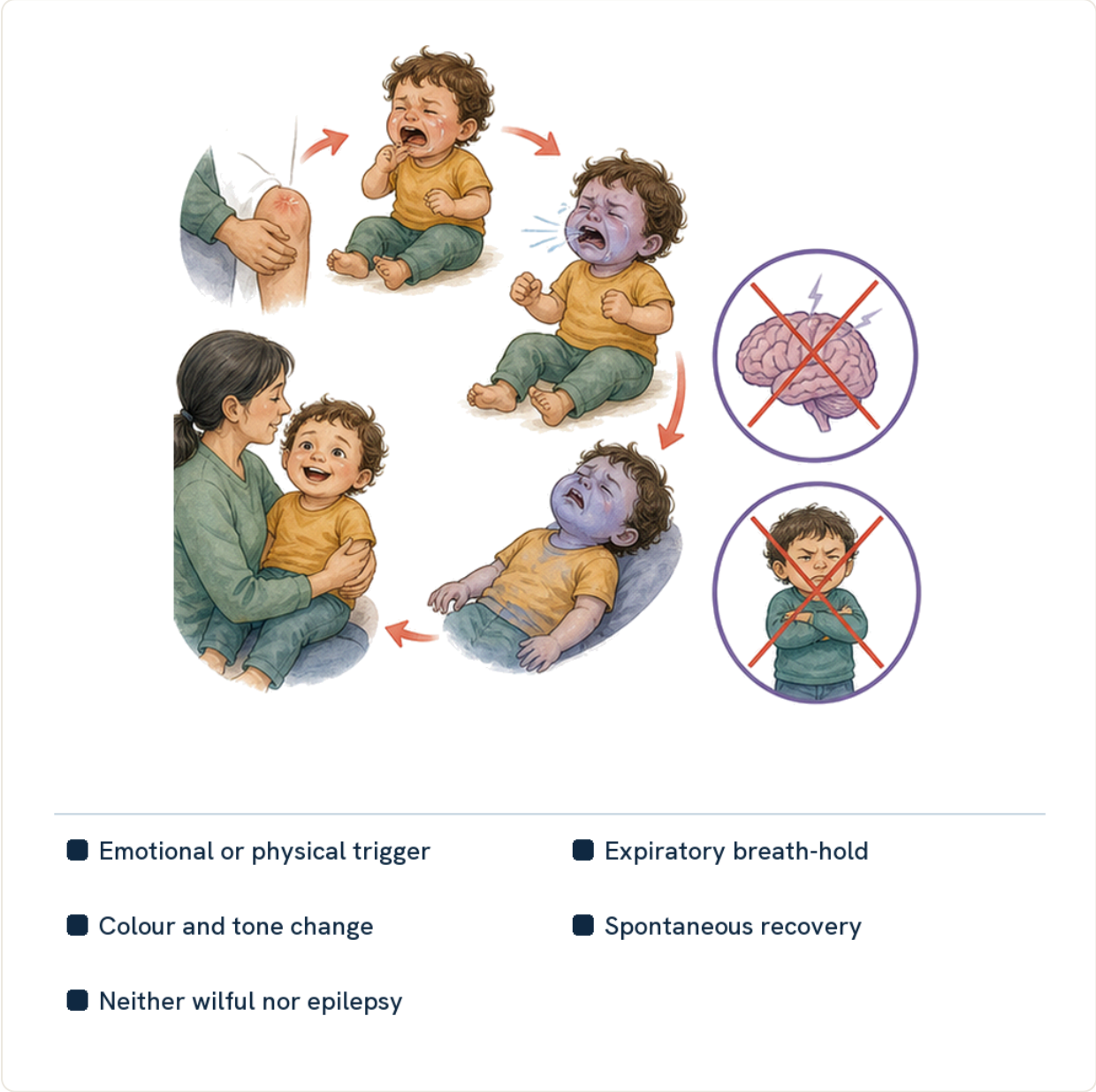


Fig 23.30 Breath-holding spells are involuntary reflex episodes after an emotional or physical trigger. Expiratory breath-holding may produce colour change, loss of tone and brief loss of consciousness, followed by complete spontaneous recovery.

The topic also carries the broader heading of the transient behavioural phenomena of early childhood, the ordinary, self-limiting habits and reflexes that occupy the wide territory between normal development and disorder. Breath-holding is the one that reaches the examination as a discrete named entity, so it is taught here in full; the others are named and placed, because their value is precisely that they do not need treating.

41.1 A reflex, not a willed act

The child does not decide to hold their breath. The name is a misnomer that has cost countless toddlers a spanking and countless parents a needless guilt. What looks like a defiant, deliberate withholding of breath is in fact an involuntary reflex arc triggered by a provoking stimulus, running to completion outside the child's control and ending on its own. This distinction is not pedantic. If the behaviour were voluntary, the correct response would be to refuse to reward it; because it is reflexive and benign, the correct response is calm handling and the removal of the fear that surrounds it. The spell always follows a provocation and never occurs in sleep, and the child has no memory of the loss of consciousness itself. Recovery is complete within a minute, with no drowsiness, no confusion and no lasting deficit, which is exactly the profile a candidate must be able to recite to separate this from the seizure it imitates.

RULE **A breath-holding spell is an involuntary, benign, self-limiting reflex, not wilful defiance and not epilepsy.** Every management decision follows from this one sentence. There is no neurological damage from the spells themselves, the child cannot be disciplined out of them, and anticonvulsants have no place. The clinician's work is to recognise the pattern, exclude the small number of genuine mimics, and hand the family confident reassurance in place of dread.

41.2 Epidemiology and natural history

Common, early and outgrown. Breath-holding spells affect between **0.1% and 4.6%** of otherwise healthy young children, so they are common enough that a paediatric or child-psychiatry clinic will see them regularly, and they cluster in a narrow developmental window. Onset is usually between **6 and 18 months** of age, the period in which the autonomic and brainstem systems that drive the reflex are still maturing, and the great majority of children have stopped having spells by **5 years** of age. That trajectory, appearing in infancy and disappearing spontaneously by school age, is itself a reassuring feature and part of the natural history a candidate is expected to know. The examiner is not testing whether the child will grow out of it, because the answer is almost always yes; the examiner is testing whether the clinician can promise that outcome without first excluding the conditions that masquerade as it.

GOOD TO REMEMBER

The natural history is the therapy. Once the diagnosis is secure, the most powerful intervention available is telling the family, plainly and confidently, that the spells are harmless, that the child is not brain-damaged and is not being manipulative, and that the episodes will fade on their own within the first few years of life. Anxious, over-protective handling and repeated capitulation to the child prolong the pattern; matter-of-fact calm shortens it.

41.3 The two types: cyanotic and pallid

Two triggers, two colours, one benign end. Breath-holding spells come in two forms distinguished by their provocation and the colour the child turns. The **cyanotic type** is the more common. It is usually precipitated by anger or frustration: the child emits a short, loud cry, then involuntarily holds the breath in forced expiration, becomes cyanosed, goes rigid or limp with a transient loss of consciousness, and then takes a long inspiration and recovers. The **pallid type** is

more often precipitated by pain or fear, such as a minor bump to the head or a sudden fright; here the crying may be minimal or silent, the apnoeic period is briefer, and the child develops pallor rather than cyanosis before losing consciousness. In both types the entire episode lasts approximately **10 to 60 seconds** and ends in full recovery.

FEATURE	CYANOTIC SPELL	PALLID SPELL
Relative frequency	The commoner of the two	The less common
Usual provocation	Anger or frustration	Pain or fear (a bump, a fright)
The cry	A short, loud cry precedes the apnoea	Crying may be minimal or silent
Colour change	Cyanosis, from breath held in forced expiration	Pallor, before loss of consciousness
Proposed mechanism	Respiratory, with autonomic dysregulation	Vagally-mediated cardiac inhibition, with reflex asystole or bradycardia
Course of the episode	Rigidity or limpness, brief loss of consciousness, then a long inspiration and full recovery	A briefer apnoeic phase, otherwise proceeds and recovers as the cyanotic spell

The two forms share a benign, self-terminating course; they differ in the stimulus that sets them off, the colour the child turns, and the physiology that drives them.

MNEMONIC

Blue with rage, pale with fright

The **cyanotic** child turns blue and is set off by anger or frustration; the **pallid** child turns pale and is set off by pain or fear. The colour names the type, and the colour points at the mechanism: cyanosis follows the held breath, pallor follows the vagal drop in heart rate.

41.4 Etiopathogenesis: why the reflex fires

The cause is multifactorial, and one strand of it is treatable. No single lesion explains breath-holding spells; the current understanding is that several immature or dysregulated systems converge to produce the reflex. **Autonomic nervous system dysregulation** underlies both types, with the pallid form in particular reflecting **vagally-mediated cardiac inhibition**, a reflex asystole or profound bradycardia mediated by an overactive vagal response to the provoking stimulus. Contributing to this immaturity is **delayed brainstem myelination**, consistent with the age window in which the spells appear and then remit as the nervous system matures. The strand that changes management is **iron deficiency anaemia**, which is associated with breath-holding and whose correction can reduce the frequency of spells, giving the clinician something to treat beyond reassurance. The mechanisms sit together rather than competing:

- autonomic dysregulation, the shared final common pathway of both types;
- vagally-mediated cardiac inhibition, the reflex asystole that defines the pallid spell;
- delayed brainstem myelination, fitting the infantile onset and the spontaneous resolution;

- iron deficiency anaemia, the one contributor that is worth actively seeking and correcting.

IN INDIA

Iron deficiency anaemia is highly prevalent among Indian infants and young children, which makes the iron strand of the etiology far more than a footnote in this setting. A child presenting with breath-holding spells warrants an assessment of iron status, and correcting a documented deficiency is a rational, low-risk intervention that can reduce the frequency of episodes. In a population where nutritional anaemia is common, this converts an otherwise "reassure and wait" condition into one with a concrete, treatable contributor worth pursuing.

41.5 Telling it apart from epilepsy, and managing it

The spell that imitates a seizure is not one. The central differential, and the one the examination targets, is the epileptic seizure. Breath-holding is a **nonepileptic** seizure-like behaviour: it is invariably preceded by a provoking stimulus and a cry or a fright, it never arises out of sleep, the loss of consciousness is brief and colour-linked, and recovery is immediate and without a post-ictal state. A genuine seizure has none of this dependence on provocation, can occur in sleep, and is typically followed by drowsiness or confusion. A prolonged pallid spell may end in a few anoxic jerks, and this is exactly where the unwary reach for an anticonvulsant, but the jerks are the consequence of transient cerebral hypoxia from the vagal asystole, not the expression of an epileptic focus. Management follows from the benign, self-limiting nature established above: confident reassurance and explanation are the cornerstones, the family is taught that the spells cause no harm and will remit, and any underlying contributor, iron deficiency in particular, is treated. Drugs directed at the brain are not indicated for the spells themselves.

TRAP **Diagnosing epilepsy and starting an anticonvulsant.** A pallid spell with a few terminal jerks, described second-hand by a frightened parent, is the classic set-up. Candidates who anchor on the convulsive movements and miss the provoking fright, the pallor and the instant recovery will label a seizure and prescribe accordingly, exposing the child to an unnecessary drug for a benign reflex. The discriminating features are the invariable trigger, the absence of sleep-onset events, and the immediate, post-ictal-free recovery.

PITFALL

The commonest clinician-and-family error is not misdiagnosis but management by appeasement. Once parents learn that a tantrum can escalate into a frightening spell, they begin to give the child whatever prevents the frustration, and the surrounding behaviour, though not the reflex itself, is powerfully reinforced. Advising a family to yield to the child in order to avert spells trades a benign, self-limiting reflex for an entrenched behavioural pattern. The guidance is the opposite: handle the trigger calmly and consistently, and do not let the fear of a spell dictate the parenting.

41.6 The wider family of transient childhood behavioural phenomena

Most of childhood's odd behaviours are developmental, not pathological. Breath-holding belongs to a larger group of transient phenomena of early childhood that share a benign, self-limiting character: the ordinary temper tantrum, thumb-sucking, nail-biting, rhythmic habits

such as body-rocking and head-banging at sleep onset, and the brief motor mannerisms of the toddler years. The unifying clinical principle is that each is common, developmentally expected, and outgrown, and that the intervention of first resort is explanation and reassurance rather than treatment. The examiner's interest here is judgement: knowing when a behaviour sits within normal limits and when its intensity, persistence or associated impairment lifts it into a disorder that is taught in its own right. The threshold at which repetitive or rhythmic behaviour ceases to be a benign habit and becomes a stereotypy or a tic, and the boundaries of the individual childhood disorders, are drawn where those topics are taught; the discipline in this section is to recognise the transient phenomenon, place it, and resist the urge to medicalise it. The general developmental context for what is age-appropriate belongs to the Normal child development and milestones notes.

Breath-holding spells are involuntary, benign, self-limiting reflexes of early childhood, not wilful acts and not epilepsy; recognise the trigger-bound pattern, exclude the seizure, treat any iron deficiency, and reassure.

0.1-4.6%	6-18 mo	by 5 y	10-60 s
OF OTHERWISE HEALTHY YOUNG CHILDREN AFFECTED	USUAL AGE OF ONSET	USUAL SPONTANEOUS RESOLUTION	DURATION OF A TYPICAL EPISODE

Discriminate, apply and consolidate

42 · Telling the disorders apart, and from normal limits

The marks in this section are not for knowing a disorder but for telling it from its neighbours. By the time a candidate reaches this point the individual entities have each been learned in their own place, and the temptation is to treat that as the finish. It is not, because the examined presentation is almost never a clean single disorder announcing its name. It is a disruptive, irritable, rule-breaking child, or a frightened, clingy, wet one, described in a paragraph that fits three or four diagnoses at once and one normal childhood at the same time. The work that earns the marks is the sorting: seeing which axis a presentation turns on, which nearest neighbour it must be held against, and whether it is a disorder at all. This section does that work once, across the whole chapter, using only what the preceding entities have already established.

Two discriminations carry most of the weight, and the chapter has been built to set them up. The first is internal to the behavioural group: the several ways a child can present as disruptive look alike from across the room and separate only on the quality of what is happening underneath. The second runs the length of the chapter: nearly every symptom here also exists as an ordinary part of growing up, so each disorder has to be told not only from its diagnostic neighbours but from its own normal counterpart. Both are done here as maps rather than as fresh teaching, because the point of a synthesis is to lay finished pieces side by side.

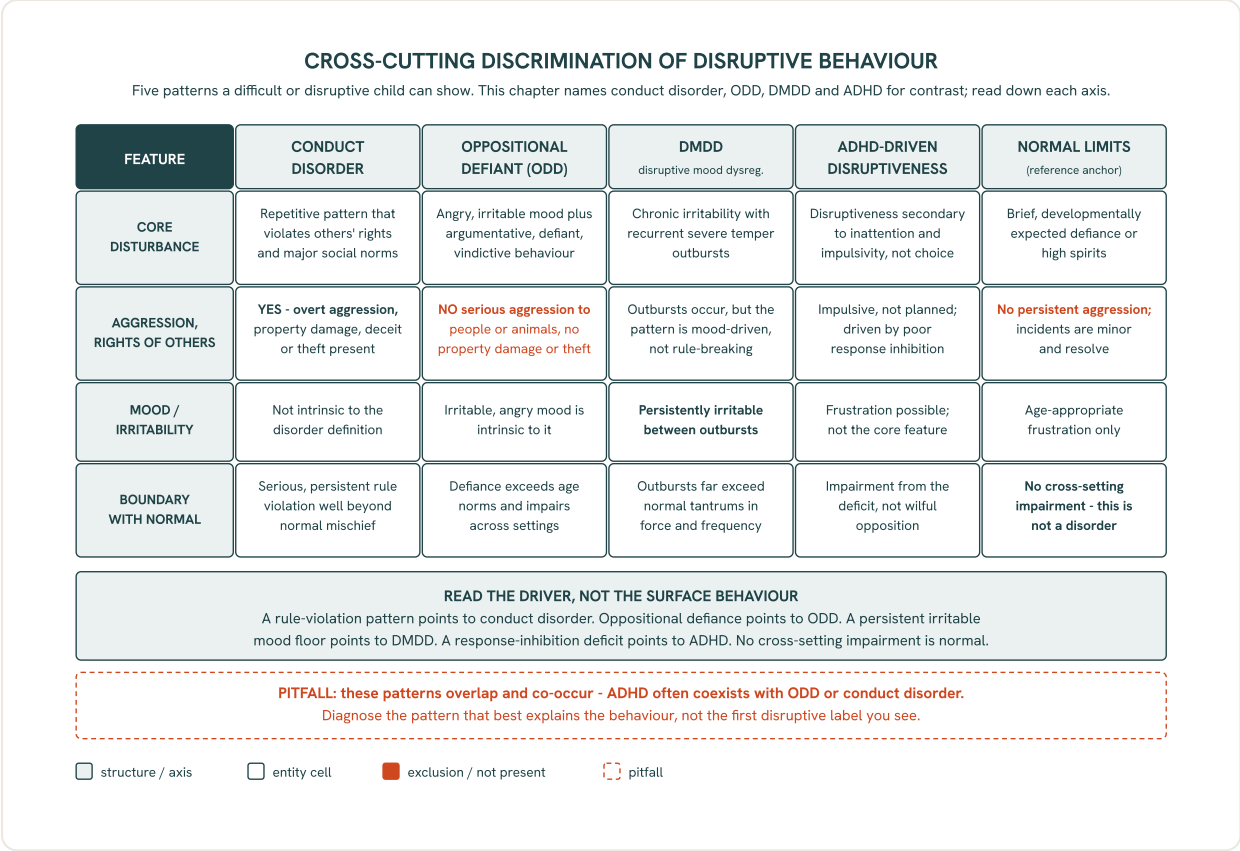


Fig 23.31. Cross-cutting discrimination of disruptive behaviour: conduct disorder, oppositional defiant disorder, DMDD, ADHD-driven disruptiveness and normal-limits behaviour separated on core disturbance, aggression, mood and the boundary with normal development.

42.1 The disruptive-behaviour differential: four disorders and one normal childhood that all look alike

Disruptiveness is a final common presentation, not a diagnosis. A great many child referrals arrive as some version of the same complaint: the child is difficult, defiant, aggressive, will not do as told, and is trouble at home or at school. That surface is shared by several distinct conditions, and the examined skill is to look past it to what the behaviour actually is. Four disorders and one band of normal development converge on this presentation, and each has been taught in full elsewhere in this chapter or its neighbours: **conduct disorder**, in which the defining feature is that the line crossed is other people's basic rights and major age-appropriate norms; **oppositional defiant disorder**, in which the pattern is an angry, argumentative and defiant stance aimed largely at authority figures, without that step into violating others' rights; **disruptive mood dysregulation disorder**, in which the outbursts sit on top of a persistently irritable and angry mood between them and the condition is at bottom a disorder of mood rather than of conduct; and the disruptiveness that is **secondary to attention-deficit/hyperactivity disorder**, where rules are broken through failure of regulation and impulse rather than through hostile intent, taught in the ADHD and specific learning/communication disorders notes. Against all four stands the ordinary difficult behaviour of a well child, which is the fifth thing the paragraph might be describing and the one most often forgotten.

None of these is re-taught here; each owning section carries its own criteria, and the local contrasts a candidate meets first - conduct disorder against oppositional defiant disorder,

disruptive mood dysregulation disorder against paediatric bipolar disorder - are drawn where those disorders live. What the synthesis adds is the single grid that holds all five at once, so that a mixed vignette can be resolved by asking, in order, what kind of thing the behaviour is.

42.2 Reading the grid: the axes that actually separate them

The five separate on a small number of questions, asked in the right order. The grid below is not a list of features to match but a sequence of discriminating axes. The first and most powerful is the nature of the line the behaviour crosses. The second is whom the behaviour is aimed at and whether an abnormal mood is present between episodes. The third, applied last, is whether the picture clears once the developmental baseline and the setting are taken into account, which is the question that separates every one of the disorders from normal difficult behaviour.

PRESENTATION	WHAT THE BEHAVIOUR ESSENTIALLY IS	THE DISCRIMINATING QUESTION	MOOD BETWEEN EPISODES
Conduct disorder	Violation of others' basic rights and major societal norms - aggression, destruction, deceit, serious rule-breaking	Is the line crossed other people's rights, not merely adult authority?	Not the defining feature
Oppositional defiant disorder	An angry, argumentative, defiant and often vindictive stance toward authority	Is defiance of authority the ceiling, without rights-violation?	Irritability is part of the pattern but is not a sustained mood disorder
Disruptive mood dysregulation disorder	Severe recurrent temper outbursts on a background of persistent irritable, angry mood	Is the mood between the outbursts itself persistently irritable?	Persistently and observably irritable or angry
Disruptiveness secondary to attention-deficit/hyperactivity disorder	Rule-breaking driven by inattention, impulsivity and overactivity, not hostile intent	Is the trouble a failure of regulation rather than of intent?	Not primarily a mood problem
Difficult behaviour within normal limits	Age-expected defiance, temper or rule-testing, situational and outgrown	Does it clear once age, setting and impairment are weighed?	Age-appropriate, not sustained

The disruptive-behaviour differential as one grid. Each row's full criteria are taught in its own place; what is set out here is the order of questions that resolves a shared surface into one of five answers. The comparison is read down the third column.

Read this way the differential becomes a decision rather than a memory test. A hostile, aggressive boy who steals and intimidates has crossed into others' rights and points to conduct disorder; the same-looking boy who argues, defies and loses his temper with adults but does not cross that line points to oppositional defiant disorder; the child whose outbursts erupt from a mood that stays sour and irritable in between points to disruptive mood dysregulation disorder; the child who breaks rules because he cannot sit, wait or attend points back toward attention-

deficit/hyperactivity disorder as the primary problem. And a good many children fitting none of these are simply behaving as their age allows.

TRAP **Collapsing every disruptive child into conduct disorder.** Aggression and rule-breaking pull the eye straight to the most severe label, and the weaker answer stops there. The disciplined answer asks what the behaviour actually is before naming it: defiance of authority is not violation of rights, a temper outburst from a persistently irritable mood is a mood disorder and not a conduct one, and dysregulated impulsivity is a disorder of regulation. Naming conduct disorder because the child is difficult, rather than because others' basic rights are being violated, is the single commonest error this part of the chapter tests.

42.3 Disorder against normal limits: the cross-cutting map

Every family in this chapter has a normal counterpart it must be told from. The developmental continuum was set out at the opening as the principle underneath the whole chapter, and it comes due here, because the second great discrimination is not between two disorders but between a disorder and ordinary childhood. Tantrums, separation distress, fears, bedwetting and repetitive self-soothing are not abnormal in themselves; they are expected at particular ages and present in well children. What lifts any of them out of normal development and into a diagnosis is not the behaviour but four features acting together, the same four the chapter has used throughout: whether it is **persistent** rather than a phase, **pervasive** across settings rather than confined to one, developmentally out of step for the child's age, and genuinely **impairing**. Each owning section fixes its own threshold in numbers; the map here holds the comparisons together so the levers can be seen doing the same work every time.

NORMAL DEVELOPMENTAL PHENOMENON	THE DISORDER IT MUST BE TOLD FROM	WHAT LIFTS IT OUT OF NORMAL LIMITS
Toddler and preschool temper tantrums	Oppositional defiant disorder	A persistent, pervasive defiant and irritable pattern continuing past the age tantrums subside, impairing across settings
Separation distress of infancy and early childhood	Separation anxiety disorder	Separation fear excessive for the child's age, persistent, and impairing rather than a self-limiting developmental stage
Age-typical fears (dark, strangers, animals, imaginary threats)	The childhood anxiety disorders	Fear out of proportion to the threat, persistent, and disabling day-to-day function
Bedwetting before continence is developmentally expected	Enuresis	Wetting continuing beyond the developmental age of expected continence, at the criterion frequency and duration
Benign repetitive self-soothing (rocking, thumb-sucking)	Stereotypies and tic disorders	Movements that are prolonged, fixed and impairing, distinguished from the sudden non-rhythmic character of tics

The normal-limits map across the chapter. Each disorder's exact threshold is taught in its own section and is deliberately named here without its numbers; the constant is the set of levers in the third column, which do the same job for every row.

The map is worth carrying whole because the same reasoning recurs in disguise. A three-year-old having tantrums, a toddler distressed at a parent's departure, a five-year-old frightened of the dark, a young child still wet at night, and an infant who rocks to settle are, far more often than not, well children doing what their age allows. The corresponding disorder is diagnosed only when the four levers pull together, and the exact age or frequency that anchors each threshold belongs to the section that owns it and to the Normal child development and milestones notes.

RULE **A behaviour never makes a childhood diagnosis; persistence, pervasiveness, developmental incongruence and impairment do.** The presence of a tantrum, a fear, a wet bed or a defiant refusal settles nothing on its own, because each is a normal event at some age. The diagnosis lives in whether the behaviour has become durable, generalised across settings, out of step for the age, and a genuine source of impairment. Read every childhood presentation through those four levers before reaching for a label.

PITFALL

The error here is the mirror of missing a disorder: over-diagnosing ordinary development. A firm parent, an anxious teacher or a crowded clinic can turn an age-appropriate tantrum, a normal separation protest or a still-maturing bladder into a referral and then into a label. Reaching for a diagnosis because the behaviour is present, rather than because it is persistent, pervasive, developmentally out of step and impairing, over-pathologises childhood and does its own harm. The two failures - under-recognising the genuine disorder and over-labelling the normal child - are opposite ends of the same missing judgement.

42.4 Putting the chapter's map to work

The two discriminations run on one underlying method. Whether the question is which disruptive disorder a child has or whether he has one at all, the move is the same: refuse the surface, name the axis the presentation turns on, and hold it against both its nearest diagnostic neighbour and its normal counterpart before committing. That method is what lets a single mixed vignette be answered cleanly, and it is why the chapter was built as a shape rather than a list. A candidate who carries the family map, the disruptive-behaviour grid and the normal-limits levers into the hall can take almost any child presentation the paper offers and place it, which is precisely what these marks reward.

- Sort the presentation into its family first, and notice when it straddles two - the acting-out child hiding an internalising disorder is the commonest such crossing.
- Within the behavioural group, ask what the behaviour essentially is - rights, authority, mood or regulation - before naming a disorder.
- For any symptom with a normal counterpart, apply the four levers before diagnosing, and be as willing to withhold a label as to give one.
- Cross-refer outward where the presentation reaches beyond this chapter, to attention-deficit/hyperactivity disorder and to the wider systems of assessment and protection, rather

than forcing the answer to stay inside these pages.

IN INDIA

Two features of Indian practice sharpen both discriminations. The operative classification is ICD-11, so the disruptive-behaviour labels that reach case files are its dissocial and oppositional categories rather than the DSM names, and the reasoning of the grid transfers unchanged even though the wording differs. More consequentially, most of these children are first seen by a paediatrician, a general physician or a school rather than a child psychiatrist, in a setting with few dedicated child mental health services. That raises the stakes on the normal-limits map in both directions: a genuinely disordered internalising child is easily missed because the distress is quiet, while an ordinary tantruming or bedwetting child is easily over-labelled by an anxious family or an overburdened clinic. The synthesis is not an academic tidy-up here; it is what protects the well child from a diagnosis and the unwell one from being overlooked.

GOOD TO REMEMBER

Before writing any childhood diagnosis, name its two comparators out loud: the nearest disorder it could be confused with, and the normal developmental phenomenon it grows out of. If the presentation cannot be told convincingly from both, the label is not yet earned. This single habit prevents the two errors that dominate this chapter's examined material at once.

MNEMONIC

Family, then Axis, then the four Levers

The chapter's whole method in three moves. First place the child among the five **Families** seeded at the outset - distress turned Out and distress turned In, with the tic, attachment, and elimination and feeding disorders apart. Then, within the disruptive group, read the **Axis** the behaviour turns on: whether it is about others' rights (conduct disorder), authority (oppositional defiant disorder), mood (disruptive mood dysregulation disorder) or regulation (attention-deficit/hyperactivity disorder). Last, before any label, pull the four **Levers** that separate every disorder from its normal counterpart: persistent, pervasive, developmentally out of step, and impairing.

Refuse the surface: place the child in a family, read what the disruptive behaviour essentially is - rights, authority, mood or regulation - and gate every childhood diagnosis through the four levers of persistence, pervasiveness, developmental incongruence and impairment before you name it.

Rights	Authority	Mood	Regulation
CONDUCT DISORDER	OPPOSITIONAL DEFIANT DISORDER	DISRUPTIVE MOOD DYSREGULATION DISORDER	ADHD-DRIVEN DISRUPTIVENESS

43 · Worked vignettes across the five groups

A map is only as good as the child in front of you. Everything set out across this chapter has been taught one disorder at a time, each in its own place and against its own threshold. The

examination does not ask questions that way. It hands you a paragraph about a real-seeming child and asks you to do, under time, what a clinician does across a first consultation: hear a presenting complaint, recognise which family of disorder it belongs to, read it against what is normal for that age, look for what travels alongside it, and land on a discriminator before committing to an answer. The worked cases below rehearse exactly that movement. They are deliberately built to be entered through the loudest symptom, because that is how children actually arrive, and then to turn on the quieter fact that decides the diagnosis.

Each vignette is arranged around one of the chapter's five families, so that the set as a whole demonstrates the spine already laid down: distress turned outward and distress turned inward as one axis, and the tic, attachment, and elimination-and-feeding disorders standing apart from it with their own logic. None of these cases re-teaches a disorder; where the full criteria, doses and course live, this chapter has already set them out, and the vignette only points back to that place. The work here is the reasoning between symptom and label, which is the part a candidate most often skips and an examiner most reliably tests.

43.1 The behavioural door: aggression that may be more than conduct

A defiant, aggressive boy is the commonest externalising vignette, and the commonest trap. Consider a school-age boy brought by a worn-out mother because he fights, lies, breaks rules at home and at school, and will not be told. The loudest reading is a disruptive behaviour disorder, and the first real task is to place it: a pattern of serious rights-violating and rule-breaking conduct points one way, while argumentativeness, temper and defiance directed at authority without that serious violation points to the milder oppositional pattern. That distinction is drawn in full where each disorder is taught, and the vignette only requires you to know which set of behaviours you are reading. A stronger answer then asks whether the boy shows the **callous-unemotional** features that mark the limited-prosocial-emotions variant, because they change the prognosis and the plan, and are set out where the conduct disorder specifier is taught rather than re-listed here.

The decisive move, and the one that separates a safe candidate from a fluent-but-shallow one, is to refuse to stop at the behaviour. The child who acts out is the child most likely to be carrying an anxiety, trauma or mood disorder underneath, presenting through irritability and rule-breaking that look purely behavioural. Ask, deliberately, what sits beneath the conduct. The hyperactive, impulsive overlap that so often accompanies this picture belongs to the ADHD and specific learning/communication disorders notes, and is named here only so that you screen for it rather than fold it into a behavioural label.

> **GOOD TO REMEMBER**
>
> When a child arrives through the behavioural door, treat the referral as telling you which door the family came through, not the whole of what is inside the room. The acting-out presentation earns a deliberate screen for the anxiety, trauma and mood that hide behind conduct, and for the attentional problem that so often rides with it. The loudest symptom is a starting point, never the finish.

43.2 The emotional door, arriving in the body: pain, and the child who will not go to school

Internalising distress is referred late, quietly, and often through the body. Consider a child with recurrent morning stomach aches and headaches who becomes distressed at the school gate and stays home, yet is well and cheerful on weekends and holidays. The physical complaints are genuine and the family may have cycled through paediatric investigations before anyone asks about mood or fear. This is the **somatisation** presentation of childhood distress, the way anxiety and depression declare themselves in a child who has few words for either, and its full teaching sits where the somatic-symptom and pain presentations of childhood are set out in this chapter. The candidate names it and moves to the discrimination the vignette is really testing.

That discrimination is between two ways a child ends up out of school. **School refusal** is anxiety-driven: the child is at home, the parents know, and the anxiety is often about separation, about the school situation itself, or about a mood disorder pulling the child down. **Truancy** is conduct-driven: the child conceals the absence and is elsewhere, and it belongs with the externalising picture of the section above. The features that separate them are worth holding as a short set:

- whereabouts and parental knowledge: at home with the family versus concealed and elsewhere;
- the affect that drives it: fear and distress versus indifference or defiance;
- the company kept: alone or clinging to a caregiver versus with a peer group away from adults;
- and the family the disorder belongs to: emotional and internalising versus behavioural and externalising.

Behind the refusal, the candidate looks for the specific anxiety or mood disorder generating it, each taught in its own place in this chapter, and for the masked, irritable presentation that childhood depression so often takes. The general adult somatic-symptom and conversion entities, which are a different construct from this childhood somatisation, are the province of the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

43.3 A neurodevelopmental door: movements and sounds that are not habits

The tic vignette is won on phenomenology, not on the movement itself. Consider a boy whose parents describe eye-blinking and throat-clearing that have waxed and waned over months, now joined by brief involuntary sounds, worse when he is tired or stressed, briefly suppressible with effort, and preceded by an uncomfortable urge that the movement relieves. That signature is a tic disorder, and the vignette is testing whether you can separate it from its mimics rather than whether you can name Tourette. The discriminating features cluster tightly: the **premonitory urge**, the brief voluntary suppressibility at a cost, the waxing-and-waning course, and the aggravation by stress and fatigue. Where the classification of tic disorders and the phenomenology of Tourette are set out, this is taught in full; the vignette needs only the recognition.

Against that signature the candidate lines up the look-alikes and lets each fall away. **Stereotypies** are rhythmic, fixed, self-soothing and typically begin earlier, often in a child with autism or intellectual disability, and lack the urge-and-relief quality. Chorea is flowing and non-

suppressible; dystonia is sustained and postural; a compulsion is performed to neutralise an intrusive thought rather than to relieve a bodily urge. Each of these separations is developed where tics are differentiated from other movements, and the vignette rewards knowing which single feature does the work in each case. The impairment in such a child, when it comes, is usually driven less by the tics than by the attention-deficit and obsessive-compulsive problems that so commonly accompany them; those comorbidities are named here and taught, respectively, in the ADHD and specific learning/communication disorders notes and the Anxiety, OCD and trauma-related disorders notes.

TRAP **Reading suppressibility as proof that the movements are voluntary.** A child who can briefly hold a tic down, or a parent who reports that he "can stop when he wants to," tempts the candidate to call the movements a habit or attention-seeking behaviour. Brief, effortful, uncomfortable suppressibility followed by a rebound is a defining property of a tic, not evidence against it, and the premonitory urge is precisely what makes suppression cost something.

43.4 A relational door: the child who came from an institution

Two children from the same depriving start present as mirror images. Consider a young child adopted after early institutional care. One is watchful and emotionally withdrawn, does not seek comfort when distressed and does not respond to it when offered, and shows little social or emotional reciprocity. Another, from a similar history, is strikingly over-familiar, wanders off with unfamiliar adults without checking back, and shows no wariness of strangers. The first is the emotionally withdrawn, internalising pattern; the second is the indiscriminate, disinhibited pattern. The **reactive attachment disorder** and **disinhibited social engagement disorder** that these two pictures represent are each taught in full in their own place; the vignette tests whether you read the direction of the disturbance correctly and, crucially, whether you anchor both to their required cause.

That cause is a history of **pathogenic care**, grossly insufficient or repeatedly disrupted caregiving, and it is what turns this from a temperament question into an attachment one. The discrimination the examiner is usually reaching for is from autism: the socially odd, poorly reciprocal post-institutional child can look autistic at a glance. What separates them is the pathogenic-care history itself, the tendency to improve once a stable and sensitive caregiver is in place, and the absence of the restricted, repetitive repertoire and the pervasive social-communication deficit that define autism. That attachment-side comparison is developed where RAD and DSED are differentiated from autism in this chapter; autism itself is the subject of the Intellectual disability and autism spectrum disorder notes and is not re-taught here. The management follows from the cause and is not pharmacological: a stable, responsive caregiving relationship is the intervention, developed where the attachment disorders' management and the effects of institutional care are set out.

43.5 A bodily-function door: the bed that is wet, and the food that keeps shrinking

Two brief cases share a family. First, a child who still wets the bed at night. The whole discrimination turns on the developmental baseline: at one age this is ordinary and expected, and at a later age, persistent and frequent, it is a disorder, with the exact threshold taught where

enuresis is classified and assessed. The vignette rewards asking the age and the pattern before reaching for a label, and it hides a genuine clinical danger in its treatment.

> **PITFALL**
>
> The tricyclic used for enuresis is cardiotoxic in overdose, and the therapeutic-to-toxic margin in a small child is narrow. Reaching for imipramine casually, or leaving a supply within a young child's or a sibling's reach, is the way this benign-seeming problem turns dangerous. The dose, the cautions and the safer first-line options are set out where the management of enuresis is taught; the point to carry from the vignette is that the drug is not a soft option and the first line is behavioural.

Second, a child whose eating has narrowed to a few textures and who is losing weight, but who has no fear of fatness and no disturbance of body image. This is the picture of **avoidant restrictive food intake disorder**, driven by sensory aversion, low interest in eating, or fear of a feared consequence such as choking, and it is discriminated from anorexia and bulimia precisely by the absence of the weight-and-shape motive. ARFID and that distinction are taught in full in their own place; anorexia and bulimia themselves belong to the Eating and sleep-wake disorders notes and are named here only as the contrast. The younger child eating non-food substances, and the infant regurgitating and re-chewing, are the other members of this bodily-function family, each taught where it sits.

43.6 Pulling the doors together: one method for any child

Every vignette above was entered through a door and decided somewhere else. The loud presenting symptom named a family; the diagnosis was settled by a quieter discriminator and by reading the child against a developmental baseline that keeps moving. That is the single transferable method, and it is worth seeing all five cases laid against it at once.

PRESENTING DOOR	FAMILY	THE DISCRIMINATOR THE CASE TURNS ON	WHERE IT IS TAUGHT IN FULL
Aggression, defiance, rule-breaking	Behavioural (externalising)	Severity of rights-violation, the callous-unemotional variant, and what internalising disorder hides beneath	Where conduct and oppositional disorders are set out
Recurrent pain, will not go to school	Emotional (internalising)	Anxiety-driven refusal versus concealed truancy; somatisation as the presenting language	Where the childhood anxiety, mood and somatic presentations are set out
Waxing movements and sounds, briefly suppressible	Tic disorders	Premonitory urge and suppressibility against stereotypy, chorea, dystonia and compulsion	Where tic classification and Tourette are set out
Withdrawn, or overfamiliar, after early deprivation	Attachment disorders	The pathogenic-care history, and improvement with a stable caregiver, against autism	Where the attachment disorders and their differentiation are set out
Bedwetting; narrowed, weight-losing eating	Elimination and feeding	Age against the developmental baseline; absence of a weight-and-shape motive in ARFID	Where enuresis and the feeding disorders are set out

The five worked cases read against the one method: a presenting door names the family, a quieter discriminator settles the diagnosis, and the full teaching lives in each disorder's own place.

RULE **The presenting complaint names the door, never the diagnosis.** The loudest symptom reliably tells you which of the five families you are in, and reliably fails to tell you which disorder within it, or what else the child is carrying. Read every childhood vignette by placing the family from the presenting picture, reading the picture against the developmental baseline for that age, screening across the outward-inward axis for what hides beneath, and only then committing to the discriminator that the case actually turns on.

IN INDIA

Which door a child reaches care through is shaped by the setting. In a family-based, service-scarce system these children very often meet a paediatrician, a general physician or a school first, and the externalising presentations, which trouble the adults around the child, arrive far more readily than the internalising ones, which cause the child the greater private suffering and are the likeliest to go unrecognised. The labels in the case file are usually ICD-11's rather than the DSM equivalents. The examination vignette written for Indian candidates leans, accordingly, on the presentations that reach an Indian clinic, and the method above is what lets you answer them without a specialist's caseload behind you.

MNEMONIC

Out, In, and three apart

The whole set of vignettes cashes in the chapter's spine. Two families share one axis: the child who turns distress **Out**, met in the behavioural case, and the child who turns it **In**, met in the emotional case that arrived through the body. **Three** families stand **apart** with their own logic: the tic disorders (neurodevelopmental and motor), the attachment disorders (relational, rooted in early care), and the elimination and feeding disorders (of bodily function). Place the child among those five, read against the developmental baseline, and the vignette becomes answerable.

Door	Baseline	Across	Home
THE LOUDEST SYMPTOM NAMES THE FAMILY	READ IT AGAINST DEVELOPMENTAL AGE	SCREEN THE OTHER SIDE OF THE AXIS	THE DISCRIMINATOR SETTLES THE LABEL

A childhood vignette's presenting door names the family, never the diagnosis: place the child among the five families, read the picture against the moving developmental baseline, screen across the Out-In axis for what hides beneath, and commit only to the discriminator the case actually turns on.

44 · Consolidation and active recall

The last hour before an examination is not the time to learn a disorder; it is the time to make sure you can find one. Everything in this chapter has by now been taught in full, each entity in its own place, with its criteria, its mechanism and its management. What has not yet been done, and what decides the marks, is the retrieval: whether the shape of the chapter is available to you under pressure, so that a mixed child presentation resolves into the right family and the right discrimination rather than into a blank or a guess. This closing section does no new teaching. It hands back the whole set as one structure, gives you a way to test that the structure is genuinely yours rather than merely familiar, and leaves you with the single mnemonic the chapter was built to earn.

Read what follows as a rehearsal rather than a summary. A summary you nod along to and forget; a rehearsal makes you produce the answer before you are allowed to see it, and that act of producing is what fixes the material and what an examiner is, in effect, paying you to be able to do.

44.1 Why the close is retrieval and not re-reading

Knowing that you have read something is not the same as being able to produce it. The most reliable finding in the psychology of learning, and the one most useful on the evening before a paper, is that **active recall** - deliberately generating an answer from memory - consolidates knowledge far more durably than re-reading, however attentive the re-reading feels. Re-reading breeds a sense of mastery that outruns the reality, because a page you have seen before is easy to process, and the ease is misread as knowledge - the **fluency illusion** that quiet revision generates and that active production dispels. Producing the answer with the page shut removes that

comfort and shows you, honestly, where the gaps are while there is still time to close them. This is why the heart of this section is a list of prompts with no answers printed beside them, and why you should resist the pull to treat them as trivia you already know.

RULE **Retrieve before you re-read.** When a prompt stops you, the instinct is to turn back to the section and read it again; the stronger move is to sit with the difficulty, reconstruct as much as you can from the family shape, and only then check. The struggle to retrieve, not the smoothness of the re-reading, is what makes the item available next time.

44.2 The whole chapter as one shape

Five families, and for each the single question the examination turns on. The chapter opened by resolving a loose-looking list into five families on two principles; it closes by reassembling them, but now keyed to retrieval. For each family the useful thing to carry is not the full criteria - those are taught where they belong - but the **discriminating question**, the pivot on which the marks in that family actually turn. The map below sets the five side by side against that pivot. It names the disorders it compares and does not re-teach them; the cross-cutting comparison that works those distinctions in detail is drawn earlier in this chapter, and the point here is only to have the pivots in a single view.

FAMILY	THE PIVOT THE MARKS TURN ON	THE DISCRIMINATION IT FORCES (TAUGHT IN FULL EARLIER)
Behavioural (externalising)	What is the behaviour violating - a rule, another person's rights, or the child's own mood control?	Oppositional defiant disorder against conduct disorder against disruptive mood dysregulation disorder, and each against the disruptiveness that rides with attention-deficit/hyperactivity disorder
Emotional (internalising)	Is the fear, worry or low mood developmentally expected, or persistent, pervasive and impairing for this age?	The separation, social and specific presentations of childhood anxiety, and childhood depression with its irritable and somatic disguises
Tic disorders	Is the movement involuntary and urge-driven, or purposeful and self-soothing?	Tics against stereotypies, chorea, dystonia and compulsions
Attachment disorders	Is there a history of grossly deficient care, and does the child withdraw or approach indiscriminately?	Reactive attachment disorder against disinhibited social engagement disorder, and both against autism spectrum disorder
Elimination and feeding	Is the bodily-function problem beyond the age at which it is expected, and is it wet, soiled, restricted or aberrant?	Enuresis and encopresis against age-appropriate continence; pica, rumination and avoidant/restrictive intake against the eating disorders proper

The five families reassembled for the close, each against the one question that carries its marks. The disorders are named, not re-taught; the detailed discriminations sit in their own sections and in the cross-cutting comparison drawn earlier in this chapter.

The map is a route back into the detail, not a substitute for it. Its use in the examination is fast and specific: a vignette lands, you place it into one of the five families within a sentence, and the family hands you its pivot, which is the question you must be seen to ask. A candidate who can name the family and state its pivot has already structured the answer; the remembered criteria then hang off that structure instead of arriving as an unsorted heap. Two families - the behavioural and the emotional - answer to the single outward-inward axis; the other three keep their own logic, and forcing them onto that axis is the error the opening warned against and the close will not undo.

44.3 The active-recall prompts, by family

Cover the section, answer aloud, then check. These are deliberately answer-free. Work them with the relevant section shut: say the answer out loud or write it, and only then open the chapter to mark yourself. A prompt you glide past with a vague nod is a prompt you have not passed. They run in the chapter's own order, one cluster per family, and each cluster asks you to produce the discrimination that the family's pivot demands.

Behavioural. How does defiance without aggression differ from the violation of others' rights, and how does chronic, non-episodic irritability differ from both? Which onset pattern of the aggressive disorder carries the worse trajectory, and toward which adult disorder does it point? What does the callous-unemotional pattern add, and why does it change the prognosis rather than the diagnosis?

Emotional. On what single feature does a childhood fear become a disorder rather than a stage? How does depression disguise itself in a child who never says he is sad? When a child complains only of stomach aches and headaches, which two internalising disorders should you actively look for behind the body, and why is that presentation not the same thing as the somatic symptom and conversion disorders proper?

Tic. What distinguishes an involuntary, urge-driven movement from a purposeful, rhythmic, self-soothing one, and which two comorbidities so define the fuller tic phenotype that they, more than the tics, drive the impairment? Why is the first-line treatment of tics behavioural rather than pharmacological?

Attachment. What single element of the history is required before either attachment disorder can be considered at all? How does the emotionally withdrawn pattern differ from the indiscriminately sociable one, and what tells both of them apart from the superficially similar social difficulty of autism spectrum disorder?

Elimination and feeding. At what point does wetting or soiling stop being a stage and become a disorder, and which of the enuresis treatments is the order-of-magnitude and cardiotoxicity trap in a child? What separates avoidant and restrictive eating from the eating disorders driven by body image?

TRAP **Mistaking recognition for recall.** Reading a prompt, thinking "yes, I know that", and moving on is the commonest self-deception of the last evening. **Recognition**, the sense that you have met an idea before, is a far weaker signal than being able to generate it cold, and the examination asks only for the second. If you did not actually say or write the answer, treat the prompt as unpassed and come back to it.

44.4 What the paper actually asks of this chapter

The marks reward placement and discrimination, not recitation. Very little in a child-psychiatry question is won by reproducing a criteria list intact. The examinable move, almost every time, is to take an untidy real-child presentation, place it in its family, and then draw the one discrimination that the family turns on - defiance from rights-violation from mood-driven irritability, expected fear from disorder, tic from stereotypy, deprivation-rooted attachment disturbance from autism, developmental wetting from enuresis. This is why the map and the prompts above are built around pivots rather than around definitions: the definitions are the raw material, and the discrimination is the finished answer. The child who sits visibly on one side of the outward-inward axis and quietly on the other is **the mixed presentation** to expect, and the answer that notices both sides is the one that scores.

IN INDIA

Two features of local practice should shape how you carry this chapter into the paper. First, the operative classification here is ICD-11, so the family names and category labels you produce should be its labels, even where the teaching above has moved between systems for clarity. Second, these children very often reach a paediatrician, a general physician or a teacher long before a child psychiatrist, and the outward-inward axis predicts which of them arrive at all: the disruptive, externalising presentations are brought in because they trouble the adults, while the internalising disorders, which cause the child the greater private suffering, are the ones a service-scarce system most readily misses. An answer that names where a disorder is likely to be first seen, and by whom, reads as clinically grounded rather than merely memorised.

PITFALL

The revision-stage error is to spend the final hours deepening the disorders you already know and avoiding the discriminations you find slippery, because the familiar material is pleasant to re-read and the slippery pairs are uncomfortable to work. This inverts the return on effort. The marks lost in this chapter are lost at the boundaries - conduct disorder against oppositional defiant disorder against disruptive mood dysregulation, the attachment disorders against autism, tics against stereotypies - and it is precisely the uncomfortable pairs, not the comfortable entities, that repay the last hour.

44.5 The one shape to carry in

If everything else falls away under pressure, this is what should remain. The chapter was built so that a single memorable shape would survive the examination hall even when individual criteria did not. It is the frame the opening laid down and every section since has filled: two families that share one axis and three that stand apart from it, all read against a **developmental**

baseline that keeps moving as the child grows. Hold that, and any presentation has somewhere to go before you have recalled a single threshold.

MNEMONIC

Out, In, and three apart

The child who turns distress **Out** is the behavioural, externalising group; the child who turns it **In** is the emotional, internalising group; these two share one axis. **Three** families stand **apart** from that axis with their own logic: the tic disorders (neurodevelopmental and motor), the attachment disorders (relational, rooted in deficient early care), and the elimination and feeding disorders (of bodily function). Every one of the five is judged against the developmental baseline, never against the behaviour alone. Five families, two principles, one shape.

GOOD TO REMEMBER

On the day, lead with the family, not the diagnosis. Placing a presentation as behavioural, emotional, tic, attachment or elimination-and-feeding takes a sentence and immediately narrows the field to the discriminations that matter, which is the ground the marks are on. Reaching first for a specific label invites the loudest symptom to capture the answer; reaching first for the family keeps the discrimination in view.

The prompts are only useful if they are worked rather than read, so a short method for running them:

- take one family at a time and shut the section before you begin;
- say or write the answer in full before you look, treating any prompt you only recognise as unpassed;
- check against the family map above, confirming you produced the pivot and not merely a definition;
- return to the pairs that stopped you after a gap of some hours rather than immediately, so the second retrieval is a genuine test;
- and leave the comfortable entities to last, spending the scarce final time on the uncomfortable boundaries.

Two families on one axis - distress turned Out (behavioural) against distress turned In (emotional) - and three families apart from it (tic, attachment, elimination and feeding), every disorder read against the moving developmental baseline: place the family first, then draw the discrimination its pivot demands.

Out	In	Apart
PLACE IT: WHICH FAMILY?	ASK IT: WHAT IS THE PIVOT?	DRAW IT: WHICH DISCRIMINATION?

Previously asked

Genuine past questions from this chapter's territory, with their board of origin. No catalogued theory question falls inside the disruptive behaviour and conduct disorders, the childhood emotional disorders, the attachment disorders, the tic disorders or the elimination and feeding disorders in the examined window held in the intel index, so none is printed here. No question is reconstructed, paraphrased into a new one, or invented to pad the list. That a topic has not been asked as a set-piece essay does not lower its yield: conduct disorder against oppositional defiant disorder and disruptive mood dysregulation, the callous-unemotional specifier, tic pharmacotherapy scoped to its indication, the imipramine enuresis dose and its cardiotoxicity, and the attachment-disorder differential from autism are all live short-note and viva territory, and the chapter is built to answer them.

TRAP **An unasked topic is not a low-yield topic.** The absence of a past essay is a fact about one board's recent papers, not about what an examiner may ask this year. Prepare the discriminations and the doses, not the past paper.

The quick review

One table, read down the left column, cover the right. Every line is taught in full somewhere above; nothing here is new. Where the sources disagree, the disagreement is the answer.

ASK	HOLD
WHAT DSM-5 REQUIRES FOR CONDUCT DISORDER	A repetitive pattern violating the basic rights of others or major age-appropriate norms, drawn from four clusters: aggression to people and animals, destruction of property, deceitfulness or theft, and serious rule violations. At least three of the fifteen criteria in the past year, at least one in the past six months. The clusters and the count are the marks.
THE TWO ONSET SUBTYPES AND WHY THEY MATTER	Childhood-onset (at least one symptom before age ten) carries the worse prognosis, more aggression and the stronger link to antisocial personality disorder; adolescent-onset is more normative in its peer context and remits more often. The subtype is a prognostic statement.
THE LIMITED-PROSOCIAL-EMOTIONS SPECIFIER	The callous-unemotional phenotype, applied when at least two of four features persist over twelve months across relationships and settings: lack of remorse or guilt, callous lack of empathy, unconcern about performance, and shallow or deficient affect. It marks a distinct developmental pathway, not merely severe conduct disorder.

ASK	HOLD
CONDUCT DISORDER AGAINST OPPOSITIONAL DEFIANT DISORDER	ODD is angry and irritable mood, argumentative and defiant behaviour, and vindictiveness, without the aggression to people and animals, destruction, theft and serious rights-violation of conduct disorder. ODD can precede conduct disorder; it is not a milder synonym for it.
PHARMACOTHERAPY OF AGGRESSION IN CONDUCT DISORDER	Psychosocial treatment is first-line: parent management training for younger children, multisystemic therapy for adolescents. Medication (risperidone the best evidenced) is an adjunct for serious aggression only, scoped to that indication. It is not a conduct-disorder cure and it is not automatically disruptive-mood-dysregulation-disorder evidence.
WHAT DSM-5 REQUIRES FOR DMDD	Severe recurrent temper outbursts out of proportion to provocation, on average three or more times a week, with persistently irritable or angry mood between outbursts, for twelve months across at least two settings, onset before age ten, diagnosed between ages six and eighteen. It is a depressive-spectrum disorder.
DMDD AGAINST PAEDIATRIC BIPOLAR DISORDER	DMDD is chronic, non-episodic irritability; paediatric bipolar is episodic mania, discrete periods of elevated or expansive mood with the syndrome change. Blurring the episodic-versus-chronic line is the error; DMDD was created precisely to catch the chronically irritable child who was being over-diagnosed as bipolar.
SOMATIC PRESENTATION AGAINST SOMATIC SYMPTOM DISORDER	Recurrent abdominal pain and headaches are how childhood anxiety and depression often present, a somatisation of distress. Somatic symptom disorder proper does NOT require the symptom to be medically unexplained; conversion, now functional neurological symptom disorder, is a distinct entity and is not reducible to mood somatisation.
SEPARATION ANXIETY AGAINST NORMAL DISTRESS	Developmental separation distress peaks in the toddler years and settles; the disorder is developmentally excessive fear of separation, persistent for at least four weeks in a child, with impairment. School refusal is anxious non-attendance with the child at home and the parents aware, distinct from concealed truancy.
PAEDIATRIC OCD AND PANDAS	PANDAS and the broader PANS are a CONTESTED hypothesis of abrupt-onset OCD or tics after streptococcal or other infection, not settled causation. Teach the definition and the controversy; presenting the streptococcal link as an established cause is the error.
THE YOUTH ANTIDEPRESSANT WARNING	An SSRI, usually fluoxetine, is the first-line medication for moderate to severe childhood depression, alongside psychotherapy. The boxed warning reflects a small increase in suicidal ideation and behaviour in the pooled paediatric trials, roughly four percent against two percent on placebo, with no completed suicides. The answer is to monitor closely early, not to withhold treatment.

ASK	HOLD
REACTIVE ATTACHMENT AGAINST DISINHIBITED SOCIAL ENGAGEMENT DISORDER	Both require a history of pathogenic care. Reactive attachment disorder is the emotionally withdrawn, inhibited child who does not seek comfort; disinhibited social engagement disorder is the indiscriminately sociable child who wanders off with an unfamiliar adult. Two patterns, one adverse-care root.
ATTACHMENT DISORDERS AGAINST AUTISM	The attachment-side view: a history of pathogenic care and clear improvement with a stable, sensitive caregiver point to attachment disorder, whereas the pervasive social-communication deficit and the restricted and repetitive behaviours of autism persist across environments. Autism itself is the intellectual disability and autism spectrum disorder notes' to teach.
WHAT DSM-5 REQUIRES FOR TOURETTE SYNDROME	Both multiple motor tics and at least one vocal tic at some time, not necessarily concurrently, present for more than one year, with onset before age eighteen. The premonitory urge and the waxing-and-waning course are the phenomenology; comorbid ADHD and OCD drive most of the impairment.
TIC PHARMACOTHERAPY, SCOPED TO THE INDICATION	Behavioural treatment first: habit reversal training within comprehensive behavioural intervention for tics. Then the alpha-2 agonists guanfacine and clonidine, and the antipsychotics aripiprazole, risperidone and the classical agents, each at its TIC dose. The tic-indication dose is not the ADHD-indication alpha-2 dose and not the autism-indication antipsychotic dose; every dose carries its indication.
TIC AGAINST STEREOTYPY, CHOREA AND DYSTONIA	Tics are sudden, non-rhythmic, involuntary and briefly suppressible with a premonitory urge; stereotypies are rhythmic, fixed, soothing and present from earlier; chorea is flowing and unpredictable; dystonia is sustained and twisting. The premonitory urge and the suppressibility mark the tic.
ENURESIS MANAGEMENT AND THE IMIPRAMINE TRAP	Behavioural measures and the bell-and-pad alarm are the durable first line; desmopressin is the most-used drug, oral preferred over intranasal for the hyponatraemia risk. Imipramine is reserved for refractory cases: the paediatric enuresis dose is tens of milligrams total at bedtime (around 50 mg for ages six to twelve, 75 mg over twelve), NOT a large per-kilogram figure, and its cardiotoxicity and overdose lethality are the reason the dose and the electrocardiogram matter.
ARFID AGAINST THE EATING DISORDERS	Avoidant restrictive food intake disorder is a failure to meet nutritional needs from restricted intake WITHOUT the body-image disturbance or the drive for thinness of anorexia and bulimia. Anorexia and bulimia are the eating and sleep-wake disorders notes'; ARFID is named and distinguished here, not taught there.

ASK	HOLD
ENCOPRESIS	Repeated passage of faeces into inappropriate places from age four, most often retentive with overflow soiling on a background of constipation; management is disimpaction, then maintenance laxatives and a scheduled toileting programme, not primarily a psychiatric drug.
JUVENILE DELINQUENCY	A legal and social construct, not a DSM or ICD diagnosis. The psychiatric task is to assess for the conduct disorder, ADHD, substance use and mood or trauma that often underlie it; the juvenile-justice framework is named and cross-referred to the child psychiatry: assessment, treatment, services and protection notes, and any statutory specific is read from the primary Act, not asserted here.
WHAT THE SOURCES REFUSE TO TELL YOU	Several India-specific prevalence figures for these disorders, the exact standardised scoring bands of some rating scales, and the precise upper age of the extended antidepressant warning are not settled in the literature consulted. The chapter says so where it happens rather than inventing them.

References

Every specific in this chapter is bound to one of the sources below, and the count is the number of claims each carried. Books and guidelines are cited author, title and year in the house convention; no PMID is asserted for a book. For every diagnostic criteria set the primary manual (DSM-5-TR 2022 and ICD-11 CDDR) is the authority, not a textbook paraphrase. This chapter touches no statute it reproduces: item 88 names the juvenile-justice framework and cross-refers rather than stating any Juvenile Justice Act specific. 9 claims are recorded at partial confidence (an honest open gap or a figure to confirm against a primary source at review), never an invented number. The must-have-papers cross-check was NOT performed for this Paper III chapter, because the paper lists do not yet exist in the intel index; for Paper III the topic bank plus the syllabus scaffolding is the completeness authority.

SOURCE	CLAIMS CARRIED
DSM-5-TR (2022)	188
Kaplan and Sadock CTP 2024	33
Lewis Child and Adolescent Psychiatry	29
Rutter's Child and Adolescent Psychiatry	22
Maudsley 15th ed	19
Stahl Prescriber's Guide / Essential Psychopharmacology	15
ICD-11 CDDR	11
PubMed	10

SOURCE	CLAIMS CARRIED
Dulcan's Textbook of Child and Adolescent Psychiatry	5
Hammad	5
Developmental Psychopathology (Cicchetti	4
Bridge et al. 2007	2
Chapter cross-reference (a pedagogy pointer, not a sourced fact)	2
Day-23 _OWNERSHIP-MATRIX.md	2
not found in parsed corpus	2
Clinical Rating Scales and Assessment in Psychiatry and Ment	1
Goodman and Gilman's Pharmacological Basis of Therapeutics	1
Hammad 2006 (Arch Gen Psychiatry) and Bridge 2007 (JAMA)	1
KDT Essentials of Medical Pharmacology	1
New Oxford Textbook of Psychiatry	1
Shorter Oxford Textbook of Psychiatry	1
not in corpus (flagged for primary retrieval)	1

PART V

V

Child Psychiatry: Assessment, Treatment, Services and Protection

Assessing and treating the child: the interview, the therapies, the services that hold them, and the duty to protect.

01 Orientation: the system around the child

02 Child psychopharmacology

03 Assessment and rating tools

04 Therapeutic interventions

05 Epidemiology, services and national context

06 Child protection, abuse and juvenile justice

07 Cross-cutting synthesis

08 Apply and consolidate

PAPER III

Child psychiatry: assessment, treatment, services and protection

Seven bands . one complete notes document

Orientation: the system around the child

1 · Orientation: the system around the child

Why this chapter matters clinically. A child does not arrive as a diagnosis detached from the people, settings and developmental tasks that give symptoms their meaning. The psychiatrist meets a young person whose distress is expressed through behaviour, feeling, body, learning, relationships and participation. The clinical task is therefore to understand the child as a **whole child**, then to make care workable for the family, school and wider systems around that child.

This is an **advance organizer** for a chapter about that surrounding system. It is not a catalogue of childhood disorders. The disorders themselves, including the **internalising and externalising axis** that organises them, are taught in *the Child behavioural, emotional and other disorders notes*. Intellectual disability and autism spectrum disorder are addressed in *the Intellectual disability and autism spectrum disorder notes*; normal temperament, developmental norms and milestones are addressed in *the Normal child development and milestones notes*. Here, the emphasis is on what the clinician does once a child needs psychiatric help: understand, plan, intervene, connect and protect.

WHOLE	CLINICAL	SHARED	SAFE
CHILD	PLAN	SUPPORT	CARE

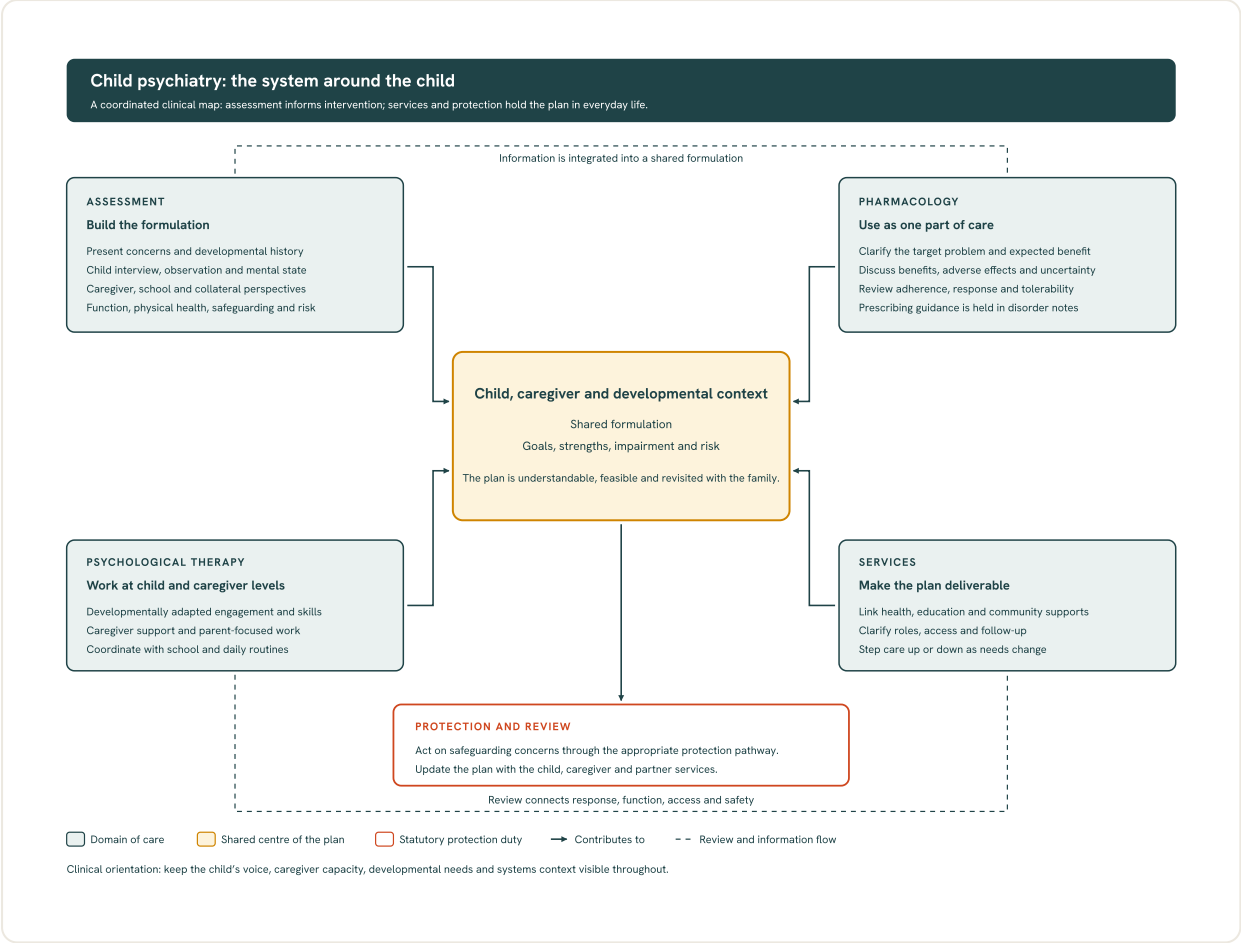


Fig 24.1. The system around the child: how assessment, prescribing, psychological and educational treatment, the Indian service platforms and the statutory protection framework connect for one child. Read it as the chapter's route map rather than as a sequence, since a real case moves between these domains repeatedly.

1.1 The clinical frame: child, context and consequence

Child psychiatry starts with a developmental question: what is happening to this child, in this context, and with what consequences for everyday life? A symptom can alter school participation, peer belonging, family routines and confidence; each of those consequences can in turn maintain distress or restrict recovery. The chapter therefore treats clinical work as a **system around the child**, rather than as a sequence of isolated consultations.

This frame protects against a familiar reductionism. A diagnostic label may guide treatment, but it cannot by itself tell the clinician what a child understands, what a caregiver can implement, what the school observes, or whether the child is safe. Nor should a child be reduced to a family problem, a school problem or a medicine problem. The useful question is always practical as well as descriptive: what would change the child's ability to develop, participate and feel secure?

RULE **Think of the child and the care environment together.** Symptoms are assessed in the child, but intervention succeeds or fails in the relationships and settings in which daily life takes place.

The accompanying figure can be used as a visual reminder of this clinical map. It should not be read as a rigid pathway. A family may enter through a school concern, a behavioural crisis, a developmental worry, a medical referral or a disclosure of harm. The psychiatrist's work is to

organise the response without losing the child's voice or the actual conditions in which care must happen.

1.2 Assessment: turning concern into an intelligible formulation

Assessment is the chapter's starting movement because treatment without a clear understanding is merely activity. The assessment sections show how history, examination, developmental perspective, observation, play, structured measures and cognitive or neuropsychological methods can contribute to an account of the child's needs. They also show why evidence from the child, caregivers, school and other relevant adults may differ without any one informant being simply wrong.

The point is not to collect every possible datum. It is to build a **working formulation** that explains the presenting concern in developmental and relational context, identifies functional impact, and clarifies what must be addressed first. Assessment should generate decisions: whether a further evaluation is needed, who needs to be involved, which supports are realistic, and whether there is a safety concern that changes the pace or setting of care.

- Listen for the child's experience and language, not only the adult account of behaviour.
- Place the concern within development, relationships, education and health.
- Use each assessment method for the question it can answer, rather than treating an instrument as a diagnosis.
- Translate findings into a plan that family and school can understand.

> **GOOD TO REMEMBER**
>
> A careful assessment is already an intervention when it helps adults replace blame with curiosity and gives the child an experience of being heard accurately.

TRAP **Do not confuse a list of findings with a formulation.** Candidates often describe history, tests and ratings well but fail to state how those findings explain the child's current difficulty or alter the management plan.

1.3 Prescribing: medication as one part of accountable care

When medication is considered, the question is not simply whether a drug can reduce a symptom. The psychiatrist must decide whether pharmacological treatment has a clear target within the child's overall plan, whether its likely benefits matter to the child's daily functioning, and how effects will be understood alongside changes at home and school. The prescribing sections address developmental pharmacology, medication classes, cautious use, monitoring, consent and review.

The chapter asks the reader to retain a **prescribing rationale** rather than a prescription habit. A rationale makes explicit what is being treated, how benefit will be recognised, what unwanted effects require attention, and how the family will participate in observation and decision-making. It also keeps medication from displacing educational, psychological, family or safeguarding work when those are the interventions that matter most.

For disorder-specific pharmacological treatment, cross-refer to *the ADHD and specific learning/communication disorders notes*, *the Child behavioural, emotional and other disorders notes*, and *the Intellectual disability and autism spectrum disorder notes*. The present chapter supplies the clinical discipline around prescribing, not a disorder-based regimen.

PITFALL

Improvement in a narrow symptom is not automatically improvement in the child's life. Review must return to function, participation, relationships and the family's capacity to sustain the plan.

1.4 Psychological, family and educational treatment

Psychological treatment in child psychiatry is not an optional conversation added after diagnosis. It is a set of developmentally adapted ways of changing patterns of emotion, behaviour, relationship and learning. The treatment sections cover play-based work, behavioural approaches, parent work, family interventions, cognitive behavioural approaches, special education, remedial measures and early developmental support. Their common thread is that the intervention must fit the child's developmental capacities and the adults who carry much of the treatment between sessions.

The key unit of care is often the **shared plan**: a plan that gives the child a comprehensible role, gives caregivers achievable tasks, and makes space for school or other supports when relevant. This is not a dilution of clinical responsibility. It is how a treatment becomes visible in ordinary life. The psychiatrist remains responsible for coherent formulation, appropriate referral, review and revision when the plan does not fit.

CLINICAL MOVEMENT	QUESTION FOR THE PSYCHIATRIST	PURPOSE WITHIN CARE
Assessment	What is happening, for whom, and in which context?	Make the problem intelligible.
Prescribing	Is medication justified within a broader plan?	Use pharmacology accountably.
Psychological and educational treatment	What change can the child and adults practise in daily life?	Build skills and support participation.
Services	Which setting can sustain the work?	Connect care beyond the clinic.
Protection	Is there harm, risk or a legal duty that changes the response?	Place safety before routine.

1.5 Services in India: making care reachable and continuous

A treatment recommendation has little value if it cannot be reached, understood or sustained. Child mental health care therefore includes the practical work of locating the child within a **continuum of care**: family, school, health services, developmental and educational supports, and community resources. The services sections describe Indian child-health and school-facing platforms, their purposes and how they can complement specialist psychiatric care.

For the psychiatrist, services are not background administration. They determine whether a child is identified early, whether caregivers receive help outside the consultation room, whether educational needs are addressed, and whether follow-up survives distance, cost and competing family demands. Referral is most useful when it is specific about the problem to be addressed and when responsibility for clinical review remains clear.

IN INDIA

The service discussion is deliberately grounded in Indian pathways. Learn to recognise what a school, child-development platform, health service and specialist team can each contribute, then connect them around the child rather than treating referral as a hand-off.

- Ask what support already exists in the child's ordinary environment.
- Specify the purpose of every referral, the information that should travel with it, and barriers that can interrupt follow-up or implementation.

1.6 Protection: safety is a clinical responsibility

Protection enters every child psychiatric assessment because distress may occur alongside abuse, neglect, exploitation, bullying, family violence or other threats to safety. The protection sections distinguish forms of harm, clinical indicators, assessment after sexual abuse, statutory duties, management, juvenile justice and related psychiatric concerns. Their purpose is to help the clinician recognise when ordinary therapeutic pacing is no longer adequate.

Safeguarding requires a **protective response**: attention to the child's immediate safety, accurate documentation, appropriate communication, lawful reporting and connection with the relevant protection system. It is neither an accusation nor a private clinical matter that can be indefinitely deferred while certainty is sought. At the same time, it requires restraint, careful language and respect for the child's dignity. The legal and procedural details belong to the dedicated protection sections and to *the Mental health legislation and forensic psychiatry notes* for general criminal responsibility, mental-health legislation and adult forensic assessment.

MNEMONIC

MAPS: Meet, Assess, Plan, Support, Safeguard

Use this master mnemonic to retain the chapter's clinical route. Meet the child as a person in context; assess before acting; plan medication and psychological care deliberately; support the family and service network; safeguard whenever safety or legal duty enters the case.

The child is never only the diagnosis: assessment, treatment, services and protection must be organised around the child's lived developmental world.

Child psychopharmacology

2 · Principles of prescribing psychotropics in children

Why it matters clinically. Prescribing for a child is not a smaller version of prescribing for an adult. The prescription enters a developing person, a family system, a school context and a network of carers. Its quality is therefore judged not merely by the medicine selected, but by whether the clinician has defined the problem, made the treatment purpose intelligible, anticipated practical obstacles and retained responsibility for review.

Psychotropic medication can reduce suffering and improve a child's capacity to participate in home, school, relationships and psychological treatment. It can also obscure an unclear formulation, displace environmental work, or become a source of conflict if introduced without shared understanding. The central task is disciplined clinical reasoning: prescribe when a medicine has a plausible, proportionate role in a broader plan, and make that role visible to the child and family.

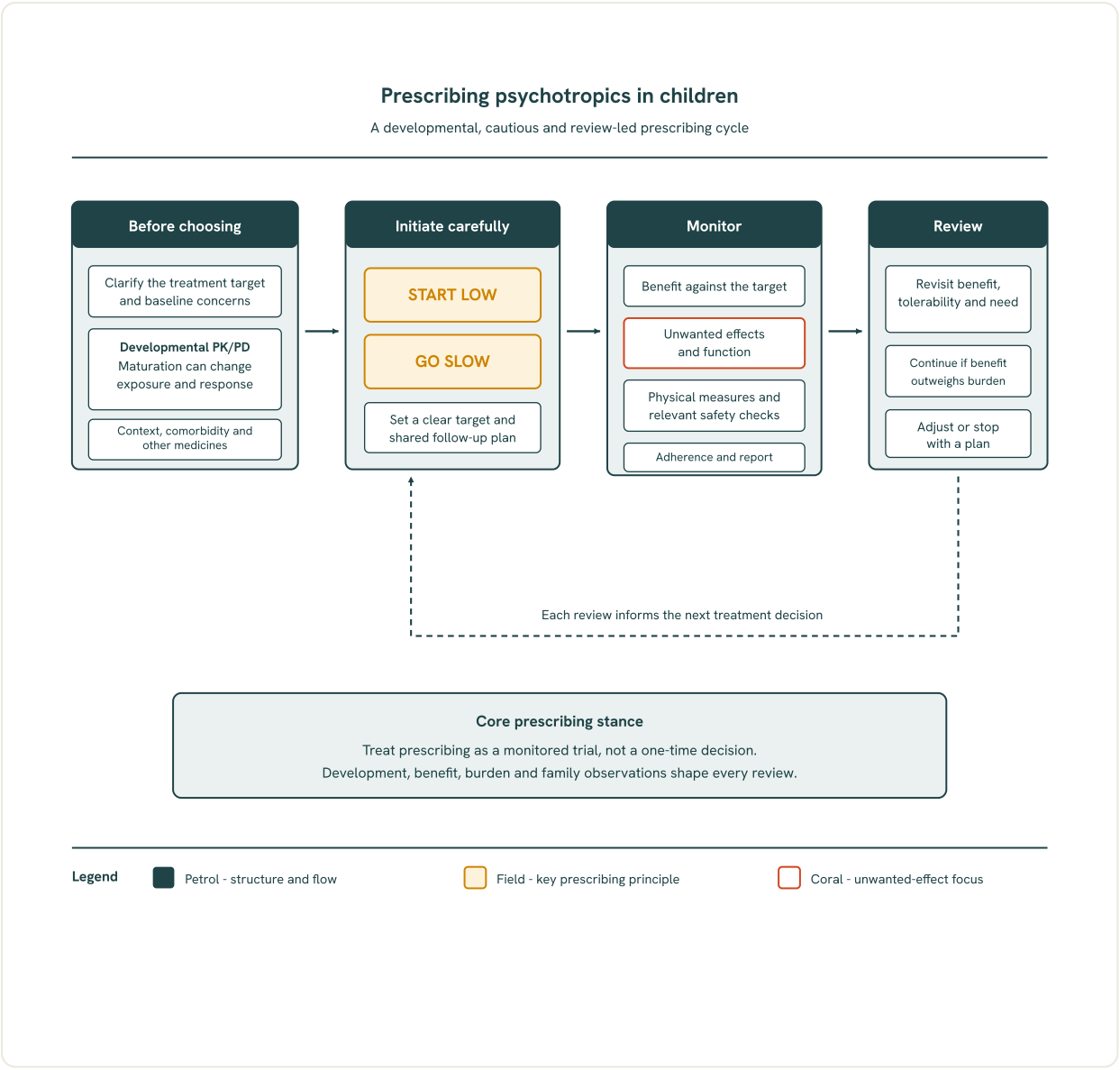


Fig 24.2. A child psychotropic prescription is a developmental, cautious and monitored trial: start low, go slow, assess benefit and burden, and use planned review to guide the next decision.

2.1 The prescribing question

A sound prescription begins with a **treatment target**. This is the concrete difficulty that the medicine is intended to change, described in observable clinical language and linked to impairment. “Behaviour problems” is not a treatment target. Nor is a diagnostic label, by itself, a sufficient instruction to prescribe. The clinician should be able to state what is happening, where it happens, what maintains it, how it affects the child, and what change would count as benefit.

That discipline protects against diagnostic momentum. A child may present with distress, disruptive conduct, sleep disruption, poor concentration, somatic complaints or emotional withdrawal. These phenomena can arise from psychiatric illness, developmental differences, trauma, family stress, learning difficulty, physical illness, substance exposure, medication effects or an interaction among these. Medication may be appropriate, but only after the presenting problem has been placed in a developmental and psychosocial formulation. The prescription should answer a clinical question rather than substitute for one.

RULE **Prescribe for a defined problem within a formulation, not for a label or for pressure to act.** A medication decision should follow a clear account of symptoms, impairment, context and the intended place of pharmacotherapy in the care plan.

Severity matters in a functional sense. The same symptom can carry very different implications depending on its persistence, setting, consequences and the child's available supports. A clinician should ask whether the intervention is intended to relieve acute suffering, reduce risk, enable engagement with other treatment, restore daily functioning, or prevent a pattern from becoming entrenched. Stating the purpose also makes later review possible: benefit is judged against the original target rather than against a vague impression that the child is "better".

- Describe the target problem in language the family can recognise.
- Identify the impairment or risk that gives the target clinical importance.
- Specify what non-medication interventions are active, planned or unavailable.
- Decide what observable change would justify continuing treatment.

2.2 Developmental formulation before pharmacotherapy

Developmental formulation means interpreting symptoms in relation to the child's developmental level, communication capacity, temperament, family relationships, educational demands and medical context. It is not a decorative paragraph added after diagnosis. It determines whether the reported difficulty is best understood as illness, an unmet developmental need, a mismatch between demands and capacity, a response to adversity, or a mixture of these.

The child's own account deserves deliberate effort, even when language, cognition, fear or loyalty to adults limits direct disclosure. Behaviour is often communication. Irritability may express distress, sensory overload, grief, pain, humiliation, anxiety or a coercive family pattern. Apparent non-adherence may reflect swallowing difficulty, unpleasant effects, stigma, a child's wish to retain control, or a caregiver's uncertainty. These meanings do not rule out medication; they determine whether medication is likely to help and how it should be offered.

Collateral information is essential, but it must be interpreted rather than collected mechanically. Different observers see different settings and bring different expectations. Disagreement between home and school accounts may identify environmental triggers, differences in structure, divergent relationships or a problem that is context-bound. It should not automatically be treated as evidence that one informant is unreliable. General child psychiatric assessment is addressed in the assessment section of this chapter; prescribing should use that formulation rather than recreate an abbreviated assessment in the prescription note.

CLINICAL QUESTION	WHY IT CHANGES PRESCRIBING	USEFUL CONSEQUENCE
What is the child experiencing?	Symptoms and their meaning may differ from adult descriptions.	Use developmentally understandable targets and explanations.
Where does the problem occur?	Context can reveal triggers, supports and limits of a medicine-only plan.	Link prescribing to home and educational interventions.
What else could account for it?	Medical, developmental and psychosocial contributors can alter the clinical question.	Address contributors rather than escalating medication reflexively.
What can the child and caregivers realistically do?	A technically sound regimen fails if it cannot be followed or understood.	Choose a plan that fits daily life and review its feasibility.

TRAP **Do not mistake a symptom description for a completed formulation.** A striking symptom can create urgency, but urgency does not remove the need to ask what the behaviour means, what context is sustaining it, and what the medicine can realistically change.

2.3 Proportionality and the place of medication

Proportionality is the fit between the expected benefit of medication and the burden, uncertainty and alternatives in the particular child. It asks more than whether a medicine can work. It asks whether it is the right next intervention, whether the expected gain matters to this child's life, and whether the family understands the trade-off. A medicine is not made benign by familiarity, and a psychosocial intervention is not made adequate merely by being recommended.

Psychological therapy, parent work, educational support, environmental adaptation and treatment of coexisting medical problems are not competitors to pharmacotherapy. Often they provide the conditions in which a medicine can be useful. A severely distressed child may be unable to use therapy until symptoms ease; equally, medication may have little effect on a coercive interaction pattern, an unsafe environment, educational mismatch or lack of routine. The plan should make clear which intervention is addressing which part of the formulation.

Polypharmacy requires particular restraint. When several changes are made at once, the clinician loses the ability to know what produced benefit, what caused harm, and what is no longer necessary. Additional medicines can also conceal inadequate adherence, an incorrect target, a missed contributor or a fragmented service pathway. There are circumstances in which combined treatment is clinically justified, but it should be deliberate, documented and owned by a clinician who can review the whole regimen.

- Ask what the medicine is expected to add to the existing plan.
- Ask what important part of the formulation the medicine cannot address.
- Prefer a plan whose effects can be interpreted clinically.
- Reconsider medication when the original target no longer justifies its burden.

GOOD TO REMEMBER

A clear prescription note links the medicine to a target, the target to impairment, and the medicine to the rest of the care plan. This protects continuity when care moves between clinicians or settings.

2.4 Partnership with the child and caregivers

Shared decision-making is a clinical method, not a formality. It means presenting the treatment purpose, anticipated benefits, important uncertainties, likely burdens and practical demands in a way that the family can use. The child should be included to the extent possible. Inclusion does not mean assigning adult responsibility to a child; it means taking seriously what the child notices, fears, values and can participate in.

Caregivers need a practical account of what the medicine is and is not intended to do. They should know which changes to observe, how to communicate concerns, and why independent changes in administration can make assessment difficult. Questions about dependence, personality change, long-term effects and stigma should be invited rather than dismissed. A family that feels corrected or rushed may agree in the room yet alter the plan outside it. Honest discussion is more likely to produce a usable treatment alliance.

Family disagreement is common and should be explored rather than reduced to "non-compliance". One caregiver may see suffering while another fears labelling; a school may seek rapid behavioural change while the child experiences the medicine differently. The prescriber's role is to restore the clinical question, distinguish values from misinformation, and avoid allowing the prescription to become a proxy battle over blame or control. Formal issues of parental permission, child assent, capacity and documentation belong to the chapter section on monitoring and consent issues in child psychopharmacology.

IN INDIA

Care is often distributed across parents, grandparents, schools and more than one medical service. Ask who actually gives the medicine, who can report change, who pays for follow-up and who may discontinue treatment if adverse effects or stigma are feared. A plan built around the person present in the clinic may fail in the household where it must operate.

2.5 Communicating a plan that can be followed

Adherence is better understood as the degree to which a treatment plan is feasible, acceptable and sustained than as an attribute of a "good" family. It can be undermined by complicated routines, cost, inconsistent supervision, formulation or swallowing difficulties, adverse experiences, poor understanding, stigma and competing household demands. Asking a neutral question such as "What might make this difficult at home?" is usually more informative than asking whether the medicine is being taken.

Written instructions should complement, not replace, conversation. Avoid unexplained abbreviations and make the plan legible to the person who will implement it. Clarify the target, the expected course of review, what observations matter, and what should prompt contact with

the treating team. Medication storage and access require attention wherever there are younger children, family members at risk of self-harm, or a possibility that a medicine may be shared, diverted or used in an unintended way.

Communication with school can be valuable when the educational setting is central to impairment or observation. It should be purposeful and proportionate. The school needs only the information required to support the child and report relevant change; it does not need a full psychiatric narrative. Protecting confidentiality is especially important when medication itself risks becoming a source of labelling or peer attention.

PITFALL

Do not treat a family's difficulty following a regimen as proof that they are careless or oppositional. First examine whether the plan is understandable, affordable, acceptable and compatible with the actual caregiving arrangement.

2.6 Review as a continuing clinical decision

Medication review is the process of returning to the original treatment target and deciding, with fresh information, whether the medicine still has a proportionate role. It is not merely a request for a repeat prescription. The reviewer should ask about meaningful change in the child's life, unwanted effects, the family's experience of administering treatment, changes in context, new symptoms, concurrent medicines and whether the original formulation still explains the problem.

Review is where diagnostic humility becomes visible. Lack of benefit may mean that the target was wrong, the medicine is not useful for that target, the plan was not practicable, a psychosocial driver remains dominant, or the observations are incomplete. The response should not automatically be escalation. Conversely, apparent improvement should not automatically be attributed to medication when school support, family change, maturation, therapy or the natural course may have altered the picture. Attribution is often provisional, which is why a documented baseline and a shared account of the target are so valuable.

Prescribing continuity needs named responsibility. Children may move between outpatient care, emergency services, paediatric specialties, schools or residential settings. At each transition, someone should reconcile the current plan, clarify who is reviewing it, and ensure that old instructions do not persist by inertia. The detailed framework for baseline assessment, safety surveillance, consent and the timing of review belongs to the chapter section on monitoring and consent issues in child psychopharmacology.

Target	Context	Family	Plan
DEFINED	FORMULATED	PARTNERED	REVIEWED

2.7 Boundaries of the general framework

This general framework should not be used to improvise drug-specific practice. Developmental pharmacokinetics and pharmacodynamics are addressed separately. Medication-specific

indications, adverse-effect issues and monitoring requirements belong to the relevant drug sections. Stimulant treatment is cross-referred to *the ADHD and specific learning/communication disorders notes*. Childhood disorders and the paediatric SSRI black-box warning are cross-referred to *the Child behavioural, emotional and other disorders notes*. Intellectual disability and autism spectrum disorder are cross-referred to *the Intellectual disability and autism spectrum disorder notes*.

The realities of off-label prescribing, dose selection and cautious titration belong to the section on off-label prescribing, dosing principles and start-low go-slow in children. This separation matters. A general principle can tell the clinician how to think about a prescription; it cannot safely replace the evidence, indication-specific reasoning or monitoring requirements for a particular medicine.

MNEMONIC

TARGET

Target the problem; **A**ssess its developmental and contextual meaning; **R**elate medication to the wider plan; **G**ive the child and caregivers a real voice; **E**xamine feasibility; **T**rack benefit and burden; retain clear clinical responsibility. It is a thinking aid, not a substitute for drug-specific guidance.

A child psychotropic prescription is justified by a clear target, a developmental formulation, a proportionate place in the plan and an accountable review process.

3 · Developmental pharmacokinetics and pharmacodynamics in children

Why it matters clinically. A child is not a smaller adult with a smaller tablet. Development changes the processes that carry a medicine from administration to the circulation, through the body, and out again. The practical consequence is not simply that a prescriber calculates a smaller amount. It is that the relation between an administered amount, the concentration that results, and the clinical effect must be interpreted through the child's developmental state. This is the pharmacological reasoning that sits beneath safe individualisation of treatment.

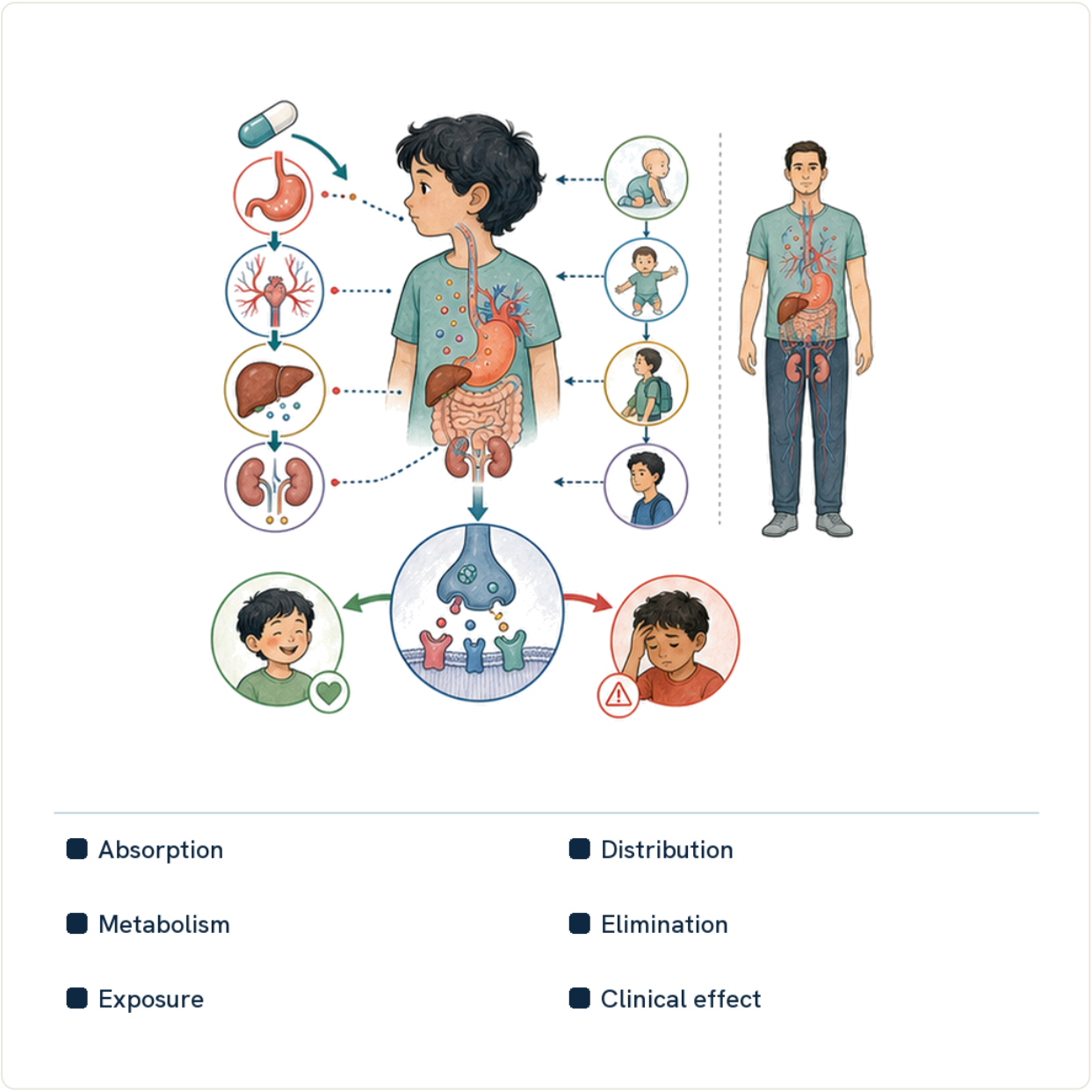


Fig 24.3 Development changes drug absorption, distribution, metabolism and elimination, altering the exposure produced by a dose. Pharmacodynamics then links that exposure to intended and unintended effects; weight-based calculation alone does not complete the reasoning.

Developmental pharmacology has two linked questions. Pharmacokinetics asks what the body does to a medicine: how much reaches the circulation, how it is distributed, transformed, and eliminated. Pharmacodynamics asks what the medicine does at its site of action: how exposure is translated into intended and unintended effects. Neither question supplies a regimen by itself. The general prescribing framework, consent and review processes are addressed elsewhere in this chapter; here the task is to understand why a concentration or a weight-based calculation cannot be read in isolation.

AGE	METABOLISM	BINDING	CLEARANCE
CHANGES DRUG HANDLING	CAN ALTER EXPOSURE	SHAPES LEVEL INTERPRETATION	GUIDES DOSE SCALING

3.1 The developmental frame

Developmental pharmacokinetics is the study of changing drug handling across childhood. Its central clinical value is explanatory. If a medicine produces an unexpected concentration, inadequate benefit, or unwanted effect, the question is not only whether the stated amount was taken. One must also ask whether the child's current physiology changes exposure at an earlier or later part of the pathway. A result that appears anomalous when compared with an adult expectation may be coherent once developmental handling is considered.

This is especially important because childhood is not pharmacologically uniform. Development proceeds along several biological processes that need not move together. A change in one process can alter the meaning of a change in another. Thus, an administered amount is only the beginning of a causal chain. What matters clinically is the exposure eventually available to exert an effect, and the child-specific processes that shape it. This reasoning protects against the easy but unsafe assumption that body size alone completely predicts drug behaviour.

The useful mental model is a pathway rather than a single number:

- the medicine reaches the body and may undergo loss before entering the systemic circulation;
- circulating medicine is present in bound and unbound forms;
- metabolic and renal processes remove parent drug or metabolites; and
- the concentration at the relevant site is interpreted alongside the observed clinical response.

RULE **In children, an administered amount is not a direct measure of exposure.** Developmental physiology lies between the prescription and the concentration that is ultimately available to act.

For the candidate, this is not an invitation to memorise isolated developmental facts. It is a way of explaining clinical variability without collapsing it into adherence, diagnostic error, or presumed treatment resistance. It also clarifies why a prescription should be revisited whenever the child's developmental context or intercurrent illness changes the likely relation between amount and exposure.

3.2 Metabolism, bioavailability and elimination

Drug metabolism is a major source of developmental variation. The capacity to transform a medicine depends on developmental changes in metabolising systems. These changes can alter both **bioavailability** and **elimination**. In other words, metabolism can influence how much medicine enters the circulation as well as how long medicine already in the circulation remains there. This is why metabolism should not be treated as a late, purely eliminative event.

The clinical implication is that the principal metabolic route and the rate at which metabolites form may differ from adult patterns and may also differ among paediatric developmental groups. A medicine can therefore have a different exposure profile in a child even when the arithmetic looks proportional to body weight. The relevant question is not whether a calculation is mathematically tidy, but whether it represents the child's likely route of handling the medicine.

Metabolism also complicates simple interpretations of effect. The parent medicine and its metabolites may not contribute to the clinical picture in the same way. If developmental metabolism changes their relative formation, the observed response may not track an adult expectation based only on the parent compound. At textbook level, the key point is conceptual: an apparent mismatch between amount and response may arise before the medicine reaches its intended site, during its transformation, or during its removal.

GOOD TO REMEMBER

A developmental explanation is most useful when it specifies the link in the chain that may have changed. "Children metabolise medicines differently" is too vague. Ask whether developmental metabolism is plausibly changing entry into the circulation, removal from it, or the relative contribution of metabolites.

This helps separate pharmacokinetic reasoning from a medication "rule." There is no universal developmental direction that can be applied indiscriminately across medicines. The useful inference is conditional: when intestinal or hepatic metabolic processes materially contribute to a medicine's handling, developmental changes in those processes can change exposure. The prescriber must then use drug-specific information and the full clinical context, rather than treating an adult amount as a template that can simply be reduced.

3.3 Protein binding and the meaning of a blood level

A measured concentration is often treated as if it were the clinical answer. It is not. **Protein binding** can change with developmental age and with concomitant illness. This matters because the measured level usually represents circulating drug in a sample, whereas pharmacological action depends on the drug available to leave the circulation and reach its site of action. The interpretation of a reported level therefore requires attention to the binding context, not merely to whether the result lies on one side of a reference interval.

The clinically relevant idea is the **free drug fraction**. When binding differs, the relationship between total measured drug and pharmacologically available drug may also differ. This does not mean that a total level is useless. It means that the level is a piece of evidence whose meaning depends on the child's physiology, illness, sampling circumstances and clinical state. A result should be integrated with the observed response and adverse effects, not made to overrule them automatically.

QUESTION	DEVELOPMENTAL PHARMACOKINETIC INTERPRETATION	CLINICAL REASONING CONSEQUENCE
What does a blood level represent?	A circulating measurement influenced by age and illness-related binding.	Interpret the result in its physiological context.
Why can a familiar value mislead?	The relation between total concentration and available drug may not be constant.	Do not let the number substitute for clinical assessment.
What should a dose adjustment address?	The likely exposure problem, not an isolated laboratory value.	Link the decision to response, tolerability and the child's current context.

Concomitant illness deserves particular attention because it can change binding at the same time as it changes the child's clinical presentation. It is therefore easy to attribute new symptoms either wholly to illness or wholly to medication. Pharmacokinetic thinking holds both possibilities open. It asks whether the illness may change the relation between a measured total level and the active exposure, while clinical assessment determines whether the observed symptoms fit that explanation.

TRAP **A total blood concentration is not automatically a direct measure of active exposure.** Ignoring developmental or illness-related binding turns a useful measurement into a falsely decisive one.

3.4 Clearance as the bridge from physiology to dose

Clearance is the most useful organising parameter for relating age and body weight to paediatric dose. It describes the body's capacity to remove a medicine from the circulation. Because clearance changes the exposure that follows an administered amount, it provides a rational bridge between physiology and dose scaling. Scaling clearance from one paediatric age group to another is a commonly used approach, but it is not a permission slip for uncritical extrapolation from adults.

The distinction matters. Body weight is clinically valuable, but it does not itself describe every developmental process that determines clearance. The same body-size calculation may conceal different contributions from metabolism, filtration, secretion and illness. Clearance-based reasoning asks what removal processes are important for the medicine in question and whether those processes are likely to be developmentally different in the child being treated. The answer can then inform the use of drug-specific dosing information.

Renal clearance is an important example. Glomerular filtration continues to increase until **approximately one to two years of age**, after which it begins to decline toward adult levels. Active tubular secretion follows a similar early trajectory until **two years of age** and then gradually increases into adulthood. For medicines substantially removed through the kidney, this changing physiology makes a fixed assumption about removal particularly unreliable in early childhood.

The point is not to convert a developmental timeline into a universal dose formula. The point is to recognise why renal handling must be part of the explanation when a renally eliminated medicine behaves unexpectedly. Both filtration and secretion belong in the conceptual map. A prescriber who thinks only of filtration may overlook another active component of renal drug removal; a prescriber who thinks only in kilograms may overlook why age-specific drug information remains necessary.

PITFALL

Do not use a general statement about renal maturation as though it determines the regimen for every medicine. Its relevance depends on how much the particular medicine and its metabolites rely on renal removal. The developmental principle guides interpretation; drug-specific information guides the actual prescription.

3.5 Developmental pharmacodynamics

Pharmacodynamics concerns the relation between exposure at the site of action and the resulting therapeutic or adverse effect. Developmental pharmacodynamics asks whether that relation may differ as the child develops. It is conceptually distinct from pharmacokinetics. A pharmacokinetic difference changes the concentration achieved. A pharmacodynamic difference changes the meaning of a given concentration for effect. In practice the two are often hard to disentangle, which is why an observed response should not be used to make a simplistic inference about either process alone.

For psychiatric prescribing, pharmacodynamic reasoning has particular relevance because the desired outcome is an observed change in symptoms, functioning and tolerability rather than a laboratory value alone. A concentration can be compatible with more than one clinical interpretation. It may reflect altered handling of the medicine, altered responsiveness at the site of action, an effect of illness, or a non-pharmacological explanation. The clinician's task is to preserve this differential rather than declare a concentration "effective" or "ineffective" in the abstract.

This distinction is also the reason a laboratory result cannot replace longitudinal observation. Pharmacokinetics helps explain exposure; pharmacodynamics helps explain the exposure-effect relation; clinical assessment establishes what is actually happening to the child. The three sources of information must be read together. This is a framework for thought, not a substitute for the broader monitoring and consent framework.

3.6 A disciplined approach to apparent variability

When response or tolerability appears out of proportion to the expected effect of a prescribed medicine, developmental pharmacology offers a structured sequence of questions. First, identify whether the concern is one of exposure, effect, or both. Second, consider whether developmental metabolism could alter bioavailability or elimination. Third, consider whether binding or intercurrent illness changes the interpretation of any measured concentration. Fourth, consider clearance, including renal processes when relevant. Finally, consider pharmacodynamic variation

and non-pharmacological explanations. This sequence prevents the common error of jumping from an unexpected outcome straight to an arbitrary dose change.

The sequence is deliberately explanatory rather than algorithmic. It does not tell the reader what dose to use, when to alter it, or what monitoring schedule to follow. Those decisions depend on the particular medicine, indication, evidence base, formulation, co-prescribed medicines, medical state and family context. General principles of child prescribing are addressed in the neighbouring prescribing fragment; off-label use and cautious titration are addressed in the fragment on off-label prescribing, dosing principles and start-low go-slow in children.

MNEMONIC

Entry, Binding, Clearance, Effect

Use this sequence to organise an unexpected response: ask what entered the circulation, what was bound, what was removed, and how the available exposure translated into the observed effect. It is a reasoning aid, not a dosing rule.

In child psychopharmacology, developmental physiology changes the path from prescribed amount to clinical effect, so dose, concentration and response must never be treated as interchangeable.

4 · Stimulants in children (recap, safety)

Why this matters clinically. A stimulant prescription is not made safe by a reassuring first review or by a neat entry on a prescription sheet. Safety lies in an organised follow-up relationship: the clinician remains alert to the child's changing body, daily functioning, family observations, and new clinical information. In a child, this matters especially because change can be gradual, expressed indirectly, or first noticed in a setting the prescriber does not see.

Stimulants are commonly discussed as if the important task were selecting a preparation and writing directions. That is not the focus here. The treatment decision and stimulant dosing in ADHD belong in *the ADHD and specific learning/communication disorders notes*. This section is a safety recap: it explains how to think during follow-up, what a useful record is trying to detect, and how to distinguish a measurement from a clinical conclusion.

4.1 Safety as a continuing clinical task

Therapeutic monitoring means using each contact to decide whether the current treatment plan still fits the child in front of the clinician. It is not an administrative ritual and it is not merely a search for adverse effects. The question is broader: what has changed since the last review, how reliable is the account of that change, and does the observed pattern call for attention, clarification, or a different plan?

This approach prevents contrasting errors. Therapeutic inertia occurs when a medicine continues simply because it was once started. Overreaction occurs when a difficult week is treated as proof that medication is responsible for every new problem. These errors arise when follow-up is

reduced to a simplified question about whether the medicine is "working." Children's lives do not present themselves in a simplified form. School demands, sleep, meals, family strain, developmental change, illness, and coexisting symptoms may all alter the picture without yielding a simple explanation.

RULE **At a stimulant review, measure change and interpret it in context before assigning a cause.** A safe review joins physical observations with the child's actual functioning and with a careful search for new medical or psychiatric concerns.

The established teaching account in a historical AACAP practice parameter is that follow-up should include review of behavioural and academic functioning, surveillance for emerging comorbidity or medical conditions, and **periodic assessment** of physical parameters. The wording is useful because it makes monitoring a clinical synthesis rather than a checklist detached from the child's life. It should be read as established teaching, not presented as a substitute for current local guidance or for individual clinical judgement.

A good review therefore begins with a narrative. Ask what the family, child, and relevant carers have actually observed, what has become easier or harder, and whether the report is consistent across settings. Then bring that narrative beside the recorded observations. The record is not there to overrule the family's account; it is there to make a trend visible and to reduce the chance that a meaningful change is missed because each visit is considered in isolation.

4.2 What should be kept in view at follow-up

The core physical safety recap is deliberately simple. At follow-up visits, **height**, weight, blood pressure, and pulse should be assessed periodically. The value of this set is not that any isolated entry automatically answers a clinical question. Its value is that it preserves a shared observational frame across visits. A record that is complete enough to compare is more useful than a collection of unconnected impressions.

Height	Weight	Blood pressure	Pulse
RECORDED OVER TIME	RECORDED OVER TIME	PHYSICAL REVIEW	PHYSICAL REVIEW

The clinical point is **trend recognition**. A value acquires meaning through method, context, and comparison with prior observations. Before deciding that a change is treatment-related, confirm that the measurement is credible and ask whether ordinary circumstances may explain it. Before deciding that a measurement is unimportant, ask whether it departs from the child's earlier pattern or occurs alongside a change in wellbeing or function. This disciplined middle position protects against both complacency and alarmism.

Physical review belongs beside functional review. The same historical AACAP account asks the clinician to review behavioural and academic functioning and to assess for emerging comorbid disorders and medical conditions. This is not an invitation to re-diagnose the child at every visit. It is a reminder that the presenting problem may evolve, that a coexisting difficulty may become more visible as one domain improves, and that treatment should not narrow the clinician's field of vision.

REVIEW DOMAIN	CLINICAL QUESTION	PURPOSE OF THE RECORD
Physical observations	Has there been a change that deserves verification or interpretation?	To make a pattern visible across contacts.
Behaviour and learning	What has changed in everyday participation and demands?	To connect treatment with the child's real-world function.
New symptoms or conditions	Is a fresh concern emerging that needs its own assessment?	To avoid attributing every development to medication.
Family and child account	Whose observations explain the change, and in which setting?	To test whether the clinical picture is coherent.

Growth surveillance is best understood as longitudinal observation, not as an isolated pass or fail event. A child may look well at an appointment while a gradual shift becomes apparent only when earlier records are available. Conversely, a concerning-looking entry may need repetition or contextual explanation before it is allowed to dominate a treatment decision. The same logic applies to **cardiovascular observation**: measure carefully, document clearly, and interpret a pattern rather than attempting to infer risk from an isolated decontextualised reading.

> **GOOD TO REMEMBER**
>
> Bring the physical record into the conversation. Showing a family the sequence of observations turns monitoring into shared clinical work and often clarifies whether the concern is a persistent pattern, an uncertain measurement, or a change in the child's wider circumstances.

4.3 Attribution: the central reasoning problem

The most important safety skill is **attribution**. An event that follows a prescription is not necessarily caused by it. Temporal proximity can be clinically important, but it is a starting signal for inquiry, not a conclusion. Children have intercurrent illnesses, altered routines, changing educational pressures, family events, developmental transitions, and untreated coexisting difficulties. A prescriber who ignores these alternatives may make an avoidable treatment change. A prescriber who uses them merely to dismiss a concern may miss a genuine problem.

Attribution is strengthened by detail. What exactly changed? When was it first noticed? Does it occur consistently or only in a particular setting? Has someone observed the same pattern independently? Was there a relevant change in routine, health, school, or family life? Have the basic observations been checked? These questions do not demand a formula. They create a defensible clinical account in which action follows evidence rather than anxiety.

It is useful to separate the tasks that are often muddled together:

- recognising that a new observation deserves attention;
- deciding what additional information is needed to understand it; and
- deciding whether the treatment plan should change.

Keeping these tasks separate improves both safety and communication. A parent can be taken seriously when a concern is recognised without the clinician prematurely promising a causal explanation or a medication change. It also leaves room for the child's own account. A child may describe an experience differently from a caregiver, and that discrepancy is information to explore rather than a nuisance to smooth away.

TRAP **Do not equate "reported after treatment" with "caused by treatment."** The equally unsafe opposite is to treat a report as irrelevant because the measurement is not yet conclusive. Record the concern, assess its context, and let the subsequent clinical picture guide the response.

Documentation serves the same reasoning purpose. It should state the concern in clinically neutral language, identify the informant and setting, record relevant observations, and make the plan intelligible to the next clinician. It should not turn a suspicion into an established adverse effect merely by the wording used. Precise notes protect the child from both fragmented care and retrospective certainty that was never actually earned.

4.4 Function is part of safety

Functional review is part of safety because a prescription that looks uncomplicated on a chart may still be poorly fitted to the child's life. The historical monitoring account specifically includes behavioural and academic functioning. The point is not to make academic performance the sole measure of treatment value, nor to reduce behaviour to a report from one adult. It is to ask whether the child's capacity to participate in ordinary expectations is changing and whether that change is experienced as helpful, burdensome, or ambiguous.

Function must be explored across the child's environments. A family may notice a different pattern from school, and neither account should be casually privileged. Apparent disagreement may reflect different demands, different observers, or a real context-dependent effect. The clinical task is to understand the discrepancy. In this respect, monitoring remains child psychiatry rather than a narrow drug review: the medicine is considered within development, relationships, education, and health.

When a child's functioning changes, resist the temptation to collapse the answer into "more" or "less" medication. First establish what is meant by change. Is the concern about attention, activity, distress, participation, conflict, tiredness, learning demands, or something else? What is the child's interpretation? Has the concern emerged alongside a medical or psychosocial change? This does not duplicate the treatment chapter; it explains why follow-up must preserve diagnostic curiosity even after a prescription has begun.

MNEMONIC

RAMP

Record the physical measurements, **A**sk about everyday function, **M**onitor new concerns and context, and **P**lan, summarised so the child and family can understand it. It is a recall scaffold for a review, not a dosing rule or a substitute for clinical judgement.

A clear summary at the end of the consultation is clinically useful. It states what has been heard, which observations were documented, what remains uncertain, and what change should prompt earlier contact. This protects against the family leaving with a vague sense that they have been reassured but no shared understanding of what is being watched. It also gives continuity when care is shared across clinicians or services.

4.5 Scope, currency, and the Indian examination answer

IN INDIA

For an Indian postgraduate answer, keep the stimulant safety paragraph distinct from the ADHD treatment paragraph. State that physical parameters and functional change are followed longitudinally, then direct the reader to *the ADHD and specific learning/communication disorders notes* for stimulant selection and dosing. This prevents an answer from importing a regimen into a question that is actually testing safe follow-up.

Safety advice often becomes unsafe when its scope is lost. A historical practice parameter can provide an enduring clinical principle while no longer functioning as a current, stand-alone protocol. The safe use of such teaching is transparent: identify the principle it contributes, preserve its limits, and check the current local policy or specialist advice when a contemporary operational decision is required. This is especially important when a trainee is tempted to convert a broad instruction to monitor into a rigid schedule, threshold, or universal response.

The practical distinction is between a **monitoring framework** and a management algorithm. A framework tells the clinician what domains deserve recurrent attention. An algorithm tells the clinician precisely what to do under defined circumstances. The supplied historical teaching supports the former. It does not license this section to invent the latter. Keeping that distinction explicit is both good scholarship and good clinical safety.

PITFALL

Do not present an older authoritative document as if it settles a current operational question. Its monitoring principle may remain useful, but current decisions require the applicable policy, the child's clinical context, and appropriate specialist judgement.

The same discipline applies to cross-references. The disorder formulation, diagnostic reconsideration, medication choice, and dosing details must not be smuggled into a safety recap merely because they are clinically adjacent. A focused answer is stronger: it says what the review must observe, why interpretation matters, and where the reader should go for treatment details.

4.6 A usable follow-up note

A concise follow-up note can carry considerable clinical intelligence when it links observation to interpretation. It should identify the child's and caregiver's account of change, note relevant behavioural and academic functioning, record whether fresh medical or psychiatric concerns have emerged, and preserve the physical observations required for longitudinal comparison. It

should then state the clinician's working interpretation and the agreed next step. This makes the reasoning visible rather than leaving a sequence of numbers with no clinical meaning.

The note should also preserve uncertainty honestly. "Concern reported, context under review" is often more accurate than a definitive label. It tells a future clinician that the issue was heard and that the current evidence did not yet justify a stronger conclusion. Honest uncertainty is not indecision. It is a deliberate safeguard against causal overstatement in a developing child whose circumstances may change quickly.

Stimulant safety follow-up is longitudinal: **periodically** record physical parameters, review real-world function, and investigate new concerns before deciding what they mean.

5 · Antipsychotics in children (indications, metabolic monitoring)

Why it matters clinically. An antipsychotic prescription in a child is never simply a choice of molecule. It is a decision to target a clearly described symptom pattern, within a developmental formulation, while accepting the obligation to look actively for physical harm that the child may neither recognise nor report. The useful examination answer is therefore not a list of drugs. It is a disciplined account of indication, scope, baseline metabolic monitoring, review of benefit, and a route back to the wider treatment plan.

In child psychiatry, these medicines are often discussed around highly visible behaviours, but visible behaviour is not itself an indication. The clinician must specify what is being targeted, how it is impairing the child or others, what non-pharmacological work is proceeding, and what observable change would justify continuing treatment. Antipsychotics can have an important place in carefully selected situations; they should not become a substitute for developmental assessment, family work, environmental modification, or treatment of the disorder that gives the symptom its meaning.

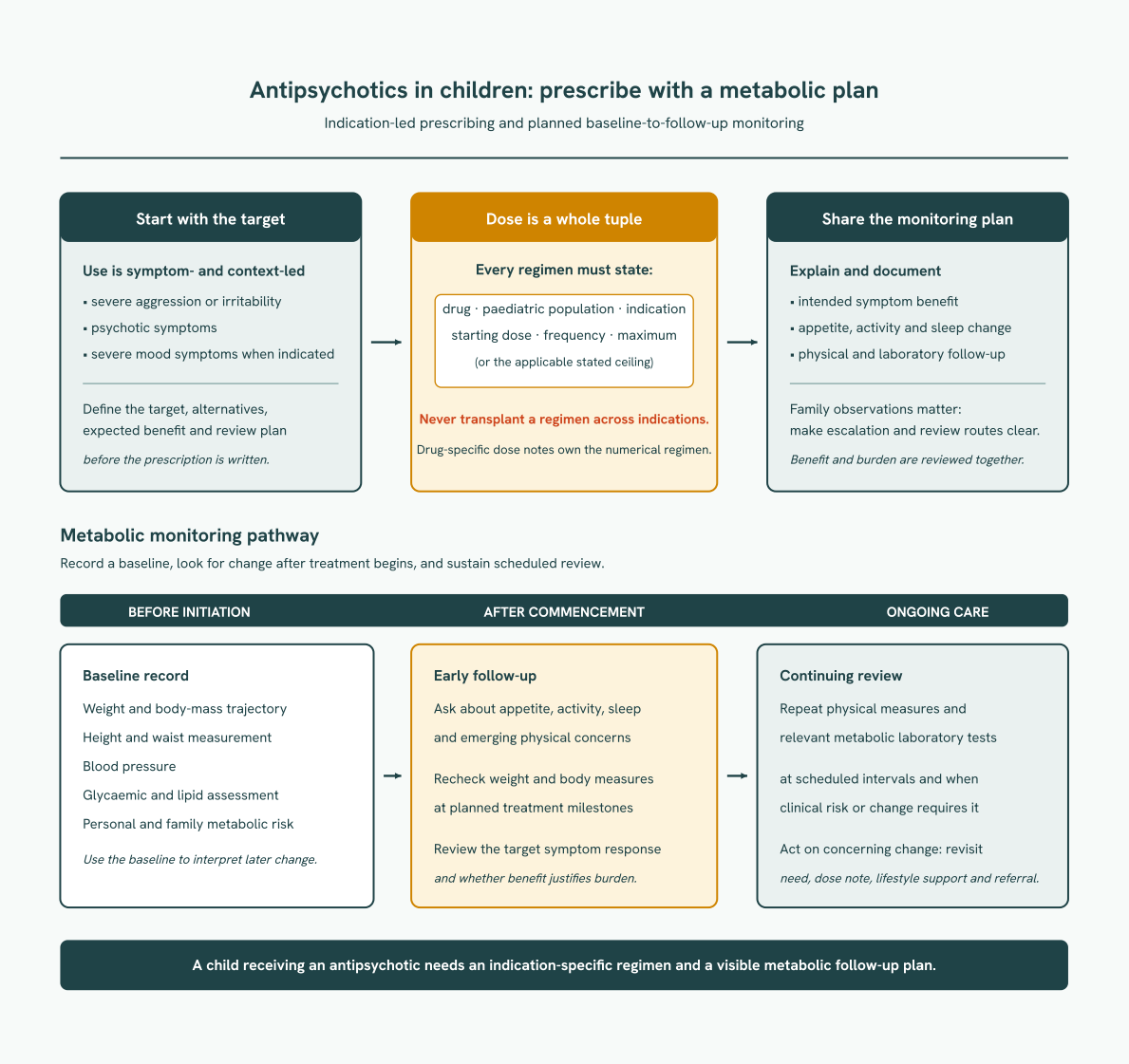


Fig 24.4. Antipsychotic prescribing in children is indication-led: a complete dose tuple belongs to the drug-specific prescribing note, while metabolic monitoring begins before initiation and continues through treatment.

5.1 The indication is a clinical question, not a behavioural label

A **target symptom** is the concrete phenomenon that the prescription is intended to change. It should be described in language that permits subsequent review: its form, setting, precipitants, consequences, and effect on functioning. This prevents the common slide from "difficult behaviour" to medication without a defensible therapeutic question. A severe behavioural presentation may arise from distress, communication difficulty, fear, pain, sleep disruption, conflict, a neurodevelopmental need, an emerging mood or psychotic state, or a safeguarding problem. Medication may be relevant to some formulations, but it cannot settle which formulation is correct.

The prescriber should translate the referral complaint into a working hierarchy. Immediate risk and intolerable suffering take priority, but urgency does not abolish assessment. The practical question is whether an antipsychotic is being considered to relieve a symptom pattern for which it is reasonable, or merely to make a setting easier to manage. The latter may occur when a family,

school, ward, or residential placement is overwhelmed. Their burden deserves attention, yet social strain alone is not an adequate endpoint for a child's long-term medication exposure.

RULE **Prescribe against a stated target and a stated review question.** The target tells the team what benefit to seek; the review question tells the team what would count as insufficient benefit, unacceptable harm, or a reason to change course.

A **functional formulation** protects against treating a symptom in isolation. It links the behaviour or experience to antecedents, developmental abilities, relationships, reinforcement, medical contributors, and the child's environment. The formulation also clarifies what medication cannot accomplish. A medicine may reduce a particular symptom, but it does not teach communication, repair attachment strain, alter a coercive interaction cycle, or create an appropriate educational placement. Those tasks remain active parts of care.

5.2 Scope discipline: named examples are not portable regimens

Regimens in child psychiatry are inseparable from the indication and population for which they were established. A drug name written beside a diagnosis can falsely imply that the same approach applies to every child with that diagnosis, every behavioural difficulty, or every service setting. That inference is especially unsafe with antipsychotics, where the balance between expected benefit and physical burden varies with the clinical problem and the individual child.

For a child with tics, **aripiprazole** may be named as a cross-referenced example; its tic regimen is taught in *the Child behavioural, emotional and other disorders notes*. Likewise, **risperidone** may be named in relation to conduct-disorder aggression, but that regimen belongs to *the Child behavioural, emotional and other disorders notes*. The relevant population and indication must accompany any reading of current labelling. These references are deliberately narrow. They neither authorise a regimen for another presentation nor provide a dose that can be lifted into another clinical context.

Risperidone may also be named as a cross-referenced example for autism-related irritability; its regimen is taught in *the Intellectual disability and autism spectrum disorder notes*. This distinction is more than editorial tidiness. When a child's presentation is linked to autism, the diagnostic formulation, communication profile, sensory context, family goals, and behavioural supports shape the treatment decision. A medication name alone cannot carry that work.

PITFALL

Do not convert a cross-referenced example into a general-purpose prescription. The same antipsychotic may appear in more than one part of child psychiatry, but each use has its own clinical question. A dose or titration recalled from one indication is not evidence for another.

PRESCRIBING QUESTION	WHAT THE RECORD SHOULD MAKE CLEAR	WHY IT MATTERS
What is being treated?	The target symptom and its functional impact.	It prevents medication from becoming a response to an unspecific label.
Why medication now?	The clinical rationale, urgency, and the work already underway around the child.	It keeps pharmacotherapy within a multimodal plan.
What benefit is expected?	A change that the child, carers, and team can recognise.	It makes continuation a clinical decision rather than an automatic renewal.
What harm is being watched for?	Physical measures and the plan for responding to change.	It gives metabolic monitoring the same status as symptom review.
Who will review the plan?	Named clinical responsibility and communication with carers.	It reduces fragmented prescribing across services.

5.3 Metabolic monitoring is part of the prescription

Metabolic monitoring is not an administrative appendix added after the therapeutic decision. It is the means by which the clinician makes the physical cost of treatment visible. Children may have limited language for bodily change, may depend on adults to arrange investigations, and may experience the effects of appetite change, weight change, tiredness, or altered self-image within family and school systems. Monitoring therefore belongs in the initial conversation and documentation, not only in a later laboratory request.

The metabolic monitoring schedule begins before treatment. Before starting an antipsychotic, record **weight or BMI**, **pulse**, **blood pressure**, and a **fasting blood glucose or HbA1c** together with a **blood lipid profile**. These baseline measures create a comparison point. Without them, later change is difficult to interpret and an emerging physical problem can be wrongly attributed to lifestyle, family care, or the child's condition.

Before treatment	Target	Physical change	Family
BASELINE RECORD	CLINICAL BENEFIT	ACTIVE REVIEW	SHARED OBSERVATION

The phrase "metabolic" should not narrow the clinician's attention to a test result. It is a clinical frame for considering bodily change over time and its implications for adherence, confidence, participation, and future health. A child who is gaining weight, distressed about appearance, avoiding activity, or receiving stigmatising comments from peers may not volunteer the connection to treatment. A respectful review asks directly, avoids blame, and includes the carers who organise meals, appointments, and daily routines. It also leaves room for the child's own account of whether the medicine's benefit is worth its burden.

Baseline measurement is not a hurdle designed to delay necessary treatment. Its purpose is to make later judgement more honest. Where clinical circumstances require prompt action, the

prescriber should still document what is known, arrange the outstanding physical work, and make clear who is responsible for seeing the information. The error is not acknowledging uncertainty; the error is allowing an urgent start to become a reason that safety information is never assembled. In the same way, a normal baseline does not predict that the child will remain unaffected. It simply gives the clinician and family a reliable starting point for noticing change.

TRAP **Do not treat baseline tests as permission to stop thinking about physical health.** Baseline information is useful only when it is compared with the child's subsequent clinical course and when concerning change leads to a renewed benefit-harm decision.

5.4 Turning measurement into clinical review

A **benefit-harm review** joins symptom observation to physical monitoring. If the target has not materially changed, the prescriber should not let elapsed time turn an unsuccessful trial into indefinite exposure. If there is benefit but emerging burden, the task is to reconsider the entire plan: the clarity of the target, whether the formulation has changed, the role of psychosocial interventions, the acceptability of the treatment to the child and carers, and whether continued medication remains proportionate.

Review is strongest when it uses information from more than one setting. Carers may observe sleep, appetite, activity, irritability, and family functioning. The child may describe internal experience, embarrassment, sedation, or a change that adults have missed. School observations can help distinguish a home-specific improvement from a more general functional change, while also revealing environmental demands that medication cannot solve. Disagreement between informants is data, not inconvenience. It may show that the target was too broad, that the context differs, or that a desired benefit is being purchased at a cost visible only in one setting.

- Return to the original target symptom rather than asking only whether the child is "better".
- Ask the child about bodily and social effects in language they can use.
- Review the carers' observations without allowing convenience to become the sole outcome.
- Connect physical findings to a documented decision about the treatment plan.

General monitoring and consent issues in child psychopharmacology require their own framework. In particular, the clinician should not mistake parental agreement for a complete account of the child's participation in care, nor allow the technical work of prescribing to crowd out collaborative explanation. The antipsychotic-specific contribution here is that physical monitoring should be explained as a shared safety task from the outset.

5.5 The child, family, and service context

Shared observation is clinically valuable because antipsychotic effects unfold in ordinary life rather than only in the consulting room. Carers need a plain explanation of the symptom being targeted, the changes that should be reported, and the purpose of metabolic monitoring. The child should receive an explanation suited to their developmental and communication level. This is not merely good manners. A child who understands that appointments include attention to

how their body feels is more likely to disclose a problem than one who experiences investigations as unexplained adult activity.

Service design affects safety. The record should make it possible for a clinician meeting the child later to see why the medicine was begun, what has changed, what baseline measures were obtained, and which team member will act on new information. A prescription without that trail can persist through handovers because no individual feels able to revisit the original decision. Conversely, clear documentation supports a proportionate review even when services are busy or the child is seen across settings.

Physical monitoring can also strengthen, rather than weaken, the therapeutic alliance. When its rationale is discussed openly, the child is less likely to experience weighing, blood-pressure measurement, or blood tests as punishment for behaviour. Families can then bring concerns early instead of assuming that appetite, appearance, tiredness, or reluctance to attend school are unrelated problems. The clinician's task is to hold both truths at once: distressing symptoms may need active treatment, and the treatment itself deserves the same careful attention as the symptoms it aims to relieve.

IN INDIA

Children may move between private consultation, hospital care, school-linked support, and family-led follow-up. The prescriber should make the indication and metabolic monitoring plan legible across those settings. A terse drug list is particularly unsafe when the next clinician cannot tell what symptom is being treated or whether physical baseline information exists.

GOOD TO REMEMBER

When a carer reports that a medicine has "settled" a child, ask what has actually changed: distress, aggression, sleep, participation, communication, or simply manageability. The answer determines whether the benefit is meaningful and whether the rest of the formulation still needs attention.

5.6 A disciplined answer in practice and in examinations

A concise but safe answer to an antipsychotic question starts with indication-specific reasoning, not a medication list. It then states that the child's broader formulation and psychological, family, educational, and environmental interventions continue alongside any prescription. Next, it names baseline metabolic monitoring and explains that the measures must inform ongoing review. Finally, it distinguishes a cross-reference from a regimen: named examples point the reader to the chapter that owns the particular condition and dose.

This structure is also useful at the bedside. It makes the clinical team declare what they are trying to change, invites the child and family into observation, and keeps physical health within the same decision loop as behavioural or emotional improvement. It is possible for an antipsychotic to be appropriate and still require active reconsideration. That is not indecision. It is the expected discipline of prescribing a powerful medicine to a developing person.

An antipsychotic prescription for a child is complete only when its target symptom, indication-specific scope, and metabolic monitoring plan can all be read from the clinical record.

6 · Antidepressants in children (SSRIs, black-box warning)

Why this matters clinically. Antidepressant prescribing in a young person is not a miniature version of adult prescribing. The clinical encounter contains a diagnostic formulation, a developmental formulation, the child's and family's account of what treatment is meant to change, and a decision about whether a medicine has a place at all. This section narrows deliberately to the safe reading of one paediatric depression regimen. That narrowness is useful: a dose can look deceptively portable when copied into a note, an examination answer, or a handover, yet it only has meaning when its indication and population travel with it.

Thus, **fluoxetine** is placed first here as the antidepressant whose current paediatric depression label supplies a usable regimen. The chapter does not turn that label into a general account of childhood depressive disorders, an argument for a particular treatment sequence, or a template for every SSRI. Those matters require the disorder formulation and the evidence base that belongs with it. A prescriber's task is to keep the medicine, the clinical problem, the developmental context, and the source of the dose in one sentence rather than allowing any one of them to substitute for the others.

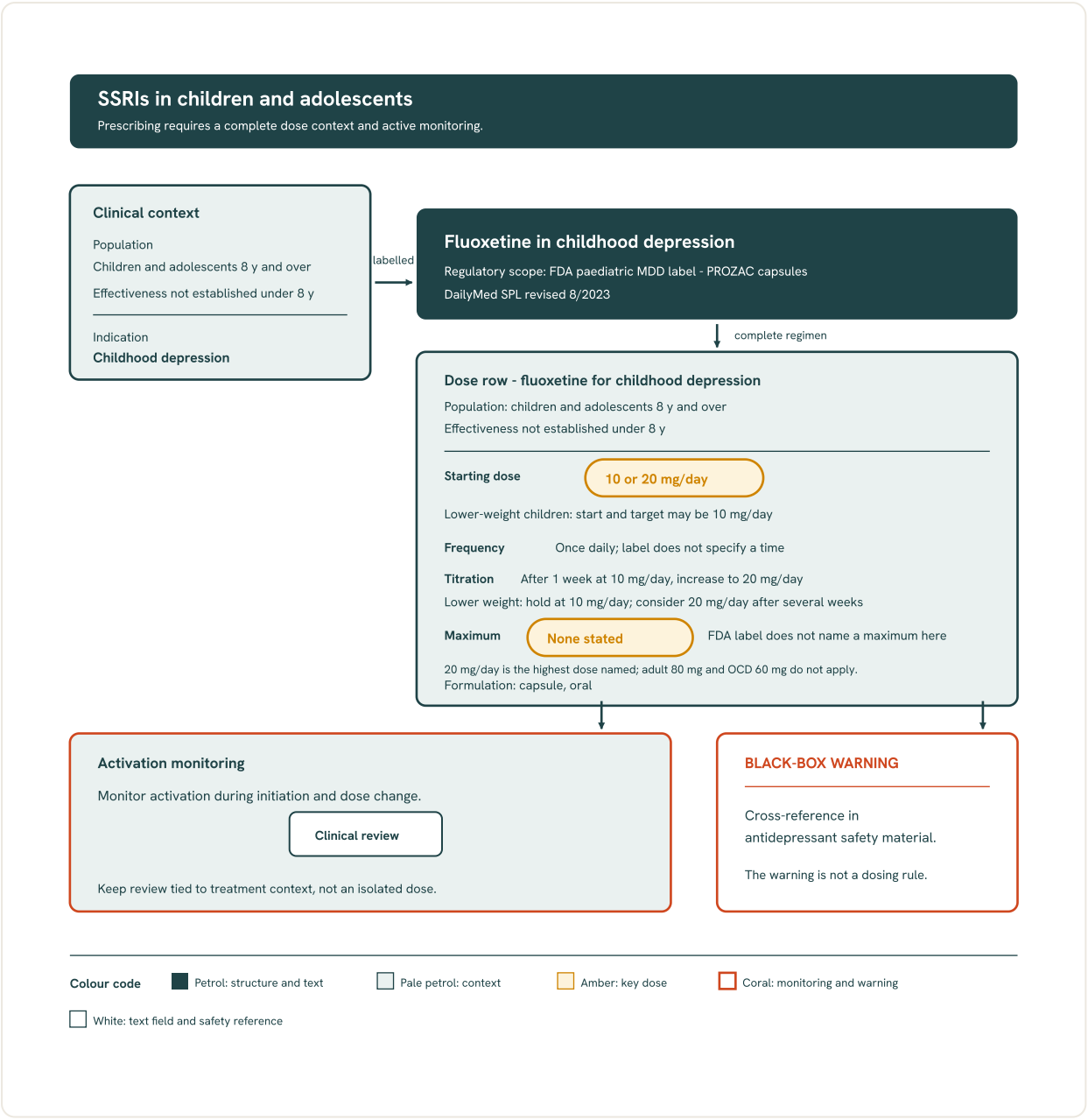


Fig 24.5. Fluoxetine is presented with the complete labelled regimen for childhood depression in the stated paediatric population. Monitor activation at initiation and dose change; handle the black-box warning through the linked safety reference.

6.1 What this section does and does not establish

The term **paediatric indication** is the essential boundary. A regulatory regimen answers a constrained question: for whom, for which named clinical use, and on what schedule has this product information been written? It does not decide that the young person in front of the clinician has that condition, that medication is sufficient treatment, or that the same wording can be exported to another indication. The dose is therefore read at its origin, not treated as a detached property of the molecule.

This distinction matters in both ward and outpatient work. Clinical teams often inherit a medication list without the reasoning that led to it. A copied drug name may survive while the original target symptoms, developmental context, and intended endpoint disappear. Restoring the missing sentence is a safety task. The clinician should be able to say what problem is being

treated, why this medicine is being considered for that problem, and which source governs the proposed regimen. If that cannot be said clearly, a dose entry should not masquerade as a complete treatment decision.

RULE **A paediatric antidepressant dose is a clinical tuple, not a standalone number.** Keep the drug, the indication, the population, the frequency, the route of change, and the ceiling statement together whenever a regimen is written or communicated.

The assessment and diagnostic work that decides whether childhood depression is the relevant formulation belongs with the childhood disorders and their assessment, rather than with a dosing paragraph. Likewise, a discussion of psychotherapy, family intervention, school support, or service referral cannot be replaced by a prescription. Naming these limits is not evasive. It prevents the dose from being used as a shortcut around the clinical work that makes prescribing intelligible.

6.2 The labelled fluoxetine regimen for childhood depression

For children and adolescents **8 years and over** with **childhood depression**, the current FDA product label describes oral fluoxetine at a starting dose of **10 mg/day** or **20 mg/day**, given once daily. The paediatric paragraph states no time of day; the once-daily-in-the-morning instruction appears in the adult depression section of the label and is not carried into the paediatric text. When the lower amount is used, it is increased after **1 week** to a target of **20 mg/day** for childhood depression. In lower-weight children, the label states that the starting and target dose may be the lower amount, and that an increase to the higher target may be considered after several weeks if clinical improvement is insufficient. The maximum statement must be retained separately: in childhood depression the target is **20 mg/day**, and the label does not name a maximum of any kind for this paediatric indication. The ceilings it prints elsewhere belong to adult depression and to paediatric obsessive-compulsive disorder, and neither may be carried across to childhood depression.

The wording above is intentionally complete. A range alone is not a regimen, because it does not tell the reader whether the range describes initiation, a target, or a limit. Nor does a target substitute for a maximum statement. Here, the paediatric paragraph simply does not state a separate weight-based ceiling, and that silence must be reported as silence. It should not be rewritten as an invented weight-based rule, and it should not be silently converted into permission to extrapolate beyond the labelled target.

Scope	Schedule	Change	Ceiling
DRUG + POPULATION + INDICATION	ONCE DAILY, NO STATED TIME	LABELLED STEP TO TARGET	STATE IT EXPLICITLY

PRESCRIBING ELEMENT	WHAT MUST REMAIN ATTACHED TO THE DOSE	WHY IT MATTERS
Drug	The exact medicine named in the label	Prevents a class label from replacing a medicine-specific regimen.
Population	The age and developmental scope stated by the source	Prevents use of a paediatric statement outside the population it addresses.
Indication	Childhood depression, not an implied alternative use	Prevents a regimen from migrating across diagnoses.
Starting plan	Initial amount, timing, and route of increase	Makes the first prescription reproducible and reviewable.
Target and ceiling	A target statement plus the label's ceiling language	Stops a range from being mistaken for either of these distinct ideas.

Write the whole regimen sentence: medicine, child population, indication, start, schedule, titration, target, and ceiling statement.

6.3 Why the lower-weight pathway is clinically meaningful

The phrase **lower-weight children** is not decorative label language. It signals that a young person's developmental and bodily context can alter the labelled starting and target plan even when the diagnostic indication is unchanged. The prescriber should therefore resist a crude age-only reading of a paediatric regimen. The relevant question is not whether the child resembles an adult closely enough to receive an adult-looking dose. It is whether the particular labelled pathway describes this child's population and clinical situation.

That is a reasoning discipline rather than a numerical trick. Weight, maturity, medical comorbidity, concurrent treatments, formulation practicalities, and the family's ability to observe change all shape how a prescription is implemented. The general developmental pharmacology of childhood, the broader principles of cautious titration, and the operational framework for monitoring are discussed elsewhere in this chapter. They should inform the encounter, but they must not be reverse-engineered into an unsourced alternative regimen.

- Identify the clinical indication before opening a dosing source.
- Check that the child fits the population described by that source.
- Preserve the lower-weight branch when it is the relevant labelled pathway.

GOOD TO REMEMBER

A prescription is easier to review when the rationale is written next to it. Record the treatment target in ordinary clinical language and retain the label-based regimen sentence in the medication plan. This allows the next clinician to distinguish a considered paediatric plan from a number that has simply been carried forward.

6.4 Titration is a decision point, not automatic escalation

The instruction to move from the lower start to the higher target is often read as a mechanical sequence. It is better understood as a planned review point. The label supplies the timing and target for its defined population; clinical work supplies the observation and interpretation that surround that plan. A clinician must still know what change is being sought, what the family has observed, whether the medicine is being taken as intended, and whether the formulation remains coherent. These are not reasons to improvise a new dose. They are reasons to decide whether the labelled pathway remains the relevant one.

There is a useful separation of roles. The label governs the regimen stated here. The therapeutic relationship makes observations usable: a young person and caregiver need language for describing benefit, distress, activation, withdrawal from usual activity, and changes that matter to them. The formal framework for monitoring, consent, assent, shared decision-making, and review cadence is owned by the child psychopharmacology section on monitoring and consent. This section names that framework but does not duplicate it.

TRAP **Do not write a target dose as though it were a command to escalate regardless of the child's course.** The target belongs to a defined regimen; the decision to continue along that pathway remains clinical and must be documented in the wider monitoring framework.

Equally, avoiding automatic escalation does not mean replacing the label with unstructured hesitation. Ambiguity can be just as unsafe as overconfidence when it produces unclear instructions for caregivers or a fragmented handover. The safe middle position is explicit: the intended plan is recorded, the source is identifiable, and any departure from the plan has a stated clinical reason rather than an accidental drift.

6.5 The source of a paediatric dose is part of the prescription

The regimen in this section is scoped to the **FDA paediatric MDD label**. This is a source statement, not a claim that regulatory status, product availability, or local practice is identical in every jurisdiction. Current labelling deserves priority over remembered textbook tables because a dose is especially vulnerable to becoming stale when it is detached from its source. A well-written clinical note therefore makes the source visible enough for another clinician to verify it rather than presenting the dose as timeless common knowledge.

Source discipline also improves examination answers. A candidate who writes only a drug and an amount has shown recall but not safe prescribing reasoning. A stronger answer identifies the population and indication, gives the starting plan and once-daily schedule, explains the move toward the target, and records the ceiling statement. It then separates this factual regimen from the broader question of whether the child needs medication, psychological treatment, family work, school intervention, or a different level of care.

PITFALL

Do not infer an Indian paediatric depression approval merely because a United States product label carries a paediatric regimen. The regimen printed here is explicitly sourced to that label. Local regulatory status and available formulations must be checked at the point of prescribing.

6.6 Boundaries with the SSRI suicidality warning

The paediatric SSRI black-box suicidality warning itself is not taught here. It belongs to *the Child behavioural, emotional and other disorders notes*, where it should be read in its disorder-level context. This cross-reference matters because a warning is neither a reason to minimise distress nor a substitute for a full risk formulation. Conversely, a brief mention of a warning must not be allowed to become a generic warning paragraph that is repeated wherever an antidepressant is named.

For the prescribing encounter, the practical implication is architectural. The medicine-specific regimen is documented here; the warning and its clinical interpretation are sought in the named cross-reference; and the general monitoring-and-consent framework is sought in its owning section. Keeping these layers separate prevents a false choice between pharmacological precision and safety. Both are required, but they are not the same construct and should not be taught as though a dose table alone can carry either one.

- Use the disorder chapter for the paediatric SSRI black-box suicidality warning.
- Use the child psychopharmacology monitoring-and-consent section for its general framework.
- Use the current product label for the regimen attached to its indicated population.

6.7 An Indian prescribing stance

IN INDIA

Use the regimen here as a clearly labelled regulatory reference, not as a shortcut to local authorisation. In Indian practice, verify the currently available formulation, the applicable local regulatory information, and the service pathway for the child and family. Documentation should make clear whether the prescribing decision rests on a locally applicable indication or on a separately justified clinical decision.

This stance avoids two opposite errors. One is therapeutic nihilism, in which the clinician treats uncertainty about a label as a reason not to formulate or treat. The other is regulatory overreach, in which an overseas label is cited as if it settles every local clinical and legal question. Neither helps the child. The disciplined approach is to identify the clinical need, use the correct source for the exact regimen being considered, and state openly what that source does and does not establish.

The larger child psychiatry system remains visible in the background. Family engagement, psychological treatment, school coordination, and safeguarding may all determine whether a medication plan can be used safely and meaningfully. They are not adjuncts to be remembered after a dose is chosen. They are parallel components of care, each requiring its own assessment,

intervention, and documentation. This section contributes one precise element: how to read and communicate the fluoxetine label without letting that precision spill into claims the source does not support.

7 · Mood stabilizers in children and adolescents

Why it matters clinically. A mood-stabiliser prescription in a young person is not a class-level decision. It is a tightly bounded clinical instruction: the drug, the indication, the child for whom the regimen was read, the way it is introduced, the safety work that makes continuation defensible, and the point at which the prescriber must reconsider. This matters especially when a familiar adult regimen is being discussed in a family meeting. Familiarity can make a dose look portable when its evidence and label scope are not.

This section is deliberately about the prescription and its safety architecture, not about diagnosing bipolar disorder or choosing a syndrome-level treatment pathway. Those clinical formulations belong with the childhood disorders in *the Child behavioural, emotional and other disorders notes*. General mood-stabiliser pharmacology is considered elsewhere. Here, the candidate should be able to read a regimen as a complete sentence and explain what must accompany it in real practice.

7.1 Reading a paediatric regimen as a whole

The useful unit of learning is the **regimen**, not the isolated milligram figure. A dose becomes clinically meaningful only when attached to a named indication and an explicitly described population. It must also state how the dose changes and where the upper boundary lies. If a label names no milligram ceiling, that silence must be reported as silence rather than as a statement that no ceiling exists; it tells the reader that a serum-guided endpoint, rather than a memorised tablet count, is doing the limiting work. The doses below are read at their regulatory-label origin; the table preserves source-specific scope instead of exporting it across settings.

That distinction protects against opposite errors. Under-reading copies the starting dose without the titration or monitoring plan. Over-reading treats an adult regimen or a foreign label as though it establishes local paediatric approval. Neither error is repaired by adding a vague warning such as “monitor closely.” The prescriber must state what is being monitored, why it is being monitored, and how the result changes the next decision.

RULE **Never quote a paediatric mood-stabiliser dose without its indication, population, titration and ceiling statement.** The dose is only an element of the instruction. Separating it from the rest creates a prescription that sounds precise but is clinically incomplete.

MNEMONIC

SCOPE

Specific indication, **C**hild population, **O**rigin of the regimen, **P**lan for titration and monitoring, and **E**ndpoint or ceiling. Use it before writing the order and again before explaining it to a family.

SCOPE	LITHIUM	VALPROATE	LEVELS
READ THE WHOLE ORDER	LABEL-SCOPED REGIMEN	OFF-LABEL CAVEAT	SAFETY DECISION POINTS

MEDICINE	INDICATION AND POPULATION	STARTING PATH AND CEILING	SAFETY READING
Lithium carbonate	Paediatric bipolar mania in **patients aged 7 years and older who weigh over 30 kg**	**Start at 300 mg three times daily in divided doses, increase by 300 mg every 3 days, and obtain serum lithium at 3 days, drawn 12 hours after the last dose, to guide titration. Maximum: the label names no milligram ceiling for this population; it gives usual dose ranges of 600 mg two to three times daily acutely and 300 to 600 mg two to three times daily for maintenance, and the limiting endpoint is the serum level, with an acute target of 0.8 to 1.2 mEq/L.** Source: US FDA lithium carbonate label, revised October 2022.	Use the baseline and continuing lithium monitoring plan (NICE CG185).
Lithium carbonate	Paediatric bipolar mania in **patients aged 7 years and older who weigh 20 to 30 kg**	**Start at 300 mg twice daily in divided doses and increase by 300 mg weekly, not every 3 days. Maximum: the label does not state a milligram maximum for this weight band. It gives dose ranges, not ceilings: an acute range of 600 to 1500 mg daily in divided doses and a maintenance range of 600 to 1200 mg daily in divided doses. The serum targets are the same as the heavier band, 0.8 to 1.2 mEq/L acute and 0.8 to 1.0 mEq/L maintenance.** Source: US FDA lithium carbonate label, revised October 2022.	Use the baseline and continuing lithium monitoring plan (NICE CG185).

MEDICINE	INDICATION AND POPULATION	STARTING PATH AND CEILING	SAFETY READING
Divalproex sodium	Bipolar mania: use in children is **off-label**.	The label establishes **no paediatric population** for this indication, so it carries no paediatric regimen. The adult mania regimen is deliberately not reproduced here: it is not transferable to a child, and printing it invites exactly that transplant. Dose only against a current label or a specialist protocol written for the child in front of you.	Make teratogenicity and the indication-specific evidence limitation explicit.

At every medication review, the order should make the following questions answerable:

- What exact indication is this medicine treating?
- Which child population does the regimen describe?
- What dose has actually been taken since the last review?
- What monitoring result is needed before the next decision?
- What is the action if benefit, safety, or feasibility changes?

7.2 Lithium carbonate: a scoped paediatric regimen

Lithium carbonate is the regimen in this section with a paediatric label scope for bipolar mania. The population boundary in the table belongs in the verbal handover, in the prescription record, and in the clinician's own reasoning. It prevents a dose learned for one child from becoming an unexamined default for another. The label sets out two paediatric weight bands, and they differ in starting frequency and in titration interval, so the band must be read before the number is used: the lighter band starts twice daily and is increased weekly, not three times daily and **every 3 days**.

The dose path is deliberately written as a sequence rather than a target tablet total. The maximum statement is as important as the start: a serum-guided endpoint is not permission to keep escalating by habit. A candidate should not substitute a remembered serum target from another setting for this label-scoped instruction.

Serum guidance does not make the clinical task mechanical. A concentration can be technically obtained yet be unhelpful if the timing, recent dose changes, adherence, fluid intake, intercurrent illness, or interacting treatment have not been reviewed. The result must be interpreted alongside the child's current clinical state and adverse-effect enquiry. This is why the medication review needs to preserve a clear sequence: what was prescribed, what was actually taken, what was measured, and what action follows. The level is a safety and dosing tool, not a substitute for reviewing the child.

GOOD TO REMEMBER

When handing over lithium care, write the indication and population beside the current dose. A future clinician can then see whether the regimen has remained within the scope in which it was originally selected, rather than mistaking a continuation dose for a universal rule.

7.3 Valproate: make the off-label boundary visible

Divalproex sodium, a valproate preparation, requires a different reading discipline in bipolar mania. No paediatric regimen is supplied here, and that absence is itself the teaching point: paediatric bipolar efficacy is not established, the label carries no paediatric population for this indication, and use in children is therefore off-label. The adult regimen is deliberately not reproduced, because a number printed in a paediatric chapter is a number that gets transplanted. Off-label is not a euphemism for routine. It means the prescriber should be able to articulate why this medicine is being considered for this child, what evidence limitation is being accepted, and what alternative plan exists if benefit does not emerge.

Where a specialist protocol does supply a regimen for a particular child, the same discipline applies to it: increase only to the lowest therapeutic dose, use the trough concentration to guide that judgement, and state the maximum as a distinct safety statement rather than letting it disappear into a dose range or be inferred from the starting instruction.

In an adolescent girl, **teratogenicity** is a hard caveat, not a footnote. The clinical conversation must make reproductive risk visible before treatment is normalised by routine follow-up. The record should show that the risk was discussed in developmentally appropriate language, that family involvement was handled within the applicable consent process, and that a plan exists for any change in pregnancy possibility or treatment circumstances. This is not a reason to withhold thought; it is a reason to make the thought auditable.

TRAP **Reciting a valproate mania dose as though it were "a paediatric bipolar dose".** No paediatric regimen is supplied here, because the label establishes no paediatric population for this indication; any figure recalled from elsewhere is an adult mania number, and the child and adolescent bipolar indication remains off-label. State both facts together, or the answer becomes unsafe.

IN INDIA

Do not infer an Indian paediatric bipolar approval from a regimen read in another regulatory setting. The supplied lithium dose is label-scoped, and no paediatric valproate regimen is supplied here at all, because that use in children is off-label. Check the locally available product information and document the indication-specific rationale rather than allowing a foreign label to stand in for local regulatory status.

7.4 Lithium before treatment: establish a safety baseline

Before lithium is started, **baseline monitoring** should include weight or BMI, urea and electrolytes including calcium, estimated glomerular filtration rate, thyroid function, and a full blood count. An ECG is arranged when cardiovascular disease or its risk factors make that

relevant. The point is not to accumulate investigations. Each element creates an interpretable reference point for later treatment decisions and exposes a reason to pause, clarify, or coordinate care before the medicine is introduced.

Baseline work is also an opportunity to prevent false reassurance. A result should be linked to a plan, not simply marked “normal” in a checklist. If a child already has a medical issue that could complicate interpretation, the prescriber needs a shared plan with the relevant clinician and a clear account of which service will act on an abnormal result. That is especially important during transfer between inpatient, outpatient, and emergency care, where an old result may be mistaken for a current baseline.

The family needs a practical explanation of why blood tests are part of treatment rather than evidence that something has gone wrong. A calm explanation improves the chance that sampling, review, and dose decisions happen in the intended sequence. It also makes room for the child’s experience of procedures and for barriers such as travel, school timing, or fear of venepuncture. Those are not peripheral details. If they are ignored, a theoretically sound monitoring plan may never become a usable treatment plan.

PITFALL

Do not treat a recent laboratory sheet from another encounter as automatically adequate lithium baseline work. Its clinical meaning depends on timing, completeness, and whether it answers the pre-treatment question now being asked.

7.5 Lithium concentrations and maintenance surveillance

Two authorities meet in this section, and it is worth naming them. The dose pathway in the table is read at the US FDA lithium carbonate label (revised October 2022); the monitoring cadence below is taken from NICE Clinical Guideline CG185. The label instruction, a **serum lithium at 3 days drawn 12 hours after the last dose**, is the label instruction for the days immediately after a dose is set. The guideline cadence, measured **1 week after starting and 1 week after every dose change**, expressly covers the same titration period, so the two sources genuinely differ on when the post-change sample is taken. This is a real divergence and not a division of labour: name the source you are following, follow it consistently, and do not blend the two into a single invented schedule. Once titration is settled, early lithium monitoring has a defined rhythm. **Measure plasma lithium 1 week after starting and 1 week after every dose change, then weekly until stable; during the first year, measure it every 3 months.** This is best understood as a series of clinical decision points. After initiation and each adjustment, the team is checking whether exposure has become stable enough to move from active titration into maintenance. The later interval guards against the quiet drift that can occur after a seemingly settled prescription.

Maintenance monitoring is broader than the plasma concentration. **Maintenance monitoring** includes weight or BMI, urea and electrolytes including calcium, estimated glomerular filtration rate, and thyroid function **every 6 months**. Monitoring should be more frequent when there is evidence of impaired renal or thyroid function, raised calcium levels, or an increase in mood

symptoms that might be related to impaired thyroid function. That last trigger is the one a psychiatrist is most likely to meet first, because the presenting change is psychiatric rather than biochemical. The distinction between the level schedule and the organ-function schedule is worth preserving in notes and handovers: they answer different questions and neither replaces the other.

A useful review asks whether the agreed monitoring has actually occurred, whether the sample and the dose history can be interpreted together, and whether the child or family has noticed a change that should alter the plan. This is careful longitudinal prescribing, not a ritual laboratory task. If monitoring cannot be completed reliably, the clinician must address that limitation directly rather than letting refills conceal an unfulfilled safety plan.

> For paediatric mood stabilisers, the safe answer is the whole regimen: indication, population, dose pathway, ceiling, and monitoring - never the milligram figure alone.

8 · Monitoring and consent issues in child psychopharmacology

Why it matters clinically. A prescription for a child is not complete when the medicine is written. It becomes clinically defensible only when the prescriber has made a plan to observe benefit, detect burden, hear the child's experience, and revise the plan with the family. Monitoring is therefore not clerical follow-up. It is the method by which an initial prescribing hypothesis is tested in ordinary life: at home, in school, and in the child's own account of how treatment feels.

Consent is inseparable from that process. A parent or legally appropriate decision-maker may provide permission, but treatment is more likely to be understood and sustained when the child is included in a developmentally meaningful conversation. The psychiatrist must distinguish explanation, agreement, assent, consent, and legal authority without turning the consultation into either a signature exercise or a negotiation in which safety is abandoned. This section addresses the monitoring-and-consent framework around child psychopharmacology. Drug-specific adverse-effect schedules and dosing belong with the relevant medicine classes.

Review	Monitor	Discuss	Record
EFFECT	BURDEN	CHOICE	DECISION

8.1 Monitoring is a clinical loop, not a checklist

The purpose of a **monitoring plan** is to make the next clinical decision easier and safer. Before treatment begins, identify what change would count as useful, which unwanted changes would alter the balance of benefit and harm, who can observe each domain, and how observations will reach the prescriber. The target should be recognisable in everyday functioning, rather than a vague promise that the child will be "better". Carers, teachers, and the child may notice different things and may disagree.

Monitoring also tells the family that medication is revisable, not a verdict about the child. At each review, ask whether the treatment remains proportionate to the child's present needs and costs, not simply whether it has been taken.

RULE **Prescribe with a review question, not merely a review date.** The question links the original target, the observations that answer it, and the decision that will follow. A date without this structure easily becomes a refill encounter; a defined question makes it a clinical reassessment.

A useful record separates observation from interpretation. Document the account of participation, distress, behaviour, or functioning with its informant and setting, then state whether the pattern suggests benefit, intolerance, a contextual change, or inadequate information. This prevents the loudest informant from becoming the sole source of truth and makes the reasoning behind a treatment change transparent.

8.2 Build the monitoring plan before treatment begins

Pre-prescription assessment should produce a baseline that can be compared with later observations. The baseline is not an attempt to measure every possible outcome. It is a disciplined description of the presenting difficulty, the child's current functioning, relevant physical context, concurrent treatments, practical capacity to follow the plan, and the family's principal concerns. When baseline information is thin, later claims of improvement or deterioration are easily distorted by expectation, crisis resolution, school changes, or ordinary developmental variation.

The plan should state who will contact whom if the family is worried, what information should be brought to review, and what changes warrant earlier assessment. Families often interpret a prescription label as a complete treatment plan. Explain that medicines are part of care and that psychological, educational, and family interventions may remain essential. Their coordination is part of safe prescribing.

- Define the treatment target in language the family and child can recognise.
- Identify the settings and informants most likely to observe change.
- Record the child's starting physical and psychological state in clinically useful terms.
- Agree how benefit, burden, adherence, and uncertainty will be discussed at review.
- Document the contingency plan if concerns arise before the planned contact.

GOOD TO REMEMBER

The child's account is data, not a courtesy. Even when the child cannot describe an adverse effect in clinical language, descriptions such as feeling unlike oneself, unable to join in, frightened, dull, or embarrassed can identify an important treatment burden. Ask in private where appropriate, then bring the child back into the shared discussion rather than treating the consultation as an adult conversation conducted over the child.

8.3 Review efficacy, burden, and physical change together

Follow-up should revisit the original target and ask what has changed in the settings where the difficulty mattered. Symptom change alone is insufficient. A treatment can alter a visible behaviour yet leave the child less able to learn, relate, play, sleep, or participate. Conversely, a family may initially report little symptom change while describing a meaningful improvement in

distress or functioning. The prescriber's task is to weigh the full pattern, rather than reward only the most easily counted outcome.

An established practice-parameter teaching account expects medication follow-up **at least several times per year** for pharmacological treatment, with adjustment directed to continuing effectiveness, dose optimisation, and clinically important adverse effects. This is a review-point principle, not a substitute for earlier contact when the clinical situation calls for it. Its source is historical guidance, so it should be understood as established teaching rather than represented as a current live standard.

At these contacts, **height, weight, blood pressure, and pulse** are assessed periodically. That cadence is stimulant-specific; other drug classes carry their own schedules. The wider review asks what has happened since the previous contact, what changed in the child's environment, whether the medicine is being taken as intended, and whether the family's understanding has shifted. Continuation is itself a decision requiring reasons.

Monitoring intensity should respond to uncertainty and vulnerability. It may need closer contact when the clinical picture is changing, the child or family reports a concerning change, a treatment is being altered, information from settings is conflicting, or reliable observation is difficult. That judgement is not a licence for indiscriminate testing. It is a requirement to match the review process to the question being answered and to explain the rationale to the family.

REVIEW DOMAIN	QUESTION FOR THE CLINICIAN	DECISION RELEVANCE
Target difficulty	Has the problem that justified treatment changed in the settings that matter?	Tests whether there is benefit worth retaining.
Function	Is the child more able to participate in ordinary roles and relationships?	Prevents a narrow focus on a visible symptom.
Burden	What unwanted experiences do the child and carers describe?	Clarifies tolerability and acceptability.
Physical observation	Are the relevant physical findings being reviewed over time?	Links safety monitoring to the prescribed treatment.
Understanding	Can the family explain the purpose and current plan in their own words?	Detects misunderstanding before it becomes non-adherence or conflict.

TRAP **Do not call a tolerated prescription an effective one.** Absence of an obvious adverse effect does not establish benefit, and a report of benefit does not remove the need to ask what has been lost or made harder. The examination answer should show that efficacy, function, physical observations, and the child's experience are reviewed together.

8.4 Drug-specific monitoring must remain drug-specific

The general framework should not blur medicine-specific risks into a generic promise that "monitoring was done". The clinician must know which concerns follow from the selected

medicine, why they matter for that child, and how a result will change management. The detailed metabolic monitoring schedule for antipsychotics in children is addressed under antipsychotics in children; it should not be reproduced as a general rule for every child receiving psychotropics.

Treatment choices for attention-related difficulties should be read with the ADHD and specific learning/communication disorders notes, while the childhood disorders themselves and the paediatric SSRI black-box warning are covered in the Child behavioural, emotional and other disorders notes. Cross-reference prevents a general monitoring section from becoming a substitute for indication-specific prescribing knowledge.

PITFALL

Copying a monitoring schedule between medicine classes can create false reassurance. A neatly completed form is not evidence that the relevant risk has been assessed. Record the medicine, the clinical question, the observation sought, and the action that would follow from a concerning finding.

8.5 Assent makes the child a participant in care

Child assent is the child's affirmative, developmentally meaningful participation in a proposed course of care. It is not identical to legal consent and should not be presented as if a child's agreement can settle every question of authority. Its clinical value is substantial: it reveals what the child understands, corrects adult assumptions, permits discussion of fears and practical barriers, and makes it more likely that the child will report benefit or harm honestly.

Adapt the explanation to the child's language, maturity, emotional state, and ability to ask questions. The child should hear the treatment's purpose, what experience should be reported, what choices are open, and what will happen next. Do not ask "Do you agree?" before the child has been enabled to understand. Refusal deserves exploration: it may reflect fear, misinformation, an adverse experience, family conflict, or a concern adults have missed. Listening does not mean that every refusal determines the outcome, but dismissing it damages safety and alliance.

Assent must be revisited. A child who initially accepted a plan may understand it differently after experiencing treatment. Conversely, a child who was fearful at the outset may develop trust after a careful explanation and review. Revisiting assent is particularly important when the treatment purpose, burden, or family circumstances change. The record should show what was explained, how the child responded, questions raised, and how those questions influenced the plan.

8.6 Indian ethics guidance: a useful analogy, not the clinical statute

IN INDIA

The **Indian Council of Medical Research framework** cited here governs biomedical research involving children. It is useful by analogy when teaching how assent differs from parental permission, but it is not a clinical-consent statute. Do not convert a research-ethics age framework into a rule about clinical legal capacity. Statutory capacity, minor-treatment provisions, and forensic questions belong to the Mental health legislation and forensic psychiatry notes.

Within that research-ethics framework, the method of assent changes with the child's age. The table gives the framework once, because its value in clinical teaching is conceptual: the form of the conversation should develop, while parent or legally authorised representative involvement remains central. It should never be quoted as though it supplies the law of treatment consent.

CHILD'S AGE IN THE RESEARCH-ETHICS FRAMEWORK	ASSENT OR PERMISSION DESCRIBED	CLINICAL TEACHING USE
Under 7 years	Parental consent alone is described as sufficient.	Explain care in a manner the child can receive; do not mistake this research rule for clinical law.
7 (84 months) to 11 years	**Oral assent** is obtained with the parent or legally authorised representative present.	Use an understandable conversation and preserve the child's opportunity to respond.
12-18 years	**Written assent** is required.	Invite fuller participation while retaining the distinction between assent and legal authority.

The clinical conversation should remain respectful even where the legal analysis lies elsewhere. There is no therapeutic advantage in treating a child as a passive object of adult permission. The psychiatrist can be clear about the limits of decision-making while still giving the child privacy for questions, acknowledging ambivalence, and making the plan intelligible enough for the child to recognise when something is wrong.

8.7 Parental involvement should match the decision and its risk

The same research-ethics guidance frames **parent or legally authorised representative consent** in relation to the degree of risk. It says that consent from **one parent or legally authorised representative** may generally be sufficient for research involving minimal or low risk, while consent from **both parents** may be needed where research involves more than minimal or high risk. This is a risk-sensitive ethics framework, not a clinical rule that substitutes for applicable law or local institutional policy.

Its useful clinical lesson is that parental involvement should not be reduced to collecting a signature from whichever adult is present. Establish who cares for the child, whether disagreement affects the plan, whether the accompanying adult understands the information, and whether a broader conversation is necessary for safe follow-through. In conflict, do not recruit the child as an ally against a parent. Clarify the rationale, hear concerns, identify immediate risks, and seek the appropriate route when authority is uncertain.

- Separate the child's wishes from the legal question of who may authorise treatment.
- Separate parental disagreement from evidence about benefit and burden.
- Separate an urgent clinical need from the convenience of obtaining agreement.
- Document uncertainty about authority rather than concealing it in a generic consent entry.

MNEMONIC

Hear, Explain, Agree, Review

Hear the child and carers; **Explain** the target and foreseeable burden; seek meaningful **Agree**ment within the appropriate authority structure; and **Review** the decision as treatment unfolds. This is a consultation spine, not a claim that assent replaces consent.

Monitor the medicine, the child's functioning, and the family's understanding; consent is a continuing clinical conversation, not a form completed before treatment begins.

9 · Off-label prescribing, dosing principles and start-low go-slow in children

Why it matters clinically. Prescribing for a child is not a miniature version of prescribing for an adult. The diagnostic formulation may be clear, yet the prescriber still has to decide whether the proposed use is authorised for that age and indication, whether the expected benefit is meaningful to this child, and how to introduce treatment without mistaking an adverse effect, a developmental change, or a change in the home environment for drug response. These decisions are especially visible when a medicine is used **off-label**.

Off-label prescribing is a practical reality in Indian child psychopharmacology. It is neither automatically poor practice nor a substitute for reasoning. It means that the intended use does not match some part of the approved product information, such as the age group, indication, formulation, route, or dose. The clinician's task is therefore to make the mismatch explicit, decide whether it is justified for the individual child, and build a cautious plan around it. This fragment concerns that reasoning and the discipline of *start low, go slow*; disorder-specific regimens belong in the relevant disorder chapters.

9.1 Off-label use: a prescribing status, not a verdict

An off-label prescription is best understood as a description of the relationship between a proposed prescription and its label. It does not establish that the medicine is ineffective, unsafe, experimental, or negligent. Equally, the absence of a matching label must not be treated as a licence to prescribe casually. The label remains important because it records the regulatory indication, formulation, precautions, and population for which approval was granted. Clinical reasoning asks a different but connected question: whether the expected balance of benefit and harm is acceptable for this child, in this context, with this plan for review.

RULE **Off-label prescribing requires a clearer rationale, not a lower standard of care.** State the target problem, explain why the proposed use is reasonable, use the smallest prudent starting exposure, and arrange review that can detect benefit and harm.

For examination answers, the useful distinction is between **regulatory indication** and clinical indication. The former is a statement in authorised product information. The latter is the problem the psychiatrist is trying to treat after assessment. They often overlap, but they are not

interchangeable. A good answer avoids claiming that a label decides all clinical questions; a poor answer implies that a label is irrelevant once a clinician is confident.

QUESTION BEFORE PRESCRIBING	LABEL-ALIGNED USE	OFF-LABEL USE
What must be checked?	That the product and intended use match.	Which part of the proposed use differs from the label.
What must be documented?	The clinical target and review plan.	The clinical target, the rationale for the mismatch, and the review plan.
What must be discussed?	Expected benefit, unwanted effects, and practical use.	The same matters, plus the meaning of off-label use and uncertainty.
What changes the decision?	Benefit, harm, and whether the target remains relevant.	The same factors, with particular attention to whether the rationale remains sound.

OFF-LABEL	LABEL	TARGET
PRESCRIBING STATUS	CHECK BEFORE USE	DEFINE BEFORE TITRATION

9.2 The Indian regulatory context

IN INDIA

The CDSCO registry includes **atomoxetine** capsules for psychiatrist-directed treatment of attention deficit hyperactivity disorders. The same entry directs attention to **growth and weight** during long-term therapy. This is a concrete reminder that a paediatric psychiatric approval can exist, while the prescriber must still verify the current Indian information for the exact medicine, formulation, age group, and intended use. For disorder-specific treatment, see *the ADHD and specific learning/communication disorders notes*.

The available Indian inpatient evidence also cautions against pretending that off-label status is unusual. In a prospective Indian tertiary-care inpatient study, **1152** of **1645** prescribed medicines were classified as off-label, amounting to **70%**. This is general paediatric evidence, not a psychotropic-specific rate, so it should not be quoted as though it measured child psychiatric prescribing. Its teaching value is narrower and useful: off-label status is common enough in paediatric medicine that clinicians need a disciplined method rather than reflexive reassurance or reflexive refusal.

PITFALL

Do not infer an Indian paediatric approval from an overseas label or from a medicine's familiarity in practice. Approval is product- and use-specific. A copied prescription may look routine while its intended age, formulation, or indication has never been checked against the product information being used.

9.3 Making an off-label decision defensible

A defensible decision starts before the prescription. The child needs a formulation that identifies the problem to be changed and separates it from difficulties better addressed by psychological intervention, school support, parent work, environmental modification, or treatment of a physical contributor. Medication becomes difficult to evaluate when it is asked to solve an undefined cluster of behaviour, distress, family conflict, and educational strain. The more uncertain the target, the less interpretable the subsequent response.

The intended outcome should be observable. It may concern a symptom, a functional impairment, a pattern reported by caregivers, or a difficulty seen across settings. The wording should allow the family and clinician to recognise improvement without retrospectively redefining success. It should also name the adverse effects or clinical changes that would make the plan unacceptable. This is not a demand for rigid measurement in every consultation; it is a protection against the common drift in which treatment continues because nobody has decided what would count as benefit.

Next, consider alternatives honestly. The question is not whether medication can possibly be helpful, but whether it is the most proportionate next intervention. An off-label decision is stronger when the assessment has considered non-pharmacological options, when the proposed medicine has a credible role for the target problem, and when delay or non-treatment also carries a recognisable burden. This reasoning should be documented in clinical language, not as a defensive recital. A note that records the target, why the chosen option was selected, and the review plan is more useful to the child and the next clinician than a label alone.

- Specify the target problem and the setting in which change should be noticed.
- Check the current product information and record why the proposed use is appropriate despite any label mismatch.
- Agree on the observations that will count as benefit, harm, or need for change.

Communication with the parent or caregiver should be direct. Explain that the intended use is off-label, what that means in plain language, what is known and uncertain in the individual decision, and what review will look like. The child should be included in the discussion in a developmentally appropriate way. Detailed consent and assent practice, as well as the general monitoring framework, are addressed in the child psychopharmacology section on monitoring and consent; they should not be reduced to a signature obtained after the decision is already made.

TRAP **“Off-label” does not mean “off-evidence,” and “commonly used” does not mean “automatically appropriate.”** Candidates lose the clinical point when they answer only with regulatory language. The examiner is looking for an individualised indication, a transparent discussion, cautious dosing, and review.

9.4 Start low, go slow: what the phrase actually requires

Indian inpatient evidence shows why off-label status should be approached as a familiar paediatric prescribing problem rather than a reason to abandon judgement. Dose titration in children is a planned clinical experiment, not a race to a familiar adult dose. “Start low” means choosing a conservative initial exposure that permits early tolerability to be observed. “Go slow” means making measured adjustments only after there has been enough opportunity to understand the direction of change. The phrase is often repeated as a slogan; its practical value lies in the safeguards it imposes on interpretation.

At the outset, record the child's current symptoms, daily functioning, sleep, appetite, behaviour, physical complaints, concurrent medicines, and relevant medical history. The point is not to create an exhaustive checklist detached from the proposed medicine. It is to establish a baseline against which a new change can be judged. Without a baseline, irritability, fatigue, reduced appetite, activation, sedation, or a shift in behaviour may be attributed to the drug merely because the timing is convenient. The reverse error is equally hazardous: a genuine adverse effect may be dismissed as the child's usual presentation.

Titration should proceed with a single clearly interpretable change whenever feasible. If several interventions, doses, routines, and school responses are altered together, later improvement or deterioration has no clear owner. A paced plan also gives families time to notice changes that do not emerge in the consulting room. Caregiver reports, the child's own account where possible, and information from the relevant setting should be brought together, not used competitively. Disagreement is often clinically informative: it may reveal that benefit is context-bound, that harm occurs at a particular time, or that the treatment target was too broad.

The prescriber must remain willing to pause, reduce, stop, or rethink. A dose increase is not the default response to partial improvement. Before changing the dose, ask whether the target is genuinely improving, whether the adverse-effect burden is acceptable, whether adherence and administration are reliable, and whether the formulation remains correct. If the signal is unclear, greater exposure may magnify confusion rather than improve care. If the signal is unfavourable, a calm reassessment is more competent than persevering until the treatment appears to have been “adequately tried.”

GOOD TO REMEMBER

Slow titration is not therapeutic passivity. It is an information-gathering strategy. Each interval should answer a clinical question: is the target changing, is the child tolerating treatment, and does the next adjustment still make sense?

MNEMONIC

LABEL

Look at the label, define the **A**im, establish a **B**aseline, **E**scalate cautiously, and **L**isten at review. The mnemonic is a sequence for a safe prescribing conversation, not a substitute for a formulation.

9.5 Reviewing response without confusing noise for effect

Review is where the quality of the original prescription becomes visible. Revisit the target in the same words used at baseline. Ask what has changed in the child's experience and functioning, what others have observed, and whether the anticipated burden of treatment has appeared. A broad question such as “better?” often produces a broad answer. More useful questions connect to the agreed target: what is easier, what is unchanged, what has become harder, and when are the changes noticed?

Interpret change in context. A new routine, a school transition, an acute stressor, altered sleep, inconsistent administration, or a concurrent intervention can all affect the apparent response. This does not make medication assessment impossible. It means the clinician should resist premature certainty. Where uncertainty persists, simplifying the plan may be safer than layering new medicines or increasing an unclear dose. The child is not a failed trial because the first plan did not yield a clean answer; the formulation may need revision.

Long-term prescribing needs periodic reconsideration of continuing need. The original target may have changed, development may have altered the risk-benefit balance, or non-pharmacological supports may now carry more of the therapeutic work. Continuation should therefore be an active decision, not a consequence of repeated dispensing. The clinician should preserve a clear account of current benefit, current harm, and the reason to continue, alter, or withdraw treatment. This is especially important when care is transferred between services.

- Compare the current presentation with the original target, baseline, and anticipated unwanted effects.
- Check whether intervening contextual changes explain part of the apparent response.
- Decide explicitly whether to continue, modify, pause, stop, or reformulate the plan.

9.6 How to write and answer the principle

In a short answer, begin by defining off-label use as a mismatch with approved product information rather than calling it illegal or experimental. Then state that it can be clinically justified when the indication is individualised, the rationale is documented, the parent or caregiver is informed, and follow-up can detect benefit and harm. Add the dosing principle: begin conservatively, adjust gradually, and make each change interpretable. Close by stating that a child must be treated as a developing person in a family and service context, not as a smaller adult receiving a scaled-down prescription.

> Off-label prescribing in children is justified by an explicit individual rationale, transparent discussion, conservative initiation, gradual titration, and review against a pre-defined target.

Assessment and rating tools

10 · Principles of child psychiatric history and examination

The central task is to turn an account of a child into an account of functioning. A child psychiatric assessment is not a compressed adult interview and not a catalogue of symptoms reported by an accompanying adult. It asks what the child is able to do, communicate, tolerate and negotiate in ordinary relationships, and how that pattern alters across settings and over time. The examiner must therefore make the child visible without treating the parent, school or wider context as background noise.

The marks in this area reward method. A good answer shows how the clinician obtains a reliable account, observes the child directly, and reconciles apparent disagreement without prematurely converting it into a diagnosis. The core work is **a paired clinical frame**: **two** components, history-taking and the mental status examination, carried out as parts of one assessment rather than as separate rituals.

History	Mental state	Collateral
FUNCTION IN CONTEXT	DIRECT OBSERVATION	FUNCTION ACROSS SETTINGS

10.1 The assessment stance

Begin by deciding what question the referral is asking, while retaining enough breadth to discover that the question may be misplaced. The presenting concern is useful because it identifies distress, urgency and the family's explanatory model. It is not a diagnosis, and it should not dictate the sequence of the interview. The clinician needs a formulation-oriented account: the current difficulty, its context, the child's developmental capacities, relationships, functioning, strengths and risks. This is a clinical map, not an invitation to rehearse the disorder chapters.

History and examination proceed simultaneously. A caregiver's description of avoidance, for example, becomes more meaningful when the child's approach to the room, proximity seeking, speech, play, posture and response to the examiner are observed. Conversely, a striking behaviour in the room should be held as a sample, not promoted immediately to a trait. Children may be tired, frightened, oppositional, ill, overcontrolled, unfamiliar with the language of the interview, or responding to a tense interaction between adults. Good assessment makes room for these possibilities before assigning meaning.

RULE **Assess the child in development, relationship and setting, not as a symptom list detached from context.** The history supplies pattern and meaning; the examination tests how that account appears in the present encounter.

Consent, assent, confidentiality limits, safeguarding responses, formal risk procedures and diagnostic formulation require their own fuller treatment elsewhere in this chapter. Here, the interviewing discipline is simpler and more exacting: explain the purpose of the meeting in language the child can use, preserve respect for privacy without promising secrecy that cannot be

kept, and be clear with caregivers about when separate conversations are helpful. Do not make the child a passive object of adult testimony.

10.2 Building a history that explains development

A chronology alone does not constitute **developmental history**. The clinician elicits what happened in development and asks what those events came to mean to the child and family. The same developmental fact may be experienced as ordinary variation, a source of parental anxiety, a conflict within a family, a marker of loss, or a reason a child has repeatedly been treated as incapable. Those meanings influence expectations, attachment, school communication and help-seeking. They can also alter what caregivers notice and how they describe it.

The history should connect early functioning to the current problem without treating childhood as a deterministic preface. Ask about the child's usual ways of regulating emotion and behaviour, communicating needs, responding to change, relating to familiar and unfamiliar people, learning and managing daily demands. Clarify the sequence: what was present before the concern, what changed around its emergence, and what maintains or relieves it now. Where the history is uncertain, record uncertainty. Retrospective accounts are valuable clinical data, but their confidence, perspective and emotional charge matter.

Family accounts should be heard for both content and process. Who speaks first, who corrects whom, whose worries are minimised, and how the child responds while adults discuss them may illuminate the current relational field. This is not licence to infer hidden motives from a single consultation. It is a reason to seek examples, compare accounts and distinguish observed behaviour from interpretation. A respectful interviewer can ask a parent what a difficult behaviour means to them, then ask the child what the same situation feels like, without making either party the unreliable witness.

- Anchor each concern to a concrete situation rather than accepting a global label such as "difficult" or "lazy".
- Separate onset, course, triggers, consequences and attempted responses, while leaving room for uncertainty.
- Document strengths and effective relationships, because they identify leverage for care as well as resilience.

> **GOOD TO REMEMBER**
> When a caregiver reports a behaviour, ask what happens immediately before it, what the child does next, how others respond and what changes afterwards. This moves the history from a moral description to an observable clinical sequence without importing a diagnosis.

10.3 Collateral information and discrepancy

Multi-informant assessment is necessary because children function in relationships and settings that no single observer can fully represent. For most children, work from at least **three** essential sources: the parent or other primary caregiver, the child and the school. Each source has a different observational position. The child can report subjective experience and meanings that

adults do not see. Caregivers provide longitudinal knowledge and accounts of home life. School information describes demands, peer context and functioning outside the family.

Collateral is not a vote in which the majority account wins. A difference between home and school may reflect variation in structure, expectation, language, relationships, sensory load or opportunities for support. A child may also disclose selectively, or an adult may have limited opportunity to observe a particular domain. The clinical task is to ask what the discrepancy tells us about conditions under which the difficulty appears, improves or becomes invisible. Treating disagreement as error too early discards useful information.

Seek information in a focused, proportionate manner. State what question the school is being asked to help answer and distinguish facts, examples and interpretations in the record. Agency material and reports from other family members may add context, but should not become a substitute for meeting the child or listening to the primary caregivers. In India, school information may be especially uneven: attendance, language of instruction, class size, family mobility and access to trained staff can affect both what is observed and what can be communicated. The response is to interpret the limits of the collateral, not to assume it is useless.

SOURCE	DISTINCT CONTRIBUTION	CLINICAL QUESTION
Child	Experience, meanings and preferred ways of communicating	What is happening from the child's point of view?
Caregiver	Developmental course and daily context	How has the pattern changed and what surrounds it at home?
School	Functioning under educational and peer demands	What changes in another structured setting?

IN INDIA

School collateral may need practical adaptation. A written report is useful when feasible, but a focused conversation with the person who knows the child's day-to-day functioning can be more informative than a generic certificate. Preserve the distinction between a teacher's direct observations and conclusions about the child.

TRAP **Do not call discrepant informants "unreliable" simply because their accounts differ.** The discrepancy may locate the setting, relationship or demand in which the problem is expressed. It requires enquiry, not arithmetic.

10.4 The child mental status examination

The **developmentally adapted mental status examination** begins before formal questions. Observe physical appearance, the manner of relating to the examiner and caregivers, and the ease or difficulty of separation. Note affect and mood, orientation, and motor behaviour, including activity level, coordination, neurological soft signs, dominance and the presence of tics or stereotyped movements. These observations must be described in neutral, behaviourally

anchored language. “Stayed close to caregiver and answered after looking towards her” is more useful than a global claim about attachment or temperament.

The examination then explores thought content and form, speech and language, overall intellectual functioning, attention, memory, neurological functioning, judgment and insight. It also records the child’s **preferred mode of communication**. For some children, play, drawing or direct conversation may make different parts of their experience accessible. The point is not to force every child through an adult verbal template. It is to create enough access to assess what can be observed and communicated, and to state the limits of that access.

Questions should be concrete enough to be understood and open enough to reveal the child’s organisation of experience. Ask for examples and clarify the child’s language before translating it into psychiatric terminology. Evaluate attention in relation to the task, the room and the interaction, rather than treating a brief lapse as a stable conclusion. Similarly, assess apparent insight in the light of the child’s developmental capacity and the information they have been given. Silence, limited language, avoidance or playful deflection can be meaningful, but none is self-interpreting.

- Record behaviour, speech, affect and engagement as observed, then separate the clinical inference from the observation.
- Use the child’s most accessible communication channel while preserving the clinical question.
- State when an item could not be assessed adequately, rather than converting incomplete examination into a negative finding.

PITFALL

A brief, highly structured consultation can make a child appear more settled or more inhibited than in ordinary life. Do not treat the examination as a performance test that overrules the longitudinal history. Integrate it with collateral and revisit uncertain findings.

10.5 Integrating observation without over-reading it

The child’s behaviour in the room is relational data. It is shaped by the examiner’s manner, the caregiver’s presence, the sequence of the visit, the unfamiliar setting and the child’s understanding of why they have come. A calm child may be containing distress; an active child may be engaging, avoiding, testing boundaries or reacting to an overstimulating room. The answer is not to abandon observation, but to make the observation precise and test alternative explanations through gentle changes in approach.

Examination and history should therefore be written so that another clinician can see the bridge between them. Describe the source, the setting, the observation and the inference. If the child’s account and caregiver’s account diverge, say how each was obtained and what further information would help. A formulation may remain provisional while the assessment continues. That is not indecision. It is appropriate calibration when the available data do not yet support a firm conclusion.

For developmental expectations and milestones, use the Normal child development and milestones notes. For the childhood disorders themselves, use the Child behavioural, emotional and other disorders notes. For intellectual disability and autism-related assessment, use the Intellectual disability and autism spectrum disorder notes. Standardised developmental, cognitive, adaptive, behavioural and neuropsychological instruments are addressed in their respective assessment sections; they complement, rather than replace, the child developmental history and mental-state examination.

MNEMONIC

Child, Caregiver, Classroom

Use this as a retrieval cue for the core sources of an assessment: hear the child's account, establish the caregiver's longitudinal account, and obtain the school view of functioning in another setting. The cue is a reminder to compare perspectives, not a licence to collect generic reports.

10.6 Documentation and the examination answer

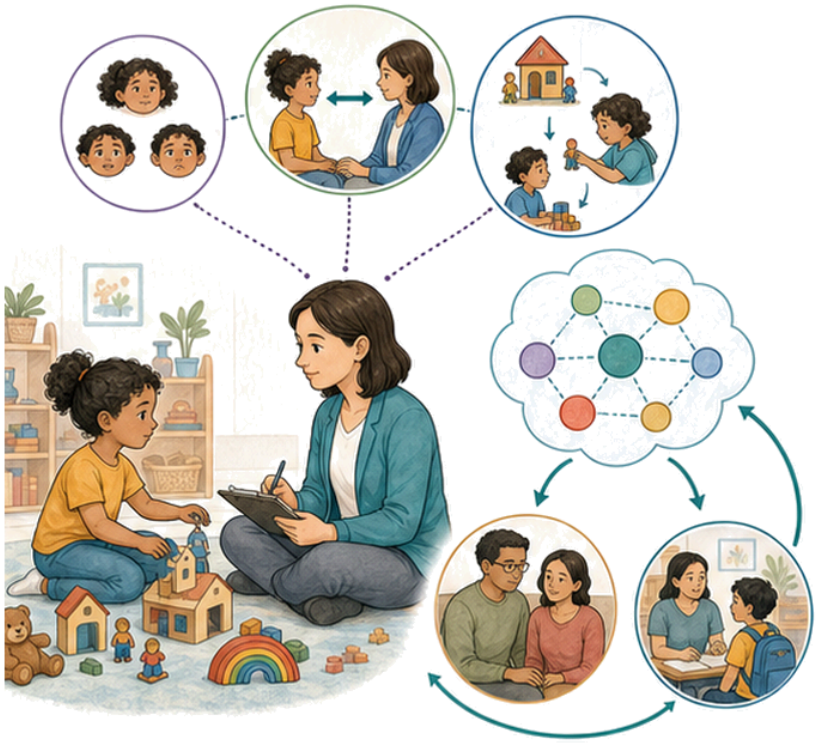
A defensible record makes the reasoning inspectable. It identifies who provided information, distinguishes reported material from direct observation, preserves relevant examples and records limitations. It should show the relationship between developmental history, present functioning and the mental state examination without manufacturing certainty. The record is strongest when it explains why a particular question was asked and how the answer altered the next clinical step.

In a written answer, begin with the need for developmental, contextual and multi-informant assessment. Then set out the history in an organised sequence, describe the directly observed mental state in developmentally appropriate terms, and finish by showing how discrepancies will be reconciled. Avoid listing adult mental-state headings without adaptation. Avoid writing an instrument catalogue where a clinical examination has been asked for. The candidate who demonstrates method, rather than reciting labels, shows that assessment can guide treatment and referral.

A child psychiatric assessment is credible when developmental history, direct mental-state observation and collateral accounts are integrated without allowing any single source to stand for the child.

11 · Play assessment and interviewing children

Play is clinical material, not a diversion. In an interview with a child, direct questioning can produce compliance, silence, borrowed adult language, or a rapid shift away from what feels unsafe. Play creates a shared activity in which the clinician can listen to what is said, watch how it is said, and notice what happens when the child has some control over the pace and distance of contact. Used well, it enlarges the interview. Used carelessly, it turns an ordinary toy interaction into a premature story about the child.



- Shared activity
- Observe
- Listen
- Form a hypothesis
- Corroborate
- Do not over-interpret

Fig 24.6 A play-based interview gives the child control over pace and distance while the clinician observes communication, affect and relationship. Play generates hypotheses that require corroboration; it is not a disguised test or a license for symbolic over-interpretation.

The marks lie in understanding this distinction. Play assessment is neither a disguised intelligence test nor a treatment session. It is a developmentally adjusted way of obtaining history and mental-state material while preserving curiosity about alternative explanations. The general child psychiatric history, examination, collateral information and multi-informant formulation belong with the general assessment framework. This section concerns the interview encounter itself: how to make room for play, observe it, and translate observations into hypotheses that require corroboration.

11.1 The purpose of a play-based interview

Children often communicate experience through action before they can organise it into an account for an adult. The clinician therefore treats play as a medium that can carry themes of threat, comfort, power, separation, rivalry, loss, bodily concern or mastery, without assuming that any single theme is a literal report. **Imaginative play** using puppets, small figures, or the clinician

as a participant can offer inferential material about the child's concerns, perceptions and ways of regulating affect and impulse.

This is especially useful when a question is emotionally loaded. Rather than pressing for an explanation, the clinician may offer an ordinary shared activity and allow the child to decide whether a story, scene, game or silence develops. The gain is not access to a hidden truth on demand. It is the chance to observe the child's manner of approaching a difficult area: whether the child can initiate, sustain, modify, share or abandon an imagined situation; whether feelings are named, enacted, avoided or rapidly displaced; and whether the adult is invited into the child's world or kept at a fixed distance.

Play has a relational function as well as an observational one. A child who has little trust in adults may first need to discover whether the interviewer can be interested without taking over, can tolerate pauses without filling them, and can set a limit without becoming punitive. The clinician's task is to offer structure sufficient for safety while leaving the child enough agency to show how contact is managed. This is interview technique, not play therapy. The purpose remains assessment and formulation, with the child's welfare taking precedence over the production of material.

RULE **Adapt the interview method to the child, rather than forcing the child into the clinician's preferred method.** Technique should be tailored to **developmental level**, **cognitive level**, **linguistic level**, the emotional difficulty of the topic, and the available **rapport**. A playful invitation may be useful in one encounter and intrusive in another.

11.2 Preparing the encounter

A useful play interview begins before any toy is touched. The room should be calm enough for conversation and permissive enough for the child to explore without the clinician repeatedly issuing prohibitions. Materials should be ordinary, durable and open to more than one use. The aim is not an impressive collection but a setting in which the child does not need special skill, prior knowledge or adult permission to begin. Materials that are too elaborate can turn the encounter into a performance; materials that demand a correct answer can recreate the pressure of school.

The opening should be plain and honest. Explain who you are and what will happen in language the child can follow. State that the child may talk, draw, play, ask questions or say that something is difficult. Do not promise secrecy that cannot be maintained, and do not announce that play will reveal what the child is unable to say. Such statements burden the child and distort the clinical relationship. A brief period of shared orientation lets the clinician observe spontaneous choice without making the child feel watched for a right response.

The caregiver's place requires deliberate management. A caregiver may help a child settle, provide essential context, or inadvertently answer every question. The clinician should neither exclude the caregiver reflexively nor allow the child's account to be overwritten. A separate space for each voice is often necessary. When the child is seen alone, the transition should be explained in a way that does not imply that either child or caregiver is under suspicion. Questions about safety,

confidentiality and separate interviewing are part of the general assessment framework and must be handled within local clinical and safeguarding practice.

- Begin with a low-demand invitation rather than a request for a problem narrative.
- Follow the child's level of engagement, but retain a clear clinical purpose.
- Close predictably, giving the child time to shift back from the activity.

IN INDIA

Language choice is often the first clinical adaptation. A child may understand the language used by adults in the family yet express play, emotion and peer experience more naturally in another language. Clarify the child's preferred language for ordinary conversation and avoid treating a quiet response in an unfamiliar language as evidence of limited feeling or limited thought. When interpretation is needed, keep questions short, allow the child time to respond, and record the limits this places on inference.

11.3 Observing play without overreading it

The useful unit of observation is a pattern, not an isolated symbol. Notice the child's entry into play, selection and use of materials, capacity to generate ideas, response to novelty, flexibility when the scene changes, tolerance of frustration, and manner of involving the interviewer. Observe the emotional tone of the activity and its transitions. A child may appear cheerful while repeatedly arranging a controlling scenario; another may use a frightening story with evident enjoyment and imaginative flexibility. Neither observation explains itself.

Content matters, but form often provides the safer starting point. Is the play exploratory or restricted? Is it reciprocal, solitary, controlling, repetitive, hurried, frozen or readily abandoned? Does the child use pretend transformation, or insist that each object retain only its literal function? Does the child's narrative have continuity, or is it made of disconnected actions? The clinician should describe first and infer second. A note that records what happened can be reconsidered against history and collateral; a note that records only a conclusion cannot.

OBSERVATION	CLINICAL QUESTION IT RAISES	APPROPRIATE NEXT STEP
Choice of a familiar activity	What does the child use to establish safety and control?	Join briefly, then see whether the child can extend or vary the activity.
Repeated theme in a story	Is the theme meaningful, rehearsed, situational or prompted by the setting?	Ask open questions and compare with the child's account and collateral.
Difficulty sharing the activity	How does the child manage reciprocal attention and adult participation?	Offer a modest invitation rather than forcing cooperation.
Rapid escalation when frustrated	How are affect and impulse managed in the moment?	Set a calm limit and observe recovery, repair and need for support.
Very limited, concrete and noninteractive imaginative play	Does the form of play raise a developmental hypothesis?	Document the observation and integrate it with the broader developmental assessment; this pattern may suggest **autism spectrum disorder**, but is not diagnostic by itself.

Description protects against projection. Children's play readily activates the clinician's own associations. A dramatic scene may tempt the clinician to infer trauma, aggression or family conflict. Those are hypotheses, not findings. The more emotionally striking the scene, the more important it is to ask whether the theme arose spontaneously, whether it recurs across contexts, whether the child can reflect on it, and whether independent history supports the concern. Silence, avoidance and change of subject may themselves be meaningful, but they are also ordinary responses to an unfamiliar adult, fatigue, shame or uncertainty about what is expected.

PITFALL

Do not translate a toy, drawing or narrative role into a one-to-one diagnostic or forensic meaning. A child may choose a frightening character because it is familiar, powerful, amusing, recently seen, or simply available. The clinical value lies in the whole interaction, its form and affect, and its fit with other evidence.

11.4 The clinician's use of self

The interviewer is part of the play field. Children may invite the clinician to be a character, assign a role, test a rule, or ignore the invitation entirely. Participation can be useful if it follows the child's lead and remains light enough for the child to alter it. Taking over the plot, improving the child's story, teaching a moral, or repeatedly interpreting the scene shifts the task from observation to adult direction. The child then reveals how they respond to the clinician's demands, not necessarily how they play.

Comments should be simple, concrete and tentative. Reflecting an observable action, naming an evident affect, or asking what happens next keeps ownership with the child. Questions that demand explanation too early can collapse imaginative material into a test of verbal skill.

Likewise, excessive praise can make play performance-oriented. The clinician should be capable of waiting, of accepting a child's refusal to include them, and of returning to ordinary conversation when play does not become a useful medium.

Limits are clinically informative when delivered without humiliation. If materials are used unsafely or the child attempts to damage the setting, stop the act clearly and offer a permitted alternative. What follows may illuminate the child's response to frustration, but it must never be engineered as a provocation. The aim is not to expose a deficit. It is to maintain a setting in which the child can continue to engage and the clinician can observe regulation and repair.

GOOD TO REMEMBER

When a child does not play, do not make play the test. Sit alongside, use conversation or a neutral activity, and return to the invitation only if it fits the child's pace. Refusal may communicate discomfort with the setting, unfamiliarity with the materials, tiredness, fear of being judged, or a wish to preserve control. Record the context as carefully as the refusal.

11.5 From observation to clinical inference

Play observations become clinically useful only when they change the next question. A child who repeatedly separates figures may be asked, in an open manner, what happens when people are apart and whom the child misses. A child who makes every adult character controlling may invite questions about rules, conflict and safety. A child who cannot tolerate a change in the game may need a broader enquiry into flexibility across home and school. The inquiry remains open because the same play pattern can arise from many pathways.

Formulation should preserve levels of certainty. A descriptive level records the activity, speech, affect, reciprocity and regulation observed. A hypothesis level states what the pattern may mean. A verification level identifies what information is required before the hypothesis influences diagnosis, risk assessment or intervention. This discipline prevents play from becoming a privileged source that outranks the child's words, caregiver account, teacher information, developmental history or direct mental-state examination.

- Write observations in behavioural language before writing interpretations.
- Link an inference to the question it raises, rather than to a diagnosis it proves.
- Seek convergence across interview, collateral history and longitudinal observation.

TRAP **Do not treat play content as a projective key with a fixed meaning.** The classic error is to move from a striking scene to a categorical conclusion. Good assessment asks what else could account for the observation, then looks for convergence. Play can generate an important clinical question; it cannot settle one in isolation.

11.6 Interviewing across developmental capacities

There is no universally correct child interview format. The same child may need a different approach when discussing a pleasant activity, a school difficulty, a conflict at home or a frightening experience. The choice of method should be guided by the child's capacity to

understand the task, use language, sustain shared attention and tolerate the topic, as well as by the relationship established in the room. The relevant principle is flexible adaptation to the **emotional difficulty** of the topic, not a rule that younger children always play and older children always talk.

For a child who uses little verbal elaboration, the interviewer may alternate short questions with observation in a shared activity. For a verbally fluent child, play can still reveal the interpersonal style that a polished account conceals. For an adolescent, a direct conversation may be preferred, while a collaborative task or informal activity can reduce the intensity of sustained face-to-face questioning. The clinician should offer, rather than impose, a mode of communication. Respecting a child's preference does not mean abandoning difficult topics; it means approaching them in a way that preserves the possibility of honest engagement.

Developmental adaptation also means distinguishing inability from unwillingness. A child who cannot answer an abstract question may understand a concrete example. A child who appears oppositional may be confused by an adult's phrasing. A child who changes the subject may be protecting themselves from affect, but may also be responding to embarrassment or loss of attention. The clinician reduces these ambiguities through clarification, pacing and repeated observation, not by assuming a motive.

11.7 Documentation, boundaries and the limits of the method

Document the setting, who was present, the invitation offered, the child's response, the relevant sequence of play, verbal statements that materially altered interpretation, affective shifts, clinician interventions and the child's response to them. Separate observation from interpretation in the record. It is preferable to note that a child repeatedly placed figures apart and became quiet when asked about reunion than to write a diagnostic conclusion. The latter move prematurely converts an observation into a conclusion.

Play should not be used to obtain a disclosure by suggestion, to test an allegation, or to bypass established safeguarding procedures. When the interview raises concern about harm, the clinician must move from exploratory technique to a careful, non-leading and safety-focused response within the relevant protection pathway. The child's immediate safety and the integrity of any necessary assessment take precedence over completing a play narrative. Detailed abuse assessment and its psychiatric sequelae are addressed in the child-protection sections of this chapter.

Nor should the clinician infer that a child who plays freely has no distress, or that a child who does not play has a severe disorder. Play is one channel among several. Its greatest value is often modest but decisive: it shows the child's style of communication and regulation in real time, suggests questions that ordinary history-taking might miss, and helps the interviewer build enough trust for a fuller account. Its limitations are the same as its strengths: it is relational, contextual and therefore demands disciplined interpretation.

PLAY	FORM	PATTERN	CONVERGENCE
A MEDIUM FOR COMMUNICATION	MENTAL-STATE INFORMATION	BASIS FOR HYPOTHESIS	BASIS FOR CONFIDENCE

Use play to open and observe the child's world; use corroboration to decide what the observation means.

12 · Developmental and IQ tests (Binet, WISC, Malin, Bhatia, Seguin form board)

Why it matters clinically. A developmental or intelligence assessment is not a hunt for a single score. It is a disciplined way of describing how a child approached cognitive demands, where performance was relatively easier or harder, and how confidently the clinician can use that information in a formulation. In child psychiatry, the test result often changes the question being asked: whether a difficulty is best understood as globally low performance, an uneven cognitive profile, a language-mediated barrier, a problem of access to learning, a state effect, or a finding that needs further assessment. The useful report therefore connects the referral question to the conditions under which the child worked and to the limits of what the result can bear.

This child developmental and IQ battery comprises child intelligence measures and performance-based tasks. These are not interchangeable labels for the same activity. They differ in the demands they place on language, motor output, visual organization and cooperation. Test choice is consequently a clinical decision, not a ritual. Developmental screening, adaptive assessment, broad-band scales, projective methods and formal neuropsychological assessment have separate roles elsewhere in this chapter.

Question	Mode	Context	Use
WHAT DECISION NEEDS HELP	VERBAL OR PERFORMANCE DEMAND	CONDITIONS OF TESTING	NEXT CLINICAL STEP

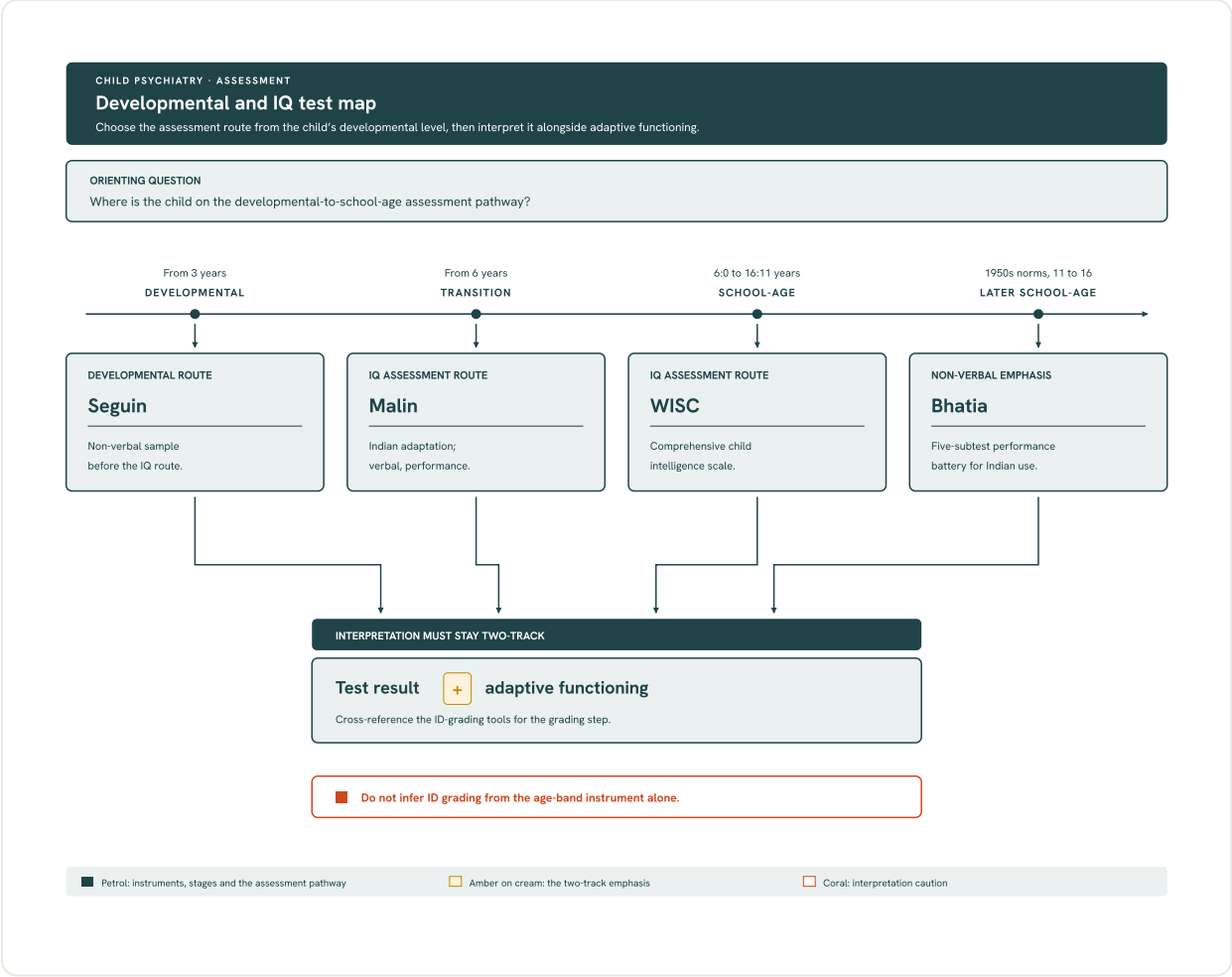


Fig 24.7. The child developmental and intelligence testing map, laid out by age band and by what each instrument is for. Choose the test by the question being asked; the intellectual-disability grading application of these instruments belongs to the intellectual disability and autism spectrum disorder notes and is cross-referred, not taught here.

12.1 What an intelligence test contributes

An intelligence test samples performance under structured conditions. Its value is not simply that it yields a summary estimate. The encounter makes visible the child's comprehension of instructions, pace of engagement, response to novelty, tolerance of correction, persistence, impulsive responding and use of help. These observations can qualify the interpretation more than a polished numerical statement ever can. A child who gives up after a first difficulty and a child who works slowly but methodically may arrive at superficially similar outcomes for very different reasons.

The report should distinguish an obtained test performance from an explanation for that performance. Low output can arise when the child did not understand the task, could not sustain engagement, was anxious, was affected by language mismatch, or had sensory, motor or educational barriers. Equally, an apparently adequate overall performance may conceal a clinically important discrepancy in how different kinds of demand were handled. The psychiatrist should ask what the test has actually sampled in this child, on this occasion, before deciding what it means.

That distinction protects the child from a common category error. Cognitive testing informs clinical judgement; it does not replace it. The result must sit beside the developmental account,

physical and neurological findings when relevant, schooling history, family context, and functional account from the adults who know the child. These surrounding data do not dilute the test. They give it a valid clinical home.

RULE **Interpret the child's way of working before interpreting the score.** A score becomes clinically meaningful only when the referral question, testing conditions, language demands and behavioural observations are made explicit.

12.2 Selecting a measure from the referral question

Begin by naming the decision that the assessment is meant to inform. A vague request for an "IQ test" invites an equally vague answer. A referral may instead concern a child whose spoken language makes verbally mediated work difficult, a child with limited opportunity to show classroom learning, a child with suspected uneven abilities, or a child whose engagement with formal tasks is uncertain. The clinician and psychologist should agree what information would move care forward and what the chosen procedure cannot answer.

The next task is to match the mode of assessment to the child rather than forcing the child to fit the instrument. Verbal demands, familiarity with the language of testing, manual dexterity, visual and motor coordination, fatigue, hearing or vision concerns, and the child's capacity to settle into a structured interaction all matter. This does not mean abandoning standardisation whenever a child is difficult to test. It means recording the circumstances faithfully and using any necessary caution in the conclusion.

- Specify the referral decision that the result is meant to inform.
- Tell the assessor about barriers that may prevent the child from showing usual abilities.

Performance-based tasks can be particularly informative where spoken responses give an incomplete picture. They are not, however, language-free truth machines. Understanding the demonstration, handling unfamiliar materials, tolerating timed or observed work, and organising action all remain part of the demand. The correct clinical question is therefore not whether one test is intrinsically fair, but whether its demands are sufficiently understood for the result to answer this referral question.

GOOD TO REMEMBER

Before requesting testing, state the clinical question in one sentence and tell the assessor about communication, sensory, motor, behavioural and school-access concerns. A better referral produces a more interpretable report and avoids treating the assessment as an administrative certificate.

12.3 A comprehensive child assessment

The **WISC-V, the Wechsler Intelligence Scale for Children, Fifth Edition**, is a comprehensive child intelligence assessment. The publisher's normative age range is **6:0-16:11 years**. Its clinical importance lies in the opportunity to examine performance across differently organised demands rather than reducing the encounter to one global label. That does not license the psychiatrist to

infer detailed cognitive strengths from a summary alone, nor to reproduce proprietary material in a case note or teaching answer.

When a report based on this assessment is available, read the narrative before the conclusion. Look for whether the child understood the task language, required repetition, rushed, sought reassurance, became frustrated, or showed marked variability in effort. Ask whether the child's educational and language background was compatible with the testing situation. A report that describes meaningful variation may guide the next clinical question, whereas a bare score without conditions of testing should be treated with restraint.

For the psychiatrist, the contribution is often relational as well as psychometric. The child's behaviour in an individual, structured encounter may illuminate a familiar difficulty that parents or teachers have described, but it should never be read as proof of a diagnosis by itself. Conversely, a cooperative testing session should not be used to dismiss difficulties reported in less structured settings. The clinical synthesis is stronger when test behaviour is treated as one sample of functioning rather than as a personality verdict.

TRAP **A comprehensive intelligence measure is not a diagnosis machine.** Candidates lose clinical precision when they convert an obtained result into a disorder label without considering language, learning opportunity, adaptive functioning, behaviour during testing and the reason for referral.

12.4 An Indian adapted child measure

Malin's Intelligence Scale for Indian Children is an Indian adaptation that assesses verbal and performance abilities. It is administered by a trained psychologist and is used from **6 years onward**. Its relevance is practical: an Indian adaptation is often encountered in clinical records and referral pathways, and the psychiatrist should be able to read its report without assuming that the name alone settles validity for every child.

An Indian adaptation does not remove the need for clinical attention to the child's actual linguistic, educational and sociocultural context. India contains wide variation in home language, medium of instruction, familiarity with formal testing and experience of school. The clinician should identify a mismatch rather than silently treating it as a child deficit. The report should make clear which language was used, whether translation or explanation was needed, and whether the observed performance reasonably reflects the child's capacity in the setting being assessed.

Verbal and performance information should be read as complementary descriptions of task performance. A difference between them is a prompt to enquire, not a self-contained explanation. Consider communication history, literacy exposure, schooling continuity, behaviour, motor competence and the family's account of everyday problem-solving. A single difference should not be converted into a sweeping statement about ability, motivation or family environment.

IN INDIA

Use the availability of an Indian adaptation as a reason to improve the assessment conversation, not to stop it. Record the language of testing, the child's medium of instruction and barriers to school participation. These details help the team decide whether the result is a sound estimate, a limited sample, or a signal that another approach is needed.

12.5 A performance battery: use and historical caution

Bhatia's Battery of Performance Tests of Intelligence is an Indian non-verbal, performance-oriented battery. Its named components are **five** subtests: **Kohs' Block Design, Alexander's Pass-along, Pattern Drawing, Picture Construction and Immediate Memory**. This makes the battery useful to recognise in Indian practice, especially when the child's performance on material-based tasks is clinically more accessible than a long verbally mediated exchange.

The attraction of a performance battery is understandable. It can offer a route into assessment when expressive language is limited or when a child is reluctant to engage in conversation. Yet performance tasks draw on more than abstract reasoning. The child must understand what is expected, coordinate perception and action, regulate pace and persistence, and work in the presence of an assessor. The psychiatrist should therefore use the result to sharpen the formulation, not to erase communication, motor or contextual difficulties from it.

The original standardisation was on Indian boys aged **11-16 years**. This historical fact has direct interpretive consequences. The clinician should not speak as if the original reference group automatically represents every contemporary child. If a report relies on the battery, ask which reference material and interpretive conventions were used, whether they fit the child before you, and what uncertainties the assessor has documented.

INSTRUMENT	CLINICAL CONTRIBUTION	INTERPRETIVE DISCIPLINE
Comprehensive child measure	Structured cognitive assessment	Read observed task behaviour and testing conditions with the report.
Indian adapted measure	Verbal and performance abilities	Attend to language and educational context.
Performance battery	Material-based, non-verbal approach	Do not mistake motor, organisational or comprehension demands for pure reasoning.
Form-board task	Rapid non-verbal performance sample	Use it as a focused sample, not as a complete account of intellect.

12.6 A focused early performance sample

The **Seguin Form Board Test** is a rapid non-verbal performance test that can be used from **3 years**. It samples motor dexterity, visuomotor coordination, spatial organisation, and the speed and accuracy of performance. This makes it clinically useful when the assessment needs a brief, concrete observation of how a young child approaches a structured material task.

The **form-board apparatus** uses differently shaped wooden blocks fitted into matching slots. The apparent simplicity is one reason it is easy to overinterpret. A child may struggle because of fine-motor difficulty, visual-perceptual difficulty, poor comprehension of the demonstration, reluctance to separate from a caregiver, impulsive placement, or difficulty sustaining the task. The observation of strategy matters: whether the child scans the board, uses trial and error, persists after an error, or abandons the task can be more clinically informative than a decontextualised label.

Its non-verbal form is a relative advantage, not an exemption from careful administration. Demonstration and rapport still matter; so do the child's visual and motor capacities. It is best understood as a focused performance sample within an assessment plan. It cannot independently settle broader questions about developmental level, educational need or intellectual functioning.

> **PITFALL**
>
> Do not reproduce test items, scoring rules or cut-offs in a clinical teaching note. Proprietary instruments require standardised administration and trained interpretation. The useful psychiatric record states the referral question, relevant conditions of testing, observed approach, report conclusion and its limits.

12.7 Observing the assessment, not merely receiving it

Psychiatrists often receive a report after the formal session rather than administering the measure themselves. That does not make the report a black box. A good discussion with the psychologist asks how the child entered the task, what forms of instruction were effective, whether the child was distractible or overcontrolled, and whether performance was consistent across the session. Such questions improve the clinical interpretation without asking the psychologist to disclose protected test content.

Behavioural observations should be described precisely and modestly. "Needed frequent encouragement" is an observation; "unmotivated" is an inference that may be unfair. "Asked repeatedly for the instruction to be restated" is useful; "poor intelligence" is neither an observation nor a formulation. This discipline matters especially when the assessment may influence educational planning, family expectations or access to supports.

Where there is a major discrepancy between the clinical picture and the test report, do not choose the more convenient version. Re-examine whether the referral question was correct, whether the child was able to show their abilities in the testing context, and whether another assessment modality is needed. A discrepancy is often the important finding. It directs curiosity towards the conditions under which the child does and does not function well.

12.8 Writing a defensible psychiatric formulation

A concise formulation after cognitive testing has several jobs. It identifies the source and purpose of the assessment, describes the adequacy of engagement, states whether language, sensory, motor, behavioural or contextual factors limited interpretation, and reports the assessor's conclusion in its proper scope. It then explains how that conclusion affects the immediate clinical

plan. The final step is essential. A report should change an action, a question, a referral or the level of certainty, rather than become an isolated attachment in the case file.

Avoid false precision. If the result is limited, say what limited it and what remains possible to conclude. If it supports a concern, distinguish this from establishing the whole condition or explaining every difficulty. If it is reassuring in the narrow domain sampled, state that narrowness. This language is not defensive hedging. It is professional accuracy, and it helps families understand that assessment is intended to open useful support rather than to impose a fixed identity on the child.

Feedback should be conducted in language that preserves dignity. Lead with what the child was able to do and how the assessment informs practical support. Explain uncertainty without making it sound like failure. Where family members request only a label, bring the conversation back to the child's current needs, opportunities for participation and the next question that needs answering. This stance reduces the risk that a test outcome becomes either stigmatising or falsely reassuring.

MNEMONIC

QUESTION

Question asked, testing **U**nderstanding, **E**ngagement, relevant **S**ensory or motor factors, observed **T**ask strategy, **I**nterpretive limits, **O**utcome for care, and **N**ext assessment step. Use this as a reporting spine, not as a substitute for clinical judgement.

12.9 Boundaries of the battery and cross-references

Intelligence measures and focused performance tasks are only one part of a child assessment. They do not substitute for developmental screening, an adaptive account, symptom ratings, play-based engagement, or a tailored neuropsychological evaluation when those are the actual clinical questions. Requests for a battery should therefore be revisited when the original question changes. Adding tests without a question can make a report longer without making it clearer.

For Binet-Kamat and **MISIC** as intellectual-disability grading tools, and for the wider clinical approach to intellectual disability and autism spectrum disorder, see *the Intellectual disability and autism spectrum disorder notes*. This section deliberately does not convert an IQ result into a severity grade. The grading decision depends on a broader clinical account and belongs with that discussion.

Similarly, normal development, developmental expectations and milestones are considered in *the Normal child development and milestones notes*. If the immediate question is a developmental screen or an adaptive-developmental tool, use the dedicated discussion of screening within this chapter rather than treating an intelligence instrument as a substitute. Clear boundaries between instruments make referrals more efficient and conclusions less misleading.

Choose the test by the question, interpret the child's performance in context, and never let a score do more clinical work than the assessment can support.

13 · Adaptive and developmental screening (VSMS, DST, DDST)

Screening is a decision aid, not a developmental verdict. In child psychiatry, a brief developmental or adaptive screen helps the clinician decide whether a reported concern deserves fuller assessment, what function is affected in everyday life, and which informant or service should be brought into the next step. Its marks lie in choosing the right tool for the question, administering it with discipline, and interpreting its result within the child's lived context.

The useful distinction is between a developmental screen, which samples observable attainments against an expected sequence, and an adaptive measure, which asks how the child manages ordinary demands in the environments in which the child actually lives. Neither replaces a careful history, examination, observation, or collateral account. The general assessment frame belongs with the principles of child psychiatric history and examination; this section concentrates on the narrow but clinically important work of using the VSMS, DST and DDST without turning a score into a diagnosis.

13.1 What screening contributes to assessment

Developmental screening is best understood as a structured way of making uncertainty visible. A parent may say that a child is "slow", "not listening", "unable to manage", or "different from the other children". These descriptions are clinically valuable but broad. A screen organizes the concern into functions that can be discussed, observed, and followed over time. It can also prevent the opposite error: dismissing a concern because the child appears comfortable or cooperative in a brief clinic encounter.

The screen is therefore an entry point to clinical reasoning. A finding that warrants concern should prompt the clinician to ask whether the observation is consistent across settings, whether the opportunity to learn the skill has been present, whether communication or sensory factors alter performance, and whether the caregiver's account describes capacity, opportunity, or a contribution from each. An apparently reassuring result should likewise be tested against the referral question. A child can perform a sampled task in a calm room yet struggle substantially with transitions, self-care, peer demands, or the pace of school.

CLINICAL TASK	WHAT THE TOOL CONTRIBUTES	WHAT REMAINS CLINICAL WORK
Clarify a vague concern	A shared functional language for the caregiver and clinician	History of onset, context, strengths and burden
Identify a possible delay	A structured prompt to consider further evaluation	Decide whether the concern is persistent, meaningful and corroborated
Describe everyday ability	Information on what the child does in ordinary settings	Distinguish ability from opportunity, support and expectation
Plan the next contact	A baseline language for reviewing change	Set goals with the child, family and relevant services

RULE **Use a screen to formulate the next question, never to close the case.** The result gains meaning only when it is integrated with developmental history, direct observation, caregiver account, school information where relevant, and the reason the child was brought for care.

This stance matters especially when a family arrives seeking a certificate, a label, or reassurance. The psychiatrist should neither promise certainty from a brief measure nor treat the family's concern as less real because a screen is not diagnostic. Instead, explain what the tool can contribute: it can map the concern, show which areas need closer attention, and provide a disciplined basis for deciding what assessment or support should follow.

13.2 Developmental attainment and adaptive functioning

Adaptive functioning concerns the practical translation of a child's capacities into daily participation. It is not identical to a test-room performance. A child may know how an activity is done yet not carry it out independently because the environment is confusing, routines are inconsistent, assistance is excessive, communication is limited, or anxiety disrupts performance. Conversely, a child can have a narrow skill repertoire but use familiar routines very effectively with stable support.

For this reason, adaptive enquiry works best when anchored to concrete examples. Ask the caregiver to describe what happens before, during and after a routine rather than accepting global labels such as "independent" or "dependent". Clarify who initiates the activity, how much prompting is needed, whether the child completes it safely, and whether the performance is habitual or exceptional. The aim is not to interrogate parenting. It is to establish the child's ordinary level of functioning in the family's actual circumstances.

Developmental screening samples attainments across functional areas, whereas adaptive assessment foregrounds real-world management. The distinction is clinically useful but should not be made artificially rigid. Each depends on the quality of the informant's report, the child's opportunity to practise, cultural expectations, language used in the interview, and the clinician's precision in recording an answer. A developmental concern can be recognized through everyday function; an adaptive difficulty may point back to a developmental, communication, emotional, physical, or environmental explanation.

GOOD TO REMEMBER

When caregiver and clinic observation do not agree, preserve each account rather than choosing a winner. The discrepancy is often the useful clinical datum: it may reveal a difference between structured and unstructured settings, between a familiar caregiver and an unfamiliar examiner, or between what the child can do and what the child routinely does.

13.3 Vineland Social Maturity Scale in Indian practice

The **Vineland Social Maturity Scale**, or VSMS, is particularly useful when the clinical question is about social maturity and everyday adaptive abilities. It was originally developed by **Doll** and adapted for India by **Malin**. That Indian adaptation makes the measure familiar in local clinical and teaching settings, but familiarity must not become ritual. Its value comes from a careful semi-

structured caregiver interview, not from treating its result as a self-explanatory property of the child.

The Indian adaptation covers **eight social domains and 89 items**, and is usable **from birth to 15 years**. This breadth supports an account of how the child manages across everyday activities rather than a narrow snapshot of one skill. The interviewer should know the manual and retain the wording and sequence needed for standardized administration. In teaching material and routine clinical discussion, it is safer to describe what the scale assesses than to reproduce protected content or substitute improvised items.

Its derived index is the **Social Quotient**, obtained by converting social age into that named index. The index can be useful as a compact summary and as a way to communicate a baseline, but the profile behind it matters more for intervention planning. A single composite cannot tell the team which routines are already established, which require cueing, which are limited by communication, or which depend on family accommodation. Those details should be carried forward into the formulation and practical plan.

IN INDIA

The VSMS has a recognisable place in Indian child assessment because of the Malin adaptation. Use it as an informed caregiver interview about the child's daily social maturity, while keeping the interview sensitive to the household's routines, available supports, language and expectations. A result is most useful when the narrative examples that produced it are retained in the clinical record.

TRAP **Do not convert an adaptive score directly into a diagnosis or a fixed prognosis.** The measure describes functioning through the information obtained at that assessment. It does not settle the causes of difficulty, replace a broader assessment, or tell the clinician which support will be effective without considering the child and environment.

13.4 DST: using a local developmental screen responsibly

The DST belongs with developmental screening rather than with formal intelligence testing. In an examination answer, its role should be stated modestly: it provides a structured sampling of developmental attainments and helps determine whether a fuller developmental evaluation is indicated. The clinician should use the authorised manual, local training and the version available in the service. Item content, scoring rules, thresholds, psychometric indices and normative claims should not be reconstructed from memory or inferred from another instrument.

A defensible DST encounter begins before the child is asked to do anything. Establish the referral question, the language used at home, the child's current health and comfort, the opportunity to practise relevant skills, and the person who can give the most reliable developmental account. During administration, create enough rapport for the child to engage, but do not coach the performance into a pass. If a caregiver supplies an answer, record it as caregiver report rather than converting it silently into observed performance.

- Record the reason for screening in functional language.

- Separate direct observation from caregiver report.
- Document conditions that may have altered engagement or performance.
- State the next assessment or referral question generated by the result.

The result is most helpful when it changes a decision. That decision may be to obtain collateral information, arrange a more comprehensive developmental assessment, explore a communication or sensory barrier, review the child after support has been instituted, or explain why no immediate escalation is needed despite a caregiver's understandable worry. It is not enough to write "screened" in the notes. The clinical record should show what was screened for, what was learned, what remains uncertain, and what will happen next.

PITFALL

Do not mix observation, reported ability and examiner assistance into one undifferentiated result. A child who succeeds only after repeated prompting has supplied different information from a child who completes the task spontaneously. The distinction changes formulation and the usefulness of later comparison.

13.5 DDST-II: scope and domains

The **Denver Developmental Screening Test, second edition**, or DDST-II, is a formal developmental screening tool for children **from birth to 6 years**. It samples development across **four domains**: **personal-social**, **fine motor-adaptive**, **language**, and **gross motor**. These headings help the psychiatrist describe where the concern lies without assuming that difficulty in one area explains all other areas.

Its administration should remain faithful to the authorised instrument. This concerns validity and professional boundaries. A screening tool is a standardized clinical aid, not a collection of memorable tasks to be copied into notes, teaching slides or a waiting-room checklist. The psychiatrist may explain the domains and the purpose to a family, while retaining the manual's protected procedures for trained use.

When considering a DDST-II result, look first for coherence. Does the screened pattern fit the developmental history? Does the family describe similar performance at home? Is a language-related difficulty being mistaken for a more global limitation? Is pain, fatigue, fear, unfamiliarity, or poor cooperation making the session a poor sample of the child's usual abilities? A screen can flag a question, but it cannot resolve these competing explanations on its own.

Screen	Profile	Context	Plan
SAMPLES FUNCTIONING	SHOWS THE PATTERN	EXPLAINS PERFORMANCE	SETS THE NEXT STEP

13.6 Interpretation, communication and follow-through

Interpretation is an ordered clinical task. Describe the observed or reported pattern without premature labels, test the pattern against context and collateral information, then decide whether it calls for fuller assessment, support, monitoring, or explanation. This sequence protects against

false reassurance and unnecessary alarm. It also keeps the result connected to the reason for consultation rather than allowing the scale to become the whole encounter.

Communicate the finding in language that respects the caregiver's observation and avoids fatalism. Explain that the screen estimates how the child is managing in selected areas at that point, and that the next step depends on the whole assessment. Families often hear any score-like output as a permanent ranking. The clinician's task is to redirect attention toward the child's current strengths, the functions needing support, and the practical information still required.

Where there is a clinically significant concern, the referral plan should identify the question for the next professional rather than simply dispatching the family. Where follow-up is chosen, record the same functional targets so that change can be discussed meaningfully. Educational observations, family routines and communication needs can be reviewed alongside the screen, but a screening result should not be used to dictate an educational placement or a formal diagnosis.

For intellectual disability, its IQ-grading instruments and ASD, see the Intellectual disability and autism spectrum disorder notes. For normal temperament, developmental norms and milestones, see the Normal child development and milestones notes. These cross-references are important because developmental screening is frequently used near those questions, but it does not replace the assessment standards set out there.

MNEMONIC

Question, Context, Profile, Plan

Question: why screen now? **Context**: what may shape the performance? **Profile**: what pattern is actually present? **Plan**: what is the justified next step? This sequence keeps the clinician from mistaking a completed form for a completed assessment.

A developmental or adaptive screen is useful only when its pattern is interpreted in context and used to decide the next clinical step.

14 · Broad-band rating scales (CBCL, SDQ, DBC)

Broad-band rating scales turn concern into a structured description. They ask someone who knows the child to rate a defined set of behaviours, emotions and strengths, so that the clinician can see the pattern rather than rely on an undifferentiated report that the child is "difficult" or "not coping". Their value lies in disciplined screening, in comparing settings, and in making subsequent change visible. They do not replace a history, direct observation, developmental examination, physical assessment, or clinical formulation.

A score is therefore an aid to judgment, not a diagnosis in miniature. A parent may be describing a child at home under stress; a teacher may be describing the same child in a highly structured setting; the young person may be reporting internal experience that neither adult sees. The useful clinical question is not simply whether the ratings agree. It is what each rating adds, what the

disagreement means, and whether the pattern alters the next assessment step. This instrument-specific use of an **informant** is central to multi-informant broad-band screening with the **Child Behavior Checklist (CBCL) / ASEBA**, the **Strengths and Difficulties Questionnaire**, and the **Developmental Behavior Checklist 2**.

2-17	25	5	5
SDQ AGE RANGE	SDQ ATTRIBUTES	SDQ DOMAINS	DBC2 SUBSCALE SCORES

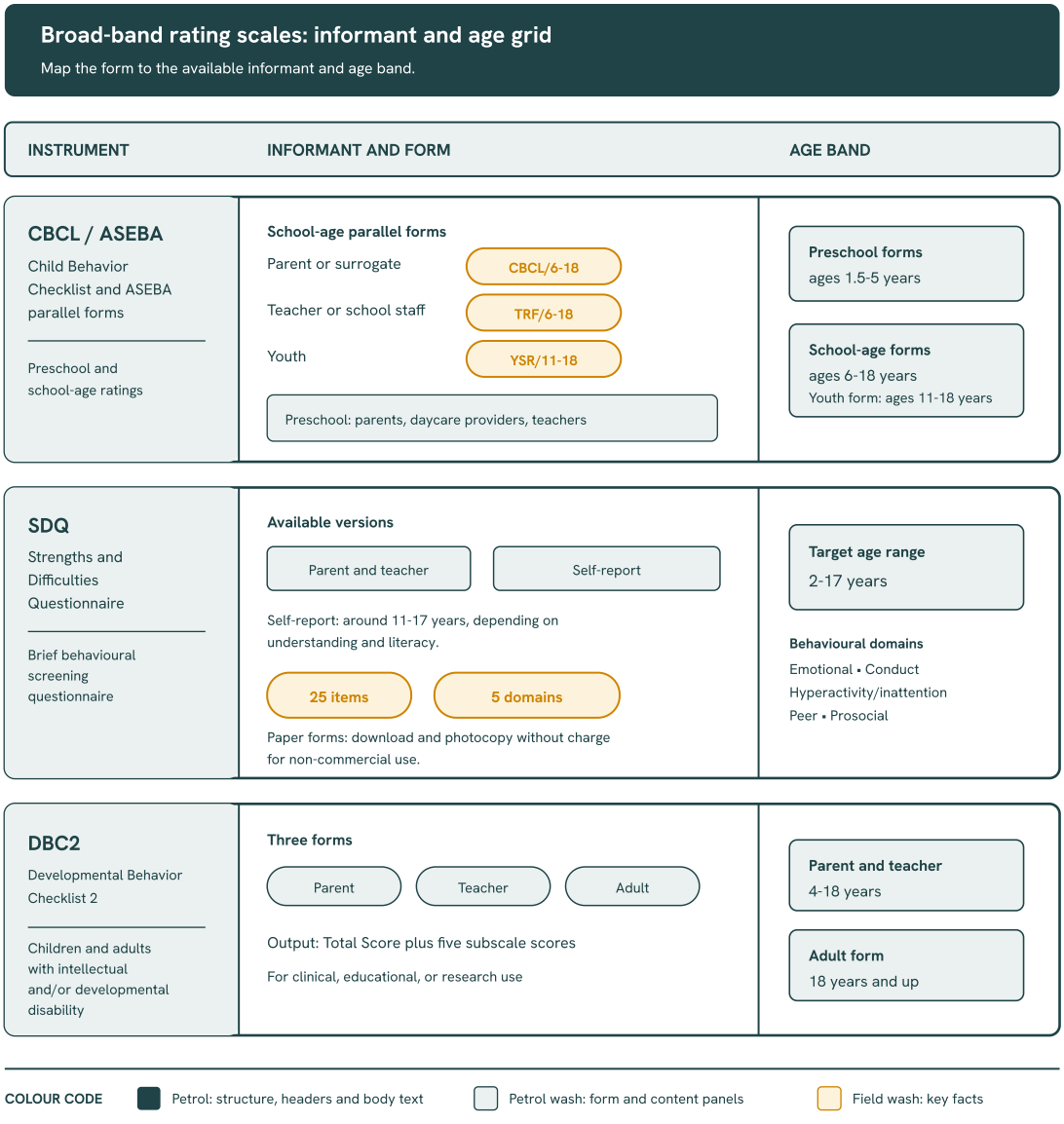


Fig 24.8. Broad-band rating-scale options differ in their available informants and age bands. The SDQ row additionally identifies its item count, behavioural domains, and non-commercial paper-use status.

14.1 What broad-band scales contribute

A **broad-band rating scale** samples difficulties from more than one clinical territory rather than beginning with a single suspected diagnosis. It is particularly useful when the referral question is broad, when the presenting complaint has changed across settings, or when the clinician needs a

common language for parents, school staff and the child. It can make hidden internalising distress easier to ask about, prevent a disruptive presentation from eclipsing strengths, and provide a baseline before an intervention is started.

The scale is not an interview performed on paper. It cannot establish onset, sequence, precipitants, meaning, developmental appropriateness, exposure to adversity, medical contribution, risk, or impairment in the manner required for clinical decision-making. A high score identifies a signal that merits explanation; a low score does not overrule a coherent history of distress or danger. The same item endorsement can have different significance depending on language ability, sensory profile, family expectations, classroom demands, and the situation in which the rater has observed the child.

RULE **Use a broad-band score to sharpen the clinical question, never to close it.** The response pattern should direct further history, observation and collateral enquiry. It should not be used as a substitute for deciding whether the reported behaviour is persistent, impairing, context-bound, developmentally expected, or better explained by another difficulty.

For this reason, broad-band screening is most defensible when the referral question is written before the form is chosen. “What is happening at home and school?” is a different question from “Has the child’s emotional burden changed since the last review?” A scale can serve either purpose, but the interpretation must match the purpose. It is poor practice to administer a familiar questionnaire merely because it is available and then let its score dictate the assessment agenda.

14.2 The informant is part of the measurement

In child work, the rater is not a neutral delivery system. Each informant samples a different relationship, setting and threshold for concern. Parents may be best placed to describe routines, transitions, sleep-related strain, sibling interactions and the child’s recovery after distress. Teachers may contribute sustained comparison with classroom expectations, peer participation, task persistence and response to structure. A young person may disclose worry, shame, loneliness or thoughts that are not outwardly visible. The record should identify who completed the form, what relationship they have to the child, and the period and context that guided their answers.

Informant discrepancy is clinical data, not a defect to be averaged away. Concordant concern across settings can support the impression of a pervasive problem, but disagreement should lead to hypotheses rather than a search for the “correct” rater. Home-only difficulty may point towards demands, routines, relationships or unstructured time that require exploration. School-only difficulty may reflect academic load, peer dynamics, sensory demands, discipline practices or a mismatch between the child and the environment. Self-report that is more severe than adult report deserves a careful, private discussion; it is not disproved by an outwardly composed presentation.

At the same time, discrepancy is not automatically meaningful. A rater may have had too little recent contact, may misunderstand an item, or may answer from a moment of acute conflict. Clarification is often more valuable than immediately repeating the questionnaire. Ask for

examples, antecedents, consequences and exceptions. Then decide whether a second informant, direct school contact, a focused interview, or another component of the assessment is needed. The broader framework for child psychiatric history and examination belongs with the assessment principles section of this chapter; the point here is that the form itself gives a structured way to organise collateral evidence.

GOOD TO REMEMBER

When scores diverge, place the forms side by side before the next interview. Ask about the items on which the accounts differ, not only the overall result. This often converts an apparent disagreement into a useful account of setting, demand and relationship.

14.3 CBCL and the ASEBA approach

The CBCL is used within the ASEBA family of parallel forms. Its practical strength is that comparable information can be sought from the adult caring for the child, school personnel and the young person, instead of treating one account as the whole case. At school age, the relevant forms are **CBCL/6-18, TRF/6-18 and YSR/11-18**. They are completed respectively by a parent or surrogate, a teacher or other school staff member, and the young person. This structure makes it possible to compare a home account, a school account and the child's own account without pretending that they are interchangeable.

The preschool family is also explicitly multi-informant: it covers **ages 1.5 to 5 years** and can draw on accounts from parents, daycare providers and teachers. That matters because early-childhood behaviour is highly dependent on routine, caregiving style, language development and the demands of the setting. A report of a behaviour in one environment should prompt inquiry into its context rather than a premature inference of stable psychopathology.

In clinical use, start with the reason for selecting the form. If the consultation concerns a mismatch between home and school, obtain the relevant adult accounts close enough in time that they represent the same clinical period. If the young person's experience is central, create conditions in which completing a self-report is private and comprehensible, then discuss it rather than leaving it unexplained in the file. The scale profile is best read as a map of areas needing clinical clarification. It does not decide what the child "has", and it should not be used to make a categorical diagnosis without the requisite assessment.

INSTRUMENT FAMILY	WHAT ITS STRUCTURE CONTRIBUTES	CLINICAL USE OF THE COMPARISON
CBCL / ASEBA	Parallel home, school and youth accounts where the relevant forms are used	Locates whether concerns are shared across settings or concentrated in one context
SDQ	A brief screen covering difficulties as well as a strength domain	Provides a concise initial overview and a language for focused follow-up
DBC2	Parallel adult perspectives and an overall score with subscale information	Frames behavioural and emotional concerns where developmental disability shapes presentation

TRAP **Do not turn cross-setting disagreement into a contest between parent and teacher.** Both may be reporting accurately from different environments. Treat the discrepancy as a question about context, exposure and demand, then test that question in the history.

14.4 SDQ as a concise broad-band screen

The SDQ is a brief behavioural screening questionnaire for children and adolescents. It asks about psychological attributes, including positive as well as negative attributes. This is clinically useful because a brief screen that records prosocial capacity alongside difficulties can prevent the assessment from being framed solely in deficit language. It is still a screen: a score pattern should lead to enquiry about severity, duration, impairment and context, rather than being read as a diagnosis.

The attributes are organised into behavioural domains covering emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour. The domains are a way of structuring attention, not a replacement for formulation. For example, a peer-related concern may require enquiry into anxiety, social communication, bullying, exclusion, language, classroom climate or a developmental difference. Similarly, a score suggesting difficulty with attention needs a full account of sleep, mood, learning demands, stress and context before it has diagnostic significance.

A **self-report version** is suitable for young people **around 11 to 17 years**, depending on understanding and literacy. The clinician should therefore check comprehension rather than assume that chronological age alone guarantees meaningful self-report. If the young person needs help with wording, preserve privacy and avoid coaching a preferred answer. The aim is to understand their perspective, not to manufacture agreement with the adult forms.

The SDQ can be especially practical when a brief, repeatable screen is needed and when a school or family can complete it without a lengthy assessment session. Its paper forms can be obtained and copied without charge for **non-commercial use**. That access should not be confused with permission to alter the instrument or to treat an informal translation as equivalent to an authorised form. Use the available version as intended, record which version was used, and retain the original response sheet or a faithful clinical record.

PITFALL

A brief score is often copied into a referral letter without the rater, setting or reason for administration. This makes the number clinically thin. Record the informant and context beside the result, and document the question the screen was intended to answer.

14.5 DBC2 when developmental disability is central to presentation

DBC2 is designed for behavioural and emotional assessment in children and adults with intellectual and/or developmental disability. It is useful when communication differences, adaptive dependence, physical health burden, sensory needs or environmental support may alter how distress and challenging behaviour are expressed. The clinical task is not to reduce a behaviour to the developmental condition. Rather, ask what the behaviour communicates, what has changed, which demands precede it, and whether pain, fear, loss, trauma, mood, communication frustration or a change in support could be contributing.

Its parent and teacher forms apply from **4 to 18 years**, while its adult form applies from **18 years and up**. The **Parent, Teacher and Adult forms** provide parallel perspectives, and the measure yields an overall score together with subscale scores. This allows behaviour to be described across familiar environments, but it does not determine cause. A change in score should trigger review of health, communication, routine, support and safeguarding, alongside psychiatric assessment where indicated.

In a child with developmental disability, the most useful preparation for a DBC2 discussion is concrete collateral: a description of the behaviour, the setting in which it happens, changes from the child's usual pattern, what reliably precedes it, and what follows. This protects against diagnostic overshadowing, in which distress is attributed to disability and a treatable contributor is missed. For intellectual disability and autism-spectrum assessment itself, consult the Intellectual disability and autism spectrum disorder notes; the present role of DBC2 is broad behavioural screening and structured follow-up.

14.6 From score to formulation and follow-up

Interpret a profile in layers. First, establish whether the form is complete, intelligible and relevant to the current clinical period. Next, identify the broad areas that require interview and observation. Then compare informants and settings, looking for convergence, divergence and missing perspectives. Finally, integrate the rating with functional impact, risks, strengths and the child's account. The report should distinguish clearly between what the instrument records and what the clinician concludes.

Measurement-based follow-up is valuable only when the same construct, informant and context are reasonably comparable over time. A changed score may reflect clinical change, but it can also reflect a new teacher, altered school demands, a family crisis, better understanding of the items, or a different person completing the form. Notes should therefore state the intervention or event occurring between ratings and any change in informant or setting. This prevents false confidence in apparent improvement or deterioration.

- State the referral question before administering the scale.
- Record the instrument version, informant, setting and date in the clinical note.
- Read the profile beside history, observation and impairment, not in isolation.
- Discuss discrepant findings with the relevant informant and, where appropriate, the child.
- Use a repeated measure only when it will answer a defined follow-up question.

IN INDIA

Collateral often has to be assembled across family members, teachers and changing school arrangements. Explain the purpose of the questionnaire in the respondent's preferred language, check that the questions are understood, and avoid treating limited literacy or unfamiliarity with questionnaire formats as evidence of psychopathology. A school form is useful only when the respondent has had enough opportunity to observe the child.

Feedback should be proportionate and non-stigmatising. Explain that the form describes reported difficulties and strengths in a particular context, and that the next step is to understand why they are present. Share only information needed for the agreed clinical purpose, especially when communicating with school. The child and family should not be left with a score whose meaning has not been explained, nor should a school be asked to act on a label that the assessment has not established.

14.7 Choosing and documenting the right scale

Selection starts with fit, not prestige. Choose a broad-band scale when the clinical question calls for a broad description of behaviour and emotion, when multiple settings need comparison, or when a structured baseline will guide later review. Choose the particular family according to the child's developmental context, available informants, respondent comprehension, and the practical setting in which the information will be used. A questionnaire chosen for convenience but mismatched to the child or respondent can create spurious precision.

Document interpretation in ordinary clinical language. A useful note identifies the source of each account, describes the pattern that emerged, names the main uncertainties, and sets out the follow-up questions. It should also record strengths and protective factors reported on the form or in interview. This is more clinically durable than copying a score alone, because another clinician can understand the reasoning and can decide whether a later change represents a real shift or a change in circumstances.

MNEMONIC

SCALE

Source, **C**ontext, **A**greement, **L**imits and **E**xplanation. Before acting on a broad-band result, identify who rated, where they know the child, what agrees or differs, what the form cannot establish, and what clinical explanation must now be tested.

A broad-band rating scale is most useful when its score is interpreted as one informant's structured account within a full clinical formulation.

15 · Projective tests in children (CAT, draw-a-person)

Why it matters clinically. Projective material is often memorable because it seems to offer a route into a child's inner world without demanding a direct verbal account. That apparent immediacy is also its danger. A child's story or drawing is an encounter between the child, the task, the examiner, the setting, and the meaning assigned afterwards. It can enrich an assessment when used as a prompt for curiosity, but it becomes unsafe when it is treated as a shortcut to a diagnosis, a hidden event, or a fixed personality conclusion.

For the psychiatrist, the examinable skill is not to recite supposed symbolic meanings. It is to know what the instrument asks the child to do, what kind of clinical material it can generate, and where its inferences must stop. Projective techniques belong after the general assessment framework, not in place of it. That framework is set out in *Principles of child psychiatric history and examination*.

CAT	DAP	Context	Adjunct
NARRATIVE PROMPT	HUMAN-FIGURE TASK	MAKES MEANING SAFER	NEVER THE WHOLE ASSESSMENT

15.1 What a projective method contributes

A projective method gives the child an ambiguous or relatively open task and attends to the response that follows. The response may be a story, a choice, an elaboration, a refusal, a drawing, a question to the examiner, or a change in affect while doing the task. Its value is therefore qualitative. It can make themes easier to approach when a child has difficulty discussing feelings directly, is unsure what is permissible to say, or is more comfortable communicating through play and imagery than through an interview.

The clinically useful output is a *hypothesis*, not a finding that proves itself. If a child repeatedly centres a theme, the examiner asks whether that theme is also visible in the history, behaviour, relationships, and the child's own later account. If it is not, it remains an observation needing exploration. This protects against the common habit of converting a striking image into a conclusion before the child has been heard.

RULE **Read projective material as a conversation starter, not as a verdict.** Its contribution is strongest when it helps the clinician ask a better next question and weakest when it is used to replace ordinary clinical evidence.

Interpretation must distinguish the product from the process. A bleak story may reflect current worry, imaginative preference, misunderstanding of the task, recent experience, fatigue, or the child's sense of what the adult expects. Likewise, a sparse drawing may be affected by comfort with drawing, visual-motor skill, motivation, time pressure, and the relationship with the

examiner. Recording the child's spontaneous comments and the examiner's invitations is often more clinically informative than preserving an isolated conclusion about the finished product.

- Describe what was actually said, drawn, chosen, or avoided before assigning possible meaning.
- Ask gentle, open follow-up questions that allow the child to confirm, revise, or reject the clinician's initial impression.
- Seek convergence with history, observation, and collateral accounts before a theme influences formulation or management.

15.2 Children's Apperception Test: a narrative task

The **Children's Apperception Test**, commonly abbreviated as CAT, is a projective technique built around pictures. It is associated with **Leopold Bellak, MD, and Sonia Bellak**. The task presents a set of **10 animal pictures** in social situations that include conflict and interpersonal relationships. The child's narrative, the way characters are understood, and the child's manner of engagement give the interviewer material to explore rather than material to decode mechanically.

The stated age range is **3 years to 10 years**. This is an aid to task selection, not a substitute for judgment about whether a particular child can understand and tolerate the task. Before beginning, the examiner should create a calm, non-evaluative atmosphere. The child should not be made to feel that there is a correct story or that the clinician possesses a concealed answer. A brief, natural invitation to tell what seems to be happening is usually more useful than repeated prompting that turns the task into a performance.

During administration, the psychiatrist should attend to the child's approach to the picture as well as the narrative itself. Does the child begin readily, seek reassurance, change the task, repeatedly ask what the examiner wants, become playful, or disengage? Does the narrative permit multiple feelings and outcomes, or does it close rapidly around danger, blame, rescue, exclusion, or triumph? Such features may indicate where a careful interview could go next. They do not establish why the feature occurred.

A practical record gives a near-verbatim account of the story and the child's behaviour. It also records tentative themes in ordinary clinical language, with alternatives rather than certainty, and notes questions to be tested elsewhere in the assessment. This prevents an attractive interpretation from hardening into the record as though the child had stated it directly.

> **GOOD TO REMEMBER**
>
> If a CAT story raises a concern about a relationship or experience, return to the child with an age-appropriate open question and examine the concern against the rest of the assessment. The useful move is clarification, not interpretation by authority.

IN INDIA

Language, family idiom, and the child's familiarity with picture-based tasks shape the narrative. Use the language in which the child can play with ideas most naturally, and document whether an interpreter, caregiver presence, or the clinic setting may have altered the exchange. A translated answer should never be stripped of its context and treated as a literal psychological code.

15.3 Reading CAT responses responsibly

A story should be approached as jointly produced material. The image makes some possibilities more available; the examiner's voice and pace influence what the child risks saying; and the child may be responding to the adult as much as to the picture. The immediate task is therefore descriptive: who is in the story, what happens, what feelings are named, how relationships are arranged, and whether the child comments on the task itself. The next task is collaborative: ask the child to explain uncertain elements rather than filling them in.

Patterns can be clinically useful when they recur across material and fit independently obtained information. For example, a recurrent difficulty in imagining comfort may prompt exploration of support-seeking and caregiving relationships. A repeated focus on control may prompt exploration of the child's recent transitions or family interactions. In each instance, the word *may* matters. The method opens a line of enquiry; it does not identify a cause, establish an event, or rank the severity of a problem.

Negative material should not be confused with pathology. Children use stories to rehearse fear, anger, competition, dependence, and repair. A dramatic narrative can be imaginative, situational, or developmentally understandable. The clinician's task is to consider intensity, persistence within the encounter, the child's own explanation, and convergence with the wider assessment. Equally, a cheerful story does not exclude distress. Children may protect adults, avoid frightening material, or choose a familiar social script.

TRAP **Do not convert a theme into a diagnosis or a factual allegation.** A projective response can justify further sensitive enquiry; it cannot carry a diagnostic or forensic conclusion on its own.

PITFALL

Do not reproduce proprietary pictures in notes, teaching slides, or informal messaging, and do not rely on a second-hand description of a stimulus as if it were the child's actual response. Record the clinically relevant narrative and process in your own words.

15.4 Draw-a-person tasks: method and history

A human-figure drawing task asks the child to make a drawing of a person and provides a different kind of material from a picture-based narrative. The finished drawing is visible, but the encounter also includes how the child begins, whether the child asks for help, the comments made while drawing, corrections, pauses, and the response to a follow-up invitation to talk about the figure. A drawing can be a gentle way to engage a child who is not ready for a sustained verbal

interview, provided the clinician does not mistake familiarity with drawing for a window of equal clarity into mental life.

The **Draw-A-Man Test** was published in **1926** with **standardized instructions for administering and scoring a human figure drawing**. This historical point matters because it corrects a frequent conflation: a drawing task may have a structured scoring purpose, while a clinician may separately use drawings in a projective or conversational way. These are related only by the medium. They are not automatically the same clinical claim.

The earlier work was later restandardized and published as the **Goodenough-Harris Drawing Test** in **1963**. In its scored form, its primary purpose is a measure of **intellectual maturity**. The **projective aspects** of drawings are a distinct use and should not be silently imported into an intellectual-maturity score. For the broader developmental and intellectual assessment battery, see *Developmental and IQ tests*.

CLINICAL QUESTION	CAT RESPONSE	DRAW-A-PERSON RESPONSE	SAFE CLINICAL USE
How does the child make sense of an interpersonal scene?	A story built around pictured social material	Comments about the figure may emerge during or after drawing	Use the material to guide open questions
What happens during engagement with an open task?	Notice narration, pauses, questions, and affect	Notice approach, revisions, requests, and affect	Record the process as well as the product
Can the result stand alone as a clinical conclusion?	No	No	Seek corroboration within the assessment
What should be avoided?	Fixed decoding of a story detail	Fixed decoding of a drawing feature	State uncertainty and test alternatives

15.5 Clinical interpretation of a drawing

The central discipline is to avoid a dictionary approach. An isolated feature of a human figure does not carry a stable meaning independently of the child, the task conditions, and the wider assessment. A clinician who says that a particular feature proves a specific feeling has moved from observation to certainty without showing the necessary reasoning. The more defensible note describes the feature, records the child's account of it, and states how it did or did not fit the rest of the clinical picture.

Ask questions that preserve ownership of meaning with the child: "Tell me about this person"; "What is happening here?"; "What is this person thinking or feeling?"; "Is there anything you would like to add?" The exact wording should be adapted to the child's language and comfort. These questions often reveal whether the drawing was simply a task, a playful character, a self-referential account, or a story about someone else. They also make the assessment less intrusive than an adult narration imposed upon the child.

When drawing behaviour suggests difficulty, consider ordinary alternatives before assigning psychological significance. The child may have limited confidence with drawing, may be

preoccupied by the clinic, may be tired, or may be avoiding an unfamiliar adult. When the drawing seems highly elaborated, consider interest, practice, and the wish to please as well as emotional themes. This is not timidity. It is the ordinary clinical requirement to separate an observation from its possible explanations.

MNEMONIC

Describe, Ask, Corroborate, Explain uncertainty

Use this sequence for any projective response. **Describe** the response and process; **Ask** the child what it means; **Corroborate** against the wider assessment; and **Explain uncertainty** in the formulation rather than overclaiming.

15.6 Documentation, communication, and scope

The clinical note should make clear which parts are observation, which parts are the child's explanation, and which parts are the clinician's tentative formulation. It should also record the context of administration: privacy, interruptions, language used, the child's willingness, and any relevant influence of adults present. This is especially important when later readers did not witness the task. A concise, transparent note is more useful than a long interpretative paragraph that obscures what actually occurred.

In feedback to caregivers, describe the task modestly. It may be appropriate to say that the activity helped the child communicate themes worth exploring, then discuss those themes alongside the child's observed functioning and the family's account. It is not appropriate to present the drawing or story as an objective detector of a private fact. Such framing can alarm families, damage trust with the child, and distract from more reliable avenues of assessment and care.

Where there is a safety concern, the response is not to intensify symbolic interpretation. Clarify the concern using an appropriate child-centred assessment, preserve the child's words carefully, and follow the relevant safeguarding pathway. The safeguarding-specific evaluation is addressed in *Child sexual abuse assessment and psychiatric sequelae*, and the clinical response in *Management and intervention in child abuse cases*. Projective material should never be used to bypass either process.

Projective tests can deepen a child assessment only when their observations are kept tentative, explored with the child, and corroborated elsewhere.

16 · Multiaxial and multi-informant assessment in child psychiatry

Why it matters clinically. A child psychiatric formulation becomes thin when it is reduced to a diagnostic label. The clinician may have recognised a symptom pattern correctly yet still fail to record the developmental picture, physical health, psychosocial context, or the effect of difficulties on everyday life. The **WHO ICD-10 multiaxial classification** is useful as a

disciplined way of holding these domains together. It asks the clinician to write a structured account rather than allow the most conspicuous complaint to stand in for the whole child.

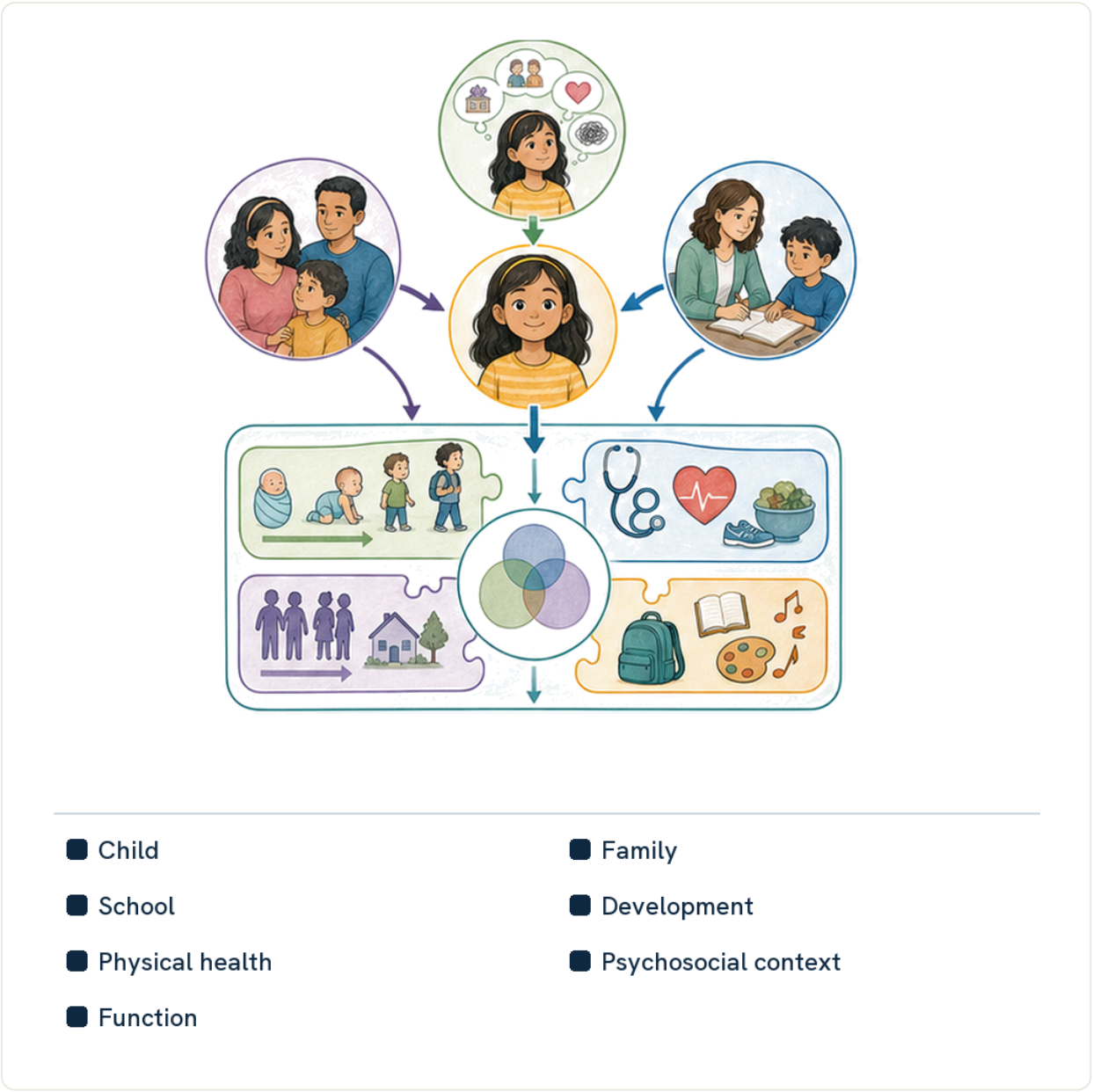


Fig 24.9 Child psychiatric assessment integrates the child's account with family and school information, then holds syndrome, development, physical health, psychosocial context and functional disability in one structured formulation.

The purpose is not to multiply diagnoses or to turn assessment into a coding exercise. It is to make clinical reasoning visible. A multiaxial record separates questions that are often blurred in hurried notes: what syndrome is present, what developmental factors matter, what physical conditions may alter presentation or treatment, what circumstances burden the child, and how much disability is being experienced. This separation makes omissions easier to see and makes the formulation more useful to families, schools, and colleagues.

WHO	BODY	CONTEXT	FUNCTION
STRUCTURED FRAME	MEDICAL CONTEXT	PSYCHOSOCIAL FIELD	DISABILITY RECORDED

16.1 What multiaxial assessment adds

Multiaxial assessment is a formulation scaffold. It does not replace a careful history, examination, developmental understanding, or collateral account. Instead, it gives each of these strands a defined place in the final record. That matters because the same outward difficulty can be shaped by developmental capacity, a medical condition, adversity, or functional impairment. A single-label summary can conceal these distinctions; a multiaxial summary obliges the clinician to state them.

The framework contains **six** axes. Read them as parallel descriptive fields, not as a ladder of importance. Clinical psychiatric syndromes and specific disorders of psychological development occupy different fields; intellectual level is recorded separately; physical conditions, psychosocial situations, and psychosocial disability are also given their own places. The practical gain is a record that can carry comorbidity and context without implying that one automatically explains the other.

RULE **Use axes to separate dimensions of a formulation, not to manufacture extra diagnoses.** A field is completed because it changes understanding, communication, or planning, not because a blank must be filled with speculation.

In a clinical note, this distinction protects against premature closure. A syndrome field may describe the current psychiatric presentation, while another field records developmental information that affects how symptoms are understood and how communication is adapted. A separate medical field prevents the physical examination and relevant health conditions from being treated as an afterthought. Context and disability fields then stop social circumstances and real-world impact from being appended as vague background prose.

16.2 Reading the axes as a biopsychosocial record

RECORD FIELD	QUESTION IT KEEPS OPEN	USE IN FORMULATION
Clinical psychiatric syndromes	What is the current psychiatric presentation?	States the clinical problem without claiming it is the whole explanation.
Specific disorders of psychological development	What developmental profile alters interpretation or communication?	Prevents developmental needs from being lost inside symptom language.
Intellectual level	What level of cognitive functioning is relevant to assessment and support?	Prompts accessible interviewing and realistic expectations.
Medical conditions	What physical health information belongs in the psychiatric formulation?	Keeps relevant bodily illness and its clinical implications visible.
Associated abnormal psychosocial situations	Which circumstances are linked to the child's difficulties?	Turns a generic social history into a clinically usable context.
Global assessment of psychosocial disability	How are difficulties affecting participation and everyday roles?	Brings functional consequence into the centre of the record.

The table is not a sequence to be completed mechanically. It is a set of safeguards against category error. A psychosocial situation may be relevant without being presented as the sole cause of a psychiatric syndrome. A medical condition may need active attention without becoming an explanation for every behavioural change. Similarly, a developmental difference may shape the interview and treatment plan without making distress less real. The axes help the clinician preserve these distinctions in language that another professional can follow.

The medical field is especially valuable when a referral arrives with an apparently psychiatric question but the child's health history has been summarised poorly. Its task is to record relevant physical conditions in the same formulation rather than leave them in a separate clinic note. This is not an invitation to diagnose beyond one's evidence. It is a prompt to decide whether medical information changes the differential understanding, risk appraisal, communication, or co-ordination of care.

> **GOOD TO REMEMBER**
>
> A useful axis entry is brief but consequential. Record the information that changes how the team understands the child or what the team must do next. Copying an undifferentiated social history into a context field creates length without formulation.

16.3 Context is neither cause nor excuse

Psychosocial circumstances deserve their own field because they are often clinically decisive, yet they should not be used as a shortcut to causal certainty. Context can maintain distress, limit attendance, alter what a caregiver can implement, or change the meaning of behaviour in a particular setting. It may also reveal strengths, available supports, and routes to practical help. A

formulation is stronger when it states the relationship it can justify and leaves causation open when the evidence does not justify more.

This approach also prevents moralising. Describing a difficult home, educational, peer, or care environment should not become a judgement about the child or family. The psychiatrist's task is to identify the clinical relevance of circumstances and translate it into a plan that can be shared. Neutral, observable language is more useful than labels that assign blame. It helps the receiving team see both burden and possibility.

IN INDIA

In Indian clinical records, the multiaxial frame can make fragmented information usable across home, school, health, and social settings. Write the context clearly enough that a colleague receiving the note understands what requires co-ordination, while avoiding assumptions about family motives, resources, or capacity.

TRAP **Do not write adversity as though it automatically proves causation.** The context field records clinically relevant circumstances. It does not license a causal story that has not been established, nor does it remove the need to describe the psychiatric presentation independently.

There is a second, quieter trap. When psychosocial information is scattered across the narrative, it can be mistaken for colour rather than clinical data. A distinct field asks the clinician to decide what is associated with the presentation and why it matters. That decision supports communication with other services without turning the psychiatric note into a catalogue of family details. Relevance, proportionality, and respectful wording matter as much as completeness.

16.4 Disability as a clinical outcome

The historical addition of **Axis Six** after the classification's introduction in **1993** made an important corrective: symptom description is not a sufficient description of a child's clinical situation. The axis directs attention to psychosocial disability, so that the formulation addresses what difficulties are doing to participation and everyday functioning rather than merely naming symptoms.

Its logic remains clinically useful even when contemporary documentation uses different formats. A child may appear less unwell in a brief consultation than in the environments where demands, relationships, transitions, and communication needs become visible. Conversely, conspicuous symptoms do not by themselves tell the clinician what the child can or cannot do with support. Recording **social disability** therefore anchors the formulation in consequence. It asks what has changed in the child's capacity to take part in ordinary life, and what support is needed to restore or protect that participation.

Disability should not be treated as a moral score or as a proxy for diagnostic severity. It is a separate clinical dimension. The interviewer should translate observations into functional language, identify setting-specific barriers, and distinguish a skill from the opportunity to use

that skill. This makes a formulation more useful for planning because it connects the clinician's account to supports that can be arranged and reviewed.

The stated purpose of this axis was a first move towards a systematic approach to assessing disability in young people with psychiatric disorder. That historical intention is worth retaining: function is not an optional closing sentence after diagnosis. It is part of what the clinician is trying to understand.

16.5 Multi-informant material: integrate, do not average

A child's assessment requires information from multiple perspectives, but the general multi-informant assessment framework, including how to obtain and weigh history, belongs with the child psychiatric history and examination. See the assessment framework in the chapter section on principles of child psychiatric history and examination. This fragment does not set out methods for collecting, prioritising, or reconciling informant accounts.

The boundary is important. *Multi-informant* describes the sources from which the clinical picture is built; *multiaxial* describes the dimensions in which that picture is recorded. They are complementary but not identical. In the final record, an informant account should support a clinical formulation field, not be mistaken for an axis in its own right. Where material remains uncertain, the formulation should say so rather than create agreement that the assessment has not established.

> **PITFALL**
>
> Do not turn a disagreement between accounts into an axial conclusion. An axis records the clinician's formulation of a domain; it is not a place to conceal uncertainty by presenting a disputed account as settled fact.

16.6 Turning the framework into a usable formulation

A concise final formulation can move from the current psychiatric presentation to developmental and cognitive context, then note relevant physical conditions, psychosocial situations, and functional disability. Each clause should earn its place by changing interpretation, communication, risk management, or the plan. This order is not a rigid script. Its value is that it forces the writer to show the relationship between dimensions while preserving the difference between them.

- Keep the current presentation distinct from developmental context.
- Record relevant physical conditions rather than burying them in general history.
- Describe psychosocial circumstances without converting them into causal certainty.
- State functional disability separately from symptoms.

MNEMONIC

FRAME

Formulate the presenting syndrome, **R**ecord developmental and cognitive context, **A**dd the relevant physical conditions, **M**ap psychosocial circumstances without asserting cause, and **E**stablish functional disability separately. Use it as a prompt for a coherent formulation, not as a substitute for clinical judgement.

When the record is shared, avoid unexplained technical shorthand. A formulation should be legible to the team and should make clear which statements are observed, reported, inferred, or still uncertain. It should also remain revisable. As further information becomes available, an axis can be clarified without rewriting the entire clinical story or pretending that earlier uncertainty was certainty. This feature makes the framework useful in longitudinal care.

Multiaxial formulation preserves the distinction between symptoms, context, physical health, development, and disability so that clinical planning addresses the whole child.

17 · Neuropsychological assessment of children (NIMHANS battery, executive function tests)

Why it matters clinically. Child neuropsychological assessment asks a different question from symptom counting: how is this child taking in information, holding it in mind, directing behaviour, learning from feedback and using skills in everyday demands? Its value is not a label produced by a test. Its value is a defensible account of a pattern of strengths and vulnerabilities that can explain why a child struggles in a particular context, despite apparently adequate ability or effort in another.

A useful assessment is hypothesis-driven. The referral question may arise from uneven school performance, apparently inconsistent attention, difficulty shifting away from a preferred response, slowed written work, or a mismatch between what the child can explain verbally and what the child can demonstrate independently. The clinician first decides whether a cognitive profile can add something to the clinical formulation, then specifies what observations or measures would materially change management. This keeps testing from becoming a collection of scores without a clinical argument.

Profile	Question	Evidence	Output
COGNITIVE PATTERN	FUNCTIONAL HYPOTHESIS	OBSERVED PERFORMANCE	PRACTICAL SUPPORTS

17.1 What neuropsychological assessment contributes

Executive functions are the control processes that help a child organise behaviour towards a goal. In the clinic, the question is rarely whether a child possesses an executive function in the abstract. It is whether the child can recruit control reliably when demands rise, distractions compete, rules change, feedback is disappointing, or an immediate response must be withheld.

The distinction matters because a child may perform well in a quiet, highly structured interaction and still fail when the same skill must be self-directed in daily life.

Neuropsychological work therefore converts a broad concern into more precise alternatives. A child who does not complete work may be struggling to sustain effort, to keep instructions active, to plan an approach, to shift after an error, or to regulate speed. Similar outward behaviour can arise through different routes. A profile does not remove the need for clinical judgement; it makes the judgement more explicit and tests whether the proposed explanation fits the child's performance across tasks.

RULE **Interpret a cognitive score as evidence about a process, never as a diagnosis by itself.** A score becomes clinically meaningful only when it is considered alongside the referral question, observed approach to tasks, developmental context and real-world functioning.

This is particularly useful when reports from home and school appear contradictory. A difference between settings may reflect different task demands, different levels of cueing, emotional load, fatigue, language demands or opportunities for distraction. It should not be converted automatically into an assertion that a child is choosing when to perform. The assessment helps identify what support allows a skill to appear and what conditions make it collapse.

17.2 The NIMHANS battery in Indian practice

The **NIMHANS Neuropsychological Battery for Children** is a structured option for child neuropsychological assessment. Its original citation credits **Kar, Rao, Chandramouli and Thennarasu**, with the **NIMHANS Publication Division** named as publisher in **2004**. What makes an age-referenced instrument useful is not merely that it produces a result. It allows the child's performance to be considered against **norms for each test at each age level**, rather than against an adult expectation or an informal impression of what children should manage.

IN INDIA

The reported growth-pattern work included **400 Indian school children between 5 and 15 years of age**. This makes the battery especially important as an Indian reference point. It does not, however, permit a clinician to treat every child from every linguistic, educational or social context as interchangeable with the reference group. Local relevance strengthens interpretation; it does not abolish the need to ask whether the comparison is fair for this child.

Norm-referenced assessment is a safeguard against an easy error: reading a performance as poor merely because it looks immature to the examiner. The reverse error is also possible. A child may appear socially fluent, compliant and bright in conversation but show a meaningful difficulty when a task requires self-monitoring or a novel rule. The examiner should describe the conditions of success and failure, not simply attach a global adjective such as “normal” or “impaired”.

17.3 Reading a profile across cognitive sections

The battery is organised into **five** section headings. These cover **motor speed**, **attention**, executive functions, **visuospatial functions**, and **comprehension, learning, and memory**. The

purpose of this organisation is clinical coherence. It encourages the examiner to look for convergence across related performances rather than to overvalue an isolated low result.

OBSERVED PATTERN	CLINICAL QUESTION	INTERPRETIVE DISCIPLINE
Slow or effortful output	Is the difficulty primarily in pace, control of response, understanding of the task, or persistence?	Describe the child's method and errors before drawing a conclusion.
Variable performance across tasks	Which demand changed: novelty, rule maintenance, interference, speed or cueing?	Seek a process explanation, not a character explanation.
Weak learning on a task	Was information encoded, retained, retrieved or used strategically?	Relate the pattern to the demands that trigger the referral.
Difficulty after a rule change	Can the child notice feedback and alter the response plan?	Do not confuse a single error with a stable inability.

For executive function, the informative observation often lies in the route to the answer. Does the child start before hearing the full instruction? Persist with a rule after it has changed? Need repeated external structure? Recognise an error but fail to repair it? Give up when the first strategy fails? Such observations are not decorative additions to a score sheet. They are the bridge from task performance to a clinical formulation of self-regulation.

- Record the child's understanding of the task and the kind of cueing required.
- Note whether errors are impulsive, perseverative, disorganised, slow or inconsistent.
- Ask what changed when the task became longer, less familiar or less structured.
- Connect the pattern only to the functional difficulty that prompted referral.

TRAP **Do not call every low executive-function result an attention disorder.** Executive control is influenced by comprehension, pace, motivation, emotional state, sensory or motor demands and the testing relationship. The task result narrows hypotheses; it does not settle them.

17.4 Administration as clinical observation

Standardised procedures matter because the meaning of comparison depends on administering a task as intended. Yet standardisation should not make the examiner passive. Behaviour during testing can qualify the result: delayed engagement, repeated checking, avoidance of uncertainty, overrapid responding, perfectionistic slowing, loss of the rule, or a response to praise and correction may each help explain a pattern. Record these observations clearly enough that another clinician can see how the conclusion was reached.

The testing relationship requires care. Children may interpret an unfamiliar task as an examination they can fail, or may protect themselves by refusing, joking, rushing or insisting that the activity is boring. The clinician should present the work in developmentally understandable language, preserve dignity when a task is difficult, and avoid turning a struggle into a contest.

This is not merely kindness. A threatened or disengaged child may be showing the examiner the consequences of the assessment context rather than the cognitive process that prompted referral.

GOOD TO REMEMBER

A useful report separates what was measured from what was observed and from what is inferred. "Performance was slow," "the child required repeated restatement of the rule," and "this may contribute to difficulty with multi-step work" are different kinds of statement. Keeping them separate makes the report more honest and more useful to the treating team.

17.5 From test pattern to treatment planning

The report should answer the referral question in practical language. A cognitive profile may guide the choice of environmental supports, the form in which instructions are given, the level of task structure, the need to reduce competing demands, or the way feedback is delivered. It can also clarify what should be monitored after an intervention begins. The report is strongest when its recommendations follow from the observed mechanism, rather than from a generic list of school accommodations.

Recommendations should be framed as testable supports. If difficulty appears when a child must hold several steps in mind, a support might make the sequence visible and check each step before the next begins. If performance deteriorates when a familiar rule changes, the support might make transitions explicit and allow guided practice with the new rule. The clinical team can then ask whether the proposed change improves participation and functioning. That feedback is more valuable than merely repeating a test score in later notes.

Assessment must remain integrated with the broader child psychiatric history and examination. A neuropsychological profile neither replaces the account of symptoms and relationships nor determines treatment in isolation. It provides a structured account of how the child approached cognitive demands, which can sharpen communication between psychiatrist, psychologist, family and school.

PITFALL

A polished numerical report can create false certainty when it is detached from the referral question. Avoid reproducing proprietary items, importing cut-offs from another setting, or presenting a score as if it explains behaviour without corroboration. The clinical task is interpretation, not score display.

17.6 Limits and communication of findings

Neuropsychological assessment samples performance under particular conditions. It cannot directly observe every demand in a classroom, home or peer setting, and it cannot decide whether a difficulty is fixed, situational or remediable without clinical follow-up. A finding may be limited by language fit, educational opportunity, fatigue, physical discomfort, anxiety, engagement or a child's understanding of why the assessment is occurring. These are not reasons to abandon assessment. They are reasons to state limits openly.

When explaining findings to caregivers, avoid converting cognitive language into a verdict on intelligence, character or future potential. Describe a pattern, the situations in which it matters, the strengths on which intervention can build, and the supports that will be tried. Families should leave with a clearer working model of the child's needs, not with a new stigmatising identity. The same discipline protects schools from treating a report as a reason to lower expectations indiscriminately.

- State the clinical question that made assessment necessary.
- Describe relevant observations during the work, including factors that limit confidence.
- Present the pattern before offering an inference about its functional significance.
- Make recommendations concrete enough to be tried and reviewed.

Neuropsychological assessment is most useful when it explains a functional difficulty through a coherent cognitive profile and turns that explanation into supports that can be tested in the child's real environment.

Therapeutic interventions

18 · Play therapy (principles, techniques, indications)

Play therapy is purposeful clinical work, not supervised recreation. It gives the child a mode of participation that does not depend on an adult-style verbal account. The clinician uses play to build a therapeutic relationship, understand the child's experience as it is communicated in action and imagination, and make psychological work possible without forcing premature explanation. The point is neither to entertain the child nor to extract a hidden meaning from every toy. It is to create a reliable interpersonal setting in which experience can be expressed, held, and worked with.

In the definition adopted by the Association for Play Therapy, **play therapy** is a systematic use of a **theoretical model** within an interpersonal process. Its distinctive resource is the **therapeutic powers of play**: play is used deliberately to help with psychosocial difficulties and to support development. This gives the method its clinical discipline. Materials, language, boundaries, interpretation and the therapist's participation all derive their meaning from the formulation and therapeutic approach, not from the presence of a toy box alone.

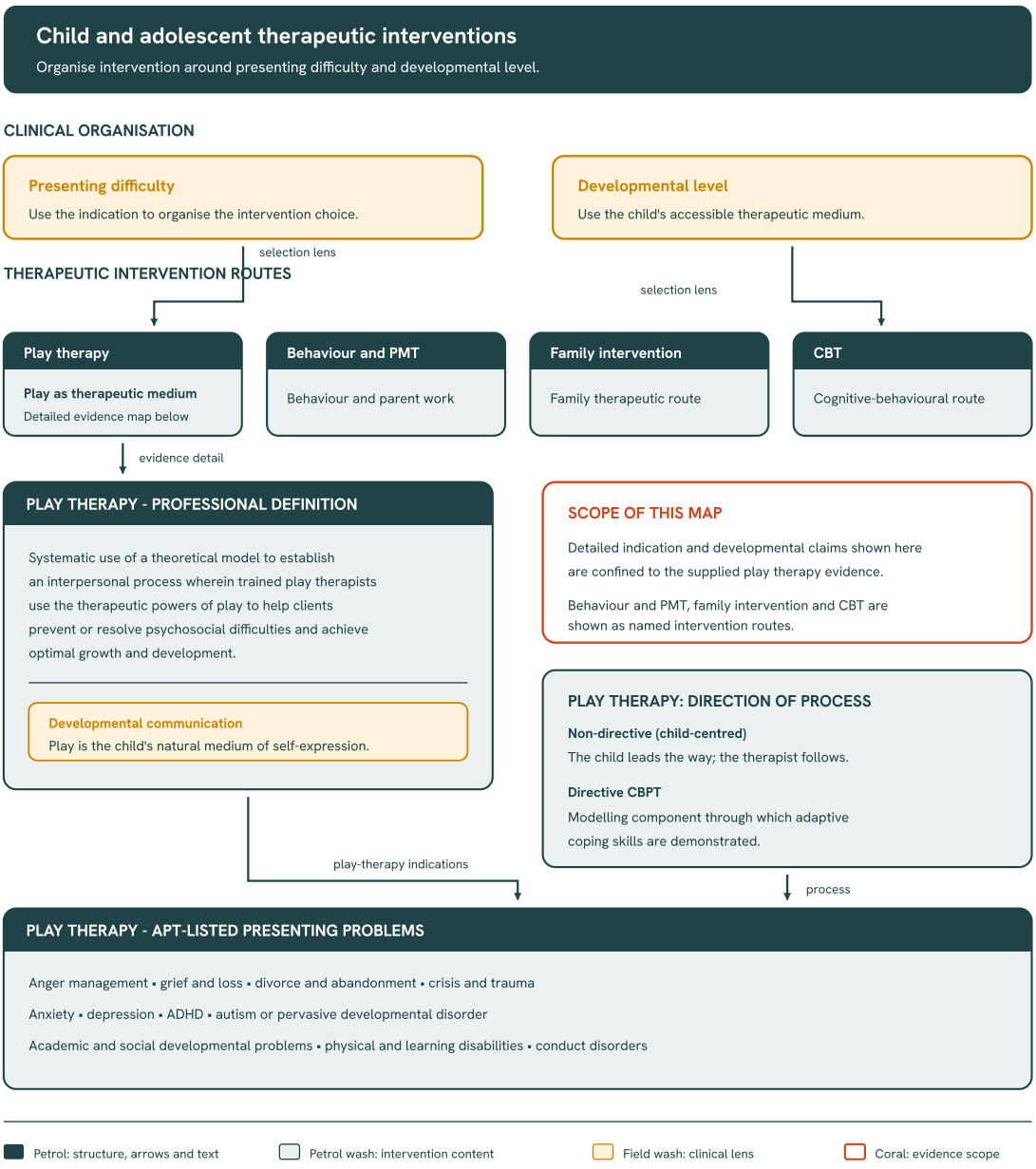


Fig 24.10. Therapeutic-intervention map for child and adolescent practice, organised around presenting difficulty and developmental level. The detailed route shows play therapy as a communicative medium, its directive and non-directive processes, and APT-listed presenting problems; behaviour and PMT, family intervention, and CBT remain named intervention routes.

18.1 Why play can become a therapeutic medium

In child work, experience can be known before it can be narrated. Worry may appear in a rescue scene, anger in a struggle over rules, or loss through disappearance and reunion. These are not codes to translate mechanically. Play creates enough distance for painful material to be approached while its emotional meaning remains alive in the room.

Axline's foundational proposition is that play is the **child's natural medium of self-expression**. The word "natural" should not be romanticised. It does not mean that every child will play freely, that every play theme is psychologically revealing, or that speech has no place in treatment. It

means that imaginative action, choice of role, repetition, construction, destruction, story and rule-making can give a child access to communication that may be less available in a direct adult interview. The therapist attends to the child's use of the medium, not merely to the objects selected.

Play also changes the balance of power in the clinical encounter. The adult remains responsible for safety, frame and professional purpose, but the child can initiate an action, alter a story, refuse a role, test a boundary or invite the therapist into a scene. This makes agency visible. Therapeutic work can then address not only the content of distress but also the child's manner of seeking closeness, managing frustration, using control, tolerating uncertainty and accepting help. What matters is the interaction that develops, not a performance judged as good or bad play.

RULE **Use play as a therapeutic language, never as a decorative substitute for therapy.** A play activity becomes treatment only when it is held in a purposeful relationship, guided by a coherent approach, and connected to the child's therapeutic needs.

18.2 The therapeutic frame

A therapeutic frame protects both spontaneity and safety. The child needs to know that the room is a place where choices can be made, feelings can be shown and difficult themes can be approached without ridicule. Equally, the child needs to discover that the therapist will not become chaotic, intrusive, frightened, punitive or collusive. The frame is therefore communicated as much through the therapist's steadiness as through spoken explanation.

Materials should permit expressive and relational uses rather than demand a correct outcome. They are offered as possibilities, not tests. The clinical question is not whether the child uses them as expected, but how choice, avoidance, repetition, pleasure, aggression, repair and participation appear in the shared space. The child must not be made to feel assessed for creativity, neatness or disclosure.

Boundaries are part of treatment rather than an interruption of it. A clear limit can show that powerful feeling is permissible while harmful action is not. The therapist names the limit calmly, offers a permitted alternative where possible, and remains available to the child's reaction. This can be therapeutically important for a child who expects either unrestricted escalation or punitive rejection. The limit must be real, however. A therapist who permits unsafe conduct in order to preserve rapport teaches that the clinical relationship cannot contain affect.

- Keep the purpose of the meeting clear without demanding a problem narrative at the outset.
- Offer choice, while retaining responsibility for the physical and emotional safety of the setting.
- Respond to feeling and relationship, not only to the visible product of play.

IN INDIA

An Indian play setting should not assume that a particular household, language, family role or cultural story is universal. Invite materials and examples that allow the child's own social world to enter the work. Ask caregivers about the child's ordinary play and preferred language, but avoid turning the family into interpreters of every symbol. Culturally responsive practice means staying curious about meaning while preserving the child's own voice.

18.3 Non-directive or child-centred practice

Child-centred play therapy places special weight on the child's initiative. The therapist aims to be accepting, emotionally available and closely attentive, while resisting the impulse to improve the story, educate the child, solve the conflict or make play conform to adult expectations. This stance is demanding because it requires the therapist to be active in attention and containment while not taking possession of the child's experience.

Axline's **sixth** principle, within her **eight** foundational principles, captures the working position: the child leads and the therapist follows. Following is not passivity. The therapist tracks what is happening, reflects feeling and action in language the child can use, notices shifts in relationship, and maintains boundaries. What the therapist does not do is turn every moment into a question, lesson, interpretation or correction. The child is allowed to discover that an adult can be present without taking over.

Reflection is often more useful than explanation in this approach. A brief response can acknowledge experience, make a sequence more thinkable, and leave ownership with the child. The therapist may reflect determination, disappointment, fear, pleasure or uncertainty without asserting why it exists. Interpretation is used with restraint because premature certainty can replace the child's unfolding meaning with the therapist's story.

Non-directive work should not be confused with lack of clinical responsibility. The therapist still decides whether this approach fits the child's needs, attends to risk and impairment, coordinates with the wider treatment plan, and recognises when the child requires a more structured intervention. It is a way of organising the relationship, not a refusal to formulate. The goal is to make room for the child's agency while providing enough security for emotional work to proceed.

MNEMONIC

PLAY

Provide a safe frame, **L**et the child lead, **A**ttend to affect and action, and **Y**ield neither safety nor therapeutic purpose. The mnemonic describes a stance, not a script to impose on every child.

18.4 Directive play and cognitive-behavioural play therapy

Directive approaches use play to introduce, practise or rehearse a therapeutic task. The therapist may select an activity, invite role-play around a difficult interaction, or guide attention toward coping. The child remains active, but the therapist contributes more structure than in child-centred work.

Cognitive-behavioural play therapy is an example of a directive approach. Its use of **modelling** allows adaptive coping skills to be demonstrated within play. A figure, puppet, story or therapist enactment can make a coping response concrete before the child is asked to attempt it. The strength of this method is that it converts an abstract instruction into an observable sequence. The limitation is that the therapist can too easily become the author of the child's play, thereby losing the child's own language and priorities.

Directive does not mean coercive. The therapist explains the invitation in developmentally understandable language, watches whether the activity is becoming too exposing or performance-based, and changes course if the child cannot engage. The activity should serve the formulation, not prove that a manual has been followed. A child who resists a structured task may be communicating avoidance, confusion, fear of failure, a mismatch of pace, or a need for a different mode of contact. The clinical response is to understand the obstacle, not simply to increase pressure.

CLINICAL QUESTION	CHILD-CENTRED EMPHASIS	DIRECTIVE EMPHASIS
Who initiates the activity?	The child's choice and unfolding play organise the encounter.	The therapist may introduce an activity linked to a therapeutic task.
Therapist's main contribution	Presence, reflection, containment and careful following.	Guidance, rehearsal and focused use of an activity.
How is change approached?	Through expression, relationship and the child's experience of agency.	Through structured experience, practice and demonstrable coping.
Principal risk if poorly used	Confusing permissiveness with a secure therapeutic frame.	Turning the activity into adult-led instruction rather than therapeutic play.

The two positions are best understood as different therapeutic emphases, not as a contest between free play and technique. A clinician chooses and adjusts the degree of structure in relation to the child, the therapeutic task and the developing alliance. The broader principles and disorder-specific applications of cognitive behaviour therapy are addressed in the cognitive behaviour therapy and adaptations for children and adolescents section of this chapter.

TRAP **Do not call every play-based encounter "non-directive".** If the therapist selects the task, teaches a response, arranges rehearsal or steers toward a stated therapeutic target, the work is directive. The distinction matters because it clarifies what the therapist is doing and why.

18.5 Core techniques in the room

Techniques are ways of using relationship and medium, not separate treatments to apply without formulation. Tracking puts into simple language what the child is doing, offering attention without intrusion. Reflecting feeling makes emotional tone available for thought without demanding explanation. Restating a plot can help a child recognise continuity in an

overwhelming story. Silence can communicate that the child need not fill the space to keep the therapist engaged.

Role-play permits a difficult situation to be approached from more than one position. The child may assign the therapist a role, reverse roles, make a powerful character vulnerable, or try out a different ending. The therapist should accept the invitation but avoid making the scene a vehicle for adult advice. Questions can expand possibilities; a moral lecture collapses the play into compliance.

Story-making, drawing and construction can assist communication when direct speech feels too exposed. The process reveals how a child begins, persists, abandons, repairs, seeks help, tolerates mistakes and responds to attention. The clinician can use this to guide therapeutic contact, but should not claim a fixed symbolic meaning for a colour, animal, weapon, house or family arrangement. Symbolic material remains contextual and open to more than one reading.

- Use reflection to make action and affect more available for the child to notice.
- Use role-play and narrative to explore possibilities without forcing disclosure or a preferred ending.
- Use limits and repair to show that strong affect can be contained within a continuing relationship.

Work with caregivers is often necessary around the edges of play therapy. Caregivers need a plain explanation of the therapeutic purpose, a way to share relevant changes in the child's life, and guidance about how the clinical relationship will be protected. They should not be asked to interrogate the child after each meeting or demand a report of play content. At the same time, the therapist should not create secrecy that excludes caregivers from essential treatment planning. The balance is to share what is clinically necessary while respecting the child's emerging sense that the therapeutic space can be trustworthy.

GOOD TO REMEMBER

When a child offers a dramatic play scene, begin by joining the child's level of meaning: notice what happens, acknowledge the feeling if it is evident, and ask whether the child wishes to say more. An interpretation can wait. Once the therapist has imposed a story, it is difficult to know whether later material belongs to the child or to the suggestion.

18.6 Formulation, selection and indications

Play therapy is selected because play is likely to be a useful route into therapeutic work, not because the child is young or because verbal treatment feels difficult for the clinician. The formulation should ask what difficulty is being addressed, how the child currently communicates distress, what kind of therapeutic relationship is possible, and whether an expressive, relational or structured play approach fits the task. It should also identify when another intervention needs to carry the main burden of treatment, with play therapy contributing a supportive role.

The Association for Play Therapy describes use across a broad range of **indications**. These include anger management, grief and loss, divorce and abandonment, and crisis or trauma. It also includes anxiety and depression, ADHD and autism or pervasive developmental disorder, academic and social developmental problems, physical and learning disabilities, and conduct disorders. These are indications for considering play therapy as a primary or supportive intervention, not diagnostic labels made by observing play.

The list is not an automatic referral rule. A child with loss may need a relationship in which remembering and reunion can be approached symbolically. A child with anxiety may externalise a feared situation or try coping. A child with disruptive behaviour may need intervention directed at daily contingencies and caregiver responses, even if play work also helps communication. Formulation, family context and engagement determine the treatment choice.

When the concern is ADHD, its treatment is addressed in the ADHD and specific learning/communication disorders notes. When the concern is a childhood behavioural or emotional disorder, its diagnostic and disorder-specific treatment is addressed in the Child behavioural, emotional and other disorders notes. Intellectual disability and autism spectrum disorder require the broader developmental formulation set out in the Intellectual disability and autism spectrum disorder notes. These cross-references protect against using play therapy as a substitute for comprehensive assessment or disorder-specific care.

PITFALL

Do not send a child to play therapy because “the child will not talk,” without first asking what makes talking difficult and what treatment task is being proposed. Silence can reflect fear, language mismatch, developmental differences, family pressure, a distressed therapeutic alliance or simple unfamiliarity with the setting. A referral without formulation burdens both child and therapist with an unclear goal.

18.7 Limits, coordination and review

Play therapy should be reviewed as therapy, not protected from evaluation because it feels child-friendly. The clinician and therapist need a shared account of the difficulty, intended direction of change, engagement and relation to other care. Lack of progress is information: it may signal a mismatch of approach, an unaddressed contextual problem, insufficient coordination or a need to revise the formulation.

Coordination must preserve role clarity. Behaviour therapy and parent management training focus on daily contingencies; family interventions address relationship patterns; and educational, remedial, early-intervention and stimulation work address other defined needs. Play therapy may coexist with each, but its unique contribution is a therapeutic use of play within an individual relationship. Describing all child interventions as “play therapy” blurs treatment goals and makes review impossible.

There are circumstances in which the clinician must move beyond ordinary therapeutic exploration. If play raises concern about immediate harm, coercion or abuse, safety takes

precedence over completing a narrative or interpreting symbolism. The clinician should use the relevant protection pathway and avoid suggestive questioning. Detailed child-protection assessment, reporting duties and management are dealt with elsewhere in this chapter. Play therapy can support recovery, but it should not be misused as a forensic method or as a means of testing an allegation.

PLAY	RELATIONSHIP	STRUCTURE	FORMULATION
A MEDIUM FOR EXPRESSION	THE THERAPEUTIC VEHICLE	VARIES BY APPROACH	GUIDES SELECTION AND REVIEW

Play therapy is a formulated therapeutic relationship in which play helps the child express, explore and work through difficulty; the therapist follows or directs the medium only as the clinical task requires.

19 · Behaviour therapy and parent management training in children

Why it matters clinically. Behaviour therapy and parent management training translate a formulation into small, observable changes in the child's daily environment. They are not shorthand for blaming a caregiver, asking a parent to be stricter, or rewarding compliance indiscriminately. Their clinical purpose is to alter the interactional conditions that keep a problem going, while preserving the child's dignity and the caregiver's capacity to remain connected.

The marks in this area usually come from showing that the psychiatrist can move from a complaint to a workable behavioural formulation. The candidate should be able to identify the target behaviour, locate its antecedents and consequences, explain the learning principle in ordinary clinical language, and describe how caregivers will practise a consistent response. The disorders themselves, including their diagnostic thresholds and disorder-specific treatment plans, belong in the Child behavioural, emotional and other disorders notes and the ADHD and specific learning/communication disorders notes.

19.1 Scope and therapeutic stance

Behaviour therapy is a structured psychological approach that uses an agreed description of behaviour and its context to guide change. In child work, the environment is usually shared with caregivers, siblings, teachers and peers. This makes the intervention relational without turning it into family therapy: the immediate task is to change the contingencies surrounding a carefully chosen behaviour, rather than to interpret the whole family system. Family therapy and broader family interventions are considered separately in this chapter.

Parent management training places caregivers at the centre of intervention because they are the people most able to make daily routines predictable and to notice small improvements. The clinician is neither a distant expert issuing instructions nor an adjudicator deciding who is at fault. The stance is collaborative: hear what the family has already tried, acknowledge exhaustion and practical constraints, then build a plan that can be carried out in the actual home rather than in an idealised household.

A good formulation distinguishes a child's intention from the function of behaviour. A behaviour can communicate distress, obtain access to something desired, avoid an aversive demand, or recruit adult attention. These possibilities are hypotheses to test with observation, not moral labels. The same outward act may have a different function in a different setting. That is why a generic instruction such as "be consistent" is weaker than a shared, concrete plan for a particular routine.

RULE **Change the interaction around a behaviour before judging the child's character.** The useful clinical question is what happens immediately before and after the target behaviour, and what each person learns from that sequence. This directs intervention toward modifiable events and protects the alliance.

19.2 Building a behavioural formulation

The starting point is an operational description. "Does not listen" is too broad to guide treatment; it blends a caregiver's understandable frustration with several possible behaviours. The team instead agrees on what an observer would see or hear, the situations in which it occurs, and the response that will count as improvement. This language makes it possible for caregivers to notice progress and for the clinician to revise an ineffective plan without personal criticism.

Antecedents are the immediate contexts in which the behaviour is more likely to occur: transitions, demands, delay, fatigue, competition for attention, ambiguity, or an escalating adult tone. They are not excuses for harmful behaviour. They are leverage points. A plan may simplify a routine, prepare a child for a transition, offer a limited choice, or ensure that an instruction is clear enough to be followed. Such changes reduce unnecessary conflict before discipline is needed.

Consequences are what follows the behaviour and therefore shape the likelihood that the sequence will recur. The relevant consequence may be attention, access, escape, relief from a demand, or the ending of an unpleasant exchange. Caregivers often discover that an apparently sensible response is accidentally maintaining the very pattern they want to reduce. This is not a parental failure. It is the clinical finding that makes a more effective response possible.

FORMULATION ELEMENT	QUESTION FOR THE CLINICAL INTERVIEW	HOW IT INFORMS THE PLAN
Target behaviour	What would an observer describe?	Creates a shared and measurable treatment target.
Setting event	What makes the routine harder on some occasions?	Identifies preventable pressures and reasonable adjustments.
Antecedent	What happens immediately before the behaviour?	Guides preparation, clarity and environmental change.
Behaviour	What does the child actually do?	Keeps the plan observable rather than judgmental.
Consequence	What changes immediately afterwards for child and adult?	Shows what needs reinforcement, withholding or replacement.
Alternative	What safer or more workable response can be taught?	Prevents treatment becoming punishment alone.

Observation may be informal but should be purposeful. Invite caregivers to recount a recent episode in sequence, including their own words, tone and actions. Ask what happened when the child complied, not only when conflict occurred. Where a setting outside the home is important, the clinician can seek a parallel account from the adults there, while avoiding a hunt for a single "correct" informant. The formulation becomes useful when it identifies a pattern that the family themselves recognises and can modify.

Target	Context	Response	Practice
OBSERVABLE BEHAVIOUR	WHAT COMES BEFORE	WHAT FOLLOWS	NEW SHARED ROUTINE

19.3 The coercive interactional cycle

Parent-child coercive cycle is a useful description of escalating exchanges in which both people seek short-term relief. A caregiver makes a demand or attempts a limit. The child protests or escalates. The adult, faced with mounting distress, may withdraw the demand or change course. The episode ends, but the sequence has taught both participants something about how conflict can be ended. This pattern can compromise the caregiver's sense of efficacy and make the next limit harder to hold.

The central learning mechanism is not that either party wishes to create conflict. It is that disengagement in the face of escalation can be **negatively reinforcing** for the child's misbehaviour: the aversive demand disappears, so escalation becomes more likely to be used again. The adult may also experience relief when the immediate conflict stops. That reciprocal relief explains why insight alone rarely changes the pattern. A different response has to be rehearsed before the next pressured moment.

The treatment aim is not stubborn endurance. It is planned, calm and proportionate follow-through, coupled with frequent attention to the behaviour the caregiver wants to see more often. When the proposed demand is unrealistic, the correct intervention may be to alter the demand.

When the boundary is necessary, the caregiver needs a brief response that does not accidentally turn escalation into negotiation. The psychiatrist helps the family discriminate these situations, because rigid application of a technique can intensify distress or rupture trust.

GOOD TO REMEMBER

When a caregiver says, "Nothing works," first ask what happens immediately after the child escalates. That question often reveals both the family's strain and the point at which a new response can be practised.

TRAP **Do not equate behaviour therapy with a harsher punishment plan.** A plan that focuses only on stopping undesirable behaviour often misses antecedents, fails to teach an alternative, and gives too little attention to cooperation. The clinical skill is contingency management with warmth, clarity and repair.

19.4 Core components of parent management training

Parent management training converts the formulation into skills that can be used under ordinary domestic pressure. The clinician selects a small set of targets, demonstrates the skill, invites rehearsal, anticipates obstacles and reviews what happened. The sequence matters. Information without rehearsal is easily understood in the consulting room and lost in a difficult bedtime or school-morning routine.

- Specify the behaviour to increase or decrease in plain, observable terms.
- Arrange the setting so that cooperation is possible before giving a demand.
- Use brief, calm and unambiguous instructions, with a realistic opportunity to comply.
- Notice and respond promptly to desired behaviour, including small approximations to the target.
- Choose a predictable response to the target problem behaviour that does not inadvertently reward it.
- Review the outcome without shaming the child or caregiver, then adjust the plan.

Reinforcement is often misunderstood as bribery. Clinically, it means arranging consequences so that adaptive behaviour becomes more likely to recur. It works best when the behaviour is clearly identified, the response is linked closely to it, and the caregiver's attention is credible rather than mechanical. Genuine descriptive praise can be especially useful because it tells the child what was done well and strengthens the relationship at the same time.

Responses to problem behaviour must be selected from the formulation, not applied as ritual. A response that reduces attention may be appropriate only when attention is maintaining the behaviour and when safety is secure. Removal of a privilege may be meaningful only if it is realistic, proportionate and not silently reversed during conflict. The child also needs an alternative route to attention, choice, help or escape from an overwhelming demand. Otherwise the plan removes a behaviour without creating a workable replacement.

MNEMONIC

Notice - Name - Nurture - Navigate

Notice the sequence, **name** the target behaviour, **nurture** the behaviour worth repeating, and **navigate** predictable conflict without abandoning the plan or the relationship.

19.5 Delivery, participation and review

For conduct-related presentations, NICE recommends offering a group parent-training programme to the parents of children aged between **3 and 11 years** when there is identified risk or established oppositional, conduct or antisocial difficulty. This is an indication for a structured parent intervention, not a substitute for a full clinical formulation. Comorbidity, developmental profile, safety concerns, caregiver mental health, substance use, domestic stress and the child's wider supports all affect whether a group format can be used as planned.

The programme model specified by NICE is a **social learning model**, using modelling, rehearsal and feedback. A typical programme has **10 to 16 meetings**, each lasting **90 to 120 minutes**. These features are worth remembering because they distinguish a genuine skills programme from general advice. They also explain why participation needs active support: caregivers have to observe a skill, try it, report the outcome and receive constructive feedback.

Group work offers normalisation and opportunities to learn from other caregivers, but it should not make a family invisible. The facilitator must be alert to caregivers who feel exposed, who cannot safely practise a recommended response, or whose literacy, language, work pattern or travel make participation difficult. A flexible clinical service may use individual contact, a different delivery format, or coordination with other supports, while retaining the same behavioural logic. Practical adaptation is not dilution when it preserves the treatment mechanism.

IN INDIA

Parent work is most useful when the plan is fitted to the household that exists: who actually cares for the child, which language carries authority and affection, how school expectations enter the routine, and what material pressures limit follow-through. Avoid importing a scripted programme unchanged. Adapt examples and homework collaboratively, while keeping the target behaviour and response plan clear.

Review is a clinical intervention, not merely an attendance check. Ask what was attempted, what the child did, what the adult did next, and what made success easier or harder. Look for improvement in the interaction before expecting every target behaviour to vanish. If a plan has not worked, return to the formulation: the target may be too broad, the antecedent may have been missed, the chosen consequence may not matter to the child, or caregivers may need more rehearsal and support.

PITFALL

Do not interpret non-completion as lack of motivation. A caregiver may be unable to attend or practise because of shift work, transport, crowded living conditions, competing care responsibilities or fear of criticism. Explore the barrier directly, then decide whether the intervention needs adaptation or additional support.

19.6 Boundaries, integration and referral thinking

Behavioural work is strongest when it is embedded in a broader child psychiatric plan rather than presented as a universal answer. The clinician should consider whether pain, sleep disruption, communication difficulty, learning problems, trauma, mood symptoms, neurodevelopmental differences, medication effects or environmental adversity are changing the child's capacity to respond. Naming these possibilities does not mean re-teaching their assessment or treatment here; it means refusing a simplistic formulation when the behavioural pattern is a signal of something else.

Behaviour therapy may be coordinated with school support, individual psychological work or other family interventions, but each contributor should know the target and avoid giving contradictory advice. Where the child's safety is at risk, where there is abuse or coercion within the caregiving environment, or where a caregiver cannot safely implement a plan, the priority changes from routine behaviour management to protection and appropriate multidisciplinary action. The clinical safeguarding response is addressed elsewhere in this chapter.

For children with intellectual disability or autism spectrum disorder, behavioural principles may still inform daily supports, but diagnostic formulation and the wider developmental intervention belong to the Intellectual disability and autism spectrum disorder notes. For attention-related presentations, disorder-specific assessment and medication decisions belong to the ADHD and specific learning/communication disorders notes. The value of parent management training here is its disciplined focus on observable interaction, not an attempt to make one method cover every need.

Formulate the sequence, strengthen the behaviour you want repeated, and help caregivers respond predictably enough that escalation no longer becomes the easiest route out of conflict.

20 · Family therapy and family interventions in child psychiatry

Why it matters clinically. A child's difficulty is lived in relationships long before it is described in a consultation. Family work therefore asks not only what is troubling the child, but what happens around the difficulty: who notices it, who responds, who is drawn into an argument, who withdraws, and what relief follows. This is not a search for a culpable relative. It is a way of understanding how a family's ordinary attempts to cope may inadvertently keep a problem active, and how the same family can become the chief resource for change.

For the psychiatrist, **family intervention** is both a treatment and a clinical stance. It makes room for the child's developmental dependence, the authority and burden carried by caregivers, and the practical realities that shape whether any plan can be carried home. It is especially useful when a child's difficulty has become organised around conflict, avoidance, inconsistent responses, divided caregiving, or a narrowing of the child's role within the household. The task is to restore useful relationships and workable caregiving, while preserving the child as a person rather than reducing the child to the family's symptom.

SYSTEM	PATTERN	CHANGE
RELATIONSHIPS MATTER	MAP WHAT REPEATS	PRACTISE IT IN SESSION

20.1 Scope and therapeutic stance

Family therapy is not a single technique applied whenever relatives are present. It is a way of working in which the unit of attention shifts between the child, the caregiver, the relationship, and the wider household context. The psychiatrist needs a clear reason for making that shift. A consultation may require brief work to align caregivers around a plan, sustained work on interactional patterns, or careful liaison when a child cannot safely be asked to carry a family conflict. The intensity and format should follow the formulation, not the therapist's preferred school.

A useful **family formulation** links the presenting difficulty to reciprocal responses. It asks what tends to precede an episode, how each person understands it, what each person does next, and what consequence makes that response likely to recur. Such a formulation remains provisional. It must accommodate developmental level, communication ability, physical illness, learning needs, stress, separation, and the child's own account. A relational account that ignores the child's individual experience is as incomplete as an individual account that ignores the household in which care is delivered.

Neutrality is often misunderstood as emotional distance or as pretending that every action has the same effect. In practice it means respectful curiosity toward each participant's position. The clinician can acknowledge a caregiver's exhaustion, a child's fear, and another family member's wish to help without endorsing harmful conduct or making the child responsible for adult distress. This stance reduces defensiveness and permits difficult material to be discussed. It also protects against the familiar error of treating the most articulate adult as the sole narrator of family life.

RULE **Formulate a pattern, not a culprit.** The clinical question is how responses connect and persist, while keeping the child's safety, experience, and developmental needs in view.

20.2 Mapping the family pattern

The opening phase is active clinical enquiry, not a social history recited for formality. Ask who is involved in daily care, who makes decisions, where authority sits, how transitions are managed, and how conflict is repaired. Notice alliances, exclusions, abrupt changes of topic, and whether the child is expected to speak only through an adult. Ask each person for a concrete account of a

recent difficult interaction. General descriptions such as “he never listens” or “she is always stubborn” often conceal an interactional sequence that becomes visible only when reconstructed in detail.

A **transactional sequence** is clinically more useful than a global label. The clinician follows the exchange from the first cue through each response to the eventual outcome. Attention to sequence reveals points where a different response could interrupt escalation. It also shows the function of behaviour in context without declaring that the child is deliberately manipulating the family. The purpose is explanatory precision, not moral judgement.

The interview should include the child in a manner that is comprehensible and emotionally safe. Direct questions can be paired with observation of how adults respond when the child speaks. The clinician may ask caregivers to describe what they believe the child is trying to communicate, then invite the child to correct or add to that account. This both gathers information and begins to alter an entrenched pattern in which the child is spoken about but not heard. Equally, a child should not be recruited to reveal private adult material or to decide between caregivers.

- Identify the concern in the family’s own language before translating it into clinical terms.
- Trace a recent interaction from trigger to consequence, rather than relying only on trait descriptions.
- Attend to participation: who speaks, who answers for whom, and whose view is absent.
- Clarify strengths, routines, and moments when the difficulty is less dominant.

> **GOOD TO REMEMBER**
>
> When a caregiver asks for the clinician to “fix the child,” hear the request for relief but widen the task gently. A useful response is to make the child’s distress important while inviting the adults to examine what they can change around it.

20.3 Structural thinking: subsystems and boundaries

Family subsystems allow a family system to differentiate and carry out its functions. In clinical work, this directs attention to the organisation of participation and responsibility rather than to personalities alone. A caregiver relationship may need room to coordinate care; children may need space for age-appropriate relationships; and the child should not be placed in an adult role simply because the family is under strain. The psychiatrist assesses these arrangements by observing interactions and by asking how decisions are actually made, not merely how the family says they ought to be made.

Boundaries are the rules within a subsystem that determine who takes part in a situation, when participation occurs, and how it occurs. They are best understood as functional patterns, not as fixed virtues. A boundary may be too permeable for a particular task, leaving a child exposed to adult conflict, or too rigid, preventing support from reaching someone who needs it. The clinical aim is not to impose an ideal household design. It is to help the family create enough clarity, protection, and flexibility for caregiving and development.

Structural observations are hypotheses to test collaboratively. If a caregiver repeatedly answers a child's questions, the clinician should not immediately infer domination. The behaviour may reflect anxiety, habit, language difficulty, fear of being misunderstood, or a response to earlier crises. The therapeutic conversation tests meaning and effect: what happens when the child is given room to answer; what makes that difficult; and what support would make a small change possible. This protects structural work from becoming a set of labels applied to families.

TRAP **Do not turn structural language into a verdict on a family.** Terms such as boundaries and subsystems organise observation; they do not excuse a clinician from hearing context, checking hypotheses, and treating each family member with respect.

20.4 Conduct of the therapeutic meeting

The meeting is both an assessment setting and a place where change can be rehearsed. The therapist establishes a clear frame: the purpose of the conversation, how each person will be invited to contribute, and what will happen if discussion becomes overwhelming. The clinician's authority is used to slow accusation, protect the child from being made a messenger, and make room for quieter participants. This is not passive chairing. It is deliberate management of the interaction so that the family can experience an alternative to its usual sequence.

Enactment means inviting family members to address a relevant issue with each other in the session rather than only reporting it to the clinician. It provides direct information about pace, tone, interruption, authority, and repair. It also lets the therapist coach a small, observable change while the interaction is live. The invitation must be graded to tolerance. Pushing a family into emotionally charged material without preparation can produce compliance in the room and collapse outside it. A modest exchange that can be repeated safely is more therapeutic than a dramatic confrontation.

Reframing changes the meaning attached to behaviour without denying its impact. A caregiver's repeated checking might be recast as an attempt to protect that has become constricting; a child's withdrawal might be understood as a signal of overload rather than simple defiance. A good reframe reduces blame and opens alternatives. It is not a clever explanation imposed by the therapist. If the family does not recognise itself in the reframe, the clinician should revise it rather than defend it.

Tasks between meetings should be concrete, proportionate, and linked to the observed pattern. They are experiments, not tests of obedience. The next meeting examines what happened, what made change easier or harder, and what the result teaches the family about its pattern. When a task has not been attempted, the response should be curiosity rather than rebuke. Non-completion may reveal that the task was unrealistic, that the family's formulation differs from the therapist's, or that an unspoken barrier requires attention.

MNEMONIC

MAP the meeting

Make room for each voice, **A**ttend to the live interaction, and **P**ractise a manageable alternative. It is a practical spine for keeping the session relational rather than turning it into parallel individual interviews.

20.5 Strategic and problem-focused work

A strategic family approach is **present problem-focused**, **directive**, and **practical**. Its clinical appeal in child psychiatry is that it keeps attention on the current interactional pattern that accompanies the referral concern and asks for observable changes. Direction is not synonymous with coercion. The therapist remains accountable for explaining the purpose of an intervention, inviting concerns, and adapting the plan to the family's capacity and safety.

Problem-focused work is most useful when the family can identify a specific interaction they want to change. The clinician clarifies the shared aim, identifies the sequence that blocks it, and collaborates on an alternative response. Progress is judged by whether the family can use a more helpful pattern in ordinary circumstances, not by whether they can reproduce the therapist's language. The approach should not flatten complex grief, trauma, coercion, or severe adversity into a simple communication problem. Where these are present, pace, protection, and appropriate parallel care take priority.

The psychiatrist should distinguish a directive that changes an interaction from advice that merely sounds firm. Vague instruction can leave caregivers feeling blamed for failing to implement an undefined plan. Conversely, overly prescriptive advice may disregard the realities of work, housing, illness, and extended-family influence. Good direction is specific enough to try, flexible enough to revise, and anchored in the family's own stated goal.

20.6 Integrating family intervention with child care

Family work should sit within a coherent treatment plan, not compete with it. The psychiatrist makes explicit what family sessions are intended to change and what they are not intended to replace. Individual psychological work, behavioural intervention, educational support, medication decisions, and safeguarding processes each have their own indications and limits. They can be coordinated around a shared formulation without being collapsed into a single intervention. The childhood disorders themselves are addressed in the Child behavioural, emotional and other disorders notes; intellectual disability and autism spectrum disorder are addressed in the Intellectual disability and autism spectrum disorder notes.

Coordination requires careful communication. Caregivers need to know why more than one professional may be involved and how information will be shared. The child needs an account that is truthful, developmentally understandable, and respectful of privacy. When parents or caregivers disagree, the clinician should not privately recruit one side into a therapeutic alliance. Instead, name the disagreement, clarify which decisions need a shared plan, and preserve a space

for the child's interests. A family meeting is not automatically appropriate merely because family conflict exists.

CLINICAL QUESTION	FAMILY-THERAPY RESPONSE	WHAT THE PSYCHIATRIST MONITORS
What has become stuck?	Map the recurring interaction.	Whether the account includes every relevant voice.
What role is the child carrying?	Examine participation and responsibility.	Whether adult conflict is being placed on the child.
What can change at home?	Rehearse a manageable alternative.	Whether the task is safe and feasible.
What requires another response?	Coordinate rather than overextend family work.	Whether protection, individual care, or practical support is needed.

Confidentiality needs thought before the first emotionally charged disclosure. The clinician should explain the practical limits of private conversations and avoid making promises that cannot be honoured. Separate conversations may sometimes be clinically necessary, but hidden coalitions can make relational work unsafe or ineffective. Where there are concerns about violence, coercion, abuse, or serious intimidation, the priority is protection and an appropriate safeguarding response, not joint exploration of the relationship.

20.7 Indian clinical practice and service realities

IN INDIA

Family participation is often central to how a child reaches care and whether a plan can be implemented. Use that strength without assuming that every relative should be in the room or that the loudest family member represents the child's interests. Ask explicitly who the child trusts, who provides daily care, and who can support a realistic change between appointments.

In an Indian setting, the family meeting may include people whose authority is practical, emotional, or financial rather than formally parental. This can be valuable when it broadens support, but it may also silence the child or overwhelm a caregiver. The clinician should decide attendance by therapeutic purpose. A meeting to support a caregiver may need a different membership from a meeting intended to reduce a child's exposure to conflict. Cultural humility does not mean accepting hierarchy as an explanation for avoidable distress; nor does it mean importing an individualistic model that ignores interdependence and care.

Language is a clinical tool. Family therapy concepts should be expressed in words that participants can use outside the clinic. Translating a formulation into everyday language helps a family notice the pattern without turning clinical terminology into another source of shame. It is also worth checking that agreement is genuine. Polite assent in a consultation may conceal confusion, fear of contradicting an elder, or an impractical burden placed on one caregiver.

PITFALL

Do not mistake family involvement for family consent to disclose everything. Bringing relatives into care does not remove the need to protect the child's privacy, to ask about safety, or to consider whether a joint meeting could increase pressure on the child.

20.8 Limits, safety, and the examination answer

Family therapy has limits. It is not a neutral container for situations in which a child or caregiver may be harmed by speaking openly. It should not be used to mediate abuse, to obtain a child's disclosure in front of a potentially unsafe person, or to distribute responsibility for adult violence onto the child. In such circumstances, the clinician must shift from relational exploration to protection, follow the relevant service pathway, and use a child-centred clinical response. The statutory and safeguarding framework is addressed in the child-protection sections of this chapter.

A strong written answer begins with the systemic rationale, then shows how the therapist assesses patterns, participation, and boundaries. It explains how an interaction is brought into the room, how a small alternative is practised, and how the work is integrated with the wider plan. It should state plainly that family work is collaborative, non-blaming, and contingent on safety. The answer gains depth when it distinguishes observation from interpretation: seeing a child interrupted is an observation; deciding why it occurs requires enquiry and hypothesis testing.

Family intervention changes the conditions around a child's difficulty by helping the family see, test, and sustain a safer and more workable pattern of care.

21 · Cognitive behaviour therapy and adaptations for children and adolescents

Cognitive behaviour therapy is a way of making change visible, testable and usable. In child psychiatry, it is not a smaller version of adult psychotherapy delivered with simpler words. It is a collaborative, structured intervention in which the clinician helps a young person notice links between situations, meanings, feelings, bodily states and actions, then practise alternatives in ordinary life. Its value lies in converting an overwhelming, global problem into a formulation that can be shared, revised and acted upon.

The examination answer should therefore show more than a list of techniques. It should explain how developmental capacity, language, play, family context and school demands alter the delivery of CBT. The therapist remains active, but does not become a lecturer or an external disciplinarian. The work is designed so that the child or adolescent can increasingly recognise a pattern, generate a manageable alternative and learn from the result. Disorder-specific indications and protocols belong in the relevant disorder chapters; this section concerns the therapeutic method and its developmental adaptation.

21.1 The therapeutic stance and cognitive formulation

Cognitive behaviour therapy begins with the proposition that distress is shaped not only by events but also by the meaning assigned to them and by the response that follows. This is not an

invitation to tell a child that their problem is imaginary or that they ought to think positively. A formulation asks what happened, what the young person noticed, what they made of it, what they felt in mind and body, what they did next, and how that response altered the situation. It preserves the reality of adversity while identifying points at which agency may be restored.

A useful **cognitive formulation** is a working map, not a diagnostic label and not a verdict on the child. It should be expressed in language the child can recognise, checked against concrete examples, and modified when it fails to fit. The therapist listens for recurring predictions, self-statements, rules and interpretations, but also for avoidance, reassurance seeking, withdrawal, impulsive responding and other behaviours that may bring immediate relief while preserving the difficulty. The formulation makes these patterns discussable without making the child feel blamed for them.

Children often communicate the relevant meanings indirectly. A drawing, game, recent disagreement, bodily complaint, or account of a difficult school moment may offer a better route into the formulation than an abstract question about beliefs. Adolescents may tolerate more direct reflection, but apparent verbal sophistication should not be mistaken for emotional readiness. The clinician tests understanding rather than assuming it, and deliberately separates a thought from a fact, a feeling from an instruction, and a feared possibility from a certainty.

RULE **Formulate with the young person rather than explaining the young person to themselves.** A shared map gives techniques a purpose and lets the child correct the therapist's assumptions.

Collaboration also changes the handling of disagreement. If the child rejects the therapist's account, the task is to find the missing context, not to persuade them into compliance. A parent may describe a behaviour as defiance while the child describes it as panic, humiliation or unfairness. Both accounts can be explored, provided the session does not turn into a tribunal. CBT is strongest when it makes competing accounts testable and when its language remains respectful of the child's experience.

A formulation ready for treatment should make clear:

- the situations in which the difficulty is most likely to occur;
- the meanings and responses that appear to keep it going; and
- a change target that the young person can recognise as relevant.

21.2 From formulation to behavioural learning

CBT is maintained by doing, observing and reviewing. Discussion can open a door, but change usually requires action outside the consulting room. The therapist and young person select a task that is understandable, relevant and within reach. The task should test a prediction, practise a coping response, or interrupt a maintaining pattern. Its result is then reviewed with curiosity. A task that did not go as hoped is information for revising the formulation, not evidence that the child has failed treatment.

Behavioural experiments are especially useful because they replace argument with learning. Rather than assure a young person that a feared outcome will not occur, the clinician helps them state the prediction, identify what would count as evidence, and observe the outcome. The exercise must be proportionate and safe. It is not an ordeal arranged to prove bravery, nor is it an adult's test of obedience. The child needs to know why the task was chosen, what support is available, and how the experience will be discussed afterward.

Graded practice is the developmental answer to the common error of asking for too much too soon. Difficult tasks are broken into meaningful steps, with the pace set by learning rather than by adult impatience. Repetition matters because a new response becomes credible when the young person has experienced it in varied contexts. Where avoidance is prominent, the therapeutic target is willingness to approach a valued or necessary activity while using skills, not the elimination of every uncomfortable feeling before action begins.

THERAPEUTIC ELEMENT	QUESTION FOR THE THERAPIST	DEVELOPMENTALLY ADAPTED DELIVERY
Situation	What was happening just before the difficulty?	Use a recent scene, picture, role play or game rather than a remote summary.
Meaning	What did the child think the situation meant?	Invite speech, drawing, choice cards or enacted alternatives.
Emotion and body	How was distress recognised?	Link words to faces, body cues, movement and familiar experiences.
Response	What happened next?	Rehearse a different response in session before asking for practice elsewhere.
Review	What was learned from trying it?	Use a brief, concrete review that credits effort and notices obstacles.

Behavioural activation is another way of restoring contact with activity, mastery, pleasure or connection when the young person has become narrowed by distress. The therapist explores what has fallen away and what might be reintroduced in a realistic form. The point is not to prescribe busyness. It is to create experiences that can challenge hopeless conclusions and provide opportunities for reinforcement. Family routines and school demands may either support this work or quietly defeat it, so they need to be considered in the plan.

TRAP **Do not mistake a worksheet for CBT.** A completed form has no therapeutic value unless it is understood, linked to an individual formulation, followed by practice, and reviewed for learning.

21.3 Developmental adaptation as a clinical skill

Developmental adaptation concerns the entire therapy, not merely the vocabulary of the handout. The child must be able to grasp the task, hold it in mind, relate it to a real situation and use it when the therapist is absent. The clinician therefore adjusts the level of abstraction, pace,

method of expression, amount of scaffolding and expected independence. This is a matter of access and therapeutic fidelity, not dilution of treatment.

With younger children, the work often needs to be anchored in the here and now. Thoughts may be introduced as speech bubbles, characters, detective clues, or alternative endings to a story. Feelings can be represented through faces, colours, body outlines or a simple scale without demanding a polished verbal narrative. Role play permits rehearsal of a response before the child has to use it in a consequential setting. Play is used purposefully: it creates psychological distance, reveals a pattern and enables practice. The principles and techniques of play therapy itself are addressed separately in the play therapy section.

Attention, memory, literacy, communication style and sensory needs all affect whether a task is usable. Instructions may need to be brief, concrete and repeated in the child's own words. Visual prompts can be co-created rather than handed down as schoolwork. A young person who cannot record a thought in writing may still notice it through speech, drawing or a cue agreed with the therapist. The therapeutic question is always: what format lets this child demonstrate understanding and practise the intended skill?

Before setting practice, the therapist checks whether the task:

- has a purpose the child can state;
- can be carried out in the setting where it matters; and
- has a review plan that treats obstacles as information.

Parents or carers often serve as **therapeutic coaches**. They can help notice opportunities for practice, reduce unhelpful accommodation, reinforce effort and bring observations back to the session. Their participation should be transparent to the child and bounded by the treatment rationale. If the adult takes over the monitoring, answers every question, or turns homework into surveillance, the work loses the child's ownership. Parent management training has its own methods and indications; CBT uses caregiver involvement to support the young person's formulation and skill use.

MNEMONIC

MAP

Make it concrete, **A**ctively rehearse it, **P**lace practice in the child's everyday world. This is a delivery check, not a substitute for formulation.

Guidance for children aged **5-11** with mild depression that continues after **2 weeks of watchful waiting**, and without significant comorbid problems or active suicidal ideas or plans, asks clinicians to consider psychological options, including CBT, **adapted to developmental level as needed**. The practical implication is important: developmental adaptation is not an optional embellishment added after a standard protocol has failed. It belongs in treatment selection, explanation, materials, tasks and review from the outset.

GOOD TO REMEMBER

If a child repeatedly cannot complete a task, first reconsider the task's developmental fit, clarity and environmental support. Escalating pressure may teach shame rather than skill.

21.4 Working with adolescents without becoming didactic

Adolescence permits greater use of reflection, self-monitoring and discussion of long-term consequences, but these capacities are uneven and context-sensitive. The therapist should not confuse an adolescent's ability to debate an idea with readiness to test it in a difficult social setting. Privacy, autonomy and the wish not to be managed by adults are clinically relevant. A collaborative agenda, clear explanation of what will be shared with carers, and genuine choice about between-session practice help preserve engagement.

Guided discovery is preferable to cross-examination. The clinician asks questions that help the adolescent examine an interpretation, identify an exception, compare alternatives and decide what experiment would be fair. This approach respects intellect while avoiding a contest about who is right. It also makes room for structural problems such as conflict, exclusion, academic pressure or unsafe environments. CBT can clarify what is modifiable without implying that the young person is responsible for adversity around them.

Digital communication can be incorporated as content where it is central to the young person's experience, but it should not automatically become the medium of therapy. The clinician considers privacy, misunderstanding, family access and whether a digital task will increase monitoring rather than learning. The durable therapeutic aim remains the same: to help the adolescent carry a flexible formulation and tested coping responses into ordinary relationships, education and daily routines.

21.5 Family, school and the treatment environment

CBT takes place in an ecology. A child may leave a useful session and return to routines that reward avoidance, amplify threat, make practice impossible or communicate that distress is a moral failure. The clinician asks which adults and settings need a shared understanding of the treatment goal. This does not mean recruiting every adult into therapy. It means choosing supports that protect practice while preserving the child's dignity and confidentiality.

Communication with school is most useful when it is specific to function: what helps the student begin a task, use a coping plan, return after distress, or avoid being singled out. It should not become a broad disclosure of private therapy content. Educational and remedial interventions are addressed separately in the special education and educational interventions section. Likewise, where family patterns themselves require therapeutic work, the reader should refer to the family therapy and family interventions section rather than relabel family therapy as CBT.

IN INDIA

Developmentally adapted CBT may need to move flexibly between the language of the child, caregiver and school. Materials that fit the family's daily routines and preferred language are often more usable than imported worksheets. Explain the formulation in plain, non-stigmatising terms, and agree in advance what information may be shared with teachers or extended family.

PITFALL

Translating a worksheet word for word is not the same as adapting therapy. If its examples, literacy demands or assumptions about privacy do not fit the child's setting, the form can make the young person appear uncooperative when the intervention is actually inaccessible.

21.6 Reviewing progress, obstacles and scope

Review is part of the intervention, not an administrative ending. The therapist asks whether the formulation still fits, whether the child understands the skill, whether practice occurred in the intended context, and what blocked it. A lack of progress may reflect an inaccurate formulation, insufficient developmental adaptation, competing stressors, an unhelpful family response, poor fit between task and setting, or a need for a different therapeutic emphasis. It should not automatically be attributed to lack of motivation.

Outcome monitoring is most helpful when it is tied to the goals the child and family can recognise: greater participation, more flexible responding, recovery after distress, improved use of coping plans, or a meaningful activity regained. The young person's own account should remain central even when adult observations are also useful. General principles of child psychiatric assessment and multi-informant work are covered in the child psychiatric history and examination section and the multiaxial and multi-informant assessment section.

CBT also has limits of scope. It cannot make an unsafe environment safe, substitute for protection when there is abuse, or resolve every social and educational barrier through individual effort. When safety concerns arise, the clinical safeguarding response belongs to the child abuse management section, with the statutory reporting framework addressed in the POCSO Act section. When the principal difficulty is a childhood disorder, the relevant formulation and disorder-specific treatment should be taken from the Child behavioural, emotional and other disorders notes, the ADHD and specific learning/communication disorders notes, or the Intellectual disability and autism spectrum disorder notes as appropriate.

Developmentally adapted CBT keeps the formulation and therapeutic aim intact while changing the route by which the child can understand, practise and own the work.

MAP	TEST	SHARE	REVIEW
MAKE THE TASK CONCRETE	LEARN FROM PRACTICE	USE SUPPORTS WITH CONSENT	REVISE THE FORMULATION

22 · Special education and remedial and educational interventions

Education is a clinical outcome. A child may improve in clinic yet remain excluded from learning if school cannot use those gains. Special education, remedial teaching and educational interventions translate a clinical formulation into opportunities to participate, learn, belong and progress. The psychiatrist is not the child's teacher and a diagnosis is not an educational prescription. The task is to identify school barriers, help family and school agree on a response, and review whether it helps.

Marks are usually earned by making distinctions. **Special education** concerns planned teaching and support for a learner whose needs cannot be met adequately by ordinary classroom provision alone. **Remedial teaching** targets a defined gap in an academic skill through explicit, graduated teaching. **Educational intervention** is the wider bridge between the child, curriculum, classroom, family and service system. These overlap but are not interchangeable. A sensible plan protects access without confusing poor attainment with laziness, low expectations, a psychiatric diagnosis, or a permanent verdict on ability.

22.1 Educational formulation: from complaint to participation

The presenting complaint is often deceptively brief: the child is “not coping”, “slow”, disruptive in class, avoiding schoolwork, or repeatedly sent out of the room. Such phrases identify a problem but not its mechanism. The educational formulation asks what the child is being asked to do, at what point performance breaks down, what the child does next, and how adults respond. It examines the fit between the learner and the demands of the setting rather than locating the whole problem within the learner.

This formulation is functional and prospective. It should specify strengths that can be used in teaching, the task that currently defeats the child, conditions that improve performance, and obstacles that recur across lessons or settings. Relevant observations may include the child’s response to spoken instruction, written work, transitions, peer demands, sensory load, pace, correction and evaluation. The educational report should convert these observations into practical requests. “Needs support” is too vague to guide a teacher; a description of the condition under which the child can start, sustain and complete a task is useful.

- Define the educational concern in observable terms, including what the child can already do independently.
- Identify the demand, trigger or environmental feature that exposes the difficulty.
- State the support to be tried, who will provide it, and what change would count as improvement.

RULE **Prescribe an educational response to a functional barrier, not to a diagnostic label alone.** A diagnosis may clarify likely needs, but it does not tell a teacher which task to alter, what support to provide, or how to know that the alteration has worked.

The psychiatric assessment provides essential context, but the general framework for child psychiatric assessment belongs in the chapter on assessment. Here, the crucial move is

translation. Symptoms, developmental profile, communication style, family stress and school observations must become an educational hypothesis that the people around the child can test. This protects against both extremes: making the school responsible for everything, and assuming that medication or clinic-based therapy alone will restore participation.

22.2 Special education and the continuum of support

Special school is one possible setting, not a synonym for educational care. The central question is the adequacy of support, participation and learning for this particular child. A child may need changes in instruction, classroom organisation, communication, materials, assessment or adult support. Some children also need a setting with specialised teaching. Placement should arise from an individual educational plan, not from the convenience of the institution, the discomfort of peers, or a belief that one setting is inherently superior.

APPROACH	PRIMARY QUESTION	TYPICAL CLINICAL CONTRIBUTION	COMMON MISUSE TO AVOID
Universal classroom support	Can ordinary teaching be made more accessible?	Describe environmental and communication needs.	Calling ordinary flexibility "special education".
Targeted educational support	Which specific barrier needs additional teaching or scaffolding?	Clarify the functional target and review progress.	Offering generic extra work without a hypothesis.
Special education	What planned, specialised provision is required for meaningful participation?	Support an individualised plan and coordination.	Equating specialised provision with segregation.
Remedial teaching	Which academic skill requires direct, graduated instruction?	Distinguish a skill gap from a broader participation problem.	Using repeated drilling as the only response.

An individual educational plan is most useful when it is brief enough to be used and precise enough to guide action. It should identify priority learning and participation goals, adaptations, responsibility for implementation, communication with family, and a method of review. Goals should describe a valued function, not merely adult compliance. For example, the aim is not simply that a child remains silent or seated; it is that the child can engage safely and productively with the learning activity.

Access does not mean lowered expectation by default. An accommodation changes the route by which a child can show learning or participate. A modification changes what is expected to be learned or demonstrated. Either may sometimes be appropriate, but they should not be used casually. The psychiatrist should ask whether a proposed change removes an irrelevant barrier, or whether it unintentionally removes the educational opportunity itself. This distinction is especially important when families are desperate for relief and schools are under pressure to manage a classroom.

TRAP **Do not treat "inclusive" as a mere place name.** Physical presence in an ordinary classroom without accessible teaching, peer participation or a responsive plan can be exclusion in another form. Conversely, a specialised setting is not automatically a failure if it genuinely meets the child's educational needs and respects family choice.

22.3 Remedial teaching as a clinical partnership

Remedial work begins with a narrow, teachable target. The target may concern understanding instruction, reading, writing, numeracy, organisation, task initiation or persistence, but it should be phrased in terms that permit the teacher and family to observe progress. A broad complaint such as "poor studies" is not a target. It may conceal an instruction-comprehension problem, a gap in prior learning, a mismatch between language of teaching and language of understanding, emotional avoidance, repeated failure, irregular attendance, or an unrecognised need for a different method of communication.

The teaching response should therefore be explicit and graded. The skill is broken into manageable steps, the child is given enough opportunity to practise successfully, feedback is immediate and specific, and the level of support is adjusted as competence grows. Teaching must be humane: repeated exposure to tasks at which the child predictably fails is not remediation. The child needs an experience of mastery, while adults need evidence about which component of the task remains difficult.

- Choose a priority skill that matters to the child's current participation.
- Start from a task the child can enter with support, then make the next step visible and achievable.
- Record the child's response and alter the teaching method when progress does not occur.

GOOD TO REMEMBER

A referral for remedial teaching is more useful when it states the functional question for the educator. "Please assess the child's learning needs and advise teaching strategies" is weaker than describing the task, the observed barrier, the strengths to build on and the outcome the family and school want to see.

Psychiatric symptoms can alter availability for learning. Anxiety, mood symptoms, sleep disturbance, medication effects, family conflict or repeated peer adversity may reduce attendance, concentration, confidence or persistence. The educational plan should acknowledge these influences without turning each academic difficulty into a psychiatric symptom. When the concern suggests a childhood disorder or a specific learning or communication difficulty, the diagnostic teaching belongs in the relevant disorder chapters, including *the ADHD and specific learning/communication disorders notes*, *the Child behavioural, emotional and other disorders notes*, and *the Intellectual disability and autism spectrum disorder notes*.

22.4 Classroom adaptations and educational participation

Many adaptations are low technology and depend more on consistency than on specialist equipment. They may include making instructions concrete, presenting one step at a time,

demonstrating before expecting independent work, using visual supports, allowing a different mode of response, reducing unnecessary copying, arranging predictable transitions, offering a quiet route back into a task, or providing planned breaks. The rationale must be clear. Adaptations should reduce a barrier while preserving the learning purpose wherever possible.

The teacher's observations are clinical data when they are specific. "Does not listen" may mean that the child loses the instruction in a noisy group, cannot hold a long sequence in mind, does not understand the language used, is fearful of public correction, or has learned that disengagement prevents humiliation. A good psychiatrist does not adjudicate this from the consulting room. Instead, the report asks the school to observe the child under defined conditions and makes it safe for the teacher to report what is not working.

PITFALL

Do not write a certificate that lists a diagnosis and simply instructs the school to "give concessions". Such language is easily interpreted as either a demand for lowered standards or a document to be filed without action. Name the functional barrier and the proposed support, while leaving detailed curriculum planning to the education team.

Peer participation also matters. Educational success is diminished if the child receives individual help at the cost of stigma, isolation or loss of agency. A plan should anticipate how support will be offered respectfully, how the child will be included in ordinary routines, and how adults will respond to misunderstanding or ridicule. These are not cosmetic matters. Belonging affects willingness to attempt difficult work, accept help and return to school after failure.

22.5 Working with family, school and the child

Educational intervention is a collaborative treatment. The child should be heard about what feels difficult, helpful, embarrassing or unfair; this prevents adults from designing a technically sound plan that the child cannot tolerate. Parents bring knowledge of strengths, language, routines and prior attempts. Teachers bring knowledge of curricular demands and classroom reality. The special educator or remedial teacher brings expertise in teaching method. The psychiatrist contributes formulation, treatment of coexisting mental-health barriers, communication and advocacy.

Collaboration works best when communication is purposeful. With appropriate consent, a concise school note should state the relevant functional concerns, strengths, suggested adaptations and a request for feedback. It should not disclose more clinical detail than the educational purpose requires. Families need realistic discussion of what the school can implement and what must be reinforced at home. They also need protection from blame. Home practice can consolidate a skill, but it should not convert every evening into a second school day or a conflict around unfinished work.

Agree on one shared priority rather than giving each adult a separate agenda. Use a common language for the target behaviour or skill so that feedback is coherent. Review barriers to implementation before concluding that the child has "not responded".

Where disagreement arises, return to the child's educational participation and dignity. Families may fear stigma; schools may fear that requested changes are unmanageable; the child may refuse support that marks them as different. The psychiatrist can hold these concerns without promising an outcome that no single professional controls. Advocacy is strongest when it is concrete, respectful and grounded in what the child needs to learn and participate now.

22.6 Indian educational rights and the psychiatrist's advocacy role

IN INDIA

The Right of Children to Free and Compulsory Education Act provides the general statutory foundation: children aged **six to fourteen years** have a right to free and compulsory education in a **neighbourhood school**. The Rights of Persons with Disabilities Act adds a disability-specific right: a child with **benchmark disability**, aged **six to eighteen years**, has a right to free education in a neighbourhood or special school of choice.

For the psychiatrist, these provisions change the tone of the consultation. Education is not a discretionary favour to be requested when a child is easy to accommodate. It is a right within a statutory framework. The clinician should explain the practical relevance of this right, document educational needs clearly, and direct the family toward an informed discussion with the school and appropriate educational services. The doctor should not make unsupported promises about admission, resources or the exact form of provision, because these require local implementation and educational decision-making.

The disability statute also requires a periodic **survey of school-going children** to identify children with disabilities, determine their **special needs** and consider whether those needs are being met. This is to occur every **five years**. It matters clinically because identification should lead to a question about support, not merely to the production of a certificate.

Access	Choice	Need
EDUCATIONAL RIGHT	SETTING MATTERS	SUPPORT MUST FOLLOW

The educational prescription is complete only when it names the barrier, the support, the responsible partner and the route for review.

23 · Early intervention and stimulation programmes

Why it matters clinically. Early intervention improves participation and developmental opportunities before difficulties entrench. Stimulation programmes are its practical means: they help caregivers and professionals create meaningful opportunities for communication, movement, play, self-care and social engagement. The psychiatrist coordinates support.

The central question is whether the child can use emerging abilities in relationships, routines and settings that matter to the family. A programme begins with strengths, interests, health, sensory and motor needs, communication style, caregiving environment, opportunities to practise and

barriers to participation. This prevents generic advice when the obstacle is distress, family strain or an unmet physical need.

START	SHARED	REPEATED	REVIEW
WITH DAILY LIFE	FAMILY GOALS	MEANINGFUL PRACTICE	PARTICIPATION

23.1 Scope and therapeutic rationale

Early intervention is a coordinated developmental and family-centred response offered when a child has developmental vulnerability, delay, disability, or a context that threatens opportunities to learn. **Developmental stimulation** refers to intentionally enriching the child's ordinary experiences so that attention, interaction, exploration and practice are more likely to occur. These are related but not identical ideas. The former is a service approach that joins assessment, goal-setting, support and review; the latter is a set of everyday therapeutic opportunities within that approach.

Its rationale is developmental rather than diagnostic. Early experience shapes how a child learns to attend, anticipate, communicate and act on the environment. When an adult notices the child's signals, responds contingently, simplifies a task without stripping it of meaning, and repeats it within an enjoyable routine, the child has a clearer opportunity to connect action with consequence. The aim is not accelerated performance for its own sake. It is growing competence and agency in activities that the child and family actually need.

This distinction has practical consequences. A child may have a label yet need a plan centred on shared attention and communication; another may have no settled label but need help with play, mobility or caregiver interaction. Diagnostic clarification remains important, but intervention need not wait passively when current developmental needs are clear and support is safe.

RULE **Build intervention around participation in daily life, not around a list of isolated developmental tasks.** A skill becomes clinically useful only when the child can access it with real people, in ordinary routines and across relevant settings.

23.2 From concern to an individualised plan

A useful plan converts a broad concern into a shared working formulation. Begin by asking what is hard for the child and family at present, what is already going well, and what change would make the next period easier or more meaningful. Observe the child in interaction when possible. The child's initiative, affect, regulation, response to adult support and preferred activities often tell the clinician more about a workable starting point than a catalogue of deficits.

Functional goals are concrete descriptions of participation rather than abstract targets. They should be recognisable to the caregiver, relevant to the child's routine and capable of being observed without a specialised test. A goal about joining a mealtime exchange, tolerating a transition with support, seeking help during play, or participating in a self-care step is more useful than a vague instruction to improve development. The clinician should ask what the family will notice when the goal is becoming easier and what support will make that change possible.

- Identify a meaningful routine or activity in which participation is currently limited.

- Describe the child's present way of engaging, including strengths and successful conditions.
- Agree on an achievable next step and the adult response that will support it.
- Decide how the family and team will recognise progress, difficulty or an unintended burden.

The plan should specify who will do what, where opportunities will occur and how responsibilities will be coordinated. It also exposes a familiar service problem: a recommendation can sound clinically elegant while requiring time, transport, money, equipment or adult availability that the family does not have. The correct response is adaptation, not blame. A smaller intervention woven into real routines is often more therapeutic than a plan that survives only on paper.

GOOD TO REMEMBER

When a caregiver says, “We cannot do all this,” treat that statement as assessment data. It may reveal exhaustion, competing care demands, poverty, grief, misunderstanding, family conflict or a plan that has not yet become usable. Simplifying the plan may be the intervention that restores continuity.

23.3 The active ingredients of stimulation

Stimulation is not the accumulation of toys, worksheets or appointments. Its active ingredients are attunement, repetition, graded challenge, feedback, enjoyment and transfer into daily life. Adults first follow the child's interests and signals. They then create a small, manageable demand, wait for the child's response, and adjust assistance so that the child has a genuine role in success. This is **scaffolding**: support that makes participation possible without permanently doing the task for the child.

Play is particularly valuable because it permits repetition without making the child feel tested. Shared play can support turn-taking, symbolic communication, motor planning, frustration tolerance and relationship-building, but it should be guided by the child's developmental level and sensory profile. The detailed principles and techniques of play therapy belong in the play therapy section. In a stimulation programme, play is usually a vehicle for practice and connection rather than a separate psychotherapy.

Communication support is embedded in ordinary encounters. Adults can make language and gestures easier to understand, allow time for a response, offer meaningful choices, and respond to attempts to communicate rather than waiting for polished performance. Motor and self-care opportunities work best when the activity has an immediate purpose. Feeding, dressing and moving through the home can become therapeutic contexts when adapted thoughtfully.

THERAPEUTIC ELEMENT	CLINICAL QUESTION	PRACTICAL IMPLICATION
Child interest	What draws the child into interaction?	Use preferred people, objects and activities as the entry point.
Adult response	How does the caregiver recognise and answer the child's signal?	Model waiting, noticing and responding in a way the child can use.
Task demand	What makes participation fail or become distressing?	Reduce unnecessary complexity and increase challenge gradually.
Routine	Where can practice happen naturally?	Attach the activity to a familiar part of the family's day.
Generalisation	Can the child use the emerging skill with other people and places?	Plan transfer deliberately instead of assuming it will occur.

The mechanism is relational. A programme works through adults as well as through the child. Caregivers gain confidence when they can read the child's cues and see that their response changes the interaction. That confidence can reduce helplessness and make ordinary family routines more predictable. Conversely, instructions that imply the caregiver is solely responsible for developmental outcome can intensify guilt and undermine engagement. The clinician should explicitly distinguish responsibility for providing opportunities from responsibility for producing a particular developmental result.

23.4 Caregiver partnership and family work

Caregiver coaching is the process of helping a caregiver observe, try, reflect on and adapt an interaction with the child. It is not simply teaching the caregiver to reproduce professional techniques. The caregiver knows the child's habits, comforts, fears and available routines; the professional contributes developmental reasoning and an outside perspective. The partnership is strongest when these forms of knowledge are treated as complementary.

Use demonstration sparingly and then return the activity to the caregiver. Ask what felt easy, what the child seemed to enjoy, where the interaction broke down, and what change might make the next attempt more feasible. This reflective loop converts advice into learning. It also avoids an unhelpful service pattern in which the child appears to perform with a therapist but the family leaves without a method that can be used between visits.

Family intervention may be needed when parental mental health difficulties, conflict, stigma, bereavement, substance use, violence, unsafe housing or competing caregiving burdens limit the child's opportunities. These circumstances are not “non-compliance.” They are part of the formulation. The family therapy and family intervention section addresses therapeutic approaches to relational difficulties in greater detail. Here, the task is to ensure that the developmental plan does not ignore the conditions that make implementation possible or impossible.

IN INDIA

Early support often requires coordination across home, clinic, educational settings, rehabilitation providers and local child-development services. The psychiatrist should help the family navigate these interfaces without assuming that every locality has the same professional availability. A written, plain-language plan can reduce fragmentation when families move between public, private and voluntary-sector care.

23.5 Interdisciplinary and educational coordination

Early intervention is rarely delivered by psychiatry alone. Depending on the child's formulation, collaboration may be needed with paediatrics, rehabilitation professionals, speech and language support, psychology, nursing, social work and educators. The psychiatrist's role is to hold the clinical formulation together, address co-occurring emotional or behavioural barriers, clarify priorities with the family and prevent parallel services from becoming competing services.

Educational support should be considered early whenever learning or participation is affected. The special education and remedial intervention section addresses educational planning in detail. Within an early intervention plan, the essential question is whether the environment can be adjusted so that the child can participate, communicate needs and experience success. A recommendation for a setting is not enough. The team should communicate the child's helpful supports, likely triggers for disengagement and practical ways to preserve dignity.

Generalisation is the transfer of a developing ability from the place in which it was learned to other people, materials and settings. It is a clinical outcome, not an optional extra. A child who can perform only under highly structured professional prompting may still be unable to participate in family life or education. Plans therefore need planned overlap between home, therapy and school, with shared language and expectations where feasible.

MNEMONIC

START

Share goals with the family, **T**ailor activity to the child, **A**rrange practice in routines, **R**eview participation and burden, and **T**ransfer gains across settings. It is a compact way to remember that stimulation is a coordinated process rather than a collection of activities.

23.6 Monitoring change and revising the plan

Review should ask whether participation is changing, not simply whether the family has completed prescribed exercises. Look for the child's initiative, comfort, capacity to recover from frustration, use of support and ability to engage with familiar people. Ask caregivers what has become easier, what remains hard, what has changed unexpectedly and what the intervention costs them in effort or conflict. A plan that expands a child's skills while exhausting the caregiving system needs revision.

When progress is limited, return to the formulation. The task may exceed the child's current readiness; the goal may lack relevance; the setting may be too distracting or demanding; the adult

prompt may be poorly timed; health, sensory, sleep or emotional difficulties may be interfering; or the family may need a different kind of support. Escalating intensity without understanding the mismatch is rarely good clinical practice. A respectful review protects the family from feeling judged and protects the team from mistaking activity for effectiveness.

TRAP **Do not equate a busy intervention schedule with an effective programme.** Candidates often describe multiple therapies but omit the child-specific goal, caregiver role, setting and review process. In practice, the same omission produces fragmented care and makes it impossible to know what should be continued, changed or stopped.

PITFALL

Do not make a caregiver demonstration into a performance test. Correcting every imperfect response can silence the very adult whose consistency the programme depends on. Preserve curiosity, identify the next useful adjustment and acknowledge what the caregiver already does well.

23.7 Boundaries, referral and ethical stance

Early intervention does not replace diagnostic assessment, medical care, safeguarding, education planning or specialist treatment when these are needed. It brings their developmental implications into the child's everyday world. If a child has acute medical concerns, sensory difficulties, nutritional problems, exposure to violence, severe caregiver distress or a marked change in functioning, address the relevant pathway rather than persisting with stimulation alone. Safeguarding concerns require the protection response described in the child protection sections.

The psychiatrist should avoid deterministic language. Families may hear a developmental formulation as a verdict about the child's future or their parenting. Explain uncertainty honestly, describe the present purpose of intervention, and invite the family to identify what a good outcome would look like in their circumstances. Respect for culture and family priorities does not mean accepting harmful practices or excluding the child from opportunity. It means designing support with the family rather than imposing a professional script.

Early intervention succeeds when a child gains meaningful participation through repeated, enjoyable opportunities that caregivers can realistically sustain.

Epidemiology, services and national context

24 · Epidemiology of child psychiatric disorders in India

Why this matters clinically. Epidemiology in child psychiatry is not a decorative prevalence quotation. It determines how confidently a clinician can describe the size and distribution of need, whether a local service claim is defensible, and whether a research finding can be carried into an individual formulation. In India, the central skill is often not recalling a headline

percentage; it is recognising the population to which that percentage does, and does not, apply. This distinction is especially important when a family, school, administrator, or trainee asks for "the Indian figure" for child mental disorder.

For the present purpose, **epidemiology** means the disciplined description of mental health phenomena in a defined population. It asks who was sampled, how cases were identified, the period to which findings refer, and whether the denominator matches the question being asked. It does not establish the diagnosis of the child in front of the clinician, nor does it replace a developmental and multi-informant assessment. Those clinical tasks are addressed in the assessment sections of this chapter and the childhood disorders themselves are covered in *the Child behavioural, emotional and other disorders notes*.

24.1 What an Indian child-psychiatry prevalence statement must mean

A prevalence statement is only as useful as its case definition and sampling frame. "Mental morbidity" may represent a diagnostic interview threshold, a symptom screen, a clinician's judgement, a service contact, or an administrative record. These are related but non-interchangeable constructs. A symptom measure can be useful for detecting need or planning further assessment; it cannot silently be converted into the prevalence of a psychiatric disorder. Likewise, clinic attendance tells us about treated or help-seeking morbidity, not the frequency of disorder in children who are outside services.

Case definition is therefore a priority interpretive question. It should make clear whether the estimate refers to current mental morbidity, symptoms, impairment, a particular diagnostic grouping, or a mixture of these. In developmental psychiatry, impairment and context matter greatly: behaviour that prompts concern in a classroom may have a different meaning after considering developmental level, language, family stress, neurodevelopmental profile, and the informant's opportunity to observe the child. A defensible epidemiological estimate preserves the method used to decide who counted as a case.

The next question is the **denominator**. A denominator is not merely a total at the foot of a table. It identifies the population from which the estimate was derived. Household samples, school samples, clinic samples, and selected community groups answer different questions because the children available for recruitment, and the pathways by which concerns become visible, differ. A school-based study may be highly valuable for school planning while excluding children whose educational participation is interrupted. A clinic sample may accurately describe service demand while being shaped by access, referral practices, stigma, affordability, and local specialist availability.

- Ask whether the source sampled the population named in the question.
- Identify how a case was defined and whether impairment was part of that definition.
- Check the age group before applying a finding to "children".
- Separate a local estimate from an all-India estimate.

RULE **Never detach a prevalence figure from its population, age group, case definition, and sampling frame.** A number may be accurate within its study yet misleading when presented as a national child estimate. In an answer, state the scope before interpreting the figure; this shows epidemiological judgement rather than rote recall.

24.2 What the NMHS adolescent finding can support

The National Mental Health Survey, commonly called **NMHS**, is the key national survey reference that candidates are likely to encounter. Its adolescent module reported current mental morbidity of **7.3%** among adolescents aged **13-17 years**. The estimate used a structured diagnostic approach. The report does not specify which instrument the adolescent module used, so this note names none. It is reasonable to cite this as an adolescent-stratum finding when the wording remains equally precise about its limits.

Its limits are not footnotes. The adolescent component was a feasibility sub-sample confined to **four** of the survey states, rather than a nationally representative adolescent survey. The wider survey covered **12** states, but that does not make the adolescent module a national child survey. The exact adolescent-stratum denominator is not provided in the cited report, so a clinician should not manufacture precision around the estimate or imply that it describes every Indian region.

7.3%	13-17 years	four	not established
CURRENT ADOLESCENT MENTAL MORBIDITY	AGE STRATUM	STATES IN FEASIBILITY SAMPLE	ALL-INDIA CHILD FIGURE

IN INDIA

Use the NMHS result as a carefully bounded adolescent finding, not as a shortcut for "Indian child prevalence." This is particularly relevant in local planning discussions: a national survey label may create unwarranted confidence if the reader does not notice which participants contributed to the adolescent result.

External validity is the question of how far a study's finding can travel beyond those studied. Here, the result travels to the adolescent feasibility stratum defined by the survey methodology. It does not automatically travel to younger children, every state, all school settings, or every clinical service context. This is not a criticism of the survey. It is the ordinary discipline of applying evidence to the population actually represented.

24.3 The honest national gap for children

No established all-India psychiatric prevalence figure can be quoted for children under **13 years**. That gap is substantive, not a wording problem. The available NMHS adolescent stratum begins later, so it cannot be extended downwards by intuition, by averaging unlike studies, or by treating "child and adolescent" as a single epidemiological population. The correct answer is that the all-India child prevalence is **not established**, while an adolescent feasibility-subsample estimate is available with the limitations already described.

This phrasing protects against a common but consequential error: welding a national-looking range from studies with different ages, settings, instruments, informants, and thresholds. Such a range looks balanced because it appears to acknowledge variation, but it does not acquire national validity by spanning several local results. It can also conceal the distinction between symptom burden, probable disorder, diagnosed disorder, and service use. Where evidence is heterogeneous, a careful narrative description of the evidence base is stronger than an invented composite.

TRAP **Do not quote the adolescent NMHS percentage as the prevalence of child psychiatric disorders in India.** The age band and sampling design limit the claim. A polished-looking number without its denominator is a category error, not a concise answer.

PITFALL

Do not substitute a foreign data platform for Indian prevalence evidence merely because it is easy to search or presents polished charts. A source that is **US-only** cannot supply an India estimate. The practical response is to label the Indian evidence gap, not to import a figure.

24.4 Geographic inference and the Karnataka limitation

National language can obscure geographic limits. In the NMHS state list, **Karnataka** was not included. Therefore, the survey cannot be cited as a Karnataka child or adolescent prevalence source. This matters for clinicians and teachers working in the state because a national report is often assumed to settle a local question. It may offer useful context about survey methods and the broader Indian evidence base, but it does not replace a population estimate from the population of interest.

Local relevance should be reasoned rather than presumed. A finding is more likely to inform local planning when the population, setting, language context, social conditions, pathways to care, and service availability resemble the intended setting. Conversely, a difference in any of these can alter observed prevalence or, more commonly, the probability that distress is noticed and reaches care. The point is not that a study from elsewhere is useless. It is that transportability must be argued, and uncertainty stated, rather than hidden behind a national title.

QUESTION BEFORE QUOTING A FIGURE	WHAT MUST BE CHECKED	CONSEQUENCE IF THE ANSWER IS UNCLEAR
Who was sampled?	Household, school, clinic, or other defined population	Do not relabel the result as community prevalence.
What ages were included?	Whether the child group matches the clinical question	Do not generalise an adolescent estimate to younger children.
How was morbidity identified?	Diagnostic interview, symptom measure, or service record	Name the construct rather than calling all results "disorder".
Where was the study done?	Geographic coverage and whether the locality was sampled	Describe it as contextual evidence, not local proof.
What is the denominator?	Whether the relevant stratum is explicitly reported	Avoid false precision and unsupported comparisons.

Transportability is the clinical version of this judgement: whether evidence collected in one context is likely to be informative in another. It is especially useful when discussing service needs. Epidemiology can guide the scale and direction of planning, but it should not be used to predict a particular child's diagnosis, family trajectory, or treatment response. Individual care remains anchored in direct assessment and formulation.

24.5 Why estimates vary without being mutually contradictory

Variation between studies does not by itself prove that a study is wrong. In child mental health, observed differences may arise from the age composition of the sample, whether parents, teachers, and children contribute information, the threshold selected for a case, the privacy of interviews, local explanatory models, and the route by which participants are recruited. These factors affect ascertainment as well as the underlying distribution of difficulties. The reader's task is to distinguish a real epidemiological difference from a difference created by study design.

Ascertainment refers to the process by which possible cases are noticed, assessed, and counted. It is vulnerable to both under-recognition and over-interpretation. Children with internalising difficulties may not be noticed in the same way as children with disruptive behaviour; conversely, school or family concern may be shaped by expectations that are not themselves diagnostic. Such observations are clinically important, but they are not grounds for supplying a prevalence figure where no appropriately sampled figure exists.

Keep symptom detection separate from diagnostic classification; functional concern separate from the prevalence of a named disorder; service utilisation separate from population burden; and an evidence gap separate from an assertion that no affected children exist. These distinctions make the epidemiological description clinically usable without inflating what the evidence can establish.

For examination writing, this reasoning earns marks because it explains why figures cannot be compared casually. For service work, it prevents a more serious problem: allocating scarce attention solely to the forms of distress that are easiest to count. Epidemiology should widen clinical curiosity, not reduce a child to a survey category.

GOOD TO REMEMBER

When asked for a prevalence figure during a case discussion, state what the available estimate actually measures, then state the limit on applying it to the child population in question. This is more clinically useful than giving an unsupported number with apparent confidence.

24.6 Using epidemiology without misusing it

At bedside level, epidemiology supports anticipation and advocacy. It reminds the psychiatrist that childhood mental health need exists beyond specialist clinics, that detection pathways are selective, and that absence of a local population estimate is not evidence of absence of clinical need. It can help frame a request for school linkage, developmental supports, family intervention, or service strengthening. It should never become a diagnostic shortcut, a reason to dismiss symptoms that fall outside a survey category, or a substitute for listening to the child and caregivers.

At service level, use epidemiological language proportionately. Describe the need as recognised but incompletely quantified when the population evidence is incomplete. Specify whether a proposed programme is responding to clinic demand, observed school concerns, or population surveillance. These categories can inform each other, yet they are not interchangeable. School mental health programmes and life-skills education are addressed separately in this chapter; their justification should not depend on pretending that a single national prevalence statistic answers every planning question.

In India, cite the NMHS adolescent result only with its age and sampling limits; for younger children, state plainly that an all-India psychiatric prevalence figure is not established.

The mature answer is therefore neither nihilistic nor numerically performative. It is evidence-literate: it acknowledges the available adolescent signal, protects the boundary around it, identifies the missing child and local estimates, and explains why those boundaries matter for clinical interpretation. That stance is not evasive. It is the ethical use of epidemiology in child psychiatry.

25 · School mental health programmes and life-skills education

Why this matters clinically. A child's mental health is lived in ordinary settings, not only in the clinic. School is where learning demands, peer relationships, exclusion, bullying, family expectations and emerging autonomy become visible. **School mental health** therefore means more than placing counselling in a school. It is a way of making the school safer, more emotionally literate and more able to notice when a pupil needs support beyond the classroom. For the psychiatrist, it is a service question: what can be strengthened in the child's daily environment, what needs clinical assessment, and how can the two remain connected without turning teachers into diagnosticians?

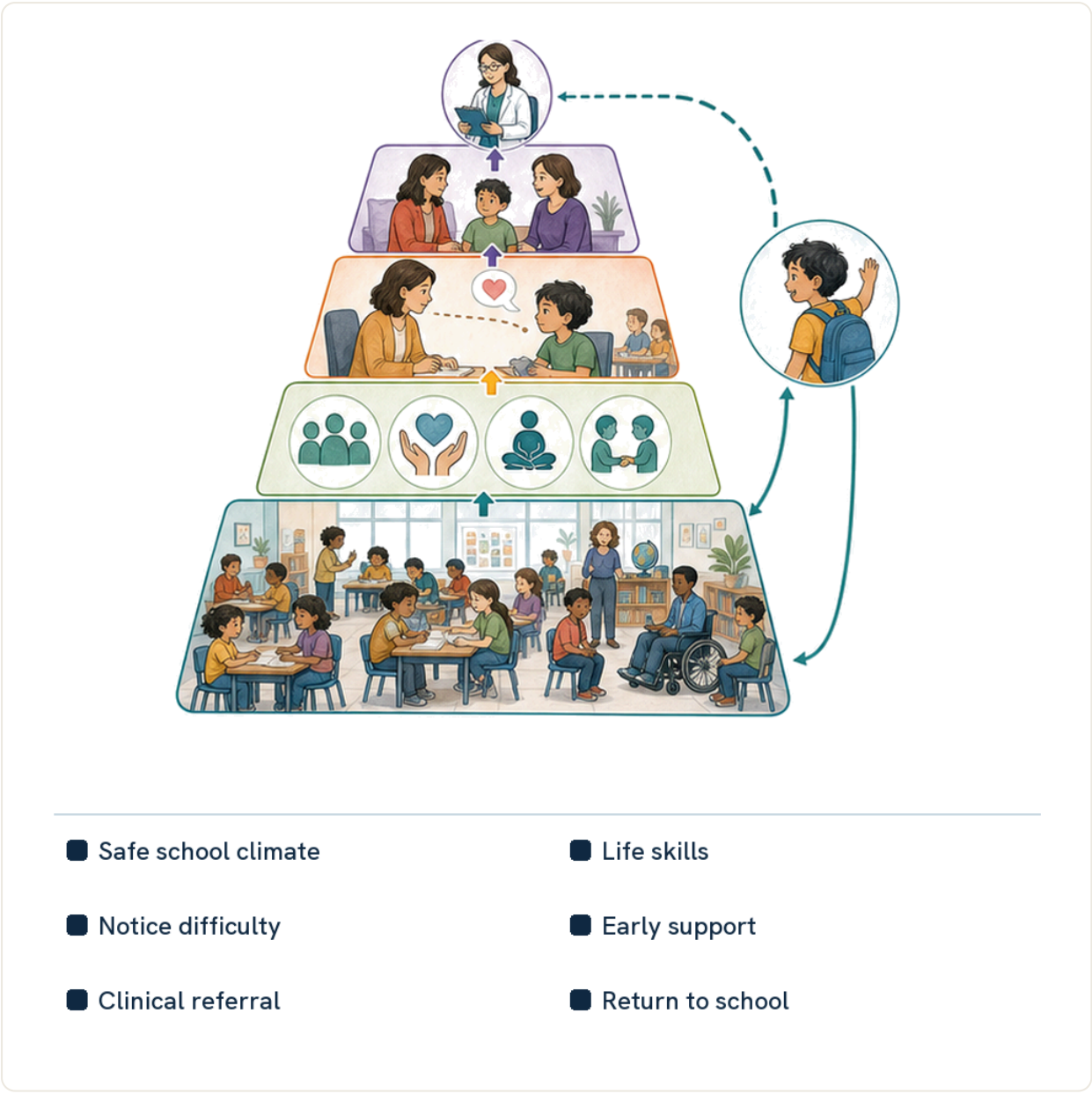


Fig 24.11 School mental-health programmes move from universal promotion and life-skills education through recognition and early support to a linked clinical referral pathway. Schools notice and support; they do not become diagnostic clinics.

The examination value of this area lies in making those distinctions clearly. A well-written answer moves from health promotion through life-skills teaching to referral pathways, then locates Indian programmes without confusing one platform with another. It does not re-teach childhood disorders, behavioural treatment or the formal child assessment. Those require their own clinical formulations and are addressed in the Child behavioural, emotional and other disorders notes; the general assessment framework is addressed elsewhere in this chapter.

25.1 What a school mental health programme is for

A school mental health programme is a planned response to the social and emotional conditions in which pupils learn. Its aim is not to find a psychiatric label for every difficulty. Its practical task is to improve the everyday capacities that help children and adolescents negotiate demands, relationships, conflict, disappointment and help-seeking. It also gives adults in the school a language for responding thoughtfully rather than with humiliation, exclusion or an automatic demand for medical certification.

Good programmes work at the level of the school climate as well as the individual pupil. A child who is quiet, irritable, distracted or repeatedly absent may be signalling distress, but none of those observations is itself a diagnosis. The school can offer predictable routines, respectful communication, opportunities for participation and an adult who takes concerns seriously. Where difficulties are persistent, impairing, risky or beyond the school's competence, the school's role is to share observations with caregivers and facilitate an appropriate referral. Diagnostic assessment remains a clinical responsibility, undertaken with developmental, family and multi-informant context.

RULE **Teach competence and create a route to care; do not convert the classroom into a diagnostic clinic.** A school can reduce barriers to disclosure and support early help-seeking, but it should neither assign diagnoses nor manage serious risk in isolation.

The distinction protects both child and school. If every academic or behavioural difficulty is medicalised, ordinary adversity is treated as pathology and the pupil can acquire a stigmatising identity. If every difficulty is dismissed as indiscipline, a child with real distress may be shamed and left unsupported. The useful middle position is curiosity: describe what has changed, ask what context might explain it, listen to the child and caregiver, and decide whether ordinary school support, a planned conversation or clinical referral is needed.

Why the setting changes the intervention. Therapy often asks a child to practise a new response between sessions. School is one of the places where that practice either becomes possible or is repeatedly undone. A programme that normalises respectful peer interaction, problem solving and asking for help can make clinical gains easier to use in real life. Conversely, a punitive or mocking environment can defeat carefully planned treatment. Liaison is therefore not an optional add-on to child psychiatry; it is part of making an intervention usable in the child's world.

25.2 Life-skills education: the educational core

Life-skills education is skills-based teaching intended to build **psychosocial competence**. It is not a lecture on good behaviour and not a covert diagnostic screen. Its central premise is that children benefit when they can recognise a situation, consider options, regulate an immediate response, communicate their needs and learn from the result. The emphasis is on rehearsal and reflection, so that an idea becomes a usable action rather than a slogan remembered after an assembly.

The WHO core set is most useful as an organising language for curriculum and teacher preparation. It connects thinking, relating and emotional self-management without implying that each domain is a separate subject or that the child must perform a particular personality. The accompanying table groups the skills for teaching purposes while retaining their practical meaning.

CORE CAPABILITY	WHAT IT LOOKS LIKE IN A SCHOOL ACTIVITY	CLINICAL RELEVANCE
Decision making and problem solving	Pausing to define a difficulty, generate options and consider likely consequences.	Supports a move from impulsive reaction to deliberate choice.
Creative thinking and critical thinking	Considering more than one explanation, questioning assumptions and imagining alternatives.	Helps pupils examine peer pressure, rumours and self-defeating conclusions.
Effective communication and interpersonal relationship skills	Listening, expressing a request, disagreeing without attack and repairing a misunderstanding.	Makes interpersonal stress discussable before it escalates.
Self-awareness and empathy	Noticing one's own feelings and perspective while attempting to understand another person's experience.	Supports reflection, peer inclusion and less hostile attribution.
Coping with emotions and coping with stress	Naming an emotional state, identifying a trigger, using a safe coping response and seeking support when needed.	Creates a common vocabulary for distress without presuming illness.

These skills are learned best through participation. A teacher may use a brief vignette, a role-play, a classroom dilemma, a guided discussion, a drawing task or a reflection on a familiar conflict. The educational sequence matters: introduce a concrete problem, allow pupils to generate responses, practise a response in a safe setting, receive feedback, and return to where that skill may be useful outside the activity. A child should not be compelled to disclose private experiences in front of peers in order to demonstrate learning.

GOOD TO REMEMBER

When a child is already in treatment, ask what skill is being practised and where it fails in the school day. A small, specific environmental adjustment - a predictable check-in, permission to step aside briefly, or a named adult for help-seeking - may make therapy more transferable without asking the school to provide therapy.

Life-skills teaching should remain developmentally intelligible. Abstract language about resilience or emotional intelligence is easily repeated without being understood. Activities should use situations pupils actually recognise, offer alternatives rather than moralising, and permit different ways of participating. The desired outcome is not silent compliance. It is a child who can think, communicate and seek help with increasing agency while respecting the safety and dignity of others.

25.3 From a session to a school culture

A programme fails when it treats a single teaching session as a completed intervention. The content needs a place in ordinary school life: teachers need to model respectful disagreement, classroom rules must not contradict the message of empathy, and pupils need safe opportunities to use the skills. Repetition is valuable when it is practice in varied situations, not when the same

message is simply recited again. Follow-up discussion allows children to identify what was difficult, what helped and what support would make the next attempt more realistic.

- Choose situations that are familiar enough for pupils to engage, but do not require public disclosure of personal adversity.
- Use active methods that let pupils try language, choices and coping responses rather than only hear about them.
- Build in a private route for a pupil to seek help after a session, because a group activity may surface an individual concern.
- Review whether the school's disciplinary and peer practices reinforce or undermine the values being taught.

Teachers are central because they are the adults who can make a classroom emotionally predictable, but they must be supported rather than burdened with a vague instruction to "handle mental health". Training should clarify the limits of the teacher role, the route for consultation, how to speak with caregivers, and when a concern needs urgent escalation. It should also address the teacher's own anxiety: staff may avoid a distressed pupil because they fear saying the wrong thing. A calm, non-judgemental first conversation and a known referral route are safer than avoidance.

PITFALL

Do not mistake a school programme for a substitute for clinical care. A school may support attendance, inclusion and help-seeking, but it cannot safely absorb a complex presentation, sustained functional deterioration or a concern about immediate safety merely because a life-skills session exists.

Peer involvement can be constructive when it expands inclusion and reduces isolation, but peers should never be made responsible for surveillance, counselling or secrecy. A child may prefer a trusted friend to accompany them in seeking an adult, yet the adult remains responsible for deciding what support is needed. This protects friendship from becoming an unacknowledged clinical role and keeps the burden of safeguarding with the institution and appropriate services.

25.4 Boundaries, confidentiality and referral

School work frequently raises a tension between privacy and collaboration. The child should know, in language they can understand, who will be told about a concern and why. Information shared with a school should be limited to what is necessary for the agreed support plan. A psychiatrist need not disclose a diagnostic formulation or detailed family history for a teacher to understand the practical accommodations that may help. Equally, a teacher should not promise secrecy when information suggests that the child may be unsafe or needs protection.

Referral communication is strongest when it is descriptive. It records observable changes, relevant school context, duration in ordinary language and the supports already tried, rather than attaching a label. The clinician can then integrate that account with the child's history, caregiver

perspective and direct assessment. This approach also reduces the common conflict in which a family feels blamed by the school while staff feel dismissed by the family. Both are usually reporting different parts of the same child's context.

TRAP **Do not equate a teacher's observation with a psychiatric diagnosis.** Teachers provide indispensable ecological information, but an observation gains clinical meaning only when it is integrated with developmental, family and direct assessment. The general assessment framework is addressed elsewhere in this chapter.

Where the concern indicates abuse, serious violence, self-harm, sexual harm, or immediate danger, the matter leaves the ordinary school support pathway. The clinician and institution must follow the relevant protection and emergency processes rather than wait for further classroom observation. The statutory duties and child-protection response are addressed in the chapter sections on POCSO, juvenile justice and management of child abuse; a school programme should have a clear pathway to those systems, not improvise one in a crisis.

25.5 India: DMHP school outreach

IN INDIA

Under the District Mental Health Programme, targeted outreach includes life-skills education and counselling in schools. The programme model specifies **100 teachers** as master trainers from each block, with a block described as having **25-30 schools**. This makes the teacher a capacity-building link, not a replacement for a mental-health professional.

The DMHP formulation is important because it places school work within public mental-health outreach rather than treating it as an isolated educational experiment. Its strength is reach: a trained teacher can carry a consistent set of activities and can identify when a pupil needs a conversation or referral. Its limitation is equally important: the quality of implementation depends on supervision, protected time, turnover of trained staff, links with the district team and the school's willingness to use a non-stigmatising approach.

For a psychiatrist working with a district or medical college service, the useful contribution is not to deliver every session personally. It is to help build a workable system: orient staff to what school support can and cannot do, advise on referral criteria, receive clinical referrals appropriately, and use feedback from schools to improve the pathway. Consultation should focus on function and safety rather than asking teachers to master psychiatric terminology. A brief, respectful response to a referred child also builds trust in the pathway and makes future help-seeking more likely.

- Clarify who in the school receives a concern and who communicates with caregivers.
- Ensure that referral does not become a disciplinary disposal of a difficult pupil.
- Agree how urgent concerns will reach a responsible adult and appropriate service without delay.
- Feed back practical school recommendations while preserving the child's privacy.

25.6 RKSK and adolescent-facing care

Rashtriya Kishor Swasthya Karyakram was launched on **7 January 2014**. It is framed to reach **253 million adolescents aged 10-19 years, including those in and out of school, across gender, residence and marital status**. This breadth matters when school mental health is discussed: school delivery is valuable, but it cannot be the only route to adolescent support.

RKSK places mental health alongside sexual and reproductive health, nutrition, substance misuse, injuries and violence including gender-based violence, and non-communicable diseases. Its Adolescent Friendly Health Clinics provide a clinical and counselling interface for these concerns. The domains should be understood as connected in the young person's lived experience. A school discussion about coping, relationships or violence may open a question that needs an adolescent-friendly health service rather than a further classroom activity.

The psychiatrist's role is to understand the interface, not to collapse it. School-based promotion can improve recognition and reduce hesitation about seeking help. Adolescent-friendly services can offer an accessible point for counselling and health concerns. Specialist mental-health care is indicated when the presentation requires diagnostic assessment, risk management or treatment beyond that setting. Clear hand-offs protect the young person from being sent repeatedly between systems with no one accepting responsibility.

25.7 The School Health and Wellness Ambassador model

The Ayushman Bharat School Health and Wellness Programme uses a teacher-led health-promotion model. The designated **Health and Wellness Ambassadors** are two teachers per school, preferably one male and one female where possible. The programme describes a health-promotion session of one hour each week. These details are useful as an examination anchor, but the clinical interpretation remains more important: the model creates a named, trained point of contact within the school rather than leaving health promotion to individual enthusiasm.

10	100	253 million	2
WHO CORE LIFE SKILLS	DMHP TEACHER MASTER TRAINERS PER BLOCK	ADOLESCENTS TARGETED BY RKSK	TEACHERS DESIGNATED PER SCHOOL

Named ambassadors can make it easier for pupils and families to know whom to approach, and for a school to sustain health conversations over time. Yet designation alone does not guarantee safety or quality. The programme needs administrative support, a private and respectful route for individual concerns, a clear escalation pathway, and collaboration with local health services. The teacher is best viewed as a facilitator of health promotion and access, not as a counsellor for every personal problem.

> School mental health succeeds when life-skills teaching, a supportive school climate and a clear route to clinical or protection services work as one system.

26 · Rashtriya Bal Swasthya Karyakram (RBSK) and the 4Ds

Why it matters clinically. A child psychiatrist sees only a fraction of the children whose development, behaviour, communication, hearing, vision, nutrition, chronic illness, or congenital health needs may affect mental health. The service question is therefore not merely whether a child meets criteria for a psychiatric disorder. It is whether the child has been noticed early, whether the family has understood the concern, and whether there is a workable route from a screening finding to assessment, intervention and review. **Rashtriya Bal Swasthya Karyakram (RBSK)** is an Indian child-health platform built around early identification and linkage to care.

For the examination candidate, RBSK is best understood as a service architecture rather than as a list of diagnoses. It supplies a common public-health language for a heterogeneous set of childhood health concerns and creates a route into district-level intervention. Its relevance to psychiatry is especially clear when developmental, sensory, medical and family factors coexist. A referral generated by the platform is a clinical starting point: it should lead to formulation and coordinated care, not to premature diagnostic labelling.

26.1 The 4Ds: a service language for early identification

The organising frame is the **4Ds**. It brings together defects at birth, deficiencies, diseases, and developmental delays including disabilities. This is deliberately broader than psychiatric nosology. A public programme must detect concerns that are visible to families, teachers, frontline workers and health staff before specialist diagnosis is possible. The framework also prevents the false separation of physical and developmental health: a concern that begins in one domain may change a child's learning, participation, sleep, communication, behaviour or family stress in another.

4Ds	birth to 18 years	up to 6 years	30
ORGANISING FRAMEWORK	SCREENING SCOPE	PRIMARY DEIC FOCUS	CONDITIONS, ORIGINAL SCHEME

Do not read the categories as separate clinical silos. They are a prompt to ask what has been found, what may be contributing to it, what the child can currently do, and what service can act next. For example, a child with poor classroom participation may need medical or sensory clarification, developmental assessment, educational support and family guidance in parallel. Psychiatry contributes a formulation of emotional and behavioural consequences, caregiver burden, adherence barriers and comorbid symptoms. It does not convert a screening category into a diagnosis by itself.

RULE **The 4Ds are a route into care, not a psychiatric diagnostic system.** Use the framework to widen the clinical lens and to organise referral, then complete the assessment needed for the individual child.

MNEMONIC

Birth, Body, Biochemistry, Behaviour and development

Use this bedside prompt to remember that the programme categories include birth defects, diseases, deficiencies, and developmental delay including disability. The added behavioural wording is a clinical reminder, not an additional programme category: it asks the psychiatrist to consider the child's functioning and family response after the health concern has been identified.

The programme's screening and referral card, as issued under the original scheme, listed **30** core health conditions under this framework, and that remains the figure most examination answers expect. It is no longer the current list. The RBSK 2.0 operational guidelines set out a revised and longer table and publish no total at all, so the count is best taught as the classical figure with that caveat rather than as a settled number. The revision matters here for a second reason: the current table names behavioural and neurodevelopmental conditions explicitly, among them anxiety disorders, sleep disorders, attention-deficit hyperactivity disorder, autism spectrum disorder, specific learning disorders and global developmental delay. The practical lesson is not to memorise a card as though it were a diagnostic manual. Rather, recognise the card as a standardised handover. It records why the child was identified and helps the receiving service decide what must be clarified, what can be acted on locally, and where specialist input is needed. A useful referral note adds the child's functional difficulty, the informant's concern, prior care, family understanding and the immediate question for the next clinician.

26.2 From population contact to a clinically meaningful referral

The programme uses **Mobile Health Teams** for **community screening** in Anganwadis and Government schools. This matters because these are routine child-contact settings rather than specialist clinics. They can surface a concern in a family that has not sought mental-health care, or in a child whose difficulties have been normalised, attributed to temperament, or hidden by school absence. The initial service task is detection and communication, not a definitive mental-state examination.

In service terms, the pathway must preserve information as it moves. A vague referral such as “developmental problem” can leave the caregiver uncertain and the receiver unable to triage. A good handover states what was observed, the context in which it was observed, the functional consequence, any already-known health information, and what the referring worker has told the family. When a psychiatrist receives such a child, the referral concern should be checked against caregiver and child accounts before it is interpreted. This protects against both under-recognition and the equally damaging tendency to treat a screening label as settled fact.

STAGE IN THE PATHWAY	PRIMARY PURPOSE	PSYCHIATRIC CONTRIBUTION	COMMON ERROR TO AVOID
Child-contact setting	Notice a possible health or developmental concern	Recognise that distress or behaviour may signal unmet developmental, medical or family needs	Expecting a screening encounter to establish diagnosis
Referral communication	Transfer the reason for concern and the next step	Clarify what the family understands and what may impede attendance	Using a label without describing functional difficulty
Receiving service	Decide what assessment and intervention are needed	Place symptoms in developmental, family, educational and health context	Reducing the case to a narrow specialty
Care plan	Make responsibilities visible to the family and services	Integrate psychological, family and educational needs with other care	Giving advice without a named follow-up route
Review	Check whether the planned help was actually accessed and useful	Reassess function, burden and emerging mental-health needs	Equating referral completion with clinical benefit

The screening population extends from **birth to 18 years**. That breadth should shape a psychiatrist's service thinking. The referral question, the informant and the setting change across childhood and adolescence, even when the broad programme language remains the same. Avoid assuming that the same presentation, threshold for concern, or pathway will be appropriate across the entire age span. The programme gives a common entry point; clinical assessment remains developmentally anchored.

TRAP **Do not describe RBSK as a child psychiatry service.** It is a child-health screening and linkage platform whose categories may bring children with mental-health relevance to attention. The psychiatrist's role begins with collaborative clinical work after the concern has been identified.

26.3 DEIC as the district intervention and coordination hub

A **District Early Intervention Centre (DEIC)** is intended to provide **comprehensive management** under one roof. This phrase should be read functionally. It signals a hub that can receive children flagged through screening, direct them towards appropriate assessment or intervention, and maintain a referral link when the required service lies elsewhere. The value is coordination: the family should not be left to translate a screening observation into a sequence of disconnected consultations.

IN INDIA

For psychiatric practice, RBSK provides a public-system route for a child whose presenting concern crosses developmental, medical, sensory, educational and emotional boundaries. The useful clinical question is not whether the DEIC replaces specialist care. It is whether the centre can help assemble the next assessment, intervention and follow-up steps around a family who may otherwise move between services without a shared plan.

DEICs primarily serve children **up to 6 years of age**. This distinction is important. The broader RBSK screening platform reaches through adolescence, whereas the DEIC is particularly oriented to the early childhood window. In an answer, state the distinction plainly rather than collapsing all RBSK functions into the DEIC. In clinical work, it prompts an early check of whether a young child with a developmental or disability-related concern has an accessible intervention route, while older children may need linkage through the relevant services available locally.

Coordination is not a passive administrative act. It includes making the referral question intelligible, checking whether caregivers can reach the destination service, identifying whether several disciplines must be involved, and ensuring that a child is not lost because one part of the plan is delayed. Psychiatric input can be particularly useful when caregiver anxiety, stigma, conflict about the meaning of the child's difficulties, or behavioural distress threaten engagement. That work is supportive and collaborative. It should not pathologise an understandable family reaction to uncertainty.

> **GOOD TO REMEMBER**
>
> When a young child is referred after programme screening, ask the caregiver to show what the child can and cannot do in daily routines. This converts an administrative referral into a functional clinical question and makes it easier to coordinate advice across services without prematurely assigning a disorder label.

26.4 Why the early-intervention window is emphasised

The rationale for early action is developmental rather than merely administrative. The programme identifies **early intervention** from **birth to 6 years** as a particularly critical period for child development, especially when developmental delay is present. This does not imply that later intervention is futile. It means that delay in recognition can allow difficulties in communication, participation, learning, caregiver confidence and access to support to compound before a plan is in place.

The guideline also locates peak brain **plasticity** in the **birth-2 year period**. For the psychiatrist, this is a reason to act on a credible developmental concern without waiting for every diagnostic uncertainty to disappear. Action may consist of developmental assessment, parent guidance, a medical or sensory referral, educational planning, or help to stabilise an overwhelmed caregiving environment. The exact package must follow the child's formulation. Early intervention is a principle of timely, proportionate response, not a justification for indiscriminate treatment.

Clinical urgency is often obscured by diagnostic anxiety. Families may be told to “wait and see” because a child is young, while professionals fear overcalling a disorder. The better distinction is between caution about labels and inaction about needs. One can remain cautious about diagnosis while actively documenting function, supporting caregivers, arranging relevant evaluations and reviewing change. This is especially important when the child is not yet able to give a full account of internal experience and when the family's ability to navigate services is limited.

26.5 The psychiatrist's role within a non-psychiatric platform

RBSK does not ask the psychiatrist to duplicate general screening. It creates an opportunity for consultation where a child's health finding has psychological, behavioural, developmental or family consequences. The psychiatrist should frame the referral question before deciding the scope of assessment: Is the immediate need clarification of behaviour, support for caregiver coping, evaluation of emotional symptoms, coordination around developmental function, or advice to another service? This protects the child from a broad but unfocused work-up and protects the family from receiving contradictory explanations.

Several principles keep this consultation clinically sound:

- Begin with function in home, learning and peer contexts, rather than with a label carried on the referral card.
- Seek the child's perspective in a developmentally appropriate manner, alongside caregiver and other relevant accounts.
- Separate the emotional effect of a health or developmental concern from symptoms that require their own psychiatric formulation.
- Return a plan that names who will do what, what the family should watch for, and how uncertainty will be reviewed.

This is also where the limits of the platform should be stated honestly. A screening pathway can identify risk or need for further attention, but it cannot substitute for the comprehensive child psychiatric assessment described elsewhere in this chapter. Nor should it be used to re-teach the childhood disorders themselves. When a disorder-specific question becomes central, use the relevant disorder chapter for diagnostic and treatment detail, while retaining the service pathway as the means of linking the child and family to care.

The multidisciplinary implication is practical. Families often experience services as multiple doors, each with a different language and waiting process. The psychiatrist can reduce this burden by translating findings into everyday goals and by ensuring that psychiatric recommendations fit, rather than compete with, developmental, medical, educational and social interventions. A medication decision, if one is eventually indicated, belongs within the child psychopharmacology framework rather than being inferred from an RBSK category.

PITFALL

Do not let a referral label become the child's identity. A programme finding may explain why a child needs further attention, but it does not establish the cause of behaviour, define family capacity, or predict outcome. Record the observed concern and its functional impact before making psychiatric inferences.

26.6 Writing and answering about RBSK with precision

A strong service answer follows the child's journey. Introduce RBSK and the 4Ds, explain screening through Mobile Health Teams in child-contact settings, identify the DEIC as the district hub for coordinated management, and distinguish the wider screening scope from the

primary early-childhood DEIC focus. Then add the clinical implication: early identification only matters when referral, family understanding and follow-up turn it into usable care. This sequence demonstrates that the candidate understands both policy language and what it changes in practice.

Be equally precise about what the programme does not establish. It does not make a psychiatric diagnosis, replace a developmental formulation, or remove the need for disorder-specific assessment and treatment. It does, however, create a structured opportunity to identify children whose needs may otherwise remain invisible. In a service-based chapter, that is its central contribution: it converts an isolated concern into a route that can be followed, clarified and coordinated.

> RBSK uses the 4Ds to identify childhood health concerns and link them to care; the psychiatrist turns a referral into an individual, developmental and family-centred plan.

27 · Integrated Child Development Services and child mental health policy in India

Why this matters clinically. A young child rarely arrives at a psychiatric service because someone has already named a mental-health problem. The concern is more often expressed as difficult behaviour, poor participation in play or learning, feeding trouble, an unresponsive child, a worried caregiver, or a pattern of missed developmental opportunities. The **Anganwadi Services** platform, formerly described as ICDS, matters because it is a continuing child-development contact rather than a specialist clinic. It can make concern visible early, place it in the child's family and nutritional context, and create a route from concern to an appropriate health or developmental response.

For the psychiatrist, this is not a substitute for child psychiatric assessment, a diagnostic service, or a treatment programme. It is a service platform through which health, nutrition, early learning and caregiver contact can be connected. A good answer therefore does not claim that an anganwadi worker diagnoses a disorder. It explains how a developmental platform can notice difficulty, support the caregiver, reduce practical barriers to care, and help a family reach the service that must take responsibility for assessment or treatment.

27.1 The anganwadi platform as a mental-health opportunity

Child mental health in a public system begins before the consulting room. Emotional regulation, communication, play, attention, attachment and behaviour are lived out in ordinary routines. A platform that sees the child in relation to food, play, caregivers and early learning can therefore detect a mismatch between what the child appears able to do and what daily participation demands. This is a developmental opportunity, not a licence to convert every variation into illness.

The useful policy question is practical: what should happen when an adult who knows the child notices that participation has become difficult or that a caregiver is struggling? The answer is a sequence of listening, documenting the concern in plain language, considering whether health or

developmental factors may be relevant, discussing it respectfully with the caregiver, and linking the family to the appropriate service. The specialist's role is to make that pathway clinically intelligible and humane. A referral letter that only says “behaviour problem” abandons the very context that makes the referral useful.

RULE **Use the anganwadi as a bridge into care, not as a diagnostic endpoint.** Its value lies in sustained contact with the child and caregiver, followed by an accountable link to the service that can assess and respond.

There is also a preventive logic. When caregivers receive understandable support around routine, play, communication and help-seeking, they may be better able to act before strain hardens into conflict, exclusion or repeated non-attendance. This is not a claim that one worker or one service can prevent all psychiatric morbidity. It is an argument for locating mental-health work within the child's actual environment, rather than waiting for distress to become severe enough to cross a specialist threshold.

IN INDIA

The anganwadi is especially important as a shared local point of contact. A psychiatrist should ask whether the child attends, what the caregiver has been told there, and whether the family would accept a coordinated conversation. This preserves continuity between clinic advice and daily life without asking a non-specialist platform to carry a specialist clinical burden.

27.2 The integrated package of services

The programme is built around an **integrated package**, rather than a single intervention. It contains **six** services. For clinical reasoning, the list matters less as an enumeration than as a reminder that behaviour and development should not be detached from nutrition, health access, caregiver knowledge or opportunities for early learning.

SERVICE IN THE PACKAGE	WHY IT MATTERS TO A CHILD-MENTAL-HEALTH FORMULATION
Supplementary nutrition	It keeps nutrition within the clinical context when a child presents with low energy, irritability, feeding difficulty or reduced participation.
Pre-school non-formal education	It provides a natural setting in which play, participation, communication and separation from the caregiver may be discussed.
Nutrition and health education	It creates a caregiver-facing channel for simple, non-stigmatising discussion of routines and help-seeking.
Immunization	It illustrates that some elements of the package depend on connection with the health system rather than stand alone at the centre.
Health check-up	It encourages the clinician to keep physical and developmental contributors in view when a behavioural concern is raised.
Referral services	It is the operational route by which a concern can move beyond observation to a service with the needed competence.

The integration is clinically useful because the same presentation can have multiple meanings. A child who is quiet in a group may be temperamentally reserved, physically unwell, fearful, communication-impaired, poorly nourished, overwhelmed by demands, or distressed by adversity. The platform should not decide among these possibilities by label. It should preserve observations, ask what has changed, involve the caregiver and create a route for further evaluation when the concern persists, impairs participation, or raises safety concerns.

- Describe what is observed before attaching a diagnostic explanation.
- Ask about the child's everyday routine, participation and the caregiver's understanding of the difficulty.
- Record what action was agreed, who will make contact, and what information needs to travel with the referral.

PLATFORM	BRIDGE	TASK
CHILD-DEVELOPMENT CONTACT	CAREGIVER TO SERVICE	NOTICE, LINK, FOLLOW THROUGH

27.3 Age focus and the clinical frame

The core child focus is **0-6 years**. This makes the platform particularly relevant to the early period in which a clinician often has to work from observation, caregiver report and the child's functioning in familiar settings. It also explains why the language of policy should remain child-development language: routine, play, communication, feeding, sleep, interaction and participation can be discussed without prematurely converting the child into a diagnosis.

A psychiatrist should resist two opposite errors. The first is to romanticise early childhood and dismiss meaningful impairment as a phase. The second is to make a categorical psychiatric diagnosis from a brief community observation. The platform is most valuable when it supports **developmentally informed observation**: what the child does across situations, what caregivers notice, what appears to help, what worsens the difficulty, and whether the child can participate in expected daily life.

Caregiver engagement is central here. Advice that ignores food insecurity, caregiving burden, transport difficulty, family conflict, stigma or a caregiver's own distress is unlikely to be carried into the home. The service contact can instead become a place where the caregiver is treated as an informant and partner. That stance is clinically safer than presenting professional opinion as a verdict on parenting.

TRAP **Do not mistake a programme contact for a completed mental-health assessment.** A familiar setting can yield valuable observations, but formulation, diagnosis and treatment decisions require the child psychiatric assessment framework.

27.4 Working with the Anganwadi Worker

The **Anganwadi Worker** is a named provider for supplementary nutrition for children aged **3 to 6 years**. That narrow, verified statement is enough to make an important clinical point: the worker's relationship to the child and caregiver is embedded in ordinary service use. The psychiatrist should build on that relationship without turning the worker into an informal mental-health technician.

Useful collaboration is specific. With caregiver agreement, the clinical team can ask for concrete observations about attendance, participation, interaction with peers and adults, response to routines, and changes from the child's usual pattern. It can then return equally concrete advice: what the family has agreed to try, what signs should prompt renewed contact, and whether the worker's support is limited to encouragement, observation or helping the family navigate a referral. Vague requests to “monitor behaviour” invite judgement and inconsistent reporting.

GOOD TO REMEMBER

When writing to a community contact, state the function rather than the diagnosis: “please note participation in play and response to routine” is more useful and less stigmatising than asking the worker to verify a psychiatric label.

Confidentiality and dignity still apply. Community collaboration is not a reason to circulate a child's clinical history. Share only the information necessary for the agreed task, speak with the caregiver rather than around them, and avoid language that brands the child as difficult, abnormal or dangerous. If there is a safeguarding concern, the clinical response and legal duties belong to the child-protection pathway discussed elsewhere in this chapter, not to informal management at the centre.

27.5 Referral, follow-through and policy translation

The point of referral is continuity. A referral becomes useful only when it carries enough context for the receiving service to understand why the concern arose and when the family can realistically complete the next step. A **functional referral** identifies the observed concern, relevant changes, caregiver concerns, actions already attempted and the reason a further opinion is needed. It does not require the community worker to make a diagnostic claim.

For the psychiatrist, policy translation means turning a broad platform into a usable local pathway. That pathway should identify who speaks to the caregiver, where the child should go next, how feedback returns to the family, and who notices if contact is lost. The details will vary by locality and service availability. What should not vary is ownership: a child should not be passed from one doorway to another because each service assumes that referral alone completes care.

- Make the next contact understandable to the caregiver, including its purpose and practical requirements.
- Use plain descriptions of concerns so that the family can repeat them accurately to the receiving service.
- Seek **closed-loop communication** where feasible: confirmation that contact occurred, clarification of the next responsibility, and renewed outreach when the plan has failed.

MNEMONIC

LINK

Listen to the caregiver, **I**ntegrate the child's daily context, **N**avigate to the appropriate service, and **K**eep responsibility visible until the next link is made.

Existing school mental-health work and the RBSK screening platform may be named as neighbouring parts of the wider child-service environment, but their structures and methods are distinct. Similarly, specialist treatment, early intervention and educational support require their own assessment and service pathways. The exam-worthy point is coordination: a platform is useful when it makes the right next contact more likely, not when it claims to contain every needed intervention.

PITFALL

Do not use the word “referral” as if it ends clinical responsibility. A slip of paper, an instruction to “go to hospital”, or an uncontextualised label can leave a caregiver unable to act. The clinically meaningful unit is a referral that the family understands and a pathway that can recognise non-completion.

27.6 How to write the service answer

A strong service answer begins with the platform's purpose, states the service package, and then explains its mental-health relevance through early recognition, caregiver engagement, contextual observation and referral. It distinguishes the function of a community child-development service

from the function of a specialist mental-health team. It also avoids the false choice between medical and social explanations: both may matter to a child's participation, and the service platform is designed precisely to keep these domains in conversation.

In practice, the psychiatrist's contribution is often to improve the quality of the handover. The medical record should translate complex formulation into a small number of observable goals, while preserving diagnostic nuance within the clinical team. The community contact should receive only what is needed to support the caregiver and the agreed plan. Where a child needs specialist assessment, the relevant assessment, treatment and protection chapters should guide that work; the anganwadi platform remains the local bridge, not the place where those specialised functions are reproduced.

> Anganwadi Services are an integrated child-development platform whose mental-health value lies in contextual observation, caregiver partnership and a reliable bridge to appropriate care.

Child protection, abuse and juvenile justice

28 · Types of child abuse (physical, sexual, emotional, neglect)

Why classification matters clinically. A child-protection formulation begins by naming the kind of harm that is being considered. Vague labels such as “a difficult home” or “poor parenting” can conceal the central question: has a child been harmed, or placed at risk of harm, within a relationship in which an adult or another person holds responsibility, trust, or power? **Child maltreatment** gives the clinician a vocabulary for making that distinction. It is not a diagnosis, an accusation, or a prediction of how a family will be judged. It is a protection concept that keeps the child’s health, survival, development and dignity in view.

The WHO framing applies to children **under 18 years of age**. It places apparently different experiences within a shared clinical frame: harm may be enacted on the body, imposed through sexual violation, communicated through degrading or frightening relationships, or created by a failure to provide necessary care. The categories are useful because they direct attention to the pathway of harm. They are not mutually exclusive boxes. The strip below names the four pathways that carry distinct clinical indicators; commercial and other exploitation is the fifth element of the same definition and is set out in the comparison table rather than the strip. The operational descriptions in this section are explanatory synthesis for teaching, not definitions established by the cited row, and the fragment records that as a declared gap. A child may live with several forms at once, and the most damaging feature may be the cumulative pattern rather than the event that initially brought the family to attention.

PHYSICAL	SEXUAL	EMOTIONAL	NEGLECT
HARM THROUGH ILL-TREATMENT	VIOLATION AND SEXUAL EXPLOITATION	HARM WITHIN RELATIONSHIPS	HARM THROUGH UNMET CARE AND NEGLIGENCE

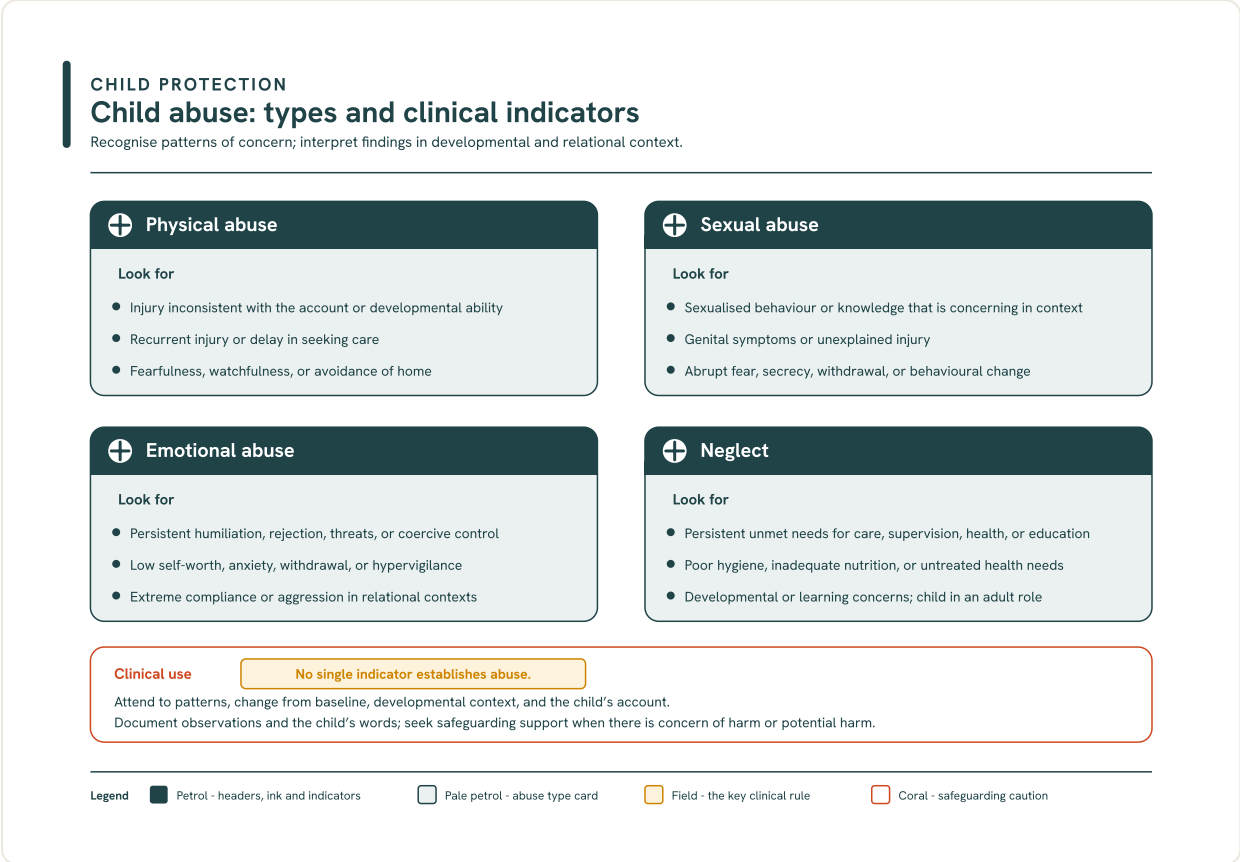


Fig 24.12. The types of child maltreatment set against the clinical indicators that should raise concern. An indicator is a reason to look further and to act on safety, never a finding of fact on its own.

28.1 The organising idea: maltreatment is relational harm

The key to the definition is not simply that a child is distressed or injured. Children can be distressed by illness, bereavement, poverty, conflict, developmental difference and many other adversities. Maltreatment concerns harm that occurs in a **relationship of responsibility, trust or power**. This directs attention to the asymmetry between the child and the person or system on which the child depends. The question is therefore not whether an adult intended to be cruel, but whether the relationship has exposed the child to harm or failed to protect the child from it.

That relational emphasis prevents errors in opposite directions. Narrowing abuse to an obviously violent act can overlook chronic humiliation, coercive sexual conduct, abandonment of care, or exploitation. Treating every imperfect interaction as maltreatment is equally unhelpful. Clinical thinking must hold context without making context an excuse. A parent may be exhausted, frightened, unwell or materially constrained; these circumstances can help explain a pathway, but they do not erase the child's experience of danger, deprivation or degradation. The task of classification is to describe what has happened to the child before attempting to explain why it has happened.

RULE **Classify the pathway of harm before you interpret the family's intention.** Physical, sexual, emotional, neglectful and exploitative experiences may coexist, and each describes a different route by which a child's welfare can be compromised.

For teaching and documentation, it is helpful to distinguish the *act or omission* from its *effect*. The same act may be experienced differently according to the child's developmental understanding, dependence, prior experiences and the surrounding relationship. Conversely, the same emotional outcome may arise from different types of maltreatment. This is why classification is a starting point for formulation, not a substitute for it. It gives a shared language to the multidisciplinary team while preserving the need to understand the individual child.

- Describe the child's experience before assigning a family explanation.
- Identify whether the route of harm is an act, an omission, exploitation, or a combination.
- Ask how responsibility, trust or power has shaped the child's freedom and safety.

28.2 Physical abuse: harm enacted on the body

Physical ill-treatment refers to harmful physical acts directed towards a child. Its clinical meaning is broader than visible injury. The body may be used as the site of punishment, intimidation, control or retaliation; a child can learn that safety depends on anticipating an adult's mood rather than on receiving reliable care. The defining concern is the harmful use of physical force or physical treatment within the unequal relationship, not the explanatory story offered after it.

Physical abuse is often imagined as a discrete incident because incidents are easy to narrate. Yet its psychological significance can also lie in the atmosphere it creates: vigilance, fear of making mistakes, concealment, divided loyalties and an altered sense of what care should feel like. The child may protect the caregiver, minimise the event, or describe it as deserved. Such language should not be read as proof that the experience was benign. Children commonly organise their accounts around preserving attachment and avoiding consequences, especially when the person who hurts them is also a source of food, shelter, affection or authority.

Classification also requires restraint. The psychiatrist does not decide the truth of a family narrative merely from a label such as "discipline," "accident," or "misbehaviour." Those words are interpretations. The clinical category asks a prior question: was physical treatment used in a way that harmed the child or placed the child at risk? This keeps the focus on the child without prematurely converting a clinical discussion into a forensic conclusion. Detailed recognition of indicators and the safeguarding response belong in the dedicated sections on clinical indicators and management.

> **GOOD TO REMEMBER**
>
> When a child describes physical punishment, listen for the relational meaning as well as the event. Fear, secrecy, conditional affection and the child's belief that pain is deserved may be clinically important even when the child does not use the word "abuse."

28.3 Sexual abuse: violation of bodily and relational boundaries

Sexual abuse concerns sexual violation of a child and includes sexual conduct that exploits the child's developmental dependence, lack of freedom, or inability to give meaningful agreement. Its defining clinical feature is not restricted to overt force. Secrecy, grooming, inducement, threats,

emotional manipulation and misuse of authority can all shape the child's experience of entrapment. The category is therefore about an adult or more powerful person using the child for sexual purposes, not about whether the child appeared compliant, curious, affectionate, or unable to resist.

This distinction matters because children may not recognise a sexual experience as abusive while it is occurring. They may have been told it is normal, private, loving, deserved, or dangerous to disclose. They may also be frightened of loss, blame or disruption within the family. A clinician should avoid importing adult assumptions about consent, resistance or disclosure into the child's account. Compliance can reflect dependency, fear, confusion, conditioning or an attempt to preserve a crucial relationship. It does not convert exploitation into a voluntary relationship.

Sexual abuse also needs to be kept conceptually separate from its psychiatric sequelae. A child may present with fear, shame, behavioural change, dissociation, somatic distress, sexualised behaviour, mood symptoms or no obvious psychiatric symptom. These presentations are not themselves the definition of sexual abuse, and the absence of a particular presentation does not settle the question. The safeguarding-specific assessment, including how to take an account without contaminating it, is taught in the section on child sexual abuse assessment and psychiatric sequelae. Legal duties and procedures belong in the dedicated statutory section.

TRAP **Do not equate absence of force or apparent cooperation with absence of sexual abuse.** The clinical concept centres on exploitation within unequal power, not on an adult model of freely negotiated sexual choice.

28.4 Emotional abuse: injury communicated through the relationship

Emotional ill-treatment is harm conveyed through how a child is repeatedly regarded, spoken to, controlled, rejected or frightened. It is sometimes called psychological abuse, but the central point is simpler: the child receives an enduring message that safety, worth, belonging or reality itself cannot be relied on. Unlike a physical act, the injury may not be visible to others. Unlike an isolated harsh remark, the concern is the harmful relational pattern and its impact on the developing child.

Emotional abuse can operate through contempt, humiliation, terrorising, scapegoating, isolation, hostility, coercive control, exposing the child to a persistently threatening interpersonal climate, or making affection contingent on compliance. These descriptions should be used as conceptual pathways rather than as a checklist to be mechanically scored. Their common mechanism is an attack on the child's secure sense of self and relationship. A child may adapt by becoming excessively compliant, volatile, withdrawn, perfectionistic, parentified or chronically alert to others' emotional states. Such adaptations can be mistaken for temperament, defiance or maturity unless their relational context is examined.

It is tempting to treat emotional abuse as less serious because there is no obvious physical injury. That is a category error. Emotional maltreatment can be the principal form of harm in a family, but it also commonly accompanies physical abuse, sexual abuse and neglect. It may be embedded in everyday language, threats, denigration or unpredictable caregiving, making it difficult for

children and professionals to name. The psychiatrist's contribution is often to translate a child's diffuse symptoms and relational expectations into a coherent account of how the environment has become psychologically unsafe.

Care is needed not to medicalise ordinary conflict, cultural difference, an impatient exchange, or the caregiver's understandable distress. The clinical question is whether a pattern of interaction is degrading, frightening, rejecting, controlling or otherwise harmful to the child. That question remains child-centred while allowing a compassionate understanding of family stress. The aim is neither to moralise nor to excuse, but to identify the relationship that the child is having to survive.

PITFALL

Do not dismiss emotionally harmful parenting as merely "a family style" because it lacks a visible injury. Conversely, do not label every family disagreement as emotional abuse. The formulation turns on the child's sustained experience of harm within a dependent relationship.

28.5 Neglect: harm through omission of care and protection

Neglect is the failure to provide or secure care, protection or responsiveness that a child requires. It is often misunderstood as the passive counterpart of abuse. In fact, omission can be an active source of harm: the child is left without reliable attention to basic needs, safety, health, emotional availability, supervision or access to necessary support. Neglect is therefore not defined by a caregiver's emotional distance alone, nor by material hardship alone, but by the child's unmet needs in a relationship where care should be organised.

This category demands especially careful reasoning. Some families face severe constraints and may genuinely lack resources, services, housing security or support. A child can be harmed by deprivation even where no caregiver wishes harm. The clinician should recognise that structural adversity and neglect may coexist without collapsing them into the same moral judgement. What matters for the classification is the lived pattern of unmet need, the available caregiving capacity and whether those responsible for the child are failing to protect or seek help in ways that expose the child to avoidable harm.

Neglect may be physical, emotional, educational, medical or supervisory in its expression, but these are ways of thinking about the area of unmet need rather than separate diagnoses. Emotional neglect deserves particular attention in psychiatric practice. A child may be fed, clothed and attending school while receiving little comfort, attunement, protection or response to distress. Such a child can appear outwardly cared for and yet experience relationships as unavailable or unreliable. Conversely, a caregiver's temporary inability to meet every need during crisis should be understood in context rather than assumed to establish a chronic pattern.

Because neglect often unfolds gradually, it can disappear into the background of a family story. The child may not complain because there is no remembered alternative. Professionals can also become habituated to low expectations for a child who is described as "independent" or "used to managing." A developmentally inappropriate burden of self-care is not evidence of resilience by

itself. It may be an adaptation to the absence of dependable adult care. The precise indicators and intervention pathway should be sought in the subsequent protection sections rather than inferred from this classification alone.

- Ask what the child needs in order to be safe, cared for and emotionally held.
- Ask which of those needs are persistently unmet and how the child compensates.
- Keep structural deprivation in the formulation without allowing it to obscure a child's unmet need for protection.

28.6 Overlap, cumulative burden and exploitation

The categories should be distinguished in order to be recognised, then brought back together in formulation. A child who is physically harmed may also be threatened and humiliated. Sexual abuse may be sustained by emotional manipulation and by the neglect of adults who fail to notice or protect. Neglect may coexist with a climate of rejection that makes it emotionally abusive as well. Recording only the most dramatic type can flatten the child's experience and can lead the team to miss the mechanism that keeps the harm in place.

TYPE	CENTRAL PATHWAY OF HARM	QUESTION THAT SHARPENS FORMULATION	COMMON INTERPRETIVE ERROR
Physical ill-treatment	Harm enacted through physical treatment	How is force, pain or bodily control being used in the relationship?	Reducing the account to an isolated injury
Sexual abuse	Sexual violation or exploitation of dependency	How are power, secrecy, inducement or coercion shaping the child's freedom?	Reading compliance as consent
Emotional ill-treatment	Harm conveyed through the relational environment	What repeated message about safety, worth or belonging does the child receive?	Ignoring harm because it is not visible
Neglect and negligence	Harm through unmet care, protection or responsiveness	Which needs remain unmet, and how does the child manage without dependable care?	Confusing material adversity with the whole formulation
Commercial or other exploitation	Harm through use of the child for another's gain	Who benefits from this child's labour, body, image or dependency?	Treating exploitation as a social problem outside the clinical formulation

The WHO framework also includes **commercial or other exploitation**. This reminder matters because a child can be harmed when another person gains from the child's vulnerability, labour, body, image, access, status or dependency. Exploitation may overlap with physical, sexual, emotional and neglectful maltreatment, but it directs attention to the use of the child for

another's benefit. The clinician need not force every experience into a single label. A better formulation states the principal pathways and explains how they interact.

MNEMONIC

Body, boundaries, belonging, basics, benefit

Use this as a brief bedside prompt: physical ill-treatment concerns the body; sexual abuse violates boundaries; emotional ill-treatment attacks belonging and safety; neglect and negligence leave the basics of care and protection unmet; exploitation turns the child into another person's benefit. It is a memory aid, not a substitute for a child-centred formulation.

28.7 Language, formulation and the limits of classification

Precise language protects the child and the clinical record. "Abuse" is a useful umbrella term in teaching, but a formulation should say what is meant: physical ill-treatment, sexual abuse, emotional ill-treatment, neglect, negligence or exploitation. The WHO description explicitly includes **negligence** alongside abuse and neglect. Naming the pathway avoids euphemism, but it should not turn a child's complex account into a label that speaks over them. Whenever possible, retain the child's own words alongside the clinician's conceptual description.

Classification has limits. It does not determine credibility, identify an alleged perpetrator, establish legal liability, replace a developmental assessment, or dictate the immediate safeguarding response. It also does not tell the clinician the child's psychiatric diagnosis. The WHO scope remains the child **under 18 years of age**, but the category alone does not explain that individual child's developmental needs or psychiatric presentation. The disorders that may be relevant to a child's presentation are addressed in the Child behavioural, emotional and other disorders notes and the Intellectual disability and autism spectrum disorder notes. Normal developmental context belongs in the Normal child development and milestones notes. Here, the aim is narrower and foundational: recognise the form of maltreatment without losing the person inside the category.

IN INDIA

In Indian practice, family, school, neighbourhood and extended-kin settings can all shape how a child describes harm and whom the child believes can be told. Use plain, non-accusatory language when eliciting the child's account, while keeping the clinical formulation explicit. Cultural sensitivity should improve understanding of context; it must not make coercion, degradation, sexual violation or unmet care invisible.

A useful final distinction is between classification and response. The present section helps the clinician identify the type of maltreatment. Recognition of clinical indicators is covered separately; child sexual abuse assessment and psychiatric sequelae have their own section; statutory obligations are addressed in the dedicated statutory section; and the safeguarding response is covered in the management and intervention section. This division is deliberate. In practice these tasks are connected, but clear conceptual boundaries prevent a rushed label from becoming a substitute for careful assessment, protection and treatment.

Child maltreatment is best understood as harm or threatened harm within a relationship of responsibility, trust or power: name the pathway - physical, sexual, emotional, neglectful or exploitative - then formulate the child's whole experience.

29 · Clinical features and indicators of child abuse

Why it matters clinically. Abuse is often first encountered as an ordinary clinical presentation rather than as a declared safeguarding concern. The child may be brought for pain, a change in behaviour, a poorly explained injury, or a difficulty noticed by another adult. The psychiatrist's contribution is not to convert a sign into an accusation. It is to recognise when the presentation cannot safely be treated as routine, to distinguish observation from interpretation, and to preserve the child's account and the clinical evidence with care.

Clinical indicators are signals for concern, not diagnostic labels. Their value lies in the relationship between the observed finding, the account offered for it, the child's developmental capacities, and the wider clinical context. An unexplained or patterned injury, a disclosure, or a behavioural change can each be clinically important. The central question is not whether a clinician can prove abuse in the consulting room. It is whether the available information makes a benign account inadequate and requires the presentation to be held as a possible protection concern.

29.1 The purpose and limits of clinical indicators

An indicator is a feature that should alter clinical attention. It may arise from the body, the history, the child's words, behaviour, or the relation between these sources. It does not identify a perpetrator, establish intent, or settle a legal question. This distinction protects both the child and the quality of clinical reasoning. A clinician who dismisses concern because one feature is non-specific may miss the pattern. A clinician who treats one feature as conclusive may contaminate an assessment, harden an uncertain narrative into a fact, and cause avoidable distress.

The useful mental move is from isolated sign to coherence. Ask what has been observed; what account is being given; whether the account can plausibly explain the observation; and whether the child can meaningfully corroborate, contradict, or qualify it. This is a reasoning task, not an exercise in detecting a particular kind of family. Abuse can be concealed within an apparently coherent story, while an anxious or inconsistent caregiver may still be describing an accidental event. The clinical standard is disciplined curiosity: neither premature reassurance nor premature certainty.

RULE **Read the finding and the explanation together.** A mark on the body is clinically meaningful in relation to its pattern, the account of how it arose, the child's capacities, and the rest of the presentation.

Indicators should also be understood as prompts to slow down. In ordinary practice, time pressure encourages rapid closure: a plausible explanation is accepted, the injury is coded, and

attention shifts to symptom relief. Protection work requires the opposite habit when concern is raised. The practitioner separates what was seen from what was reported, records uncertainty honestly, and avoids allowing the emotional force of a case to replace careful description. This is especially important in psychiatry, where behaviour may be quickly attributed to temperament, stress, or a psychiatric disorder even when the change requires a broader safeguarding lens.

OBSERVE	COMPARE	CONTEXTUALISE
WHAT IS PRESENT	ACCOUNT WITH FINDING	DEVELOPMENT AND PRESENTATION

29.2 Pattern as clinical evidence

Patterned bruising is a particularly important physical indicator because the morphology of the mark can retain information about the force or object involved. Clinical recognition guidance treats bruising in the shape of a **hand or ligature**, **stick, teeth mark, grip or implement** as a reason to suspect maltreatment. The teaching point is not that every such mark determines the history. It is that a recognisable pattern should make an unexamined explanation feel insufficiently safe.

Describe before interpreting. The record should preserve the clinician's own observations in plain language, including what made the mark appear patterned, rather than replacing description with a conclusion. A conclusion can later be tested against examination, photographs where lawfully obtained, medical opinion, and the evolving history. A vague note such as “bruise present” loses the very feature that generated concern. Equally, a categorical note that labels an injury as abuse overstates what the observation alone can establish.

Pattern matters because accidental histories commonly describe an event, whereas a patterned mark invites attention to the means by which force may have been applied. That is a clinical inference to examine, not a shortcut to judgment. The account should be heard without coaching or adversarial questioning. The psychiatrist may need to acknowledge that a caregiver's narrative is emotionally compelling while still recognising that it does not answer the physical question raised by the finding.

GOOD TO REMEMBER

When an injury is concerning, the most useful note separates observation, reported history, and clinical interpretation. This preserves both the uncertainty and the reason concern was raised.

A pattern can be missed when the consultation is framed around an apparently unrelated symptom. A child may be distressed, withdrawn, irritable, or reluctant to be examined. The task is not to search the body indiscriminately, but to allow physical findings that are already apparent or clinically relevant to alter the assessment frame. The psychiatrist should remain alert to the possibility that emotional and physical data belong to the same presentation without assuming that they do.

29.3 The unsuitable explanation test

A clinician should be concerned by **bruising or petechiae** that are not explained by a medical condition when the history offered is unsuitable. This is a combined test. The physical finding must be considered alongside medical possibilities and the account of its occurrence. It is not sound practice to infer maltreatment merely because a bruise has no immediately obvious cause. Nor is it safe to accept a history merely because it is confidently delivered.

An **unsuitable explanation** is one that is **implausible, inadequate or inconsistent**. In practice, the explanation is examined against the presentation, the child's ordinary activities, any relevant medical condition, and developmental stage. An account may be unsuitable because it does not describe a mechanism capable of producing the observed finding, because essential elements change, or because it asks the child to have done something outside their capacities. The point is not to demand a perfect story from frightened adults. It is to notice when the story does not carry the clinical weight placed upon it.

CLINICAL QUESTION	WHAT IS BEING EXAMINED	WHY IT MATTERS
What is observed?	The finding itself, described without conclusion.	It keeps the record anchored to evidence.
What account is offered?	The reported sequence and mechanism.	It identifies what is being tested, rather than what the clinician assumes.
Could the account fit?	Its plausibility in the clinical and developmental context.	It reveals whether reassurance is justified.
What else could explain it?	Medical and contextual alternatives.	It prevents both missed illness and over-attribution.

This formulation is deliberately more rigorous than asking whether the adult “seems believable.” Demeanour is a poor substitute for evidence. Fear, shame, anger, exhaustion, language difference, and prior difficult experiences with institutions can all affect how a history is given. Conversely, a calm account can be rehearsed. The clinical work is therefore to compare content with content: the observed presentation, the mechanism described, and the child's developmental context.

TRAP **Do not equate inconsistency with proof.** An inconsistent account increases concern when it cannot explain the presentation; it does not by itself establish why the inconsistency occurred.

Medical uncertainty should not be used as a refuge from safeguarding thought. If a medical condition is possible, it deserves proper consideration. If the account remains unsuitable after that consideration, the presence of an alternative question does not erase the protection question. These lines of reasoning can proceed together. Psychiatry contributes by resisting simplistic psychological explanations for either the child or the caregiver, and by keeping the formulation open enough for new information to matter.

29.4 Hidden injury and delay in seeking care

Concern is heightened when a child has an **intra-abdominal or intrathoracic injury** in the absence of major confirmed accidental trauma and there is no explanation, an unsuitable explanation, or **delay in presentation**. This is a useful corrective to the visual bias of clinical practice: a serious injury may not declare itself through an external mark. The **absence of external bruising** does not remove concern in this setting.

Delay is not a moral verdict on a caregiver. Families may encounter fear, uncertainty, limited resources, competing demands, or difficulty recognising severity. Its clinical importance comes from the way it interacts with the injury and the history. A delay can be understandable, or it can sit uneasily beside a presentation that requires explanation. The psychiatrist should avoid transforming this indicator into an accusation about care-seeking. Instead, it should prompt careful clarification of what was noticed, when concern arose, what changed, and how the family understood the child's condition.

The same discipline applies to the absence of an explanation. “No explanation” may mean that nobody asked in a way the child could understand, that the available adult does not know, that communication is difficult, or that an account has not yet emerged. It is an important clinical state, but not a completed conclusion. A quiet, non-leading approach protects the integrity of what the child says and avoids making the consultation into an interrogation.

> **PITFALL**
>
> Do not let an unremarkable skin examination create false reassurance when the clinical presentation raises concern about internal injury. Visible and invisible evidence do not have the same relationship in every case.

29.5 Behaviour, preoccupation, and the meaning of a disclosure

Behavioural indicators demand particular restraint because behaviour is meaningful but rarely self-interpreting. A behavioural change may signal distress, but it is not an abuse determination. The psychiatrist should ask whether the change fits the child's broader presentation and whether it is accompanied by other concerning information. Its value is often as a reason to listen more carefully, rather than as a label placed on the child or family.

A **disclosure** is itself a high-risk clinical signal. It should not be dismissed because it is difficult to hear, incomplete, or not immediately corroborated in the consultation. The clinician must distinguish the child's communication from the clinician's interpretation of it. Detailed evaluation of a possible sexual-abuse disclosure belongs to the child sexual abuse assessment and psychiatric sequelae section; the present task is recognition without premature conclusion.

In a **pre-pubertal child**, **repeated or coercive sexualised behaviours or preoccupation** should raise suspicion of maltreatment, particularly sexual abuse. The term requires careful use. It does not refer to a clinician's discomfort with a child, a family, or a topic. It describes behaviour or preoccupation whose repetition or coercive quality makes it a protection indicator in the relevant

developmental context. The child should not be shamed, labelled, or treated as responsible for the concern raised by their behaviour.

There is a vital distinction between recognising an indicator and conducting a sexual-abuse assessment. The latter is a specialised safeguarding evaluation and is addressed in the child sexual abuse assessment and psychiatric sequelae section. The general child psychiatric assessment framework is set out in the assessment section of this chapter. Here, the responsibility is narrower and earlier: notice the signal, take it seriously, avoid contaminating the account, and do not reduce it to a disorder label.

MNEMONIC

See, hear, separate, preserve

See the finding, **hear** the account, **separate** observation from inference, and **preserve** the child's words and the clinical uncertainty.

29.6 Integrating indicators without overreach

Integration means asking whether different pieces of information support, contradict, or leave unanswered the working account. Physical findings, behaviour, the child's communication, the reported mechanism, and the timing of presentation should not be pooled into a dramatic narrative merely because each is concerning. They should remain distinguishable. A strong formulation names what is known, what is reported, what is inferred, and what remains uncertain. This form of precision is clinically protective: it permits later reviewers to see the reasoning rather than inherit an unsupported conclusion.

The psychiatrist should also be alert to diagnostic overshadowing. A pre-existing developmental, behavioural, emotional, or physical difficulty can become an all-purpose explanation for new concerns. It should instead be treated as context. It may affect communication, examination, emotional expression, and the way adults understand the child; it does not make the child less deserving of a safeguarding formulation. For normal temperament, developmental norms and milestones, see the Normal child development and milestones notes. For childhood disorders themselves, see the Child behavioural, emotional and other disorders notes.

Conversely, safeguarding concern must not become a substitute diagnosis for every presentation involving adversity. The child may need a psychiatric formulation for distress and impairment while the facts around possible abuse remain incomplete. Holding both truths prevents a false choice between “mental health problem” and “protection problem.” It also prevents the clinician from allowing a familiar diagnosis to close inquiry into a newly concerning sign.

REASONING ERROR	WHY IT FAILS	BETTER CLINICAL POSITION
One sign is decisive	Indicators are not equivalent to proof.	State the concern and the evidence that supports it.
One benign possibility ends inquiry	Possibility is not explanation.	Test whether it accounts for the actual presentation.
Behaviour explains the injury	Psychiatric formulation can obscure physical evidence.	Keep physical and psychological observations in view.
Inconsistency explains motive	Clinical observation cannot infer intent from discrepancy alone.	Record the discrepancy and retain uncertainty.

Language matters. “Alleges,” “claims,” and “admits” can insert judgement into the record. Neutral attribution is usually better: “the child said,” “the caregiver reported,” “the clinician observed.” Such wording does not weaken the seriousness of a concern. It makes clear whose information is being recorded and protects against an assessment becoming more certain on paper than it was in the room.

29.7 Indian clinical use of recognition guidance

IN INDIA

The indicator set used here is clinical recognition guidance drawn from **NICE** guidance. It should not be presented as an Indian statutory or national standard. The clinical signs remain useful because recognising concern precedes the locally governed protection response; the legal and service pathway is addressed in the protection sections of this chapter.

For the Indian postgraduate reader, the practical implication is modest but important. Use the indicators to improve recognition and documentation, not to borrow a foreign legal framework. A psychiatrist may encounter the child in a general hospital, outpatient setting, school-linked service, or mental-health service. The setting changes access to collateral information and the immediate clinical environment, but it does not change the need for careful observation, respectful listening, and disciplined language. What happens after recognition belongs to the management and statutory sections, not to the indicator list itself.

Cultural humility is part of clinical accuracy. Family practices, language, privacy, and power differences affect what can be asked and what will be said. They must not become reasons to lower the threshold for attentive listening, nor reasons to pathologise unfamiliar family life. The clinician should maintain the same evidentiary discipline across families: attend to the observed presentation, evaluate the suitability of the account, and acknowledge uncertainty where it remains.

29.8 A defensible clinical formulation

A concise protection-oriented formulation can be written without claiming more than the evidence permits. It identifies the presenting concern, the material indicator, the account offered, the degree to which that account fits the presentation, and the child's current emotional or behavioural state. It then states the level of concern in neutral language. This helps the next

clinician understand why the case could not be treated as routine, while avoiding a forensic conclusion beyond the encounter's scope.

It is equally important to make absence visible. If the child has not provided an account, say so without implying that this reassures. If an explanation is unavailable, say that it is unavailable rather than inventing a reason. If a medical possibility is under consideration, distinguish it from a confirmed explanation. Precision at these points prevents a later reader from mistaking silence for denial, delay for proof, or uncertainty for lack of concern.

- Record what was observed without converting it into a conclusion.
- Record whose account is being reported and where the account does not fit the presentation.

> Clinical indicators of abuse require recognition, not premature conclusion: preserve the finding, test the explanation, hear the child, and keep uncertainty explicit.

30 · Child sexual abuse assessment and psychiatric sequelae

Why this matters clinically. An assessment after suspected or disclosed child sexual abuse is not an exercise in extracting a complete account. It is a psychiatric encounter conducted in the presence of possible trauma, compromised safety, family conflict, and a legal process that may later scrutinise the record. The clinician's first task is to create enough psychological safety for the child to be heard without turning the consultation into an investigation. The second is to identify the child's current needs and formulate a plan that protects both care and the quality of the child's account.

Marks in this area are earned by showing that one understands the distinction between a clinical assessment and a forensic investigation. The psychiatrist contributes careful listening, mental-state assessment, developmental understanding, risk formulation and treatment planning. The psychiatrist does not need to prove the allegation, determine credibility by demeanour, or repeatedly seek detail in the hope that certainty will emerge. For the general child psychiatric framework, including the developmental history and multi-informant approach, see the child psychiatric assessment section.

Listen	Assess	Formulate	Document
THE CHILD'S WORDS	CURRENT SAFETY	PSYCHIATRIC NEED	OBSERVATIONS CLEARLY

30.1 The purpose and stance of the assessment

The useful opening question is not, “Did this happen?” but, “What does this child need from me now?” That question keeps the assessment clinically anchored. A disclosure may be direct, partial, withdrawn, communicated through behaviour, or reported by another person. None of these forms authorises the clinician to infer an event from a single sign. Equally, an apparently calm child, an inconsistent sequence, or an absence of dramatic affect does not settle the matter in the opposite direction. Children communicate under developmental, relational and emotional constraints; the task is to understand those constraints rather than treat them as a test of truthfulness.

A **trauma-informed stance** means that the interview is paced around the child's capacity to participate. It gives the child a sense of control over pauses, clarification and the limits of what can be discussed. It uses language the child can understand, accepts uncertainty, and avoids disapproval, shock or leading reassurance. The clinician should be steady rather than neutral in the cold sense: the child should experience belief that their distress matters, without being supplied a narrative that is not their own.

The assessment has several linked purposes:

- to establish immediate safety and the need for medical or protective action;
- to understand the child's account sufficiently for clinical care while preserving spontaneity; and
- to assess consequences, risks and supports for the child and caregiving system.

RULE **Ask enough to care safely, not enough to conduct the investigation yourself.** Open prompts and reflective listening can clarify the child's immediate needs. Repeated, detail-seeking questioning can overwhelm the child, blur the source of information and make later accounts harder to interpret.

This boundary is clinically protective, not evasive. The psychiatrist may need a concise account of what the child says occurred, when there may have been contact, whether the alleged source of harm remains accessible, and what the child fears will happen next. Those questions serve safety and treatment. A fuller evidentiary account belongs in the appropriate safeguarding and legal pathway. The statutory duties and child-friendly procedures are addressed in the section on the POCSO Act, and the clinical safeguarding response is addressed in the management of child abuse cases section.

30.2 Preparing the setting and beginning the conversation

The setting communicates before the clinician speaks. Privacy, an unhurried pace and a predictable structure reduce the sense that the child is being examined for a performance. Before meeting the child, obtain the referral account, identify those present, and consider whether an accompanying adult may be a source of fear, pressure or information contamination. The child's preference about who remains nearby matters, but it does not replace clinical judgment about safety.

Begin by explaining one's role in plain language: the clinician is there to help with feelings, safety and health; some information may need to be shared to keep the child safe; and the child may say when they do not know, do not remember, need a break, or do not want to answer a question. This is assent-sensitive communication. It is not a legal consent tutorial. It is an everyday clinical method for restoring agency after an experience in which agency may have been compromised.

Rapport should not be mistaken for prolonged informal conversation designed to “win” disclosure. Ordinary topics, play, drawing or an activity may help a younger child regulate and communicate, but they are not diagnostic tests and should not be interpreted symbolically as proof of abuse. The psychiatrist notices how the child uses the activity: whether it permits

engagement, reduces arousal, supports language, or reveals an immediate concern. The methods of play assessment are covered in the play assessment and interviewing children section.

When the child begins to describe an experience, invitation is preferable to suggestion. “Tell me what you mean,” “What happened next?” and “Tell me more about that” preserve the child's language. Questions that offer the answer, supply body terms the child has not used, or repeatedly contrast alternatives can create pressure to agree. Clarification is legitimate when it affects immediate safety, but the clinician should be able to state why each question was necessary.

TRAP **Do not confuse a coherent adult-style chronology with a reliable child account.** Trauma, fear, developmental language and loyalty conflicts can all affect how an account is told. Conversely, apparent detail is not a substitute for careful assessment. The psychiatrist records what was said and the context in which it was said, rather than grading the child as believable or unbelievable.

30.3 Eliciting the account without contaminating it

The core interviewing skill is **narrative invitation**. Let the child start with their concern and follow their language. If the child makes a statement that signals possible sexual abuse, acknowledge it calmly and use open invitations before narrowing where a clinical decision requires it. The distinction is crucial: “Can you tell me more?” invites recall; “Did he do this?” imports a proposition. It is a disciplined interview in which the child's account, rather than the clinician's hypothesis, does the work.

Observe the conditions of disclosure. Note whether the child speaks freely, whether an adult answers for them, whether the child checks another person's reaction, and whether there are interruptions or visible distress. These observations provide context; they are not credibility verdicts. A child may disclose and later minimise, deny, become silent or ask that the matter be kept secret. Such shifts should be recorded with care and explored for their emotional meaning, particularly fear of consequences, attachment to the alleged person, shame or concern about family disruption. They should not be labelled manipulation.

It is useful to separate information into three streams in the notes:

- the child's own words, preferably marked as a direct statement where possible;
- the collateral history and the identity of the person giving it; and
- the clinician's observations, formulation and actions.

This separation prevents an inference from acquiring the appearance of a quotation. It also protects the team from a common drift in complex cases, in which repeated handovers transform a concern into a purported fact. If the child uses unfamiliar words, unusual labels or a gesture, describe them faithfully and avoid translating them into a more definite sexual act unless the child has made that meaning clear. If a physical examination or specialised forensic interview is indicated, the psychiatric record should state the clinical reason for referral rather than attempt to replace that assessment.

PITFALL

Writing “history of abuse” when the information is an unverified report erases the source and certainty of the statement. A defensible record distinguishes disclosure, allegation, collateral report, observed affect and clinical opinion. That precision protects the child as well as the clinician.

30.4 Psychiatric examination and formulation

A **psychiatric formulation** is more useful than a checklist of symptoms because it asks how the child's present difficulties relate to the alleged experience, developmental stage, relationships, prior vulnerabilities and current environment. It should cover affect regulation, sleep, appetite, concentration, fears, avoidance, intrusive experiences, dissociation, anger, behaviour at home and school, peer relationships, bodily concerns, sexualised behaviour, substance use where relevant, and thoughts of death or self-injury. The assessment should also identify strengths: a protective adult, capacity to seek help, meaningful routines, school connection, interests, or a prior ability to recover after stress.

The mental-state examination is adapted to developmental communication. Observe play, movement, speech, attention, facial expression, engagement, thought content and the child's ability to make sense of their feelings. Avoid translating a developmentally typical limitation into psychopathology. A young child may express trauma through clinginess, irritability, regression, nightmares or changed play rather than verbal fear. An older child may present with anger, self-blame, risk-taking, emotional numbing or withdrawal. These are possibilities to examine, not signatures that establish abuse.

Formulation should keep causal language proportionate. The child may have symptoms associated with the experience, symptoms worsened by the response of adults, difficulties that predated the concern, and difficulties produced by the ongoing crisis. The clinician should resist the false choice between “all due to abuse” and “unrelated to abuse.” A formulation can hold several pathways at once and describe what needs treatment now without overclaiming causation.

CLINICAL DOMAIN	QUESTION FOR THE PSYCHIATRIST	REASONING VALUE
Safety	Is there continuing access, intimidation, coercion or fear of return?	Determines urgency and the need to coordinate protection.
Trauma response	What has changed in arousal, sleep, memory, avoidance or sense of safety?	Connects current distress to a treatable pattern without assuming a diagnosis.
Development	How does language, understanding and dependence shape what the child can describe?	Prevents adult expectations being imposed on the account.
Relationships	Who comforts, pressures, disbelieves or protects the child?	Shows whether the environment is buffering or perpetuating distress.
Risk	Are there self-directed, other-directed or escape-related risks?	Links assessment directly to a safety plan.

Why formulation matters. The diagnostic label is only one possible output. In the early phase, an accurate account of distress, risk, functioning and supports may be more clinically useful than premature categorisation. The treatment plan can then address regulation, sleep, family response, school support and specialist referral while diagnostic understanding develops over time.

30.5 Psychiatric sequelae and clinical discrimination

Child sexual abuse can be associated with both immediate and enduring **psychiatric sequelae**. The clinical task is to look actively for harm without assuming that every child will show the same pattern or that the absence of one expected pattern is reassuring. The consequences may sit across health, emotional regulation, behaviour, relationships and development, and may become clearer only as the child's circumstances change.

The health consequences associated with child sexual abuse include **STI**, **traumatic injury** and **unwanted pregnancy**. Their possibility is a reason for integrated medical assessment, not a reason for psychiatrists to make physical findings the sole arbiter of concern. A psychiatric consultation should ask what bodily symptoms mean to the child, whether there is pain, fear, shame or confusion, and whether medical care has been arranged through the appropriate pathway.

Psychiatric and behavioural associations include **substance misuse**, **major depressive disorder**, **PTSD**, **complex PTSD**, **anxiety disorders** and **antisocial behaviours**. These associations should guide enquiry, not become a diagnostic shortcut. The disorders themselves are dealt with in the Child behavioural, emotional and other disorders notes.

There are several discriminations worth making. First, symptoms may be trauma-related without fitting a settled syndrome at the first interview. Second, a psychiatric disorder may be present alongside a normal-range response to extraordinary stress. Third, a symptom may have predated the alleged abuse and still have been exacerbated by it. Fourth, treatment should not wait for a perfect causal model when risk, distress or impairment is evident. The formulation should

therefore describe temporal relationships, maintaining factors and current priorities in plain clinical language.

GOOD TO REMEMBER

Ask about the child's own explanation of change. “What has been hardest since this began?” often reveals sleep disruption, fear of places or people, guilt, worries about pregnancy or infection, and family tensions that a symptom checklist can miss. It also tells the clinician what the child most wants help with.

30.6 Family work, collateral information and confidentiality

The caregiver interview has two functions: it gathers context and it assesses the caregiving environment. Ask what changed, who first noticed it, what the child has said, how adults responded, and whether anyone has coached, threatened, blamed or isolated the child. The clinician must remain alert to the possibility that an apparently supportive adult is also distressed, disbelieving or unable to keep the child safe. Conversely, a caregiver's anger or confusion may reflect fear and helplessness rather than hostility to the child. Assessment should clarify this rather than moralise it.

Confidentiality needs to be explained as a relationship practice, not as a bureaucratic warning. The child should know that private feelings are respected but that information relevant to safety cannot simply be kept between child and clinician. Where information must be shared, tell the child what will be shared, with whom, and why, as far as safety permits. This preserves trust better than making a promise that later has to be broken.

Collateral information from school, relatives or other services should be used purposefully. It may establish changes in functioning, identify a safe adult, or clarify practical risk. It should not become a broad search for character evidence. A child who is struggling academically, behaving aggressively or avoiding school needs support for those problems whether or not the collateral source agrees about the allegation. That distinction keeps the psychiatric role therapeutic.

IN INDIA

Indian practice often requires the psychiatrist to work at the intersection of family dependence, school pressures, medical services and protection systems. Keep the clinical note readable across those settings: record the source of information, the child’s own words, observed distress, immediate risks and the action taken. For the statutory reporting framework and child-friendly legal procedure, see the POCSO Act section; for protection, reporting, referral and treatment coordination, see the management of child abuse cases section.

30.7 Documentation and communication with other systems

Forensic-quality documentation does not mean writing like a lawyer. It means producing a contemporaneous clinical record that another responsible professional can understand without guessing which parts are observation, report or opinion. Use the child's language for key disclosures, record questions that materially shaped the response, identify who was present, and describe affect and behaviour without embellishment. Write “became quiet and looked away”

rather than “appeared guilty”; write “said she was afraid to go home” rather than “home is unsafe,” unless the latter is your clearly stated formulation based on recorded facts.

Document negative findings with the same restraint. “No suicidal thoughts disclosed in this interview” is different from “no suicide risk.” A child may be unable, unwilling or unsafe to disclose. The risk formulation should show what was asked, what was observed, what remains uncertain and how the uncertainty is being managed. Avoid copying language from another professional's record unless its source is attributed. Repetition can make an error look corroborated.

Communication should be need-to-know and clinically purposeful. The psychiatric team may need to coordinate with medical, protection, legal and school systems, but should not casually circulate sensitive details. When handing over, separate the immediate concern, the child’s current mental state, the risks, the supports already in place and the requested action. The precise legal mechanism is outside this section; the psychiatrist's contribution is a clear clinical account and timely coordination.

MNEMONIC

LISTEN

Let the child lead; **I**dentify immediate risk; **S**eparate report from observation; **T**rack trauma and functioning; **E**xplain confidentiality; **N**ote words and actions clearly. It is a memory aid for the clinical posture, not a substitute for safeguarding procedures.

30.8 A practical psychiatric plan after assessment

The assessment should conclude with a plan that answers the child's practical question: “What happens now?” State the immediate safety concern, the mental-health priorities, the support needed from carers, the referrals or coordination required, and the follow-up arrangement. A plan that merely records “counselling advised” fails to show what problem is being addressed or who is responsible for the next step.

Psychological treatment should be matched to the child's presentation, developmental communication and capacity for stability. Early work may focus on safety, emotional regulation, sleep, routine and helping caregivers respond without blame. More focused trauma work requires safety and a shared formulation. When a child presents with a disorder requiring treatment, its disorder-specific management belongs in the Child behavioural, emotional and other disorders notes; this section does not convert abuse assessment into a disorder chapter.

Follow-up revisits both symptoms and context. A child may initially minimise distress, become more symptomatic after disclosure, or deteriorate when contact, family conflict or legal proceedings change. The clinician should invite the child to say what has become easier or harder and re-check risks without making every visit a repeated interview about the alleged event. Continuity itself can be therapeutic when it demonstrates that adults can hear difficult material, act predictably and remain available.

In suspected or disclosed child sexual abuse, the psychiatrist listens carefully, assesses safety and psychiatric need, documents source and uncertainty, and does not turn clinical care into a repeated forensic interview.

31 · POCSO Act 2012 (provisions, mandatory reporting, child-friendly procedures)

Why it matters clinically. A disclosure, a worrying account from a parent, or information suggesting that a child may be at risk can place the psychiatrist at the boundary between therapeutic work and a statutory process. The central examination point is not whether the clinician can prove an offence. It is whether the statutory threshold for **mandatory reporting** has been crossed. In India, the **POCSO Act 2012** makes this a legal duty and sets out a deliberately child-sensitive route from information to investigation and trial.

The Act should be understood as a procedural protection, not as an alternative diagnostic or therapeutic framework. It regulates the public response to suspected offences against a child; it does not ask a psychiatrist to decide guilt, conduct a criminal investigation, or replace the court. Its design matters to clinical practice because a child who has already been frightened, coerced, or disbelieved can be harmed again by a process that demands repetition, confronts the child with the accused, or turns the child's account into an adult summary. The provisions below are therefore best learnt as one coherent pathway: report on the statutory threshold, preserve the child's own account in the appropriate legal process, and protect the child during evidence and trial.

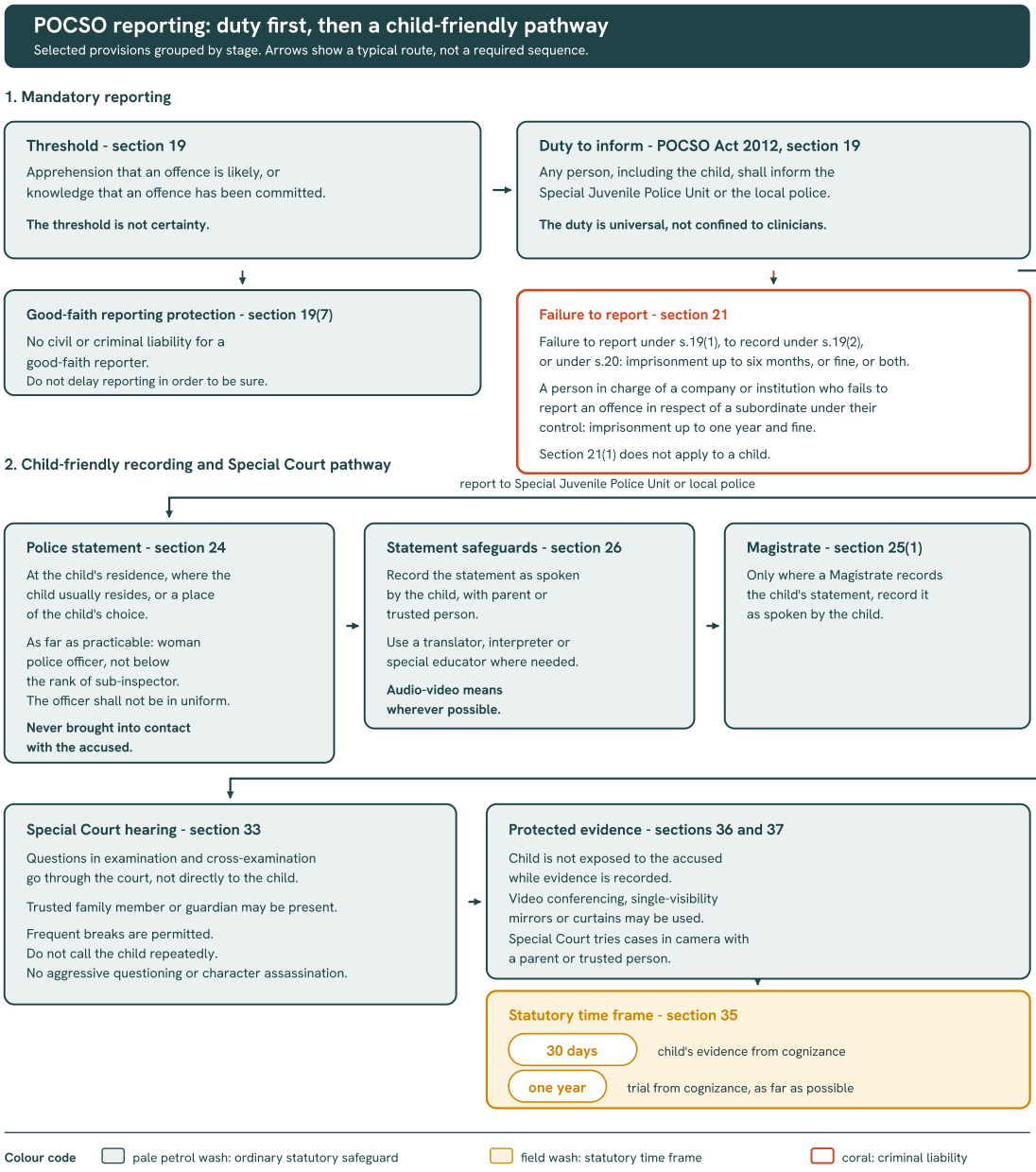


Fig 24.13. POCSO reporting is triggered by apprehension or knowledge, not certainty, and applies to any person including the child. After information reaches the Special Juvenile Police Unit or local police, the statute requires child-friendly recording and a protected Special Court pathway.

31.1 The reporting duty: threshold, person and destination

Mandatory reporting is often wrongly remembered as a duty that starts only after a clinician has reached diagnostic or forensic certainty. That is not the statutory structure. **Any person**, including the child, who has apprehension that an offence is likely or knowledge that one has occurred must provide the information to the **Special Juvenile Police Unit or the local police**. The threshold is thus framed around apprehension or knowledge, rather than a private conclusion that the allegation has been proved.

RULE **Under POCSO, report at apprehension or knowledge; do not wait for certainty.** The legal question is whether information has brought the statutory duty into operation, not whether the psychiatrist can resolve every inconsistency, establish intent, or predict the result of a future trial.

This distinction has practical force. Children may speak indirectly, may use developmentally idiosyncratic language, or may reveal information in fragments. Adults around them may be uncertain, distressed, defensive, or divided about what has occurred. None of those features gives the clinician a licence to convert the statutory threshold into a requirement for proof. Conversely, reporting is not a declaration that an accused person is guilty. It is the act that enables the legally constituted process to receive information and determine what follows. Keeping those two ideas separate protects both clinical thinking and legal compliance.

The duty is universal. A psychiatrist is not exempt because the information arose in a consultation, because the child is reluctant to speak further, or because a family member asks that the matter be kept private. Professional confidentiality remains important in ordinary care, but it cannot be used to erase a statutory reporting obligation. The therapeutic task is to communicate honestly and calmly about the limits of secrecy, without making promises that the law will not permit the clinician to keep. That stance preserves trust better than later disclosure that the clinician had silently made an assurance that could not be honoured.

IN INDIA

The statutory destination is specific: information goes to the **Special Juvenile Police Unit** or local police. The Act does not make the psychiatrist the final arbiter of whether an offence has been established. A good-faith reporter has statutory protection from civil or criminal liability, reinforcing why hesitation while seeking certainty is the wrong legal frame.

There is a useful distinction between *clinical ambiguity* and *legal inaction*. Clinical ambiguity may appropriately remain in a formulation: the psychiatrist may not yet know the meaning, reliability, context, or consequences of the information. Legal inaction is different when the reportable threshold has been reached. Candidates should be able to say that the Act makes room for uncertainty in the facts while refusing to make certainty a precondition for passing information to the designated authority.

- Do not convert the reporting threshold into a requirement for corroboration.
- Do not treat a child's reluctance to continue talking as a reason to promise secrecy.
- Do not treat reporting as a clinical finding of guilt or as a substitute for treatment.
- Do not confuse a lawful report with a licence for indiscriminate discussion of the child's account.

31.2 Failure to report: a statutory offence, not an ethical lapse alone

The legal character of the duty is made plain by the provision on **failure to report**. Failure to report or record the relevant information is itself a punishable offence. For a person who fails in

this duty, the Act provides imprisonment that may extend to **six months**, or fine, or both. The point for clinical practice is direct: a delayed report cannot be defended merely by saying that the clinician was still trying to become sure.

The Act also distinguishes institutional responsibility. A person in charge of a company or institution who fails to report an offence in respect of a subordinate under their control carries a more serious statutory exposure, with imprisonment that may extend to **one year** and fine. The first of those offences, the failure to report or to record, does not apply to a child. The exemption is written against that offence alone rather than against the section as a whole. The heightened exposure is confined to that supervisory relationship, but it remains relevant in hospital, school, residential, and child-care settings, where uncertainty about who should act can become a mechanism of delay. The individual clinician's responsibility does not disappear into a committee, hierarchy, or internal inquiry.

TRAP **"I need to be certain before I report" is the classic wrong answer.** It imports a proof standard that the reporting provision does not require. The Act places the decision about proof within the legal process, while making non-reporting a punishable omission.

The statutory offence should not be taught as a threat alone. Its purpose is to prevent a child's access to protection from depending on an adult's confidence, personal relationship with the family, or fear of being mistaken. It also makes clear why an institution should not use a private fact-finding exercise as a holding pattern. Internal processes may have their own legitimate purpose, but they cannot be allowed to displace the reporting route required by the Act.

In India, **mandatory reporting** under POCSO is a legal duty: any person with apprehension or knowledge must inform the designated police authority, and failure to report is punishable.

31.3 Child-friendly investigation: preserving the child's account

The reporting duty is only the entry point. The Act attempts to prevent the investigation itself from becoming a further source of injury by requiring a **child-friendly investigation**. A child's police statement is to be recorded at the child's residence, at the place where the child usually resides, or at another place chosen by the child. As far as practicable, it is recorded by a woman police officer of the required rank. Separately, and without that qualification, the recording officer must not be in uniform. The child must not be brought into contact with the accused during examination.

Each element has a clinical logic. A familiar or chosen setting may reduce the sense that the child is being taken into an adult-controlled system. The absence of uniform reduces the symbolic pressure of formal policing. Separation from the accused protects against fear, intimidation, and the contamination of the child's ability to speak. These are not therapeutic techniques, and they do not guarantee that the child will be comfortable. They are procedural safeguards that reduce avoidable pressure at a point when the child may be highly vulnerable.

For the psychiatrist, the important conceptual boundary is that the legal statement belongs to the legal process. A consultation may contain clinically relevant material, but the psychiatrist should not try to create a substitute forensic record by repeatedly testing the child's narrative, seeking a polished chronology, or forcing the child to rehearse details for adult reassurance. The child's welfare remains central, but the statute has assigned the formal recording function to specified officials using specified safeguards. The forensic and psychiatric assessment of child sexual abuse is addressed in the chapter section on child sexual abuse assessment and psychiatric sequelae.

PROCEDURAL POINT	STATUTORY SAFEGUARD	WHY IT MATTERS
Threshold for information	**Apprehension or knowledge**	Reporting does not await private proof.
Receiving authority	**Special Juvenile Police Unit or local police**	The statute identifies a formal destination.
Setting for the police statement	**Place chosen by the child**	Procedure is adapted to the child rather than institutional convenience.
Form of the record	**As spoken by the child**	The record should preserve the child's own expression.
Protection from confrontation	**No exposure to the accused**	Evidence can be obtained without compelled face-to-face contact.

Additional provisions protect the integrity of the child's words. The statement is recorded as spoken by the child in the presence of parents or another person in whom the child has trust or confidence. Where needed, a translator, interpreter, or special educator is to be provided, and audio-video recording is to be used wherever possible. These are not mere courtesies to be extended when a system has spare capacity. They recognise that communication access, language, developmental needs, and trust affect whether a child can participate meaningfully.

The same emphasis applies to the magisterial statement. Where the child's statement is recorded by a Magistrate under the current criminal procedure code, the protective requirement is that it be recorded as spoken by the child. The essential teaching point is the safeguard itself, not a recital of general criminal procedure. A psychiatrist who understands this can recognise why the legal process should not replace a child's words with an adult's interpretation, even when that adult is well intentioned.

GOOD TO REMEMBER

The phrase **as spoken by the child** is a safeguard against adult paraphrase. A child may need support to communicate, but support must not become substitution of the adult's language, meaning, or theory for the child's account.

The focus on trusted presence is also nuanced. A parent or trusted adult may help the child feel sufficiently safe to participate, but the statute does not turn that adult into the author of the account. In a clinical setting this distinction is valuable: adult distress, anger, fear, or a need for

immediate certainty can easily dominate the encounter. The child-friendly framework returns attention to the child's voice, communication needs, and protection from avoidable exposure.

31.4 Special Court procedure: evidence without intimidation

The Act carries the same protective logic into the **Special Court**. In examination and cross-examination, counsel communicates questions to the court, and the court puts them to the child. A family member, guardian, or another trusted person may be present. The court may permit frequent breaks, should avoid recalling the child repeatedly, and must not allow aggressive questioning or character assassination.

This does not mean that the child's evidence is insulated from scrutiny. Rather, scrutiny is structured so that the adversarial contest does not itself overwhelm the child. Direct confrontation by an adult advocate may be frightening or confusing even when the words used are technically permissible. Court mediation provides a protective filter: it does not predetermine the answer, but it places responsibility for the manner of questioning with the tribunal that has a duty to protect the child's participation.

The provision also helps candidates articulate why a child-friendly court process serves justice rather than competing with it. A child who is exhausted, terrified, humiliated, or repeatedly summoned may be less able to give a coherent account. Fair process is not achieved by maximising distress. It is achieved by allowing relevant questions to be put in a manner that preserves the possibility of reliable participation while respecting the procedural position of the accused.

- Questions reach the child through the court rather than directly from counsel.
- A trusted person may be present while the child gives evidence.
- Breaks may be permitted when the child needs them.
- The child should not be repeatedly called merely because adults have not organised the process well.
- Hostile questioning and attacks on character are not permitted.

A psychiatric report, when one is relevant to proceedings, should therefore be written with a clear understanding of role. It may assist the court on mental state, communication, or the impact of procedures, but it does not authorise the psychiatrist to decide the legal issue. Plain language, careful distinction between observation and inference, and fidelity to the child's actual communication are especially important where the report may become part of a process intended to minimise further harm.

> **PITFALL**
>
> Do not describe the protective procedure as though it prevents testing of evidence. The safeguard is that the **Special Court** mediates questions and controls the manner of participation, not that relevant questions disappear from the process.

31.5 Time, visibility and privacy during evidence

Delay can extend the burden on a child witness, particularly when the child remains uncertain about repeated attendance, future questioning, or possible contact with the accused. The Act therefore states that the child's evidence should be recorded within **thirty days** after the Special Court takes cognizance, with reasons recorded if there is delay. It further provides that the trial should be completed, as far as possible, within **one year** from cognizance. These are procedural commitments to reduce avoidable prolongation, not a reason for clinical care to become rushed or superficial.

THRESHOLD	EVIDENCE	TRIAL	HEARING
APPREHENSION OR KNOWLEDGE	WITHIN THIRTY DAYS	AS FAR AS POSSIBLE WITHIN ONE YEAR	IN CAMERA

The child must also be protected from seeing the accused while evidence is recorded, while the accused remains able to hear the child and communicate with counsel. The statute permits methods such as video conferencing, single-visibility mirrors, or curtains to achieve that balance. The educational point is not to memorise technology as a checklist. It is to understand the paired commitments: the child is protected from direct exposure, while the process retains the features needed for a fair hearing.

Finally, cases are tried **in camera**, in the presence of the child's parents or another person in whom the child has trust or confidence. Where the court is of the opinion that the child needs to be examined at a place other than the court, it shall issue a commission for that purpose. Privacy here is part of the architecture of participation. It limits unnecessary public exposure while allowing the court to obtain evidence in a setting more responsive to the child's needs.

The psychiatrist's role is to understand these protections well enough not to create false expectations. It is reasonable to explain that the legal system contains child-sensitive safeguards; it is not appropriate to promise a particular procedural outcome or to present a clinical opinion as a direction to the court. Honest explanation lowers anxiety without blurring the boundary between care and adjudication.

31.6 An integrated way to answer and practise the statute

A strong short answer begins with the legal duty, not with a catalogue of offences. State that mandatory reporting applies to any person with apprehension or knowledge, identify the Special Juvenile Police Unit or local police as the destination, and state that failure to report is punishable. Then show that the Act is child-friendly throughout its procedure: the statement is taken in a child-sensitive setting, preserved in the child's words with communication support where necessary, and followed by protective Special Court arrangements.

The deeper clinical lesson is one of disciplined role boundaries. Psychiatry contributes careful listening, humane communication, assessment of the child's mental state and needs, and treatment within its proper remit. The statute supplies a reporting obligation and a protected legal pathway. Neither role should swallow the other. When a clinician mistakes private uncertainty for permission to delay, the child may lose access to the statutory process. When a

clinician mistakes reporting for proof, the family may be misled about what a report means. When a clinician tries to become investigator, therapist, and adjudicator at once, the child's account may be burdened by adult needs rather than supported by a structured system.

For this reason, the provisions are best remembered as an ethic expressed in law: act when the threshold is met; preserve the child's voice; minimise coercive contact and repetition; protect the child in court; and maintain fairness without demanding that the child carry the full weight of an adult adversarial process. That is why this statute belongs in child psychiatry. It tells the clinician not only that protection is required, but also what a child-sensitive public response is meant to look like.

32 · Management and intervention in child abuse cases

Management begins by changing the question. Once abuse is disclosed or suspected, the immediate clinical task is not to obtain a fuller narrative for its own sake. It is to help the child move from exposure and uncertainty toward protection, care and a pathway that can be sustained. The psychiatrist brings a particular contribution: a calm, developmentally sensitive therapeutic stance, attention to safety, formulation of the child's current distress, and coordination with the adults and services that must act around the child.

These cases attract marks because they test clinical priorities rather than recall alone. A good answer separates the response to danger from the assessment of symptoms, separates treatment from investigation, and recognises that protection cannot be delivered by one professional in isolation. The detailed forensic assessment belongs with child sexual abuse assessment and psychiatric sequelae, and the statutory reporting duty and procedures belong with the POCSO Act. This section addresses the clinical response that follows recognition: **safety planning**, coordinated care, and trauma-focused intervention when it is indicated.

SAFE	TEAM	TRAUMA
PROTECT BEFORE PROCEEDING	COORDINATE THE RESPONSE	TREAT THE CURRENT NEED

32.1 The management frame: protect, organise, treat

The clinical response has several linked tasks, but they should not be confused.

- **Protection** asks whether the child can be kept safe while the next steps are arranged.
- **Organisation** asks who must communicate, who will remain a reliable therapeutic contact, and how the child will not be passed from room to room without explanation.
- **Treatment** asks what the child is experiencing now and what help is appropriate.

These tasks overlap, yet they have different purposes. Confusion between them produces a common failure: the clinician becomes absorbed in reconstructing events while the child's immediate environment remains unsafe or the family has no clear plan.

Safety is not an administrative prelude to mental health care. It is the condition that makes mental health care possible. A child who expects renewed exposure, retaliation, disbelief or chaotic handovers may be unable to use a therapeutic relationship freely. Conversely, a plan that

is formally protective but incomprehensible to the child can itself heighten fear. The clinician should therefore work in language the child can understand, avoid promises that cannot be honoured, and explain the next step before moving to it. The child does not need to carry responsibility for adult decisions; the child does need a coherent explanation of what is being done to help.

RULE **In an abuse response, safety planning comes before diagnostic neatness.** The working formulation can evolve, but the clinical encounter should immediately reduce avoidable danger, confusion and exposure.

A useful mental model is to ask, at every handover, whether the next action increases protection, preserves the child's sense of control, or makes later care easier to deliver. If it does none of these, it deserves scrutiny. This does not mean that care is passive or that difficult decisions are postponed. It means that the clinician distinguishes necessary action from hurried action, and uses the least disruptive route consistent with the child's safety.

32.2 Safety planning as an active clinical intervention

Safety planning is an active, child-centred process rather than a note stating that somebody else will manage risk. The immediate plan should make clear:

- where the child will be and which adults can be relied upon;
- how contact with a suspected source of harm will be prevented while protection arrangements are considered; and
- whom the child can approach if fear or pressure returns.

Its content must remain responsive to the child's circumstances and to the capacities of the adults around them. A plan that assumes a supportive adult without examining whether that adult can actually protect is fragile.

WHO's guidance places action to enhance safety and reduce harms associated with disclosure among the **first-line** clinical responsibilities in responding to child sexual abuse. This includes attention to **visual and auditory privacy**. Privacy is practical as well as relational: conversations should not be audible to people who have no clinical role, the child should not be made to repeat sensitive material in public spaces, and the setting should not permit a potentially unsafe person to control the exchange. These small features communicate whether the service understands the child as a person needing protection rather than as a source of information.

Safety planning should be revisited when circumstances change. A plan may look adequate during a supervised clinical contact and fail during transport, school attendance, family visits, or communication between adults. The psychiatrist need not personally control every setting in which the child lives. The responsibility is to make safety a visible clinical priority, identify uncertainty clearly, and ensure that the relevant protection pathway is activated rather than assumed. When the child's account and an adult's account differ, the child should not be asked to resolve the discrepancy by further exposure or confrontation.

GOOD TO REMEMBER

Ask the child what would make the next few hours and the next contact feel safer. The answer may reveal a practical risk that is invisible in a formal record, such as fear of a particular handover, a place in the home, or being left alone with a particular adult.

The clinician's language matters. It is helpful to validate that the child has done the right thing in seeking help without making the child responsible for proving anything. It is equally important not to create false reassurance. Statements such as "nothing will happen without your permission" may be untrue where protective action is required. A more trustworthy stance is to say that the adults will explain what has to happen, will try to involve the child in a way that feels manageable, and will continue to care even if the process is difficult.

32.3 Preserve the therapeutic space without duplicating the forensic task

The management consultation is neither an interrogation nor a substitute for the safeguarding-specific evaluation. The detailed assessment of child sexual abuse, including its psychiatric sequelae, is addressed in the section on child sexual abuse assessment and psychiatric sequelae. Here, the psychiatrist's task is to listen sufficiently to understand current safety and distress, then to organise care without turning each review into a demand for a more elaborate account. Repeated, uncoordinated retelling can leave the child feeling disbelieved, observed or responsible for the adult process.

A therapeutic conversation can therefore remain focused on immediate experience: what the child is afraid of now, whether sleep, concentration, mood, bodily distress or relationships have changed, and what support feels possible. The clinician can record what is clinically necessary in a clear, restrained way and avoid interpretive excess. When uncertainty is present, it should be documented as uncertainty. The discipline of saying "not yet known" is clinically safer than filling a gap with assumptions, whether those assumptions minimise harm or enlarge it.

TRAP **Do not mistake a compassionate clinical interview for a licence to conduct a fresh forensic inquiry.** The urge to obtain a complete story can crowd out safety, fragment the response, and blur the psychiatrist's therapeutic role.

There is a second reason to preserve role clarity. The child may need the psychiatrist over time, after external processes have moved on. If the child experiences the clinician primarily as another adult collecting an account, later work on fear, trust, shame, anger or relationships may be harder to establish. A reliable therapeutic stance is not neutral about harm. It is clear that the child deserves protection, while remaining careful about the limits of what the clinician knows and what the current consultation is for.

Families may also press the psychiatrist to decide who is telling the truth, to arbitrate a conflict, or to certify that no further action is needed. Such requests should be recognised as pressure on the clinical frame. The psychiatrist can acknowledge the family's anxiety and return to the child's welfare: safety concerns require a coordinated response, and symptom care requires a relationship in which the child is not made to manage adult disagreement.

32.4 Coordinated multidisciplinary management

Abuse cases commonly demand **multidisciplinary management**. The value of a team is not merely that several professionals are involved. It is that their tasks are made complementary. A coherent team can reduce contradictory messages, prevent unnecessary repetition, arrange the right referral at the right time, and keep the child's clinical needs visible while other processes unfold. A collection of professionals acting independently is not yet a team.

Structured clinical practice guidance can support complex work by **multidisciplinary teams**. In practice, the psychiatrist should establish a shared formulation of the immediate problem, identify the person responsible for coordinating communication, and clarify what information needs to travel with the child and what should not be casually circulated. Coordination is especially important when the child's home, school, clinical setting and protection pathway give different adults partial pictures of the situation. A shared plan should make these partial views usable without making the child retell the same distressing material to every service.

CLINICAL QUESTION	PURPOSE OF COORDINATED ACTION	PSYCHIATRIST'S CONTRIBUTION
Is the child safe for the next step?	Make protection explicit rather than assumed.	Keep safety planning central to the formulation.
Who needs to act now?	Avoid diffusion of responsibility.	Communicate the clinical concern and identify the needed links.
What should the child be told?	Reduce uncertainty and preserve trust.	Use developmentally understandable explanations.
What needs follow-up?	Prevent care ending after the first crisis.	Review distress, functioning and the safety plan.

Teamwork should not erase confidentiality. Information sharing should be purposeful and limited to what is needed for protection and care. The child and caregiver should be told, as far as possible, why information is being shared and what the next contact will involve. When a caregiver's interests conflict with the child's safety, the clinician's primary orientation remains the child's welfare. This is not hostility toward the family. It is the ethical discipline needed when the family system cannot be presumed to be a safe container.

IN INDIA

Management in India must join the clinical plan to the child-protection and legal pathway rather than treating psychiatric care as a parallel, private service. The statutory duties and child-friendly procedures are set out in the POCSO Act section; the psychiatrist's role here is to ensure that safety, communication and continuing care do not disappear while those processes are being activated.

32.5 Formulation after abuse: treat the child in front of you

Protection and treatment are related but not interchangeable. Removing an immediate source of danger may reduce distress, but it does not automatically restore sleep, trust, concentration, affect

regulation or a sense of bodily safety. Equally, beginning psychological work without attending to ongoing exposure asks therapy to compensate for an environment that remains unsafe. The psychiatrist should formulate the child's present difficulties in context: the meaning the child gives to what happened, the current relational environment, the responses of important adults, and the practical conditions under which treatment will occur.

Formulation protects against two opposite errors. One is to see every reaction as evidence of a psychiatric disorder and to medicalise an understandable response to danger. The other is to assume that distress is simply transient because it follows a known stressor. The child may need support even when a formal diagnosis is not the immediate clinical question, and may need more focused treatment when symptoms are persistent, impairing or organised around traumatic reminders. The clinician should follow change over time without requiring the child to demonstrate suffering in a particular way.

Caregiver work is often central to the formulation. An adult who can believe, protect and remain emotionally available can help the child recover a sense that relationships can be safe. An adult who is overwhelmed, disbelieving, dependent on a suspected source of harm, or preoccupied with blame may require support and careful boundary-setting before being treated as a therapeutic resource. This is why involvement of family cannot be automatic. The relevant question is whether a particular adult can safely contribute to the child's care.

PITFALL

Do not treat the presence of a caregiver as proof of protection. The clinically relevant issue is whether that adult can reliably support the child without exposing the child to pressure, disbelief, divided loyalty or renewed risk.

32.6 Trauma-focused psychological intervention

For children and adolescents who have been sexually abused and are experiencing symptoms of PTSD, WHO recommends that **trauma-focused CBT** be considered. The wording matters. It points to a focused psychological intervention for a defined clinical presentation, not to a generic requirement that every child who discloses abuse should be placed into the same therapy immediately. The psychiatrist should connect the intervention to the child's current symptoms, readiness, safety and ability to attend, rather than treating a therapy label as a complete formulation.

Trauma-focused work is organised around helping the child approach distress in a planned, tolerable way rather than leaving reminders to govern the child's life. It requires a therapeutic relationship in which the child has enough predictability to engage and enough choice to communicate limits. The work should neither compel disclosure on the clinician's timetable nor collude with complete avoidance of the child's experience. Its clinical value lies in giving experience a form that can be thought about, linked to present safety, and integrated without defining the child's identity.

Psychiatric review remains important during psychological treatment. Symptoms may change as memories, fears and family tensions become more discussable. The psychiatrist monitors whether the treatment setting continues to feel safe, whether the child is becoming more isolated or pressured outside therapy, and whether additional support is needed around functioning and relationships. This is not a reason to fragment care by adding multiple unrelated interventions. It is a reason to keep a coherent formulation alive while treatment proceeds.

When trauma-focused CBT is being considered, the explanation to the child should be plain: the work is intended to reduce the hold that frightening memories and reminders have on present life. Children should not be told that they must revisit everything at once, nor should they be led to believe that recovery depends on producing a particular account. A respectful explanation protects engagement and makes it less likely that therapy will resemble another process imposed by adults.

32.7 Involving the non-offending caregiver

WHO further advises considering **trauma-focused CBT for the child and non-offending caregiver** when it is safe and appropriate to involve that caregiver. The intervention is for **both** child and caregiver, rather than treating family participation as an optional afterthought. It recognises that the caregiver's emotional response, protective capacity and understanding of the child's distress can shape the child's treatment environment. Caregiver involvement can help the adult respond more steadily to fear, anger, withdrawal or reassurance-seeking without making the child responsible for the adult's emotions.

"Non-offending" should not be treated as a sentimental label. It names a clinical and safeguarding question: can this adult participate without compromising the child's safety or making therapy unsafe? The answer may differ across caregivers and may change with circumstances. The clinician should avoid inviting an adult into the therapy space simply because that adult is available, socially expected to participate, or distressed by exclusion. Involvement is justified by the child's welfare, not by adult entitlement.

Caregiver sessions can create room for the adult's confusion, guilt, anger or grief while keeping the child free from having to regulate those reactions. They can also clarify what supportive responses look like in everyday life: believing the child without demanding repeated details, protecting routines where possible, and keeping conflict away from the child. If the caregiver cannot safely take this role, the team must not pretend otherwise. A stable therapeutic frame is more valuable than nominal family participation.

MNEMONIC

SAFE TEAM TRAUMA

Safe environment first, a coordinated **team** around the child, then **trauma**-focused work when the child's presentation calls for it. The phrase is a sequence of clinical priorities, not a substitute for formulation.

32.8 Continuity, review and the endpoint of care

Continuity is a therapeutic intervention in its own right. Abuse may leave the child expecting adults to become unavailable, disbelieving or preoccupied with procedure. A service that offers one sympathetic consultation and then disappears can unintentionally repeat that experience. Follow-up should therefore review safety, the child's experience of the plan, current distress, the availability of a protective adult, and whether the various parts of the response are still communicating. The question is not simply whether symptoms have reduced. It is whether the child now has enough safety and support to resume development without being defined by the abuse response.

Ending care should be planned, not allowed to occur by default after the crisis has quietened. The child and supportive adults should understand what has improved, what difficulties may recur, and how to seek help again without having to reconstruct the entire story. A clear ending acknowledges recovery while leaving the door open to return. It also prevents the false binary in which the child is imagined as either permanently damaged or completely unaffected.

For the psychiatrist, the enduring discipline is to resist both rescue fantasy and procedural detachment. One clinician cannot repair every consequence of abuse, but can ensure that psychiatric care adds safety, clarity and a sustained therapeutic relationship to the wider response. That is the practical meaning of child-centred management.

> In child abuse management, protect the child first, coordinate the adults and services around the child, and use trauma-focused intervention for the child's current clinical needs.

33 · Juvenile Justice (Care and Protection of Children) Act 2015

Why it matters clinically. The **Juvenile Justice (Care and Protection of Children) Act** 2015 is not a diagnosis framework or a substitute for child psychiatric formulation. It decides which authority receives a child, what question that authority must answer, and when a psychiatrist may assist. It prevents an alleged act by a child from obscuring vulnerability, and vulnerability from being mistaken for criminality. For legal wording, read the primary Act rather than a paraphrase.

The safest way to learn the Act is through its offence route and protection route. They can meet in the same child, but begin with different questions and are handled by different statutory bodies. Identify the route before naming the forum.

ACT	VULNERABILITY	BOARD	COMMITTEE
ALLEGED OFFENCE BY THE CHILD	NEED FOR CARE AND PROTECTION	FORUM FOR THE OFFENCE ROUTE	FORUM FOR THE PROTECTION ROUTE

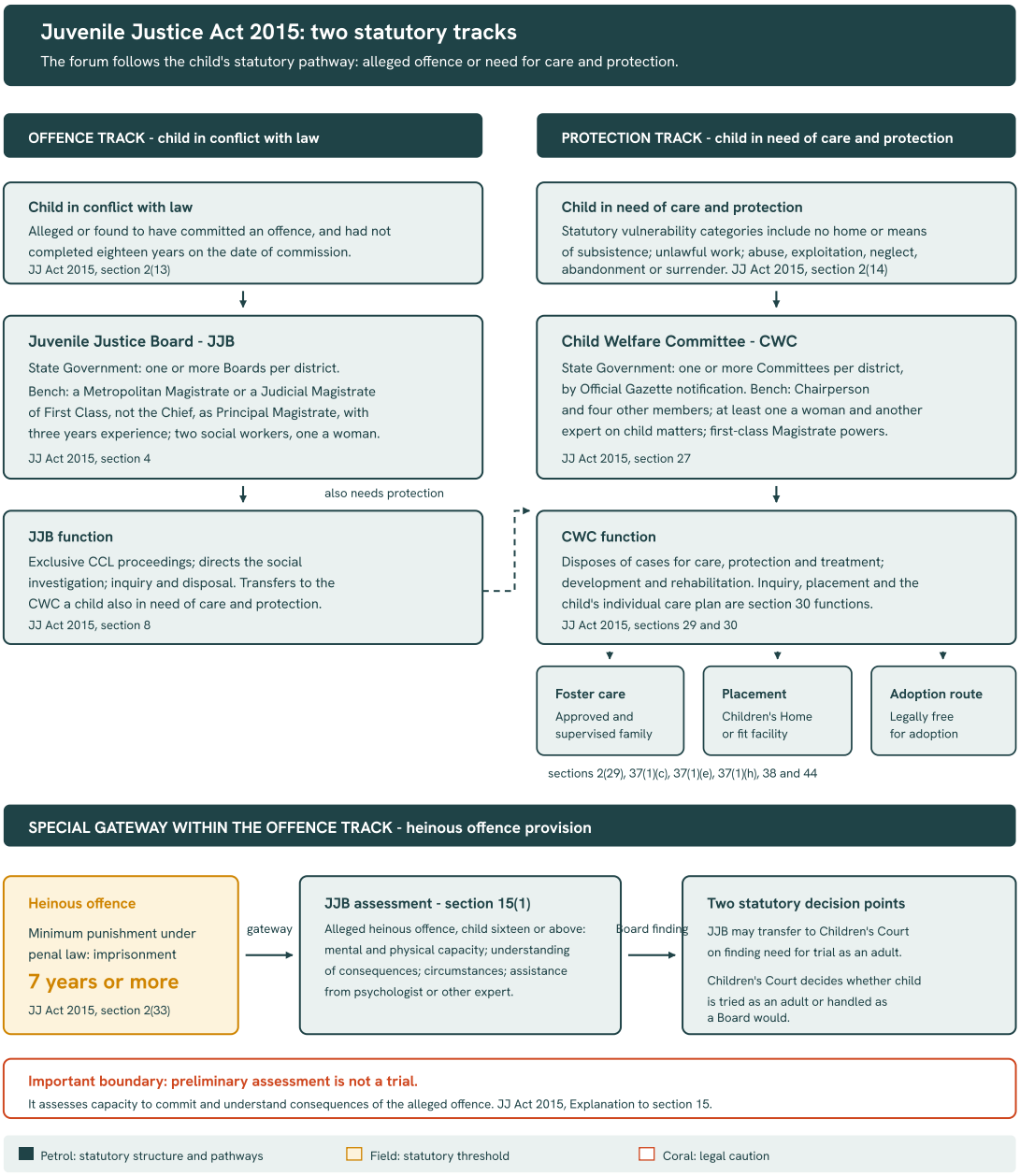


Fig 24.14. The JJ Act 2015 separates the offence-based CCL pathway governed by the JJB from the vulnerability-based CNCP pathway governed by the CWC. Heinous-offence assessment is a capacity assessment by the Board, with a separate subsequent decision by the Children's Court.

33.1 The statutory map: act, vulnerability and forum

A **child in conflict with law** is a child alleged or found to have committed an offence, provided the child had not completed **eighteen** years on the date of the alleged offence. The date of the act, rather than the date of apprehension or hearing, is therefore the legally relevant anchor. This is a narrow, offence-based description. It does not tell the clinician whether the child is distressed, impaired, exploited, traumatised, or unsafe. Those are clinical and protective questions that still need attention.

By contrast, a **child in need of care and protection** is identified by vulnerability. The statutory categories include a child without a home or apparent means of subsistence, a child working

contrary to labour law, and a child who has been abused, exploited, neglected, abandoned or surrendered. The practical distinction is morally important. On the offence route, the system asks what the child is alleged to have done. On the protection route, it asks what danger, deprivation or failure of care has happened to the child.

QUESTION THAT STARTS THE ROUTE	STATUTORY TRACK	PRIMARY FORUM	CLINICAL IMPLICATION
Is the child alleged to have committed an offence?	Child in conflict with law	Juvenile Justice Board	Keep developmental and welfare needs visible during the inquiry.
Is the child exposed to a statutory form of vulnerability or unsafe care?	Child in need of care and protection	Child Welfare Committee	Frame the problem as protection, treatment and rehabilitation, not misconduct.
Does the same child meet both descriptions?	Overlapping need	Board with transfer to Committee where required	Do not allow one label to erase the other route.

RULE **Classify the child by the legal question before discussing the psychiatric opinion.** The Act separates alleged offending from need for protection, and it gives each route a distinct decision-making body.

These labels should not become clinical identities. Anger, withdrawal, substance use, developmental limitations, fear or apparent indifference do not alone determine the statutory track. Conversely, a child alleged to have offended may also need immediate safety planning. The Board can transfer a child in conflict with law to the Committee when the child is also in need of care and protection. This seam allows care needs to be addressed without denying the allegation.

33.2 Juvenile Justice Board: the offence-route authority

The **Juvenile Justice Board** is constituted by the State Government for each district and is a Bench, rather than a lone magistrate making an administrative referral. Its Principal Magistrate is a Metropolitan Magistrate or Judicial Magistrate of the first class, not being a Chief Metropolitan Magistrate or Chief Judicial Magistrate, with at least **three years** of experience. The statutory composition also includes social workers, with a woman member required. The point of this design is not ceremonial. It brings judicial authority and child-welfare expertise into the same decision-making structure.

The Board deals exclusively with proceedings concerning children in conflict with law within its district. It directs the Probation Officer, or where a Probation Officer is not available the Child Welfare Officer or a social worker, to undertake the social investigation and report within **fifteen days** of first production. It conducts the inquiry, disposes of cases, and can transfer to the Child Welfare Committee a child who also requires care and protection. A psychiatrist should therefore understand that a report may inform the Board's work, but does not replace its inquiry or decide the case. The clinical task is bounded by the question put to the expert and by the child's developmental context.

GOOD TO REMEMBER

When a referral comes through the offence route, write the referral question at the top of the assessment. Separate observed symptoms, developmental functioning, the child's account, collateral information and limits of inference. This keeps a clinical opinion useful without allowing it to drift into a judicial conclusion.

For the psychiatrist, the Board is often the point at which a child's mental health needs become legible to the justice system. That does not make the psychiatrist a prosecutor, defence witness, or final arbiter of legal responsibility. It makes the psychiatrist a clinician who can describe relevant capacities and vulnerabilities with precision, including what the available information can and cannot support. Neutrality is especially important where family pressure, institutional narratives, or the seriousness of an allegation makes a quick explanatory label tempting.

33.3 Child Welfare Committee: the protection-route authority

The **Child Welfare Committee** is the statutory authority for the protection route. It is constituted for each district by State Government notification and functions as a Bench with magisterial powers. It consists of a Chairperson and **four** other members, including a woman member and a member with expertise in child matters. Its orders are not merely recommendations: its legal authority is what permits a protective plan to become an operative placement or care decision.

The Committee has authority to dispose of cases concerning care, protection, treatment, development and rehabilitation of children in need of care and protection. It may conduct inquiry and make placement decisions in relation to the child's **individual care plan**. The phrase matters clinically. The child's psychiatric needs are part of the care problem, but they should be considered alongside safety, attachment, family capacity, educational continuity and the feasibility of the proposed setting. A diagnosis alone cannot answer whether a placement is protective or sustainable.

IN INDIA

The Board and the Child Welfare Committee are statutory Indian forums, not informal multidisciplinary meetings. In a referral letter, name the route clearly and state whether the child's presentation raises protection needs in addition to the immediate clinical question. This makes it harder for a vulnerable child to be passed between services with nobody owning the protective decision.

The Committee's remit also corrects a clinical blind spot. A child who has been neglected or exploited may present with disruptive behaviour, school refusal, self-harm, dissociation, substance use, somatic complaints, or a flat account of serious adversity. The clinical formulation must not convert this into an account of individual pathology alone. The statutory route requires attention to the environment that is failing the child. Detailed recognition and management of abuse are addressed in the child-protection sections of this chapter; here, the essential point is

that vulnerability can activate a protection process even when no offence is alleged against the child.

33.4 When both routes are present

The two tracks are distinct, not mutually exclusive. A child may be alleged to have committed an offence while also being homeless, exploited, abused, neglected, abandoned, or otherwise unsafe. The Board's transfer power to the Committee is the statutory answer to this overlap. In clinical language, the allegation must not eclipse the formulation, and the formulation must not erase the allegation. Both statements can be true, and the system has a route for both.

> **TRAP** **Do not treat "conflict with law" as the opposite of "in need of care and protection."** The first phrase describes an alleged offence; the second describes vulnerability. A child can fall within both descriptions, so a protection concern must be surfaced even during offence-route proceedings.

This is where psychiatric language can either help or harm. Descriptions such as conduct problems, impulsivity, intoxication, trauma symptoms, intellectual limitations, or family conflict should be used to illuminate the child's situation, not to shortcut the statutory analysis. The clinician should state what has been observed, what has been reported, whose account is being relied upon, and whether the available material supports an opinion on the question asked. A report that becomes a broad moral explanation for the allegation is both clinically weak and legally unhelpful.

33.5 Heinous offences and the preliminary assessment

A **heinous offence** is defined by the minimum punishment prescribed in the penal law: imprisonment of **seven years** or more. This statutory threshold is the gateway to the special preliminary-assessment process for an older child within the Act's definition of childhood. It is a legal classification of the alleged offence. It is not a psychiatric diagnosis, an index of dangerousness, or a conclusion about the child's maturity.

For a heinous offence alleged against a child who has completed or is above **sixteen** years, the Board conducts a **preliminary assessment**. It considers the child's mental and physical capacity to commit the alleged offence, ability to understand its consequences, and the circumstances in which it is alleged to have occurred. The Board may take assistance from psychologists or other experts. The clinician's contribution is consequently evidence for a statutory assessment, not an independent decision to move the child into an adult process.

The legal formulation deliberately requires more than a label. A diagnosis, a screening score, an intelligence estimate, a history of adversity, or the apparent sophistication of one act cannot by itself answer the entire question. Capacity and understanding have to be considered in relation to the alleged conduct and its context. The assessment should therefore be careful about language, avoid conclusions that exceed the records and interview, and distinguish a clinical observation from an inference about the legal question.

MNEMONIC

Capacity - Consequences - Circumstances

For the preliminary assessment, organise the psychiatric contribution around the child's capacity in relation to the alleged act, understanding of consequences, and the circumstances in which the allegation arose. The Board remains the authority that assesses these matters with expert assistance.

PITFALL

Do not write a report as though the preliminary assessment were an insanity opinion. The statutory question is developmental capacity and understanding in relation to the alleged offence. A report that imports another legal test can obscure the exact issue the Board must decide.

33.6 What the preliminary assessment is not

The Act expressly states that this preliminary assessment is not a trial. This distinction has practical force. The clinician does not determine guilt, assess the evidentiary strength of the allegation, decide the final forum, or pronounce a general conclusion on criminal responsibility. The assessment addresses the limited statutory questions of the child's capacity to commit and to understand consequences of the alleged offence.

General criminal responsibility, the insanity doctrine, the current criminal-law provisions and adult forensic assessment belong in *the Mental health legislation and forensic psychiatry notes*. Cross-refer there rather than importing that doctrine into a juvenile preliminary assessment. The two inquiries can sound similar because both involve mental state and legal consequence, but they are not interchangeable. In an answer, saying that the preliminary assessment is not a trial and not a general criminal-responsibility determination earns clarity because it protects the statutory boundary.

Expert assistance does not make the expert the decision-maker. The Board conducts the assessment, may use psychological or other expert assistance, and retains the statutory role. A well-written psychiatric opinion is therefore disciplined: it identifies the clinical material, explains its relevance to the specified capacity or understanding question, and records uncertainty where the material does not permit a defensible inference. It should not mimic a judgment or use conclusory phrases that collapse assessment, culpability and disposal into one opinion.

33.7 Transfer and the second decision point

After the preliminary assessment, where the Board finds a need for **trial as an adult**, it may transfer the trial to the Children's Court. That transfer is not the endpoint. The Children's Court itself decides whether the child is to be tried as an adult or handled as the Board would handle the case. The Board's finding and the Court's decision are separate statutory steps.

STAGE	WHO ACTS	QUESTION ANSWERED	WHAT THE PSYCHIATRIST MUST NOT ASSUME
Preliminary assessment	Juvenile Justice Board, with expert assistance where used	Capacity, understanding of consequences and circumstances in the statutory setting	That expert input decides guilt or adult trial.
Transfer decision	Juvenile Justice Board	Whether transfer to the Children's Court is required after the assessment	That transfer itself converts the child into an adult defendant.
Post-transfer decision	Children's Court	Whether adult trial is appropriate or the matter should be handled as by the Board	That the Board's view is the final legal outcome.

This sequence is a frequent examination discrimination because the language of adult trial can lure the reader into collapsing the stages. It is also a clinical safeguard. The psychiatric assessment may be influential, but it does not erase the child's statutory status or collapse judicial functions into a medical opinion. In reports and oral evidence, keep the limited purpose of the opinion visible.

33.8 Protection decisions and continuity of care

For a child in need of care and protection, the Committee may make decisions that connect immediate safety with longer-term care. Its statutory options include placement in a Children's Home, fit facility or Specialised Adoption Agency, the last for the purpose of adoption, an order for **foster care**, and a declaration that a child is legally free for adoption. The legal content of adoption and the psychiatric aspects of child labour and adoption are addressed elsewhere; psychiatric care must remain connected to the placement decision.

Foster care means placement in the domestic setting of a selected, qualified, approved and supervised family other than the child's biological family. It is not simply an informal arrangement with any available household. When asked to advise, the psychiatrist does not select the placement, but can identify mental-health needs that should shape the care plan.

> The Juvenile Justice Act separates an alleged offence from a child's vulnerability, and a psychiatric opinion assists the statutory forum without replacing it.

33.9 A disciplined examination and clinical approach

In a short answer, proceed in a disciplined order:

- identify the offence route or the protection route;
- name the Board or Child Welfare Committee as the relevant forum;
- state that age on the date of the alleged offence anchors the offence-based definition;

- for the heinous-offence provision, describe capacity, understanding of consequences and circumstances, then state that the assessment is not a trial and the Children's Court decides after transfer.

In practice, the same sequence is a safeguard against role confusion. Identify the forum, obtain the precise referral question, preserve a developmental and trauma-informed formulation, state evidential limits, and flag protection concerns that may require the other route. Where the child is frightened, poorly understood, or embedded in an unsafe family or institutional context, the report should make those needs visible in clinically careful language. It should never offer a shortcut from symptom to culpability, or from allegation to a conclusion that the child has no claim to protection.

34 · Child in conflict with law and child in need of care and protection

Why this distinction matters clinically. A child may enter the juvenile justice system because of an alleged act, or because the child is unsafe, unsupported, exploited or without care. Those are not interchangeable descriptions, and they call for different clinical questions. The psychiatrist's first task is to avoid allowing the presenting label to flatten the child into either an offender or a passive victim. The useful formulation asks what has happened, what the child needs now, what relationships and environments are available, and what information the statutory process needs from mental-health care.

The marks in this area lie in making a clean discrimination before discussing intervention. The legal label supplies a pathway; it does not describe the whole child, establish a psychiatric diagnosis, or determine whether treatment is needed. Disorders, developmental variation and general criminal responsibility are addressed elsewhere. Here the focus is the distinction between an offence-based pathway and a protection-based pathway, and the practical meaning of protective placement for psychiatric work.

OFFENCE	VULNERABILITY	PLACEMENT
ALLEGED ACT PATHWAY	PROTECTION PATHWAY	CARE MAY NEED TO CHANGE

34.1 The distinction that prevents category error

A **child in conflict with law** is a child alleged or found to have committed an offence, provided the child had not completed **eighteen years** when the alleged offence was committed. The anchor is the time of the alleged act, rather than a later procedural event. This is not a diagnosis and it does not establish an explanation for the behaviour. A psychiatric opinion may help describe symptoms, developmental capacity, adversity, substance use, family context and treatment need, but it should not casually transform a legal label into a clinical conclusion.

By contrast, a **child in need of care and protection** enters the protection pathway because of vulnerability, not because the child is alleged to have done something. The statutory idea is deliberately broad. It can apply where a child lacks a stable home or visible means of subsistence, is found working contrary to labour law, or is abused, exploited, neglected, abandoned or surrendered. In clinical language, the question is not simply "what is wrong with the child?" It is

also "who is reliably keeping this child safe, and what setting can support recovery and continuity of care?"

RULE **Start with the pathway, then formulate the child.** The offence-based label is triggered by an alleged act; the protection label is triggered by vulnerability and unmet care. Neither should be treated as a psychiatric diagnosis or as a moral summary of the child.

CLINICAL QUESTION	CONFLICT-WITH-LAW PATHWAY	CARE-AND-PROTECTION PATHWAY
What brings the child into view?	An allegation or finding concerning an offence.	A concern that the child is vulnerable or lacks safe care.
What must not be assumed?	That the alleged act proves a disorder, intent or a fixed character.	That vulnerability means the child has no agency, preferences or strengths.
What is the immediate psychiatric task?	Describe current needs without replacing the legal process with a clinical opinion.	Clarify distress, safety, relationships and the supports needed for stable care.
What is the placement question?	Do not infer a placement answer from the label alone.	Match the care plan to safety, continuity and the child's developmental needs.

Child in conflict with law concerns an alleged act; child in need of care and protection concerns vulnerability and the need for safe care.

34.2 Why age anchoring and language matter

The age element is often tested because it forces attention to the correct clinical-legal timeline. Record the child's account, collateral history and available documentation with their source and degree of certainty. Do not silently substitute the date of assessment, apprehension, remand, referral or hearing for the legally relevant time point. Such substitution can make an otherwise careful report misleading. The treating team does not decide the legal issue by itself, but it must avoid producing imprecise prose that appears to decide it.

Language also changes what the team notices. "Delinquent," "criminal," "bad family," and similar shorthand can obscure trauma, coercion, learning difficulty, acute distress, disability, peer influence or unmet social needs. The converse error is equally important: compassion does not require excusing away all agency, and a psychosocial explanation is not a legal conclusion. The psychiatrist should use person-first, behaviour-specific language: what is reported, what is observed, what remains uncertain, and what treatment or environmental support is indicated.

TRAP **Do not decide status from the child's age at assessment.** The statutory definition fixes the relevant age at the time of the alleged offence. A later age belongs in the chronology, not in place of that anchor.

For general criminal responsibility, adult forensic assessment and the wider legal framework, see *the Mental health legislation and forensic psychiatry notes*. The present distinction is narrower. It

helps the clinician identify whether an alleged act is the doorway into the system, or whether the system is being asked to secure care for a child whose circumstances have become unsafe.

34.3 The psychiatrist's role: formulation without role confusion

When the referral concerns a child in conflict with law, the clinical report should answer the clinical question asked and stay within that scope. It should distinguish observed findings from reports by others, and acknowledge limits imposed by the setting, distress, language, separation from carers or incomplete collateral. A report gains authority by being precise about its boundaries, not by using legal language it cannot support. The general child psychiatric assessment framework is addressed elsewhere in this chapter; this context changes how its findings must be communicated, not the need for disciplined assessment.

When the referral concerns care and protection, clinical work is often inseparable from the experience of disruption. A child may have lost routines, separated from familiar adults, entered an unfamiliar setting, or had prior care marked by neglect or exploitation. Symptoms can be meaningful responses to uncertainty as well as evidence of a disorder. The formulation should therefore account for the child's felt safety, supportive relationships, ordinary routines, fears about change and practical barriers to treatment. This is not a separate forensic battery. It is good child psychiatry applied to a protection context.

The clinician should resist being recruited into a false binary. A child can require protection while also being involved in an alleged offence. Conversely, a child referred after an alleged offence may disclose violence, exploitation or absence of care. The point is not to assign a single identity. It is to ensure that a disclosed protection concern is not overlooked because the referral arrived through an offence-related doorway. The statutory route and the clinical formulation may interact, but they answer different questions.

> **GOOD TO REMEMBER**
>
> A useful report separates facts, the child's account, collateral information, clinical inferences and recommendations. That separation protects the child, makes uncertainty visible and prevents a treating opinion from masquerading as a legal finding.

34.4 Care planning and placement are clinical continuity issues

For a child in need of care and protection, a placement decision is not merely an address. It changes who can observe symptoms, bring the child to appointments, hold medication safely, support therapy attendance, understand triggers, and notice deterioration or improvement. The mental-health contribution is therefore practical: identify the supports that preserve safety and continuity, rather than making a vague recommendation for "rehabilitation." Recommendations should be tied to the child's current presentation and should state what information needs to travel with the child when care arrangements change.

The statutory options include **placement in a Children's Home, fit facility, or Specialised Adoption Agency**, the last of these for the purpose of adoption, for either temporary or longer-term care. These words identify possible care settings, not a hierarchy of emotional adequacy.

Any setting can be destabilising if a child's history, relationships and treatment requirements disappear at the point of transfer. Equally, a stable transition can be therapeutic even when a change of setting is unavoidable. The psychiatrist should communicate needs in a form that a receiving care team can use.

Before a change in care arrangements, the clinician should communicate:

- the child's current emotional and behavioural presentation, including any immediate safety concern;
- what tends to reduce distress and what predictably escalates it;
- the relationships, routines and communication supports that help engagement; and
- the practical plan for continuing medication, psychological work and follow-up.

IN INDIA

Use the statutory language accurately, but keep the clinical recommendation readable by the receiving service. A sentence that names the support needed, the reason it matters and the information that must accompany the child is more useful than a broad declaration that the child requires institutional care.

PITFALL

Do not let a transfer become an undocumented clinical reset. Repeating the full assessment is sometimes necessary, but loss of the prior formulation, current treatment plan and known calming supports can itself create avoidable distress and apparent non-engagement.

34.5 Foster care: an alternative family environment, not an informal arrangement

Foster care is alternate care in the domestic environment of a family other than the child's biological family, where that family has been selected, qualified, approved and supervised. This definition matters because it distinguishes statutory foster care from an informal arrangement with relatives, neighbours or acquaintances. The emotional quality of informal support may be important clinically, but it should not be inaccurately described as the statutory placement option.

For a child declared in need of care and protection, a **foster-care order** is a possible disposal pathway, made under **section 44**. The statutory process is covered in the chapter section on the Juvenile Justice Act. The psychiatrist's narrower responsibility is to help the care plan anticipate adjustment: how the child responds to unfamiliar adults, separations and limits; what supports foster carers will need to understand; and how treatment can continue without turning the foster setting into a clinic.

MNEMONIC

OVP - Offence, Vulnerability, Placement

Use this as a quick organising spine. Identify whether the system entry is an alleged offence or vulnerability, then ask what care arrangement will preserve safety and psychiatric continuity.

34.6 Adoption pathway and respectful clinical handover

A child in need of care and protection may be the subject of a declaration that the child is **legally free for adoption**. The declaration opens an adoption pathway; it is not a psychiatric prediction about attachment, future behaviour or the quality of a prospective family. Avoid language that pathologises the child because the child has experienced separation, institutional care or disruption. At the same time, do not conceal clinically relevant history that a future care plan needs in order to be safe and realistic.

Adoption law and assessment of adoptive-parent fitness are beyond this section. The psychiatric contribution is a careful, minimum-necessary handover: current symptoms and treatment, communication and learning needs, known trauma-related sensitivities where clinically relevant, protective routines, and follow-up needs. It should be written with awareness that records can affect a child's future relationships. Include what helps, not only what has gone wrong. Do not convert uncertain formulation into a permanent label.

The same discipline applies across all protective placements. Explain the child in a way that supports care, preserves dignity and keeps legal decisions in their proper forum. In practice, that is the bridge between child psychiatry and protection work: a report that is clinically useful, developmentally sensitive and exact about what it can and cannot decide.

35 · Child labour and adoption (psychiatric aspects)

Why it matters clinically. Child labour and adoption are not diagnoses. They are contexts that can alter a child's exposure to adversity, the meanings given to symptoms, the people who can provide safety, and the relationship through which treatment is delivered. A psychiatric opinion is useful when it describes the child's current difficulties without collapsing the child into either a legal category or a family story.

Child labour requires attention to the working environment, coercion, abuse and interrupted developmental opportunities. Adoption requires attention to the child's life narrative, relationships and questions of belonging. Neither permits casual assumptions: a working child may be silent without being symptom-free, and an adopted child may have difficulties that are neither caused by adoption nor explained by it.

LABOUR	ADOPTION	FORMULATION	CARE
CONTEXT AND RISK	NARRATIVE AND RELATIONSHIP	BEFORE LABELS	SAFETY WITH DIGNITY

35.1 Psychiatric frame for child labour

Child labour is clinically important not because it supplies a diagnosis, but because work may organise a child's daily life around demand, fatigue, fear, adult control and restricted access to ordinary supports. The consultation should therefore ask what the work means in this child's life. Is it described as contribution to the family, a source of pride, an obligation, a punishment, a means of survival, or an experience the child cannot safely discuss? The answer changes the formulation and the safety response.

The psychiatric task is not to decide the legal status of employment from a clinic interview. It is to identify mental-state symptoms, functional effects, coercion, maltreatment, available support and immediate danger. Symptoms are assessed as symptoms, while the circumstances in which they arose are explored carefully.

RULE **In a working child, formulate exposure and safety before attributing behaviour to character.** A difficult or guarded presentation can be an adaptation to threat, exhaustion, divided loyalties or a learned expectation that adults will not help. It should prompt careful enquiry rather than a moral judgement about the child or family.

A useful formulation separates linked questions:

- What does the child experience during and around work, including supervision, control, injuries, humiliation, threats and contact with adults?
- What is the present psychiatric picture, including distress, behaviour, cognition, sleep, physical symptoms and functioning across settings?
- What protective relationships and practical alternatives are available if the child discloses harm or cannot return to the same environment?

This prevents a common clinical collapse in which social hardship is treated as an explanation that ends assessment. Poverty may be relevant to why a child works, yet it does not make abuse, coercion or treatable distress inevitable or unimportant. Conversely, the presence of work does not establish a particular psychiatric disorder. The formulation must make room for agency and strengths as well as risk: a child may be caring for siblings, preserving school contact, seeking help, or relying on a trusted adult. These features can guide engagement and planning.

GOOD TO REMEMBER

Ask to speak with the child in a developmentally appropriate private setting when possible, while explaining the limits of confidentiality in plain language. The child should know that concern about safety may require the clinician to involve others; promises of absolute secrecy are unsafe and undermine trust when they cannot be kept.

35.2 What the evidence supports, and what it does not

Available multi-country evidence associates child labour with a **higher prevalence of mental and behavioural disorders** than among non-working children, and also links it with **one or**

more forms of abuse. This is an important clinical signal: the working situation should raise the threshold for complacency and make direct, sensitive enquiry essential.

Association is not a shortcut to individual causation. A child may have entered work after prior adversity, family illness, educational difficulty or displacement; the work setting may add new stressors; and symptoms may reflect several interacting pathways. In an examination answer, this is the difference between a contextual formulation and a slogan. The psychiatrist can state that work is a relevant exposure and then show how the child's own chronology, relationships, symptoms and protective factors support the formulation.

Chronology is particularly valuable. Explore what was present before work began, what changed after the work arrangement changed, and whether symptoms vary with particular people, places or demands. Ask about fear of going to work, ability to leave, payment or withholding of payment, access to food, rest, school and healthcare, injuries, sexual boundary violations, violence, and retaliation for disclosure. Use neutral language and avoid leading questions. If the child gives a partial account, do not turn the consultation into an interrogation. Clarify only what is needed for care and protection, document the child's words accurately, and link the child to the safeguarding response owned in the child-abuse management section.

TRAP **Do not diagnose trauma, conduct pathology or malingering from a work history alone.** The work history is a high-value contextual finding, not a substitute for psychiatric assessment. Over-attribution can miss unrelated illness; under-attribution can normalise danger.

CLINICAL QUESTION	WHY IT CHANGES THE FORMULATION	HOW TO RESPOND IN THE INTERVIEW
What is the child expected to do?	Task demands may explain fatigue, fear, injury or absence from ordinary settings.	Invite a concrete account without asking the child to justify the arrangement.
Who controls the work setting?	Control, surveillance and dependence shape both risk and freedom to disclose.	Explore trusted adults and whether the child can speak safely.
What changed in mood, behaviour or sleep?	A symptom timeline tests the proposed link without assuming it.	Ask for examples and variation across settings.
What happens if the child refuses or seeks help?	Retaliation risk determines how safely any plan can be made.	Do not encourage confrontation; activate appropriate protection pathways.
Who can provide immediate support?	Support figures are part of both risk assessment and recovery.	Map safe contacts with the child, not only with accompanying adults.

When a history suggests abuse or unsafe conditions, the clinician must not try to manage the case as a private therapeutic problem. Recognition, protection, reporting, referral and treatment are the clinical safeguarding response taught in the child-abuse management section. Child sexual

abuse assessment has its own forensic and psychiatric framework. General assessment should follow the chapter's Principles of child psychiatric history and examination.

IN INDIA

The principal statutory reference is **The Child and Adolescent Labour (Prohibition and Regulation) Act, 1986**. Its amendment record includes the **Child Labour (Prohibition and Regulation) Amendment Act**, enacted in **2016**. For the psychiatrist, the practical point is to recognise the statute as a protection context, while leaving legal interpretation and statutory procedure to the relevant legal and child-protection services.

35.3 Adoption as a developmental and relational context

Adoption should be approached as part of a child's personal and family narrative, not as a pathological event. The clinical question is not whether a child is adopted, but how adoption is understood, spoken about and lived within this family. A child may have questions about origins, separation, belonging, resemblance, loyalty, loss or difference. These questions can emerge indirectly through behaviour, schoolwork, peer relationships or conflict at home. They deserve curiosity rather than reassurance that closes the conversation.

Adoption communication openness matters because greater openness is linked to healthier family dynamics and more positive child adjustment. Openness is not merely a disclosure event. It is an ongoing family capacity to answer questions honestly at a level the child can use, to tolerate changing feelings, and to invite the child's perspective without demanding gratitude or emotional certainty. In practice, the clinician listens for whether the child is allowed to ask, whether parents can acknowledge what they do not know, and whether difficult feelings can be held without being interpreted as rejection.

There is a difference between privacy and secrecy. Families may reasonably protect personal information and decide how broadly to share it. Secrecy, however, can make the child responsible for managing adults' discomfort and can turn normal curiosity into a forbidden subject. Equally, disclosure delivered abruptly, as a weapon during conflict, or with excessive detail can overwhelm the child. The clinical aim is not to prescribe a uniform family script. It is to support a truthful, sensitive and revisitable conversation that matches the child's capacity and questions.

MNEMONIC

OPEN

Offer questions, **P**ace information, **E**xplore feelings, and **N**ame what is not known. This is a communication stance, not a rigid sequence or a test of parental adequacy.

Parents may fear that discussing adoption will destabilise the child or weaken attachment. That fear is understandable, particularly when family life has already included loss or uncertainty. The therapeutic conversation can make space for parental anxiety while retaining the child's right to experience and express mixed feelings. Help parents distinguish the child's question from an accusation. “Why was I adopted?” may be a question about belonging, origins, anger, grief,

fantasy or ordinary developmental curiosity. Its meaning must be explored with the child rather than supplied by an adult.

PITFALL

Do not treat a parent's discomfort with adoption talk as proof of poor parenting, or a child's curiosity as proof of psychopathology. Both may be understandable starting points for careful family work. The risk lies in shutting down the conversation, not in the existence of difficult questions.

35.4 Formulating difficulties in an adopted child

Attachment difficulties and **adoption-related attributions** can undermine self-esteem, identity, relationships and well-being. This directs attention to process rather than to a simplistic explanation that adoption itself caused the difficulty. A formulation asks what the child has inferred about self and others, what experiences sustain those inferences, how caregivers respond, and where the child finds safety, continuity and competence.

Some children may carry a painful personal explanation for separation or adoption, such as an idea that they were unwanted, defective, disloyal, or obliged to prove that they belong. Such meanings can influence mood, conflict, help-seeking and relationships, but they should not be assumed merely because the child was adopted. The psychiatrist should test the formulation against the child's language and behaviour, the caregivers' account, school context, current stressors and any relevant history available to the family. Where information is incomplete, say so and avoid inventing a coherent story on the child's behalf.

Work with the family often begins by strengthening reflective conversation. Caregivers can be helped to notice the feeling beneath an apparently provocative question or behaviour, respond without immediate correction, and return to the subject later if emotions are high. Individual work may offer the child a place to make sense of conflicting feelings without forcing disclosure to parents before the child is ready. Joint conversations can then be planned around a shared purpose: improving understanding, not extracting a confession or deciding whose version is correct.

The clinician should also resist diagnostic overshadowing. Adopted children can have the same range of psychiatric presentations as other children, and an adoption history should neither be ignored nor allowed to explain everything. Assess presenting symptoms and impairment using the general child psychiatric framework. Refer to the relevant disorder chapters when a disorder-specific assessment or treatment is indicated, including the Child behavioural, emotional and other disorders notes and the Intellectual disability and autism spectrum disorder notes.

RULE **Use adoption history to enlarge the formulation, never to replace it.** Adoption may shape meanings, relationships and the available narrative, but diagnostic reasoning still depends on the child's current presentation, developmental context and evidence from appropriate informants.

35.5 Boundaries, law and the psychiatrist's role

Psychiatrists frequently encounter adoption questions in situations of conflict, anxiety about disclosure, school difficulty, attachment concerns or a request for a certificate. The clinician's role is to assess mental health needs, support communication and document findings within competence. It is not to make unsupported predictions about family suitability, to validate an adult's account over another, or to convert a therapeutic formulation into a legal conclusion.

India's central regulatory reference is the **Adoption Regulations**, **2022**, notified on **23 September 2022**. Adoption law and the fitness of adoptive parents are addressed in the Mental health legislation and forensic psychiatry notes. In a clinical setting, the safest contribution is a clear account of symptoms, functioning, strengths, risks, interventions offered and the limits of the opinion.

TRAP **Do not confuse a therapeutic opinion with a legal fitness opinion.** A helpful account of a child's distress and family interaction does not by itself answer legal questions about adoption procedure or parental suitability. Stay within the referral question and state the limits of inference.

Child labour and adoption are formulation contexts: assess the child carefully, protect safety, and work with the meanings and relationships around the child without turning context into diagnosis.

36 · Bullying and its mental health consequences

Bullying is a clinical exposure, not merely a school-discipline problem. A child may present with distress or an apparently unexplained change in functioning while the peer context remains undisclosed. The psychiatrist's task is to make that context speakable, formulate its relation to the presenting difficulty, and ensure that risk is not missed. This is especially important when the child is ashamed, fears retaliation, has been told to ignore the behaviour, or assumes that adults will dismiss it as ordinary peer conflict.

This section concerns **bullying** and its mental-health consequences. It does not replace the assessment of the childhood disorders themselves, which is addressed in the Child behavioural, emotional and other disorders notes, nor the general child psychiatric assessment framework, which is addressed elsewhere in this chapter. The useful clinical question is not simply, “Has bullying occurred?” It is: what has happened to this child’s sense of safety, agency, belonging, self-appraisal, relationships, and capacity to function?

36.1 Defining the clinical exposure

Traditional bullying is not synonymous with every unpleasant peer interaction. Its defining structure is **intentional and repeated harm** in a relationship marked by a **power imbalance**. Power need not be overt; explore how it operates in the peer relationship and how it limits the target’s ability to stop or escape the pattern. An isolated disagreement can be distressing; bullying becomes a different kind of exposure when harm is organised around domination and recurrence.

Intentional	Repeated	Power	Digital channel
HARM IS DIRECTED	THE PATTERN PERSISTS	RESISTANCE IS CONSTRAINED	MAY EXTEND EXPOSURE

RULE **Call it bullying only after examining intent, repetition, and power.** This protects the child from minimisation while also preventing the term from becoming a label for all peer conflict. The distinction matters because a child caught in a power-imbalanced pattern may need a different level of protection, follow-through, and clinical attention than a child negotiating an isolated quarrel.

The child's account remains central, but it should not be treated as a forensic contest in the clinic. A child may describe a sequence rather than use the word "bullying." Ask for what happens before, during, and after contact with the peer group; who joins, watches, laughs, excludes, records, forwards, or remains silent; and what the child believes will happen if they tell an adult. This clarifies the lived structure of power without forcing a legalistic vocabulary on the child.

TRAP **Do not dismiss a pattern as "normal teasing" because the children sometimes exchange remarks.** Mutuality at the surface does not rule out a coercive pattern. The relevant question is whether a child is repeatedly positioned to absorb harm with less social power and less freedom to disengage.

36.2 Cyberbullying changes the setting, not the clinical seriousness

Cyberbullying refers to bullying conducted **over the Internet or by text message**. A complementary conduct-based description emphasises **online harassment, defamation, or intimidation intended to degrade, belittle, or harass**. These definitions are useful because they prevent a false split between "real-world" and digital harm. The medium changes how exposure is delivered and witnessed; the clinical work still concerns humiliation, threat, loss of control, and the effects of peer power.

CLINICAL AXIS	TRADITIONAL BULLYING	CYBERBULLYING
Setting	Peer harm in an in-person social environment	Online or text-message channel
Useful enquiry	Ask how the peer pattern operates around school, transport, activities, and friendships.	Ask how messages, posts, group interactions, images, or account access are affecting the child.
Clinical formulation	Attend to repeated harm and constrained escape.	Attend to the same peer-power process and to the child's experience of continuing access to the harm.
Common error	Reducing the account to a quarrel.	Reducing the account to "screen time" rather than interpersonal victimisation.

Digital material may create a painful sense that the audience cannot be contained. Even when the child cannot know who has seen something, anticipation itself can maintain vigilance, shame, and avoidance. Conversely, an adult who focuses only on the device can miss the relational

system: peers, bystanders, group allegiances, and the child's fear of social exclusion. The clinician should ask in ordinary language about where peer contact continues after school, rather than assuming that the child will volunteer this part of the story.

IN INDIA

A defensible prevalence figure for cyberbullying among school-going children and adolescents in India is **not established** by the material available for this section. Do not transfer a figure from a different population into child practice. The exam-safe and clinically honest position is to recognise cyberbullying as a relevant adolescent concern, enquire about it directly, and avoid unsupported numerical claims.

36.3 From victimisation to psychiatric presentation

Bullying can function as a continuing interpersonal stressor. Its psychological force is rarely captured by the visible incident alone. Repeated anticipation of ridicule or attack can reshape attention toward threat; public humiliation can alter self-appraisal; exclusion can turn ordinary school and peer settings into cues for alarm. A child may then look oppositional, withdrawn, "unmotivated," or preoccupied when the more coherent formulation is that they are trying to manage an unsafe social world.

Among Indian school-going children and adolescents who experience cyberbullying victimisation, reported mental-health consequences include **depression**, **anxiety**, and **low self-esteem**. These are not interchangeable outcomes. Each calls for a formulation that identifies the child's dominant experience and its functional impact, rather than treating "stress" as an adequate endpoint. This protects against the common error of using the bullying history as a substitute for understanding the actual psychiatric presentation.

Association is not automatic proof that bullying explains every symptom. Some children have pre-existing vulnerabilities, concurrent family adversity, neurodevelopmental differences, interpersonal difficulties, or an emerging disorder that changes both their peer experience and the way they report it. The appropriate stance is neither credulity without inquiry nor scepticism that makes disclosure impossible. Establish chronology, changes from the child's own baseline, the meaning the child assigns to the events, and whether symptoms fluctuate with contact or anticipated contact. This allows bullying to be placed in a formulation as a precipitant, perpetuating factor, consequence, or a combination of these.

GOOD TO REMEMBER

If the history includes **suicidal thoughts**, **self-harm**, or **suicidal-behaviour attempts**, assess current safety directly and act on the level of risk. Bullying may be the context that opens the conversation; it must not become a reason to postpone a full safety response.

36.4 The consultation: making disclosure possible and formulation useful

Children often test whether the clinician is going to minimise, sensationalise, or immediately take control away from them. Begin with a private, developmentally appropriate conversation when

possible, explain the limits of confidentiality in language the child can understand, and signal that the purpose of questions is protection and help rather than punishment. The child may be loyal to peers, worried about being labelled a complainant, or frightened that adults will make an intervention that increases retaliation. These concerns are clinical data, not resistance to be argued away.

- Invite a narrative: what happened, who was involved, what the child did, and what followed.
- Ask about avoidance, distress before peer contact, changes in self-talk, and the child's sense of safety.
- Ask directly about thoughts of death, self-harm, and harm to others when the presentation indicates risk.
- Clarify what the child wants adults to understand and what outcome they fear most.

Collateral accounts can add context, but they are not a mechanism for overriding the child. Parents may notice changes without knowing their meaning. Teachers may see a social interaction but not the private messages or the group dynamics surrounding it. A careful record separates reported events, observed mental state, collateral information, and the clinician's formulation. This makes later communication clearer and protects against the common drift from a child's narrative into an adult's assumption about what "really happened."

PITFALL

Do not make the consultation a demand for screenshots, perfect chronology, or immediate corroboration before offering containment. A distressed child may have deleted material, avoided looking at it, or be unable to recount it in a linear way. Clinical care begins with safety, validation, and careful inquiry; where safety requires wider action, use the applicable local pathway.

36.5 Treatment principles: restore agency without narrowing the problem

Treatment should address the child's symptoms, meaning-making, and social context. Validation is not the same as confirming every unverified detail; it means communicating that the distress is intelligible and worthy of help. Work can help a child name emotions, notice shame-based or hopeless conclusions about the self, distinguish danger cues from global expectations of rejection, and rebuild activities and relationships that have contracted around fear. The exact psychological intervention is selected according to the child's presentation and developmental capacity, not according to the label of bullying alone.

Parents need help to move between opposing unhelpful poles: dismissive reassurance and intrusive takeover. They can communicate belief in the child's distress, keep communication open, monitor changes in safety, and participate in a proportionate plan. Where school involvement is needed, clinical communication should be purposeful: describe functional impact and the need for a safe response, while sharing only what is necessary. This section remains focused on the psychiatric consequences for the individual child rather than on programme design.

MNEMONIC

PAUSE

Privacy for disclosure, **A**cknowledge distress, **U**nderstand the peer-power pattern, **S**creen for safety, and **E**ngage the child and caregivers in a proportionate plan. It is a consultation spine, not a substitute for assessment or safeguarding procedures.

Medication is not a treatment for bullying itself. When a child has a psychiatric syndrome requiring treatment, prescribe and monitor according to the relevant disorder guidance and the child psychopharmacology sections of this chapter. Avoid using a medicine decision as a way of bypassing an unresolved exposure. Equally, do not withhold indicated treatment on the theory that changing the peer environment alone will resolve every symptom. A good formulation keeps both the clinical syndrome and the social stressor in view.

36.6 Risk, documentation, and the candidate's clinical answer

Risk is dynamic. Escalating humiliation, threatened exposure, social isolation, hopelessness, a recent self-harm act, or a child's belief that there is no safe adult can alter urgency. Ask about what keeps the child going as well as what increases danger: a trusted relationship, a valued role, future plans, or willingness to accept help may inform the immediate plan. Do not promise secrecy that cannot be maintained if safety requires adult action, but do explain in advance, as far as possible, what information may need to be shared and why.

The record should make clinical reasoning visible. Document the child's words where they clarify meaning, the pattern alleged, the mental-health effects, the risk inquiry, relevant collateral, protective factors, and the agreed next steps. Avoid pejorative shorthand such as "attention seeking" or "peer issue." Such language prematurely closes formulation and may influence later professionals to underestimate a potentially serious exposure.

Bullying is defined by intentional, repeated harm and a power imbalance; when it is disclosed, assess its psychiatric impact and current safety rather than treating it as routine peer conflict.

Cross-cutting synthesis

37 · Cross-cutting synthesis

Why the synthesis matters. A child does not arrive in separate assessment, prescribing, therapy, service and protection compartments. The clinician must make one coherent plan from information that arrives at different times, from different people, and sometimes in conditions of risk. Marks are earned here by showing the movement from one domain to the next: not merely naming each domain, but explaining why a finding in one changes the action in another.

The organising question is not, "Which intervention belongs to which discipline?" It is, "What must change for this child, what could prevent that change, and who must know what next?" A

clinical formulation is useful only when it guides the next decision and remains open to revision. The parts of care must **interlock**: assessment directs the initial plan; prescribing creates observation duties; observation may reveal risk; protection obligations alter the order of care; and service access determines whether psychological work can actually be delivered.

FORMULATION	PRESCRIBING	PROTECTION	SERVICES
WHAT CHANGES	WHAT TO WATCH	WHAT MUST HAPPEN	WHAT IS POSSIBLE

37.1 Begin with the decision, not the silo

The assessment is not a prelude that ends when treatment begins. It establishes the decision that has to be made now, the information on which that decision rests, and the information that could reverse it. The general child psychiatric assessment framework, interviewing, developmental testing, screening, rating tools and neuropsychological assessment are taught in their respective sections. Their synthesis value lies in converting their findings into a shared account of the child's difficulties, capacities, relationships, daily setting and immediate risks.

At this point, the clinician should distinguish a **presenting complaint** from a **treatment target**. The former is the concern brought by the family, school or another agency. The latter is the change that the current plan can reasonably try to produce. If the account is incomplete, contradictory, or shaped by an unsafe setting, the correct response may be to clarify the formulation before choosing an intervention. This is not therapeutic delay for its own sake; it prevents an apparently efficient plan from treating the wrong problem or placing an impossible burden on the child.

RULE **Every intervention must answer a question raised by the formulation.** If a proposed intervention cannot be linked to a stated target, a relevant risk or a feasible route of delivery, it is a habit rather than a plan.

- State what the current assessment permits the team to act on.
- State what uncertainty needs follow-up rather than concealment.
- State which person or setting can confirm whether the intended change is occurring.

37.2 Let assessment alter the prescribing decision

Child prescribing is not a detachable response to a label. Its principles, developmental considerations, drug-specific practice, off-label questions and consent framework belong to the psychopharmacology sections. The cross-cutting task is to make the assessment visible in the prescribing decision. A child's developmental communication, physical health context, pattern of impairment, family understanding, competing explanations for change and access to follow-up can each determine whether medication is appropriate now, whether another intervention must lead, or whether a proposed trial needs to wait for safer clarification.

A prescription therefore carries a **clinical rationale**, not merely an instruction. The rationale identifies the target, the anticipated observation and the contingency if the observed course does not fit the formulation. It protects against the common drift in which a medicine becomes the

whole plan because it is the most concrete action available. Psychological intervention, educational support and family work do not become optional simply because medication has been considered. Conversely, therapy should not be presented as a substitute for a review when assessment indicates that a prescribing question requires one.

ASSESSMENT CONCLUSION	HANDOFF TO THE PRESCRIBING PLAN	QUESTION RETURNED TO FOLLOW-UP
The target problem is clear	Link the intervention to that target	Is the intended change visible in ordinary life?
The account remains uncertain	Preserve uncertainty in the plan	What new information would change the decision?
Family or setting constraints are prominent	Test whether the plan can be carried out safely	Who can observe and communicate concerns?
Risk is present or emerging	Reorder care around safety and protection	Has the required pathway been activated?

PITFALL

Do not write “assessment completed, medication started” as though the first phrase has no bearing on the second. That wording hides the formulation, makes later review arbitrary and can obscure why a non-pharmacological or protective action was prioritised.

37.3 Treat monitoring as a new source of assessment

Once a prescribing decision is made, monitoring is not an administrative afterthought. The detailed monitoring-and-consent framework and drug-specific schedules are taught elsewhere. In the integrated plan, follow-up is a **monitoring loop**: it asks whether the target changed, whether the child’s functioning changed in the settings that matter, whether an unwanted effect or new difficulty has appeared, and whether the caregivers can still implement the plan they agreed to.

This loop can validate the original formulation, qualify it, or expose that the team has been looking at only one part of the child’s life. A change reported by one adult may have a different meaning when connected with the child’s own account, school experience, peer context or home atmosphere. The clinician should neither dismiss discordant accounts as nuisance nor automatically average them into a false consensus. Disagreement is often the handoff back to assessment: it identifies where further understanding is needed before escalating, continuing or changing treatment.

The record should make responsibility visible. It should show what is being watched, how the family can raise a concern, and what event requires earlier contact or a change in the plan. This is a continuity task, not a demand that one clinician personally observe every setting. The plan is safe only if its observers understand their role and the team knows how information will return.

GOOD TO REMEMBER

A useful review question is not simply whether the child is "better." Ask whether the observed change supports the working formulation and whether it has made the child safer, more able to participate, or more reachable for the next intervention.

37.4 Allow monitoring to surface safeguarding concerns

Follow-up sometimes reveals more than response to treatment. New information may become a **safeguarding signal**. The types and indicators of abuse, child sexual abuse assessment, and the clinical response to abuse are taught in the protection sections. The synthesis point is that a new concern is not a reason to defer attention until the next routine assessment. It changes the clinical task immediately from simple treatment review to safety-oriented decision-making.

At that seam, the clinician should separate two questions that are often mistakenly fused. One question is what is needed for the child's current mental health care. The other is what must be done because the information raises a safeguarding concern. Treatment uncertainty does not cancel a protection concern, and a protection process does not remove the need to address distress, functioning and engagement. They proceed in a coordinated order, with the child's safety setting the limit on what can be attempted therapeutically.

TRAP **Do not wait for clinical certainty before recognising a possible statutory pathway.** A diagnostic formulation and a safeguarding response answer different questions; confusing them can leave the child without timely protection.

- Reclassify the contact as a potential safety handoff, not only a treatment review.
- Use the relevant protection and reporting route without turning the clinic visit into an improvised investigation.
- Keep a clinical route of contact while the necessary services take their part.

37.5 Put statutory duty beside, not after, treatment

Where a safeguarding concern triggers a **statutory pathway**, the legal duty and child-friendly procedures are governed by the child-protection and juvenile-justice sections of this chapter. The psychiatrist's synthesis task is to ensure that the legal and clinical tracks are connected without allowing either to swallow the other. The protection handoff should tell the receiving service what is known clinically, what requires urgent attention, and how further contact can be made without increasing risk to the child.

Protection also changes the therapeutic frame. A child cannot be asked to practise trust, regulation, disclosure or family communication in a plan that ignores an unsafe relationship or setting. The immediate work may need to focus on stabilisation, engagement and safe contact while the appropriate statutory and service responses proceed. This is not a lesser form of therapy. It is the precondition for therapy that has a realistic chance of being used.

IN INDIA

An integrated plan must connect the clinical team with the relevant local child-protection and child-development services rather than treating referral as a discharge destination. The statutory route, protection response and national service platforms are set out in the dedicated sections; the psychiatrist's role here is to maintain a clear clinical handoff and a continuing treatment plan.

37.6 Make service fit part of the treatment formulation

Therapy is delivered through a child's actual environment, not through the referral letter. Play therapy, behavioural work and parent management, family interventions, cognitive behaviour therapy, educational intervention and early intervention are taught in their own sections. Their feasibility depends on a **service fit**: whether the child can attend, whether a caregiver can participate, whether the school can support a consistent plan, whether communication is possible across professionals, and whether protection arrangements permit the proposed work.

Services are therefore active parts of treatment. A school mental-health pathway may make observation and support possible. A child-development platform may make developmental, family or educational work reachable. A referral to protection services may create the safety and continuity without which therapy cannot proceed. The relevant Indian service platforms are described in the sections on school mental health, the child health screening programme and child-development services. The synthesis is to decide which service changes the child's ordinary environment enough for treatment to become practicable.

The handoff must be specific in purpose even when it is brief: what has been assessed, what the receiving service is being asked to do, what information may be shared, and when the clinical team will reassess the plan. A generic referral transfers neither reasoning nor responsibility. It also leaves families to coordinate systems that were designed for professionals to navigate.

MNEMONIC

TRACE

Track the formulation, **R**elate each intervention to its target, **A**ct on new risk information, **C**onnect statutory and service pathways, and **E**nable the therapeutic work that the child can actually use.

37.7 Close the loop without closing the formulation

Integrated care is iterative. Each contact should return the team to the same chain: current formulation, chosen intervention, observed consequence, new risk information, service capacity and revised plan. The purpose is not paperwork completeness. It is to prevent a child from being lost at the seams - assessed but not followed up, prescribed for but not understood, referred but not treated, protected but then left without recovery-oriented care.

Childhood disorders themselves are cross-referred to the Child behavioural, emotional and other disorders notes; ADHD and its treatment to the ADHD and specific learning/communication disorders notes; intellectual disability and autism spectrum disorder to the Intellectual disability

and autism spectrum disorder notes; and temperament and developmental expectations to the Normal child development and milestones notes. Questions of general criminal responsibility, the Mental Healthcare Act and adult forensic assessment belong to the Mental health legislation and forensic psychiatry notes. These boundaries matter because an integrated plan is not a licence to repeat every domain. It is the disciplined account of how each domain changes the next clinical move.

> The best child psychiatry plan is a visible chain of handoffs: assessment informs treatment, treatment generates monitoring, monitoring can activate protection, and services make recovery work possible.

Apply and consolidate

38 · Applying the chapter

Why these cases matter. A child psychiatry vignette tests whether the candidate can make a safe next move when the story is incomplete. The marks lie in showing a disciplined sequence: hear the child and family, identify what needs deciding now, state the information that changes that decision, and connect the child to the right help. It is not an invitation to display a long differential diagnosis or to recite a service manual.

In a standalone answer, the **clinical formulation** is the bridge between a child's presentation and an action. It keeps symptoms, development, relationships, school context, physical health, risk and strengths in the same frame. The diagnosis may be part of clinician reasoning where appropriate, but it is not a label to be delivered to the child or family in the answer. Explain the difficulties and the proposed help in language they can use.

PRESCRIBE	ASSESS	LINK	PROTECT
ONLY AFTER A DECISION FRAME	ACROSS INFORMANTS AND SETTINGS	NEEDS TO USABLE SERVICES	WHEN DISCLOSURE CHANGES SAFETY

38.1 Reading and writing a clinical vignette

A good response begins by locating the decision point. The presenting complaint is often deliberately noisy: a school concern may conceal unmet learning needs, a request for medicine may be a request for containment, and a disclosure may be offered after the child has tested whether the clinician is safe to tell. The candidate should neither flatten this complexity into a label nor become so comprehensive that the urgent decision disappears.

DOMAIN IN THE STEM	WHAT THE ANSWER MUST SHOW	SAFE CLOSING ACTION
Request for a medicine	What is being treated, what has already been tried, and whether benefit, harm and agreement can be reviewed	A reasoned prescribing decision with planned follow-up
Concern about behaviour or progress	Child's account, developmental context, functioning, observations and accounts from relevant settings	A focused assessment plan and feedback formulation
Family unable to sustain care	Which participation barrier matters most and which agency can address it	A coordinated referral with responsibility for follow-through
Possible abuse or exploitation	Immediate safety, a careful response to disclosure, documentation and the safeguarding pathway	Protection, statutory action and therapeutic support

The following vignette answers use the same spine.

- Name the immediate decision rather than merely naming a condition.
- Give the clinical reasoning that would change the decision.
- End with an action, communication plan and review responsibility.

RULE **Answer the decision in front of you, then show why it is safe.** A broad formulation earns its place only when it clarifies the next action for this child, in this setting, with this family.

MNEMONIC

PAST: Pause, Assess, Support, Take action to protect

Use this as the closing spine of a vignette. **Pause** before reflex prescribing; **Assess** the child in context; **Support** the child through family, school and services; and **Take action to protect** when safety is in question. It is a reasoning aid, not a substitute for the detailed frameworks elsewhere in the chapter.

38.2 A prescribing decision when the family wants a quick answer

Presentation. A school-aged child is brought after repeated complaints of restlessness, conflict and incomplete work. The parent asks for a medicine because the school has said that the child must "settle down". The child looks exhausted, says that lessons feel impossible when classmates mock the errors, and reports sleeping poorly. The parent is angry with the school and expects a prescription at the end of the visit.

Decision point. Should the clinician start or change a psychotropic medicine at this consultation?

Reasoning the candidate must show. The request for medication is not yet a prescribing indication. The clinician needs to distinguish a persistent pattern from a recent contextual

change, understand the child's experience as well as the parent's account, and ask what happens across home, school and other settings. The answer should identify sleep, distress, peer experiences, learning demands, physical contributors, safety and previous interventions as information that could alter the formulation. It should also establish what the family understands and what the child is willing to discuss, rather than treating the child as a passive recipient of an adult decision.

The relevant **prescribing frame** is then applied, not reproduced from memory. If a medicine is contemplated, its target difficulties, expected benefit, possible unwanted effects, consent and assent process, and route for review must be made explicit. If the available account is too incomplete to support a safe choice, delaying the prescription is an active clinical decision, not therapeutic neglect. A clinician may still address immediate distress, coordinate with the school and arrange prompt reassessment while the assessment proceeds.

Answer. Do not prescribe simply to meet the school's demand. Complete a focused multi-setting assessment and discuss the formulation with the child and parent in plain language: "We need to understand what is making school so difficult before deciding whether medicine would help." Offer practical interim support, obtain the information required for a safe decision, and return to treatment selection using the child-prescribing and monitoring frameworks. If the eventual formulation concerns ADHD, its stimulant and non-stimulant treatment belongs in *the ADHD and specific learning/communication disorders notes*; if it concerns another childhood disorder, consult *the Child behavioural, emotional and other disorders notes*.

> **GOOD TO REMEMBER**
>
> A child's reluctance, a parent's urgency and a school's request are all clinical data. None alone decides the prescription. The interview should leave the family with a comprehensible plan even when the medicine decision is deferred.

38.3 An assessment when the accounts do not agree

Presentation. A child is referred because teachers describe disruptive behaviour and falling classroom performance. At home, the caregiver sees a quiet child who spends long periods drawing and has few arguments. In the interview, the child speaks little at first, then says that school feels frightening and that adults assume deliberate defiance. The referral letter asks for a "test" to establish what is wrong.

Decision point. What assessment should be arranged, and how should the disagreement between adults be handled?

Reasoning the candidate must show. Contradictory accounts are not a reason to choose the most authoritative informant. They are a finding that requires explanation. The candidate should seek a **multi-informant assessment**: the child's own narrative, developmental and medical history, caregiver observations, school examples, direct clinical observation, and information about functioning in relevant environments. The question is not whether either adult is correct

but what differs between settings: task demands, relationships, communication expectations, sensory load, peer safety, family stress or the way behaviour is interpreted.

Assessment must be purposeful. A developmental, adaptive, educational or neuropsychological evaluation is chosen only when it answers a formulation question that cannot otherwise be answered. A score should not replace the child's history or be used as a verdict. The candidate should describe the **functional impact** that needs clarifying - participation in learning, relationships, self-care, play, emotional regulation or daily routines - without importing cut-offs or proprietary test content. The child's strengths, including the sustained interest in drawing, matter because they can shape engagement and school planning.

Answer. Explain to the caregiver and school that the assessment will bring together accounts rather than declare either side wrong. Obtain examples of antecedents, behaviour and consequences in each setting; interview and observe the child in an age-appropriate way; review development and health; and select further testing only for a defined question. Feed back a shared formulation that describes needs and strengths without naming a diagnosis to the child or family. For the general assessment framework, see the chapter section on child psychiatric history and examination; for developmental and adaptive screening, and for the formal test batteries, use the relevant assessment sections. Intellectual disability and autism spectrum disorder are addressed in *the Intellectual disability and autism spectrum disorder notes*, and developmental expectations belong in *the Normal child development and milestones notes*.

TRAP **Do not turn a request for "a test" into a test-led assessment.** Instruments answer selected questions; they do not reconcile conflicting accounts, establish context or determine what the child and family need next.

38.4 A services referral that must be more than a name on paper

Presentation. A child has attended intermittently after a recent family disruption. The caregiver can travel only with difficulty, the school is considering exclusion, and a relative says that the family should seek a disability certificate before accepting any other help. The child wants to remain with familiar peers but says that nobody has explained what support might be possible. The immediate symptoms have been discussed, yet attendance and participation remain fragile.

Decision point. Is a generic referral enough, or does the clinician need to build a **service map** around the child's actual barriers?

Reasoning the candidate must show. Referral is a clinical intervention only when it reaches a service that can act on the stated problem. The candidate should identify the bottleneck: access to care, educational participation, family support, therapeutic work, social protection, transport, communication between agencies or an unrecognised safeguarding concern. A certificate may be relevant to future entitlements, but it is not a substitute for asking what will help the child participate now. Likewise, sending the family to multiple agencies without a named purpose transfers the coordination burden to the person least able to carry it.

The referral should link mental-health care with the child's everyday setting. This may include discussion with school, educational assessment and support, family intervention, developmental services, community follow-up or a social-work response, according to the formulation. The clinician remains responsible for making the reason for referral clear, obtaining appropriate agreement to share information, and checking whether the connection occurred. The child should hear a practical explanation: "We are asking these people to help make school and home more manageable," rather than a diagnostic label.

Answer. Make a coordinated referral plan with the caregiver and child. State the target for each contact, identify who will communicate with school, arrange follow-up that reviews participation rather than only symptoms, and address barriers that would make the plan fail. Use the chapter's sections on school mental health, RBSK and ICDS to select the appropriate Indian platform rather than treating services as interchangeable. If the child is at risk of harm or lacks safe care, move to the protection pathway instead of leaving that concern inside a routine referral.

IN INDIA

Families often encounter school, health, developmental and welfare systems as separate doors. The clinical task is to translate a formulation into a coordinated request that each service can understand, while retaining the family's voice and the child's participation.

38.5 A child-protection disclosure in the consultation room

Presentation. During a review attended by a caregiver, an adolescent asks to speak alone. The young person then describes unwanted sexual contact by someone known to the family and asks the psychiatrist not to tell anyone, fearing blame and disruption at home. There is no visible injury at the consultation. The caregiver outside has been pressing for medication because the adolescent has become withdrawn and irritable.

Decision point. How should the clinician respond in the room, and what must happen next?

Reasoning the candidate must show. The immediate task is a **safeguarding response**, not diagnostic classification and not an attempt to prove the account during a routine psychiatric interview. Thank the young person for telling, respond calmly, and avoid leading questions or repeated detailed questioning. Explain the limit of confidentiality honestly: the clinician will involve the appropriate people to help keep the young person safe. Assess immediate danger, identify whether a safe adult and safe place are available, and document the disclosure accurately in the child's own words as far as possible.

The candidate must then activate the hospital child-protection process and the applicable POCSO reporting and child-friendly care pathway. The response includes protection, medical and forensic referral where indicated, and ongoing mental-health support. A visible injury is not required for the disclosure to be taken seriously; equally, the clinician's role is not to make an evidentiary finding before seeking protection. Communication with the caregiver must be planned around safety, the child's wishes where they can be respected, and the statutory process.

Do not name a psychiatric diagnosis to the adolescent or family; describe distress as an understandable response and explain the supports being arranged.

Answer. Remain with the young person, ensure immediate safety, explain the next steps without making promises that cannot be kept, document carefully and initiate the safeguarding, reporting and referral pathway without delay for certainty. Arrange continuity of therapeutic support after the acute response. The detailed clinical response to abuse is in the child-abuse management section, and the statutory duties and procedures are in the POCSO section. General criminal responsibility and adult forensic assessment belong in *the Mental health legislation and forensic psychiatry notes*.

1. Listen without interrogation and acknowledge the disclosure.
2. Make safety, protection and accurate documentation the immediate priorities.
3. Use the formal safeguarding pathway while preserving therapeutic continuity.

PITFALL

Never promise absolute secrecy before hearing what the child needs to say. A promise that must later be broken can feel like a second betrayal. State privacy and its safety limits early, then explain each necessary disclosure as transparently as possible.

In every vignette, show the child's experience, the decision that cannot wait, the reasoning that makes it safe, and the person who will carry the next action.

39 · Consolidation

The final task is not to reread the chapter, but to retrieve it. A child psychiatry answer becomes clinically useful only when the candidate can recognise which part of the system is being tested, select the relevant frame, and state the next defensible action without being handed a menu. This closing section turns the chapter into an active recall exercise. The prompts are deliberately answer-free: pause, write or say the answer, then return to the relevant section only to correct what was missed.

Retrieval is more demanding than recognition. A familiar heading may create the impression of mastery while leaving the clinician unable to organise an assessment, explain a prescription, locate an appropriate service, or respond safely to a disclosure. Use each prompt to construct a brief **problem representation**: what is happening, whose account is needed, what decision is pending, and what could be unsafe if delayed. That habit integrates the chapter without turning its separate components into a blurred checklist.

PRESCRIBE	ASSESS	TREAT	PROTECT
RECALL THE FRAME	RECALL THE SOURCES	RECALL THE FIT	RECALL THE RESPONSE

39.1 How to use the closing prompts

A useful **retrieval cue** names a decision, not merely a heading. Before answering, decide whether the question is principally about prescribing, assessment, psychological intervention, access to support, or safety. Several domains can be relevant, but identify the domain that sets the immediate **decision threshold**. State that priority at the outset, then bring in adjacent domains only where they change the decision.

RULE **Retrieve the clinical action before reopening the text.** The point of review is to detect a gap in reasoning, not to replace reasoning with recognition. A short spoken answer is sufficient when it includes the child, the caregivers, the setting and the immediate clinical responsibility.

Do not treat a weak answer as a reason to copy a paragraph. Identify the missing link instead. It may be an absent informant, an unasked developmental question, a poorly matched intervention, an overlooked school or community pathway, or a safety obligation that should have changed the order of events. Revisit that missing link and attempt the prompt again after an interval. This makes uncertainty visible early, when it is still easy to repair.

- Answer from memory in complete clinical sentences before checking the chapter.
- When your answer is incomplete, label the missing step rather than memorising isolated phrases.
- Use the next patient encounter to test whether the recalled framework changes what you ask, document or arrange.

PITFALL

Passive rereading can feel fluent because the wording is familiar. It does not show whether you can choose between competing priorities when a child, caregiver, school and service system each provide only part of the picture.

39.2 Master spine for the chapter

The chapter can be held together by **PATS**. It is a navigation cue rather than a substitute for the detailed sections. On every revision pass, ask whether the case needs a prescribing frame, an assessment frame, a therapy frame, a service frame, or a safeguarding frame. The same child may require several of these, but the mnemonic prevents a familiar diagnosis from crowding out the surrounding system of care.

MNEMONIC

PATS: Prescribing, Assessment, Therapy, Services, Safeguarding

Use the mnemonic to scan the chapter's linked domains. It is a prompt to ask what remains unaddressed, not a claim that every child needs every component at every encounter.

Why this matters in practice. A technically correct intervention may still fail if it is not grounded in a credible assessment, understood by the caregiving system, workable in the child's everyday setting, or safe to deliver. Conversely, a protection concern can change the sequence of

care even when a therapeutic plan is otherwise sound. The clinical skill is **cross-setting transfer**: carrying the formulation from the consultation room into family, school, community and protection contexts without losing the child's perspective.

GOOD TO REMEMBER

When a case feels complicated, do not add interventions indiscriminately. First ask which PATS domain is driving immediate risk or impairment, then identify the relevant collaborator or setting that must be brought into the plan.

39.3 Answer-free active recall prompts

Attempt the following without looking back. They are written as questions because the act of retrieval is the device. Do not convert the table into model answers: the value lies in exposing what cannot yet be reconstructed from memory.

CLINICAL DOMAIN	RETRIEVAL PROMPT	SELF-CHECK AFTER RECALLING
Pharmacology	Before initiating or changing a psychotropic medicine for a child, what prescribing, developmental, communication, monitoring and follow-up questions must you answer?	Have you distinguished the treatment decision from the wider monitoring-and-consent framework?
Assessment	How would you construct a child psychiatric assessment when accounts from the child, caregivers and other settings do not fully agree?	Did you include developmental context, direct observation and the appropriate role of structured tools?
Therapy	How would you choose and adapt psychological work when the child's needs, caregiver capacity and educational setting pull in different directions?	Have you explained why the chosen approach fits rather than simply named a therapy?
Services	What local health, school and community pathways could support a child whose needs cannot be met by a clinic appointment alone?	Can you describe how referral, collaboration and continuity would work in the child's setting?
Protection	When concern, injury, neglect or a disclosure raises a child-protection question, what must determine the immediate sequence of clinical action?	Have you separated recognition, safety, documentation, reporting, referral and therapeutic follow-through?

IN INDIA

For each services and protection prompt, practise naming the locally available pathway as well as the clinical rationale for using it. A generic referral answer is incomplete if it does not show how the child and caregivers will reach, understand and remain connected with support.

TRAP **Do not answer a systems question by reciting a disorder formulation alone.** The question may begin with symptoms, but marks and patient safety often turn on the next assessment source, treatment adaptation, service link or safeguarding responsibility.

39.4 Consolidating clinical judgement

The strongest final answer does not list every resource available to a child. It explains why a priority action comes first and how the rest of the plan follows. A **safeguarding lens** is especially important: it asks whether the ordinary pace of assessment or treatment is appropriate when safety, coercion, neglect or exploitation may be present. That lens does not replace clinical formulation. It determines whether the formulation can safely be acted upon.

For revision, convert each missed prompt into a small plan for re-learning. Return to the relevant section, identify the rule or distinction you failed to retrieve, and rehearse it in a fresh scenario. Then use PATS to check that the new answer still respects the child's developmental position, the caregiver relationship and the realities of the setting. This is how a chapter on systems becomes a method of practice rather than a collection of headings.

Before you close a child psychiatry case, ask: what must be prescribed, assessed, treated, connected and protected?

Previously asked

Genuine past questions from this chapter's territory, with their board of origin. One catalogued theory question falls inside child psychopharmacology, the child assessment battery, the therapeutic interventions, the service and policy context, or child protection and juvenile justice, and it is printed below exactly as it was set. No question is reconstructed, paraphrased into a new one, or invented to pad the list. The catalogue behind this list is a single board's record and is not a complete account of what has been asked, still less of what may be asked.

QUESTION	MARKS	ASKED
Play therapy	10	MUHS 2013

The shape of that question is worth reading closely. It is a bare noun phrase carrying ten marks, which is the examiner asking for a structured account rather than a definition: what play therapy is and why play is the medium, the non-directive and directive traditions, the technique, the indications and the limits, and the evidence. A candidate who writes four lines on what play therapy means has answered a two-mark question that was not asked.

TRAP **An unasked topic is not a low-yield topic.** The absence of a past essay is a fact about one board's recent papers, not about what an examiner may ask this year. This chapter carries two bodies of material that are examined far more often than the catalogue above suggests, because they are asked in the viva and as short notes rather than as set-piece essays: the paediatric doses, each scoped to its population and its indication, and the statutory duties under the child-protection and juvenile-justice framework. Prepare the discriminations, the doses and the statute, not the past paper.

The quick review

One table, read down the left column and cover the right. Every line is taught in full somewhere above and nothing here is new: each is that topic's single must-hold line, lifted verbatim from the section that teaches it, so a line you cannot recover is a section to reread rather than a fact to memorise here. Doses are deliberately not restated in this table; a dose is a fact about an indication in a population and belongs with the whole regimen where it is taught.

ASK	HOLD
CHILD PSYCHOPHARMACOLOGY	
PRINCIPLES OF PRESCRIBING PSYCHOTROPICS IN CHILDREN	A child psychotropic prescription is justified by a clear target, a developmental formulation, a proportionate place in the plan and an accountable review process.
DEVELOPMENTAL PHARMACOKINETICS AND PHARMACODYNAMICS IN CHILDREN	In child psychopharmacology, developmental physiology changes the path from prescribed amount to clinical effect, so dose, concentration and response must never be treated as interchangeable.
STIMULANTS IN CHILDREN	Stimulant safety follow-up is longitudinal: periodically record physical parameters, review real-world function, and investigate new concerns before deciding what they mean.
ANTIPSYCHOTICS IN CHILDREN	An antipsychotic prescription for a child is complete only when its target symptom, indication-specific scope, and metabolic monitoring plan can all be read from the clinical record.
ANTIDEPRESSANTS IN CHILDREN	Write the whole regimen sentence: medicine, child population, indication, start, schedule, titration, target, and ceiling statement.
MOOD STABILIZERS IN CHILDREN AND ADOLESCENTS	For paediatric mood stabilisers, the safe answer is the whole regimen: indication, population, dose pathway, ceiling, and monitoring - never the milligram figure alone.
MONITORING AND CONSENT ISSUES IN CHILD PSYCHOPHARMACOLOGY	Monitor the medicine, the child's functioning, and the family's understanding; consent is a continuing clinical conversation, not a form completed before treatment begins.

ASK	HOLD
OFF-LABEL PRESCRIBING, DOSING PRINCIPLES AND START-LOW GO-SLOW IN CHILDREN	Off-label prescribing in children is justified by an explicit individual rationale, transparent discussion, conservative initiation, gradual titration, and review against a pre-defined target.
ASSESSMENT AND RATING TOOLS	
PRINCIPLES OF CHILD PSYCHIATRIC HISTORY AND EXAMINATION	A child psychiatric assessment is credible when developmental history, direct mental-state observation and collateral accounts are integrated without allowing any single source to stand for the child.
PLAY ASSESSMENT AND INTERVIEWING CHILDREN	Use play to open and observe the child's world; use corroboration to decide what the observation means.
DEVELOPMENTAL AND IQ TESTS	Choose the test by the question, interpret the child's performance in context, and never let a score do more clinical work than the assessment can support.
ADAPTIVE AND DEVELOPMENTAL SCREENING	A developmental or adaptive screen is useful only when its pattern is interpreted in context and used to decide the next clinical step.
BROAD-BAND RATING SCALES	A broad-band rating scale is most useful when its score is interpreted as one informant's structured account within a full clinical formulation.
PROJECTIVE TESTS IN CHILDREN	Projective tests can deepen a child assessment only when their observations are kept tentative, explored with the child, and corroborated elsewhere.
MULTIAXIAL AND MULTI-INFORMANT ASSESSMENT IN CHILD PSYCHIATRY	Multiaxial formulation preserves the distinction between symptoms, context, physical health, development, and disability so that clinical planning addresses the whole child.
NEUROPSYCHOLOGICAL ASSESSMENT OF CHILDREN	Neuropsychological assessment is most useful when it explains a functional difficulty through a coherent cognitive profile and turns that explanation into supports that can be tested in the child's real environment.
THERAPEUTIC INTERVENTIONS	
PLAY THERAPY	Play therapy is a formulated therapeutic relationship in which play helps the child express, explore and work through difficulty; the therapist follows or directs the medium only as the clinical task requires.
BEHAVIOUR THERAPY AND PARENT MANAGEMENT TRAINING IN CHILDREN	Formulate the sequence, strengthen the behaviour you want repeated, and help caregivers respond predictably enough that escalation no longer becomes the easiest route out of conflict.
FAMILY THERAPY AND FAMILY INTERVENTIONS IN CHILD PSYCHIATRY	Family intervention changes the conditions around a child's difficulty by helping the family see, test, and sustain a safer and more workable pattern of care.
COGNITIVE BEHAVIOUR THERAPY AND ADAPTATIONS FOR CHILDREN AND ADOLESCENTS	Developmentally adapted CBT keeps the formulation and therapeutic aim intact while changing the route by which the child can understand, practise and own the work.

ASK	HOLD
SPECIAL EDUCATION AND REMEDIAL AND EDUCATIONAL INTERVENTIONS	The educational prescription is complete only when it names the barrier, the support, the responsible partner and the route for review.
EARLY INTERVENTION AND STIMULATION PROGRAMMES	Early intervention succeeds when a child gains meaningful participation through repeated, enjoyable opportunities that caregivers can realistically sustain.
EPIDEMIOLOGY, SERVICES AND NATIONAL CONTEXT	
EPIDEMIOLOGY OF CHILD PSYCHIATRIC DISORDERS IN INDIA	In India, cite the NMHS adolescent result only with its age and sampling limits; for younger children, state plainly that an all-India psychiatric prevalence figure is not established.
SCHOOL MENTAL HEALTH PROGRAMMES AND LIFE-SKILLS EDUCATION	School mental health succeeds when life-skills teaching, a supportive school climate and a clear route to clinical or protection services work as one system.
RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK) AND THE 4DS	RBSK uses the 4Ds to identify childhood health concerns and link them to care; the psychiatrist turns a referral into an individual, developmental and family-centred plan.
INTEGRATED CHILD DEVELOPMENT SERVICES AND CHILD MENTAL HEALTH POLICY IN INDIA	Anganwadi Services are an integrated child-development platform whose mental-health value lies in contextual observation, caregiver partnership and a reliable bridge to appropriate care.
CHILD PROTECTION, ABUSE AND JUVENILE JUSTICE	
TYPES OF CHILD ABUSE	Child maltreatment is best understood as harm or threatened harm within a relationship of responsibility, trust or power: name the pathway - physical, sexual, emotional, neglectful or exploitative - then formulate the child's whole experience.
CLINICAL FEATURES AND INDICATORS OF CHILD ABUSE	Clinical indicators of abuse require recognition, not premature conclusion: preserve the finding, test the explanation, hear the child, and keep uncertainty explicit.
CHILD SEXUAL ABUSE ASSESSMENT AND PSYCHIATRIC SEQUELAE	In suspected or disclosed child sexual abuse, the psychiatrist listens carefully, assesses safety and psychiatric need, documents source and uncertainty, and does not turn clinical care into a repeated forensic interview.
POCSO ACT 2012	In India, mandatory reporting under POCSO is a legal duty: any person with apprehension or knowledge must inform the designated police authority, and failure to report is punishable.
MANAGEMENT AND INTERVENTION IN CHILD ABUSE CASES	In child abuse management, protect the child first, coordinate the adults and services around the child, and use trauma-focused intervention for the child's current clinical needs.
JUVENILE JUSTICE (CARE AND PROTECTION OF CHILDREN) ACT 2015	The Juvenile Justice Act separates an alleged offence from a child's vulnerability, and a psychiatric opinion assists the statutory forum without replacing it.

ASK	HOLD
CHILD IN CONFLICT WITH LAW AND CHILD IN NEED OF CARE AND PROTECTION	Child in conflict with law concerns an alleged act; child in need of care and protection concerns vulnerability and the need for safe care.
CHILD LABOUR AND ADOPTION	Child labour and adoption are formulation contexts: assess the child carefully, protect safety, and work with the meanings and relationships around the child without turning context into diagnosis.
BULLYING AND ITS MENTAL HEALTH CONSEQUENCES	Bullying is defined by intentional, repeated harm and a power imbalance; when it is disclosed, assess its psychiatric impact and current safety rather than treating it as routine peer conflict.

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PART VI

VI

Mental Health Legislation and Forensic Psychiatry

The law the psychiatrist works inside: the mental health statutes, and the criminal, civil and family forensic questions.

01 Orientation: mental health law and the forensic questions

02 The Mental Healthcare Act 2017

03 The Rights of Persons with Disabilities Act 2016

04 Substance and narcotics law

05 Criminal responsibility and forensic assessment

06 Civil law, capacity and family law

07 Violence risk and dangerousness assessment

08 Cross-cutting synthesis

09 Apply and consolidate

PAPER III

Mental health legislation and forensic psychiatry

Eight bands . one complete notes document

Orientation: mental health law and the forensic questions

1 · Orientation: mental health law and the forensic questions

Why these marks are here. Mental health law and forensic psychiatry is the one part of the paper that asks you to reason as a clinician and as a party to the legal system in the same breath. On the wards you already work inside a statute book that decides whom you may admit, what you may treat, and how far your authority reaches; and every so often a court reaches into that clinical world and puts a question only a psychiatrist can answer - was this act excused, is this person competent to this particular legal step, is this patient a risk the law must weigh. Candidates lose marks here less because the material is obscure than because the two worlds are usually taught apart, are easy to confuse under time pressure, and turn on fine distinctions that are either read straight from the statute or badly reconstructed from a half-remembered lecture. What this opening section gives you is the chapter's advance organizer: a single map to carry in your head, so that each later provision arrives as a marked place on ground you already hold rather than as one more law to be memorised in isolation.

The map has one shape, and fixing it is worth more than any single provision. The chapter runs on two spines, with one idea threaded down the length of both. The first spine is legislation, the statutes you operate inside; the second is the run of forensic questions a court reaches in to ask; and the idea beneath both is **capacity** - whether a particular person, faced with a particular decision, at a particular moment, could do the thing the law asked of them. Every statute in the chapter is worked from its own enacted text rather than from a summary, because a paraphrase drifts and a digest goes out of date; and one of those texts has been recodified recently, which makes the currency of a citation itself an examinable point. Hold the two spines, look for the capacity under whatever question sits in front of you, and the topics that follow stop competing for memory and begin to reinforce one another.

Inside	Across	Beneath
THE LAW YOU PRACTISE WITHIN	THE QUESTIONS A COURT ASKS	CAPACITY, THE SINGLE IDEA

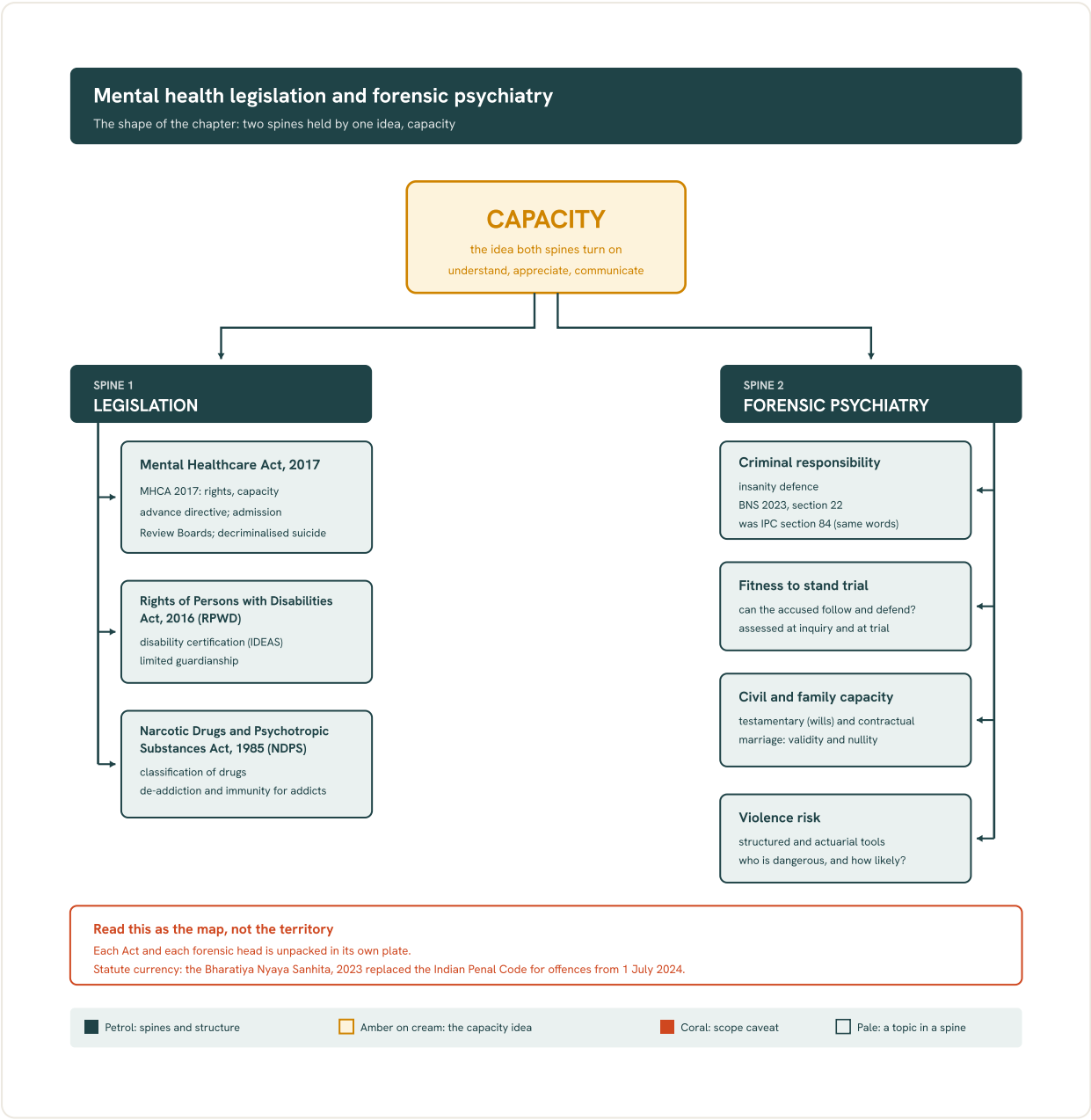


Fig 25.1. The chapter runs on two spines. Legislation (the Mental Healthcare Act 2017, the RPWD Act 2016 and the NDPS Act 1985) sits on one side, and the forensic questions of criminal responsibility, fitness to stand trial, civil and family capacity, and violence risk on the other. Both turn on a single organising idea, capacity, so read this as the shape of the chapter and study each head in its own plate.

1.1 The whole chapter on one map

Read as a flat list, the mental health legislation, the disability law, the narcotics law, the tests of criminal responsibility, the several civil and family capacities and the assessment of violence risk look like unrelated statutes to be learned in parallel, each with its own numbers to be crammed. They are not unrelated. They sort into two columns - the law a psychiatrist works within, and the questions a court puts from outside - and one construct runs down both columns and ties them together. Seeing this before any single provision is not decoration: it converts memorising into placement, and a new rule is learned far faster when there is already a labelled slot waiting to receive it.

The table below sets the two spines against shared axes so the parallel is visible at a glance. It teaches no rule of its own, and every provision it names is developed in the section that owns it.

The accompanying figure carries the same map in a single view, to keep beside the text as the picture the words are describing.

SPINE	WHAT IT IS	THE QUESTION BENEATH IT	WHERE THE PSYCHIATRIST MEETS IT
First spine: legislation	The statutes you practise inside - the Mental Healthcare Act, the Rights of Persons with Disabilities Act and the narcotics law	May I admit, treat and protect this person, and on what lawful authority	On the ward and in the clinic, and in the certificates the law asks you to sign
Second spine: forensic	The questions a court reaches in to ask - about responsibility, civil and family competence, and risk to others	Was this act excused, is this person competent to this legal act, is this patient a danger the law must weigh	In the report to the court and in the witness box, on the court's timetable rather than the clinic's

1.2 The first spine: the law you practise inside

The first spine is the **mental health legislation** a psychiatrist works within, and its centre of gravity is the Mental Healthcare Act. What makes the Act the natural opening of the whole chapter is that it is **rights-based** and capacity-based rather than custody-based: it starts from the person's rights and their ability to decide, and builds its powers of admission, treatment and protection on that foundation, instead of around a bare power to detain. Its definition of illness, its consent and admission machinery, its review boards, its authorities, and its limits on procedures such as electroconvulsive therapy and restraint are each taught in their own place. For the map it is enough to see that all of them descend from the same rights-and-capacity root, which is why a question on any one of them can be reasoned toward from that root when the exact section will not come.

Two further statutes stand beside it. The disability legislation, the Rights of Persons with Disabilities Act, recognises mental illness among the disabilities it protects and carries its own machinery of certification, benefit and guardianship - a logic aimed at inclusion and entitlement rather than at treatment, and therefore a different instrument doing a different job. The third is the narcotics law, which this chapter reads purely as law: how it classifies controlled substances, how it scales its penalties, and what it provides for treatment and for immunity. The clinical management of dependence and its de-addiction belongs to another chapter and is named at the border below. What unites the three is that each is an instrument you operate from the inside, not a question put to you from without.

IN INDIA

Every statute in this chapter is an Indian primary Act, and you are examined on the Indian book, not on a Western framework a general textbook might describe. The Mental Healthcare Act is rights-based and capacity-based by deliberate design, a clean break from the older custodial model; the disability and narcotics statutes are likewise Indian instruments, with Indian thresholds and Indian certifying authorities. One of the criminal statutes has moreover been recodified recently, so a candidate working from an older text must confirm that the provision cited is the one currently in force. Reading each Act from its own words, and checking that those words are still the law, is the whole discipline the chapter rewards.

1.3 The second spine: the questions a court asks

The second spine is **forensic psychiatry** proper: not a body of statute you practise inside, but a set of questions the law reaches in to ask, to which your clinical assessment is the answer it needs. They gather into three families. The first is **criminal responsibility** - whether unsoundness of mind at the time of an act should excuse it - together with the neighbouring questions of fitness to stand trial, of diminished responsibility and automatism, of the legal concepts of intent, of the legal standing of deception-detection methods, and of the detection of malingering. The second is civil and family capacity - whether a person is competent to make a will, to enter a contract, to marry or to be divorced, to keep custody of a child, to manage property, or to be certified fit for work. The third is the assessment of violence risk - how dangerousness is conceived, and how the risk of future violence is estimated, by structured clinical judgement and by actuarial method.

These are questions with forums and timetables that are not the clinic's. The court sets the question, fixes the moment at which it must be answered, and receives the answer as evidence rather than as treatment - which is why a forensic opinion is written and defended quite differently from a ward note, and why the audience for it is a judge and not a patient. Where a forensic question brushes against child law - the protection of a child, or a juvenile in conflict with the law - the governing statutes are taught in another chapter and are only named, at the border below. The ethics of giving evidence, the confidentiality owed, and the certification of a report for a court are a subject of their own, and are placed with their own chapter below. This chapter keeps the clinical questions; it does not absorb the statutes and the professional duties that neighbour them.

1.4 Capacity: one idea seen from many benches

Why one construct carries the whole chapter. The reason the two spines belong in one chapter, rather than in two, is that a single question sits beneath almost every topic on either of them. Whether the setting is a ward or a courtroom, the law is finally asking whether a specified person could make a specified decision. On the legislation spine it asks in order to protect and to empower - may this person decide their own treatment, and if not, who decides for them and how. On the forensic spine it asks in order to attribute or to withhold - may this person be held responsible for what they did, may this will stand, may this marriage be undone. The asking is the same act in different robes, and once that is seen the chapter reads as one subject rather than as a dozen.

Capacity in this sense takes a recognisable set of forms, each a full topic in its own right and each owned and taught in its own place. It is worth naming them here, as a set, precisely so that you meet each later one as a member of a family you already recognise:

- the capacity to consent to treatment, under the mental health legislation;
- the capacity to make a valid will, the testamentary capacity;
- the capacity to enter a binding contract;
- the capacity to be held criminally responsible for an act;
- and the capacity to stand trial, the fitness to plead.

Two properties make this family behave as it does, and the chapter's cross-cutting synthesis draws them out in full where it is owned. Capacity is **decision-specific**, so the same person may hold it for one decision and lack it for another at the very same moment; and it is **time-specific**, so it is judged as at a fixed instant - the time of the act, the time of the will, the time of the trial - and can change between one moment and the next. The work of this opener is only to plant that idea; the individual tests, and the grid that contrasts them, are developed where they are owned and are not restated here.

TRAP **Treating capacity as a single global switch a person either has or lacks.** The examiner watches for the candidate who writes that a patient "lacks capacity" full stop, or who reads one capacity off another - competent to consent, therefore competent to make a will. Capacity is asked of a named decision at a named moment. An opinion that omits the decision or the moment is not an incomplete opinion but no opinion at all, and every individual test in this chapter is built to be applied to one decision, at one moment, at a time.

1.5 Every statute from its primary source, and why currency now matters

The habit that separates a reliable answer from a merely plausible one is reading each statute from the **primary source** - the Act as enacted - rather than from a secondary summary, a coaching note or a half-remembered lecture. A paraphrase softens the exact word the law turns on; a summary drops the proviso that decides the hard case; and a textbook written a few years ago may faithfully describe a provision that has since been amended or replaced. This chapter therefore works every statute from its own text, quotes the operative words where they carry the point, and treats the precise wording, not the gist of it, as the thing to be learned.

RULE **Read the law from its primary source, and find the capacity beneath the question.** Two habits carry this chapter: go to the Act itself for the words that decide a point, and, when a question empties your head, ask which spine it sits on and which capacity lies under it. The first keeps your citation accurate; the second keeps your reasoning organised when the exact section will not come to you cold.

Currency is part of that same discipline, and it is why the substantive criminal law of this chapter now needs particular care. The long-standing penal code has been recodified into a new statute, and the insanity exception, together with the rule that places the burden of proving it, have moved with it into the new penal code and the new law of evidence, carried across in substance

rather than rewritten from scratch. The new code's own transition provisions decide which text actually governs a given case: the recodified provision applies to an offence committed on or after the recodification's commencement date, while the superseded provision remains the operative law for an offence committed before that date and for a proceeding already pending when the new code commenced, because the new code expressly saves it for that purpose. An answer forfeits the currency mark when it cites a provision that does not govern the offence or proceeding in front of it, in either direction; it does not forfeit the mark for correctly citing the superseded provision to a case the savings clause keeps under it. The precise sections, the effective date, the savings provisions, and the names of the current and the historical provisions are taught where the criminal-responsibility topic owns them; for the map, the only point is that the citation must match where the offence or proceeding actually falls.

PITFALL

The recurring real-world error is citing whichever provision does not govern the case at hand - reciting the recodified section for an offence committed before its commencement date, or reciting the superseded section for an offence or a proceeding the new code has already moved forward, or stating an immunity or a presumption without the conditions the statute attaches to it. The wording of the insanity exception survived its recodification almost unchanged, so the doctrine usually survives the slip; the citation does not, and an opposing advocate who spots a report resting on the wrong side of that line has an easy way to weaken the witness before a word of substance is heard. Confirm which provision the offence date or the proceeding's pendency actually selects, then cite it.

1.6 What is named here and taught elsewhere

A map is as much its borders as its interior, and four subjects a reader might reasonably expect to find in a law-and-forensic chapter are deliberately kept outside it, named at the edge and cross-referred so that the pointer is never lost. Each belongs to a chapter that teaches it in full, and the reason to keep them out is that answering a border question with the neighbour's material is one of the commonest ways to lose marks here:

- the child-protection statutes, including the provision for trying certain juveniles as adults, belong to the Child psychiatry: assessment, treatment, services and protection notes;
- forensic ethics, consent and confidentiality, the certification of a report for court testimony, and disaster and prisoner psychiatry belong to the Forensic ethics, consent and legal procedure notes;
- the clinical technique of electroconvulsive therapy and other neurostimulation belongs to the ECT and neurostimulation notes, while this chapter keeps only the statute's consent rules for it;
- and the clinical side of the narcotics law, the substance use disorders themselves and their de-addiction pharmacology, belongs to the Substance use disorders notes.

The boundary is not arbitrary, and the fitness-to-work certificate makes the logic plain. A single occupational-fitness certificate signed for an employer is this chapter's business; the report and

certificate written for a court are the forensic-conduct chapter's, because the duty owed and the audience addressed are different. Keeping these lines clean is itself examinable, and a candidate who can say where a topic stops has usually understood where it belongs.

1.7 Carrying the map into the hall

The value of an advance organizer is that it can be rebuilt from almost nothing when memory fails under pressure, and this one reduces to three phrases that regenerate the whole chapter between them.

MNEMONIC

Law inside, court across, capacity beneath

Rebuild the whole chapter from three phrases. **Law inside** is the legislation you practise within - the Mental Healthcare Act, the Rights of Persons with Disabilities Act and the narcotics law. **Court across** is the run of questions a court reaches in to ask - responsibility for an act, competence to make a will, to contract, to marry or to be tried, and risk to others. **Capacity beneath** is the one foundation carrying both, because each of those is finally a question of whether a particular person, for a particular decision, at a particular time, could do what the law asked of them. Recall the two spines, then the foundation under them, and the chapter reassembles itself from memory.

GOOD TO REMEMBER

When a legislation-or-forensic question empties your head in the hall, run the map before you panic. Ask which of the two spines the question belongs to, then find the capacity beneath it and name the decision, the moment and the forum the question is really about. That almost always surfaces the section, the test or the instrument you could not summon cold; and on the ward the same three-part habit - which decision, which moment, which forum - is what keeps a real opinion from being quoted later for a question it never actually answered.

Read the chapter now with the map already in place, and each statute and each test arrives as a named location rather than a loose fact. The detail - the sections, the durations, the criteria, the cases and the instruments - is taught, and cited to its source, in the topics that own it. What this opener leaves you with is the frame those details hang on.

This chapter has two spines, the law you practise inside and the questions a court asks, held together by one idea, capacity: name the decision, name the moment, name the forum, and every section and test in the chapter finds its place.

The Mental Healthcare Act 2017

2 · Salient features and objectives of MHCA 2017

This is the statute a psychiatrist in India actually practises inside, and the examiner opens the whole law paper with it because everything downstream is a working-out of the reorientation

it announces. The Mental Healthcare Act, 2017 did not simply update the machinery of admission and licensing that had governed the field for a generation. It changed the question the law asks. Where the older regime asked how an unwell person could be taken into care and kept there, the new statute asks what rights that person holds and whether they retain the capacity to decide, and it builds every other mechanism around the answer. A candidate who grasps that single reversal can reconstruct most of the Act from first principles; a candidate who misses it will recite features without a spine.

The marks here reward two things done together: a precise statement of what makes the Act a **paradigm shift**, and the enactment facts that fix it in time and place. Salient features answered as a shopping list read thin, and objectives answered without the primary Act read as opinion. The safe answer reads the Act as a coherent design, names the enactment facts that pin it down, and shows why the design is what it is.

10 of 2017	7 Apr 2017	29 May 2018	30 Oct 2019
ACT NUMBER	PRESIDENTIAL ASSENT	BROUGHT INTO FORCE	UNION-TERRITORY EXTENSION

2.1 The paradigm shift: from custody to rights

The organising idea of the statute is that it is **rights-based** rather than custody-based. The law it replaced approached mental illness through the lens of confinement and management: its central acts were reception, detention and the appointment of someone to hold authority over the unwell person and their property. The person at the centre of that scheme was, in law, largely an object of decisions made for them. The current Act inverts that posture. It treats the person with mental illness as a **rights-holder** whose entitlements the State must protect and whose own will and preferences the system must seek before it overrides them.

Calling the Act rights-based is not decoration; it is a description of how the statute is engineered. A rights-based law starts from what is owed to the person and treats every power to act against their expressed wishes as an exception that must justify itself. The older **custodial** model ran the other way: the power to detain and treat was the starting point, and the person's objection was a problem to be managed. This is why an answer that lists admission categories and licensing rules, however accurate, misses the examiner's point. Those mechanisms exist in the new Act too, but they now sit downstream of a prior commitment to rights, and their whole shape is bent by it.

TRAP **The Act is a rights statute, not a rebadged custody-and-licensing law.** The commonest error is to answer "salient features" with a catalogue of admission routes and registration rules, as though the reform merely modernised its custodial-era predecessor. That misreads the question. The Act reorganises mental-health law around the person's rights and capacity, and the admission and licensing machinery is a consequence of that reorientation, not the substance of it. State the reversal first, then the features that flow from it.

2.2 Capacity and autonomy as the organising logic

If rights are the destination, **capacity** is the road the Act builds to reach them. The statute keys the lawfulness of acting for a person to whether that person has the capacity to make the

particular decision at hand, and it protects the person's **autonomy** by requiring that their capable choices be respected and that their earlier or represented wishes be sought when capacity is impaired. The precise legal test for capacity, and the definition of mental illness that sits beside it, are set out in full where this chapter treats the definition of mental illness and the capacity to make treatment decisions; the point to hold here is architectural rather than definitional. Capacity is the hinge on which the entire Act turns.

Two design consequences follow, and they are worth seeing as consequences rather than as separate features. First, decision-making about a person is meant to be **supported** before it is substituted: the law prefers helping a person to decide over deciding for them, and it provides instruments to make that support real. Second, when the system must act despite a person's wishes, it is meant to reach for the **least restrictive alternative** consistent with safety and care. Care becomes the default and coercion the guarded exception, and every coercive power in the Act carries conditions precisely because the design treats coercion as something to be justified and limited, never assumed.

A useful way to feel the size of the shift is to watch where the burden sits. Under a custodial law the unwell person effectively had to earn their liberty back: the authority to hold and treat them was assumed, and the onus lay on the patient to displace it. A capacity-based law moves that burden the other way. The person's decisional autonomy is the starting position, and it is the system that must show why a particular choice may be taken out of their hands rather than left with them. That inversion is what turns a catalogue of features into a rights statute, because it makes every power to act against a person's wishes answerable for itself rather than automatic.

RULE **The Act is built around capacity and autonomy: care is the default and coercion the guarded exception.** Read any provision by asking what it does to the person's decisional autonomy and how tightly it conditions any power to override it. Provisions that support the person's own decision are the rule; powers that substitute for it are exceptions hedged with conditions. That single lens organises the whole statute and is what the examiner is really testing.

2.3 The objectives: why Parliament enacted it

The objectives of the Act are best read against the pressures that produced it. India had bound itself to an international obligation to align its domestic law with a rights-based conception of disability, and the older custodial statute could not be reconciled with that conception. The Act is the instrument that closes the gap. Its preamble frames its purpose in the language of provision, protection and the fulfilment of rights, and the working objectives can be stated plainly:

- To protect, promote and fulfil the rights of persons with mental illness during the delivery of mental healthcare and services.
- To align domestic law with India's obligations under the international disability-rights framework, which the older custodial statute could not satisfy.
- To provide for mental healthcare and services and to regulate the establishments that deliver them, so that care meets a national standard.

Read together, these objectives explain the temper of the whole statute. It is simultaneously a charter of entitlements and a scheme of regulation: it tells the State what it owes the person, and it tells providers what they must meet. The rights language is not aspirational preamble that the operative sections then ignore; the operative sections are the machinery by which the objectives are meant to be delivered, which is why the objectives and the salient features are two views of the same design.

IN INDIA

India enacted this statute to bring its mental-health law into line with its obligations under the international disability-rights framework, retiring a custodial-era predecessor in favour of a rights-based scheme. Because public health is administered by the States, the Act sets a national floor of rights while the bodies that carry it - the health authorities, the review boards and the registered establishments - are stood up unevenly across the country. The distance between the right guaranteed on paper and the service available on the ground is therefore itself part of the Indian reality a psychiatrist works within, and a realistic answer acknowledges it rather than describing the Act as if it were fully operational everywhere.

2.4 Enactment, commencement and extent

Because this is a statute read from the primary Act, the enactment facts are examinable in their own right and are easy marks when stated exactly. The law is **10 of 2017** and it received the assent of the President on **7 April 2017**. Its commencement provision, section **1(3)**, is a two-limbed rule and its verbs matter: the Act shall come into force on such date as the Central Government may appoint by notification, or on the completion of **nine** months from the date of assent. The coming-into-force is mandatory; what is discretionary is only the choice of the appointed date.

In the event, the Central Government exercised that power and the Act was brought into force on **29 May 2018** by notification, well past the nine months from assent that the alternative limb described above would otherwise fix; this chapter flags that gap between the statutory text and the notification record as an anomaly rather than resolving it. Its extent provision, section **1(2)**, applies the Act to the whole of India; the reach was later widened to the union territories of Jammu and Kashmir and Ladakh by a further notification. Keeping the extent point in view matters clinically, because it fixes the territorial scope within which the rights and duties the Act creates are enforceable.

The fallback commencement limb is not a technicality worth skipping over. Reform statutes are sometimes passed and then left unnotified, so that a law sits on the books yet binds no one because no commencement date is ever appointed. On its face, a nine-month fallback limb of this kind is meant to guard against exactly that hazard, an ambitious statute that a reluctant administration might prefer not to switch on; but the Act's actual commencement date on the official record runs past that nine-month mark, so the limb should not be taught here as an unqualified outer bound that was in fact honoured.

PITFALL

Reading the date of assent as the date the Act took effect. The Act received Presidential assent on **7 April 2017**, but it did not operate until it was brought into force by notification more than a year later. Citing the Act as effective from its assent, or loosely from its year of passage, mis-states the law that governed any event in the interval and confuses a mandatory duty to commence with the discretionary choice of when. It is exactly the kind of statute-currency error that a clinician giving evidence, and a candidate under examination, cannot afford.

2.5 The salient features as a single system

The features of the Act are best learned as expressions of the one design, each named for the right or value it serves rather than memorised as an unconnected list. The mechanics of each feature are developed in full in its own place in this chapter; what belongs here is the map that shows how they hang together. The accompanying survey sets each pillar beside the entitlement it delivers.

PILLAR OF THE ACT	WHAT IT ESTABLISHES	THE RIGHT OR VALUE IT SERVES
RIGHTS OF PERSONS WITH MENTAL ILLNESS	A statutory charter of enforceable rights during care	Dignity, non-discrimination, access to services
CAPACITY TO MAKE TREATMENT DECISIONS	Decisions keyed to the person's decisional capacity	Autonomy
ADVANCE DIRECTIVE	A means to record wishes ahead of a future loss of capacity	Prospective autonomy
NOMINATED REPRESENTATIVE	A personally appointed, or absent appointment, statutorily deemed or Board-appointed representative	Supported decision-making
ADMISSION CATEGORIES	Consent-led and safeguarded routes to inpatient care	Least restrictive care
MENTAL HEALTH REVIEW BOARDS	An independent body to oversee and adjudicate	Protection from arbitrary detention
MENTAL HEALTH AUTHORITIES	Registration and standards for establishments	Regulation and accountability
ATTEMPTED SUICIDE	Met as a matter for care rather than prosecution	Compassion over criminalisation
REGULATION OF COERCIVE TREATMENTS	Statutory control of electroconvulsive therapy, psychosurgery, restraint and seclusion	Protection from harm
PENALTIES FOR CONTRAVENTION	Defined consequences for breach of the Act	Enforceability

Two cautions attach to the last two rows. The Act sorts the regulated treatments into those it forbids outright and those it permits only under safeguards, and the placement of each into its category is set out where this chapter treats the prohibited and restricted procedures; the clinical

technique, dosing and mechanism of electroconvulsive therapy are not this chapter's at all and belong to the ECT and neurostimulation notes. Naming a feature is the work of this section; teaching its inner rules is the work of the sections that own it.

MNEMONIC

Rights, not custody; capacity, not status

The paradigm in one breath. The Act treats the person as a rights-holder rather than an object of custody, and capacity is a central organising principle for admission and treatment decisions rather than diagnostic status or another's authority, though some emergency, safety and prohibited-procedure provisions turn on their own statutory criteria, not on capacity. The directive written in advance, the representative the person nominates, the review boards and the regulation of coercive treatment are all consequences of those two reversals, not separate inventions.

2.6 The State's positive obligations

A distinctive feature of the Act, and one candidates routinely underweight, is that it does not only restrain the State from wronging the person; it obliges the State to act for them. A rights-based statute of this kind carries positive duties as well as negative limits, and the Act places several of them squarely on government:

- To provide mental healthcare and services and to work towards their availability and accessibility.
- To regulate mental health establishments through registration and enforceable standards of care.
- To reduce reliance on coercion by favouring supported decision-making and the least restrictive option.

These duties are what give the rights their teeth. A right of access to care means little without a State obligation to provide it, and a right against arbitrary detention means little without an independent body empowered to test detentions. The Act's ambition, then, is not merely to draw a boundary the State must not cross but to commit the State to a programme it must deliver, which is also the source of the reform's central practical tension, taken up below.

GOOD TO REMEMBER

On the ward the change is concrete. The opening question is no longer whether a person can be admitted and managed, but whether they have the capacity to decide, what they set down in any advance directive, and whom they nominated to speak with them. Default to the least restrictive option, record the capacity assessment in the notes, and involve the nominated representative early. The statute expects the person's own voice to be sought first, and the record is what shows that it was.

2.7 Currency, controversy and the implementation gap

The reform is genuine and the ambition is real, and the exam rewards seeing both the achievement and its unfinished edge. The central controversy is the distance between the rights

the Act guarantees and the services needed to honour them. A statute can declare a duty to provide care in a single clause; building the crisis services, the review boards and the trained workforce that discharge that duty is the work of years, and it proceeds unevenly because public health is administered by the States. The result is a law whose promise on paper outruns its delivery on the ground, and commentators reasonably ask whether a rights-based statute that is only partly resourced can secure the rights it names.

A second live point is one of currency at the statute's edges rather than its core. The Act sits alongside the wider disability-rights legislation and interacts with a criminal law that has since been recodified, so the exact provisions bordering the Act shift over time and are treated where those neighbouring laws are owned; this section flags that movement rather than settling it. What the Act itself decides is not in doubt, and that is what an answer should assert without hedging: a rights-based, capacity-based statute that reframes the person with mental illness as a rights-holder, keyed to capacity, defaulting to care, and conditioning coercion at every turn.

> The Mental Healthcare Act, 2017 is a rights-based, capacity-based statute that reframes the person with mental illness as a rights-holder: care is the default, coercion the guarded exception, and decisional capacity, not another person's custody, is a central organising principle across the Act's admission and treatment provisions.

3 · Definition of mental illness and capacity to make treatment decisions

Why the marks concentrate here. Two threshold questions decide everything the Mental Healthcare Act 2017 then does to a person: is this a **mental illness** the Act recognises at all, and does this person have the capacity to make their own treatment decisions. Every later power and protection in the statute - the advance directive, the choice of admission route, the consent to a treatment such as electroconvulsive therapy, the limits on restraint - hangs off these two definitions. Examiners return to them because they are compact, they are frequently misremembered, and each carries a cluster of traps that separate a candidate who has read the Act from one who is paraphrasing half a memory of it.

The difficulty is that both concepts sound familiar and are not what a clinician assumes. The definition of mental illness is not a list of diagnoses but a functional description with a deliberately drawn boundary, and where it draws that boundary - substance-associated conditions inside it, intellectual disability outside it - is exactly what is examined. Capacity is not a global attribute a patient either has or lacks; it is a rebuttable presumption, attached to a particular decision, tested against a short functional standard whose bare statutory wording surprises most readers. Alongside these sits a third provision that keeps the clinical determination of illness from being read as a legal verdict on the person.

2(1)(s)	3	4
MENTAL ILLNESS DEFINED	DETERMINATION OF ILLNESS	CAPACITY TO DECIDE

3.1 The definition of mental illness

The definition sits at section **2(1)(s)**, and its structure is worth dissecting rather than reciting, because the structure is where the reasoning lives. Mental illness means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life. Read it as two joined requirements. First, there must be a substantial disturbance in one of a named set of faculties - thinking, mood, perception, orientation or memory. Second, that disturbance must grossly impair one of a named set of functions - judgment, behaviour, the capacity to recognise reality, or the ability to meet the ordinary demands of life. A disturbance without gross functional impairment does not satisfy the definition, and impairment without an underlying substantial disorder does not either.

The Act has chosen a **functional** definition rather than a categorical one, and the choice is deliberate. It does not enumerate diagnoses, so it does not go out of date each time a classification is revised, and it does not turn on a label but on severity and consequence. Only a disorder grave enough to grossly impair one of those core functions satisfies the definition. This matters because the provisions expressly predicated on an established mental illness - the coercive powers as much as many of the safeguards - are reserved for illness of that gravity, and a milder disturbance that leaves judgment, behaviour, reality-testing and everyday functioning broadly intact is, by the Act's own words, outside the definition. The definition does not gate the Act as a whole: provisions built around suspected or self-perceived mental illness, taught in their own place elsewhere in this chapter, engage without waiting on that threshold. The word doing the heavy lifting is "grossly": the definition is built around gross impairment, not any impairment.

3.2 What the definition takes in, and what it keeps out

Two boundary rules inside the same definition are the most heavily examined lines in this topic, and they run in opposite directions. The definition expressly *includes* mental conditions associated with the abuse of alcohol and drugs. It expressly *does not include* **mental retardation**, which it describes as a condition of arrested or incomplete development of mind specially characterised by subnormality of intelligence. So substance-associated mental conditions are in, and intellectual disability, standing alone, is out.

Hold the direction of each, because candidates routinely reverse them. The inclusion of alcohol- and drug-related conditions means a person whose mental state is disordered in association with substance use falls within the Act's definition and may draw on its protections and be subject to its provisions; the clinical management of substance use disorders themselves is a separate subject, taught in the Substance use disorders notes, and is not the concern here. The exclusion of intellectual disability means that a person whose only condition is arrested or incomplete development of intelligence is not, by that fact, a person with mental illness for the Act's purposes. That exclusion is not a withdrawal of rights: the framework that recognises and certifies intellectual disability, and confers benefits and safeguards on that basis, is the disability legislation dealt with elsewhere in this chapter. The Act simply keeps the two constructs in separate boxes. A person with intellectual disability who also develops a substantial disorder of

mood or perception can, of course, have a mental illness on the ordinary meaning of the definition; what the exclusion denies is that subnormality of intelligence is itself the illness.

MNEMONIC

Substance in, subnormality out

The two boundary rules of the definition, in the order they trip candidates. A mental condition associated with the abuse of alcohol or drugs is **included**; mental retardation, a condition of arrested or incomplete development of mind characterised by subnormality of intelligence, is **excluded**. If you can only carry one line on this definition into the hall, carry the two directions.

TRAP **The definition includes substance-associated conditions and excludes intellectual disability - not the reverse.** Because addiction is so often spoken of as a "vice" and intellectual disability as a lifelong "mental" condition, candidates flip the two. The statutory text is explicit and settled: conditions associated with the abuse of alcohol and drugs are within the definition of mental illness, and mental retardation is expressly outside it.

3.3 How mental illness is determined

A definition needs a method of application, and section 3 supplies it. Mental illness *shall* be determined in accordance with such nationally or internationally accepted medical standards, including the latest edition of the World Health Organisation's International Classification of Diseases, as may be notified by the Central Government. The verb is mandatory and it anchors the clinical judgment to recognised diagnostic standards rather than to idiosyncratic opinion. The **determination of mental illness** is thus a disciplined exercise: the clinician works from accepted nosology, not from personal conviction about who is or is not ill.

The provision then does something a purely clinical statute need not do: it fences off the reasons that may *not* be used. A determination *shall not* be made on the basis of a person's political, economic or social status, or membership of a cultural, racial or religious group, or for any reason not directly relevant to that person's mental health status. Nor may it rest on non-conformity with the moral, social, cultural, work or political values or the religious beliefs prevailing in the person's community. And a past history of treatment or hospitalisation, by itself, is not a ground for determining that a person is presently or will in future be mentally ill. Each clause closes a historically abused route by which unpopular, eccentric or merely inconvenient people were declared ill. The section is, in effect, a bar against psychiatry being used as an instrument of social control, and its clauses are best learned as the specific abuses they were written to prevent.

- not political, economic or social status;
- not membership of a cultural, racial or religious group;
- not non-conformity with prevailing moral, social, cultural, work, political or religious values.

IN INDIA

This is a distinctively rights-based drafting choice and a deliberate break from the older custodial law. By tying determination to notified medical standards and to the current International Classification of Diseases, and by forbidding determination on social, cultural, religious or political grounds, the Act aligns Indian practice with an internationally recognised evidence base and writes the safeguard against misuse into the statute itself. For the practising psychiatrist the working discipline is simple: the record should show that a determination rests on recognised diagnostic criteria and on the person's mental health status, and never on their beliefs, conduct or standing in the community.

3.4 Mental illness is not unsound mind

The most consequential firewall in this whole topic is the rule that a clinical finding of mental illness is not a legal finding of **unsound mind**. The determination provision states it plainly: the determination of a person's mental illness *shall* alone not imply, or be taken to mean, that the person is of unsound mind, unless they have been declared as such by a competent court. The modal is mandatory and the effect is a hard separation of two spheres. Mental illness is a medical construct, determined by a clinician against accepted standards. Unsound mind is a legal status, and it can be conferred only by a court.

Why this earns its place is that the two are constantly conflated, to a patient's cost. A diagnosis does not, of itself, strip a person of the legal capacities that unsoundness of mind would affect. Whether a person is criminally responsible for an act, whether they are fit to stand trial, whether they can make a will or a contract or manage their property - these are decided on their own tests, by the appropriate legal process, and are set out elsewhere in this chapter; none of them follows automatically from a psychiatrist's determination that a mental illness is present. The clinician determines illness; the court, on the relevant legal test, determines unsoundness of mind and its consequences. Keeping the two apart is not a technicality but the point of the provision.

PITFALL

A recurring clinical and medico-legal error is to let a diagnosis do a court's work - to write or imply that because a person has a mental illness they are therefore of unsound mind, incompetent, or not responsible. The Act forbids that inference: determination of mental illness alone does not mean unsound mind unless a competent court has so declared. A report that slides from a clinical diagnosis to a legal conclusion about capacity or responsibility oversteps the clinician's role and misstates the law.

3.5 Capacity to make mental-healthcare and treatment decisions

This is the required core of the topic. Section **4** sets the test of **capacity to make** mental-healthcare and treatment decisions, and its architecture must be learned exactly. Every person, including a person with mental illness, *shall* be **deemed** to have capacity to make decisions regarding their mental healthcare or treatment if they have the ability to do the following:

- understand the information relevant to taking the decision on treatment, admission or personal assistance;
- appreciate any reasonably foreseeable consequence of a decision, or of a lack of decision, on treatment, admission or personal assistance;
- communicate the decision, by means of speech, expression, gesture or any other means.

Two features of that text are examined again and again, and both cut against the way capacity is usually taught. The first is the deeming clause. The Act does not ask the clinician to establish that a patient *has* capacity; it deems every person to have it, so the presumption runs in the patient's favour and it is incapacity that must be demonstrated. This is a rebuttable presumption of capacity, and the burden sits with whoever asserts that the person cannot decide. The second is the connector. In the bare statutory text the three abilities are joined by the disjunctive word "or", not by "and" - a wording that is identical across the authoritative sources of the Act and that differs from the familiar functional model of capacity, imported from other jurisdictions and general teaching, in which a person must understand, retain and weigh the information and then communicate a choice, all elements being required together. The Indian provision, read literally, lists three abilities and joins them disjunctively. Whatever the interpretive debate about how those limbs are best applied at the bedside, the examinable textual fact is that the statute uses three limbs and the word "or".

A third clause completes the picture and guards the presumption from a common abuse. A decision that others regard as inappropriate or wrong does not, by itself, mean the person lacks capacity. Capacity is about the *process* of deciding - understanding, appreciating consequences, communicating a choice - and not about whether the choice matches what the clinician or family would prefer. An unwise decision by a capacitous patient is still that patient's decision. The generous means-of-communication clause points the same way: a decision expressed by gesture or any other means counts, so a person is not treated as incapable merely because they cannot speak in the expected register.

RULE **Capacity is presumed, decision-specific and functional - it turns on the decision, not the diagnosis.** Every person, including a person with mental illness, is deemed to have the capacity to make mental-healthcare and treatment decisions, and that presumption is displaced only by showing, against the statutory abilities, that this person cannot make this decision now. A diagnosis does not rebut it, and a decision the team dislikes does not rebut it.

3.6 Capacity as the switch the rest of the Act turns on

The capacity test is placed early in the Act because it is the switch several later provisions depend on. Whether a person is admitted on their own request or on another's application, whether an advance directive lies dormant or comes into operation, and whether consent to a treatment such as electroconvulsive therapy can be given by the patient themselves - each of these begins by asking whether the person presently has the capacity to make the relevant decision. Physical restraint is not on that list: it is authorised on its own statutory conditions, tied to imminent and immediate harm and to psychiatrist authorisation rather than to the patient's capacity, and is

taught under prohibited and restricted procedures elsewhere in this chapter. Those provisions invoke this test and are taught in their own right elsewhere in this chapter; none of them redefines it. What must be carried across all of them is that capacity here is **decision-specific** and time-specific: a person may have capacity for one decision and not another, and may regain it as their state changes, so it is assessed for the decision in front of the clinician at the moment it must be made, not settled once and recorded as a global finding.

It is worth naming, without teaching them here, that this treatment-decision capacity is one of a family of capacities the law recognises - the capacity to make a will, to enter a contract, to be held criminally responsible, to stand trial - each decision-specific, each with its own test, and each examined in its own place in this chapter. The thread that runs through all of them, that capacity is asked of a particular decision at a particular time rather than of the person in general, is drawn together in this chapter's cross-cutting synthesis. For the Act's own purposes the point stays contained: the capacity this section defines is the one the definition of mental illness and the rest of the statute are built to serve.

3.7 Four statuses candidates merge, kept apart

The commonest way this topic is lost is by treating four distinct statuses as one. The definition, the determination, the capacity test and the legal status of unsound mind answer different questions, are settled by different actors, and carry different consequences. Setting them on shared axes shows why each must be cited to its own provision and why one cannot be read off another.

STATUS	WHAT IT ASKS	WHO SETTLES IT, AND HOW	WHAT IT DOES NOT IMPORT
Mental illness (the definition)	Is there a substantial disorder that grossly impairs a core function?	Set by the definition provision; substance-associated conditions in, intellectual disability out	Does not by itself mean incapacity or unsound mind
Determination of mental illness	Is this person, now, mentally ill on that definition?	A clinician, against notified national or international standards including the current International Classification of Diseases	May not rest on social, cultural, religious or political grounds, or on past treatment alone
Capacity to make treatment decisions	Can this person make this mental-healthcare decision now?	Presumed for everyone; rebutted only against the statutory abilities, decision by decision	Not rebutted by the diagnosis, nor by an unwise choice
Unsound mind	Is this person, in law, of unsound mind?	A competent court, on the relevant legal test	Does not follow automatically from a determination of mental illness

Read across the last column and the discipline is clear: nothing on this list is a licence to infer the next. Mental illness does not import incapacity; determination does not import unsound mind; and capacity, presumed for all, is displaced only for the decision actually in issue. A clinician who keeps these four apart, and cites each to its own provision, has understood not just the definitions but the design.

GOOD TO REMEMBER

Assess capacity for the specific decision in front of you, and start from the presumption that the patient has it. Document the determination of illness against recognised diagnostic criteria, and keep it separate from any statement about the patient's legal capacity or responsibility, which is not yours to pronounce. A refusal you consider unwise, made by a patient who can understand, appreciate the consequences or communicate the choice, is a capacitous refusal - not evidence of incapacity.

Mental illness is a substantial disorder grossly impairing a core function - substance-associated conditions included, intellectual disability excluded - determined against accepted medical standards; and every person, including a person with mental illness, is deemed to have the capacity to make mental-healthcare and treatment decisions, tested by the ability to understand, appreciate or communicate, a presumption that a diagnosis alone does not rebut.

4 · Rights of persons with mental illness under MHCA

Why the marks cluster here. Of everything the Mental Healthcare Act sets out to do, its catalogue of rights is the part an examiner can turn into a one-line question and the part a clinician answers for on every ward round. The statute rewrote the relationship between the psychiatrist and the person in their care: where the earlier, custodial legislation treated the patient largely as an object of detention and management, this Act makes the same person the bearer of enumerated, enforceable rights that the appropriate Government, the mental health establishment and the treating professional are all bound to honour. To know these rights is to know the spine of the whole Act, because admission, treatment, the advance directive and the review machinery all exist to give them effect.



Fig 25.2 The Mental Healthcare Act 2017 is rights-based: the person with mental illness holds enforceable rights, and government, establishments and professionals carry corresponding duties. Admission and treatment mechanisms exist to give those rights effect.

The rights are gathered in Chapter V of the Act, and reading them at origin rather than from a summary is what separates a safe answer from a vague one. Two features organise the entire chapter. First, every right is written in the mandatory voice: the person shall have the right, never may, so each clause is a duty and not a discretion. Second, each right is a duty placed on a named actor, and identifying that duty-bearer is often the real content of the question.

4.1 A rights-based statute: the architecture of Chapter V

Chapter V does not create rights in the abstract. It follows a person from the door of the service to the ward and back into the community, attaching a duty at each step: a right to reach care at all, a right not to be warehoused once well, a right to be treated decently while admitted, a right to be treated as the equal of a person with a physical illness, a right to know what is happening, and a right to have it kept private. The examiner's favourite move is to give the guarantee and ask for

the section, or to give the section and ask whose duty it creates, so the map below is worth holding whole before the detail.

RULE **Every entitlement in this chapter is a mandatory duty, not a courtesy the service extends.** Each clause is drafted with "shall", which binds the appropriate Government, the establishment and the individual professional; a right the service could grant or withhold at will would not be a right. When you answer, name the guarantee, the section that carries it and the actor on whom the duty falls, because the mark usually sits in the duty-bearer, not the slogan.

RIGHT	SECTION	CORE GUARANTEE	WHOSE DUTY
Access to mental healthcare	Section **18**	Affordable, good-quality, sufficient, geographically reachable, non-discriminatory care from Government-run or funded services	Appropriate Government
Community living	Section **19**	To live in and not be segregated from society; not to be detained merely for want of family, home or community facilities	Government and establishment
Protection from cruel, inhuman and degrading treatment	Section **20**	To live with dignity, with enumerated protections inside the establishment	The establishment and its staff
Equality and non-discrimination	Section **21**	Parity with physical illness across all healthcare, including insurance	Providers and every insurer
Information	Section **22**	Understandable information on admission, review, illness and treatment	The treating team
Confidentiality	Section **23**	Confidentiality of mental and physical health information, with defined exceptions	All health professionals

18	21	23	3
ACCESS TO CARE	INSURANCE PARITY	CONFIDENTIALITY	CHILD WITH MOTHER

4.2 The right to access mental healthcare

The chapter opens with its most ambitious guarantee. Every person shall have a **right to access mental healthcare** and treatment from services run or funded by the appropriate Government. The Act does not leave "access" as a slogan; it defines its content. Care must be affordable, of good quality, available in sufficient quantity, geographically accessible so that a person need not travel

unreasonably far, and provided without discrimination on any ground. A service that exists only in a distant city, or only for those who can pay, does not satisfy the section even if what it offers is excellent.

The section does not stop at principle; it adds concrete, enforceable promises. A minimum range of mental health services is to be available in every district, which is the statutory hook for decentralised, district-level care rather than a handful of state asylums. Persons who are below the poverty line, destitute or homeless are entitled to treatment free of charge, so poverty may not be the reason a person goes untreated. And medicines on the Essential Drug List are to be provided free of cost from Community Health Centres upwards, which matters directly for the person on maintenance antipsychotic or mood-stabiliser treatment who would otherwise default for want of money.

The clinical significance is that this section reframes treatment from charity to entitlement: the person does not petition for care, the State owes it. Its honest limit, and a fair examination point, is that a positive socio-economic right of this kind is only as real as the budget and the workforce behind it, which is where Indian implementation is still catching up with the text.

4.3 The right to community living

Every person with mental illness shall have a **right to community living**: to live in, be part of and not be segregated from society. The section's sharpest clause is the one an examiner loves, because it targets a real and documented abuse. A person shall not continue to remain in a mental health establishment merely because they do not have a family, are not accepted by their family, are homeless, or because there are no community-based facilities to receive them. Clinical readiness for discharge is not to be defeated by a social problem; want of a home is not a psychiatric reason to detain.

To make the right achievable rather than aspirational, the Government is to support less restrictive, community-based establishments such as half-way homes and group homes, so that a person who no longer needs hospital care has somewhere to go. This is the statute's embrace of deinstitutionalisation and of care in the least restrictive setting, and it is the natural counterpart to the access right: one gets the person into care, the other stops that care from hardening into indefinite custody.

IN INDIA

The community-living right collides with a long-standing reality. Government mental hospitals still hold long-stay residents who are clinically fit for discharge but have nowhere to go, and community facilities such as half-way homes and supported accommodation remain scarce and unevenly distributed. District-level services under the national and district mental health programmes are the intended delivery route for both the access and the community-living guarantees, and the distance between the words of the sections and the services actually available on the ground is itself a favourite discussion question.

4.4 Protection from cruel, inhuman and degrading treatment

This section begins with a simple, powerful statement: every person with mental illness shall have a right to live with **dignity**, and shall be protected from cruel, inhuman or degrading treatment in any mental health establishment. It then refuses to leave "dignity" undefined and spells out what it means in the daily life of an admitted person: a safe and hygienic environment with adequate sanitation; access to leisure, recreation, education and the practice of religion; privacy; proper clothing and the right to wear one's own clothes; freedom from being forced to work, with appropriate remuneration where work is undertaken; freedom from compulsory tonsuring, that is forced head-shaving; and protection from all physical, verbal, emotional and sexual abuse.

Read against the history of custodial care in India, the chaining, the seclusion, the neglect and the stripping away of ordinary human texture that repeated inquiries have documented, each of those guarantees is an answer to a specific, remembered wrong. The protections candidates most often overlook are the most telling: the bar on forced labour without remuneration, and the bar on compulsory tonsuring. Both mark the line between a hospital and a place of confinement, and both were written in precisely because they had been ignored.

4.5 Equality, non-discrimination and the insurance-parity clause

Every person with mental illness shall be treated as the equal of a person with physical illness across the whole provision of healthcare. This **equality and non-discrimination** right forbids discrimination on grounds such as gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class and disability, and it demands emergency services, ambulance services and living conditions of a quality equal to those provided for physical illness. A protective clause adds that a young child shall ordinarily not be separated from a mother who is receiving care, preserving the mother-infant bond wherever it can be preserved; the section fixes that protection at a child below **three** years of age.

The clause that decides the mark. Set within the same equality section is the provision examined more than any other single line in this chapter: every insurer shall make provision for medical insurance for the treatment of mental illness on the same basis as is available for the treatment of physical illness. This is the statutory **mental health parity** mandate, and it is a mandatory "shall", not a recommendation. It is the clause that ended the routine exclusion of psychiatric illness from health insurance, and in practice it prompted the insurance regulator to direct insurers to bring their products into line.

TRAP **Candidates list the rights and forget that insurance parity lives inside the equality section.** The parity mandate is not a separate consumer-protection statute and it is not discretionary; it is a "shall" sitting within the non-discrimination right. That is exactly why an examiner can ask which provision made insurance cover for mental illness compulsory and watch half the room reach for the wrong chapter, or downgrade a binding duty into a mere recommendation.

4.6 The right to information

A person with mental illness, and their nominated representative, shall have a **right to information**. The pairing is deliberate: the person and the nominated representative hold the right together, because the section anticipates that a very unwell person may not be able to take everything in at the moment of admission. What must be disclosed is set out plainly. The person is entitled to be told the provision of law under which they have been admitted and the criteria for admission under that provision; their right to apply to the Mental Health Review Board for a review of that admission; and the nature of their illness together with the proposed treatment plan, including the treatment proposed and its known side effects. All of this must reach the person in a language and form they can actually understand.

The section then closes a familiar loophole. If full information cannot be given at the time of admission because the person cannot yet receive it, it must be provided promptly once they can, and it must be given to the nominated representative immediately in the meantime. The information right is therefore the practical substrate of informed consent and of the Act's separately defined test of the capacity to make mental-healthcare decisions: a person cannot exercise a treatment choice, or challenge a detention, on facts that have been withheld from them. The appointment and duties of the nominated representative, and the composition and powers of the Review Board, are provisions in their own right and are described elsewhere in this account of the Act.

> **GOOD TO REMEMBER**
>
> The information right is discharged, and defensible, only if it is documented. Record that the admission provision and its criteria, the right to seek a Review Board review, and the treatment plan with its known side effects were explained, and in what language and form. Where the person could not take it in, note that the nominated representative was informed and that the person was told again once able. A treatment plan the patient cannot understand has not been disclosed within the meaning of the section, however carefully it was written.

4.7 The right to confidentiality and its lawful exceptions

A person with mental illness shall have a right to **confidentiality** in respect of their mental health, their mental healthcare, their treatment and their physical healthcare, and all health professionals providing that care shall have a duty to keep the information confidential. The examination trap is to stop at the duty and call it absolute. It is not: the section itself enumerates the circumstances in which the duty yields, and knowing those circumstances is the substance of the answer. Disclosure is permitted, on necessary and limited terms:

- release to the nominated representative so that they can discharge their functions;
- disclosure to other mental health or health professionals for the person's care and treatment;
- disclosure to protect any other person from a real risk of harm or violence, confined to the information necessary for that purpose;
- disclosure to prevent a threat to the person's life;

- on the order of the Review Board, the Central Authority, a High Court or the Supreme Court, or another statutory authority competent to make such an order; and
- in the interests of public safety and security.

The exception permitting disclosure to protect a third party from harm supplies statutory permission for a necessary, proportionate disclosure; the section does not itself impose a positive duty to warn or protect, and any such duty arising under another law or professional standard must be analysed separately. The ethical reasoning around when and how confidentiality may be breached for the safety of another, together with the wider consent and certification duties of the psychiatrist, belongs to the Forensic ethics, consent and legal procedure notes and is not rehearsed here. What this section settles is the legal permission and its boundary: the duty is the rule, the enumerated grounds are the only exits, and disclosure under any of them is confined to what the situation genuinely requires.

PITFALL

Opposite errors flow from misreading the exceptions. The first is treating confidentiality as absolute and refusing to disclose even when a person is at credible risk of harm, when the section positively permits the necessary disclosure. The second is breaching confidentiality without an enumerated ground, or disclosing far more than the risk requires, on the loose assumption that a psychiatrist may share freely with family or police. State the exception you are relying on, and release only what that ground needs; a duty repeated without its conditions is how both mistakes are made.

4.8 Making the rights real: representative, Review Board and the ward

Rights on paper need a route to enforcement, and the chapter builds one into its own text. The information right points the person to the Mental Health Review Board to have an admission reviewed; the confidentiality section names the Board and the higher courts as the bodies that can order disclosure. The Board is the forum in which these entitlements are made justiciable, and running alongside it is the nominated representative, the person's appointed or statutorily identified voice, who co-holds the information right and receives disclosures the person cannot yet take in. Neither of those is taught here, because each is a substantial topic on its own; the point to carry is that the rights of this chapter are not merely declared, they are given a person to speak them and a body to enforce them.

Chapter V does not end with the six rights read here. It continues with further entitlements that the same rights-based logic generates, among them restrictions on releasing a person's information to the media, access to one's own medical records, rights to personal contact, communication and visitors, and access to legal aid. The exact section numbers of those later rights sit outside the provisions read at origin in this topic, so they are named rather than numbered; the reader should simply know that the chapter is broader than the core it is usually examined on, and that its later sections extend the same principle of dignity and self-determination.

MNEMONIC

A CoDE I Confide

The run of core rights in order: **A**ccess to care, **Co**mmunity living, **D**ignity and protection from cruel treatment, **E**quality with insurance parity, **I**nformation, and **C**onfidentiality. Recovering the phrase recovers both the guarantees and the order in which their sections run through the chapter.

Read every clause of this chapter in the mandatory voice, because the Act says the person shall have each right: a right the State could grant or refuse at its own discretion would not be a right at all.

5 · Advance directive under MHCA (making, revocation, override)

Why this earns marks. The **advance directive** is the Mental Healthcare Act's clearest break from substituted decision-making. It lets a competent adult record, ahead of time, how they wish and do not wish to be cared for and treated for a mental illness during a future period in which they can no longer decide for themselves. The marks sit here because the directive is a compact cluster of sections that pulls in almost every other theme of the Act at once: the capacity that triggers it, the nominated representative named inside it, the Mental Health Review Board that is the exclusive first-instance forum able to set it aside, and the liability of the clinician who follows or departs from it. A candidate who keeps the making, the operation, the revocation and the override apart, and who cites the correct section for each, has shown they can read a statute rather than paraphrase it.

The recurring difficulty is that the phrase sounds absolute, as though a directive, once signed, governs the person whatever happens next. It does not. The Act deliberately provides distinct routes by which a directive can be displaced or changed, and telling them apart is the commonest place candidates and clinicians go wrong: the person's own decision while they still have capacity, the person's formal revocation, and an override granted by the Board on application. Each has its own actor, its own section and its own modal verb, and the gap between a discretionary power and a mandatory duty is exactly what is being examined.

5	8	11	13
MAKING	REVOCATION	BOARD OVERRIDE	CLINICIAN LIABILITY

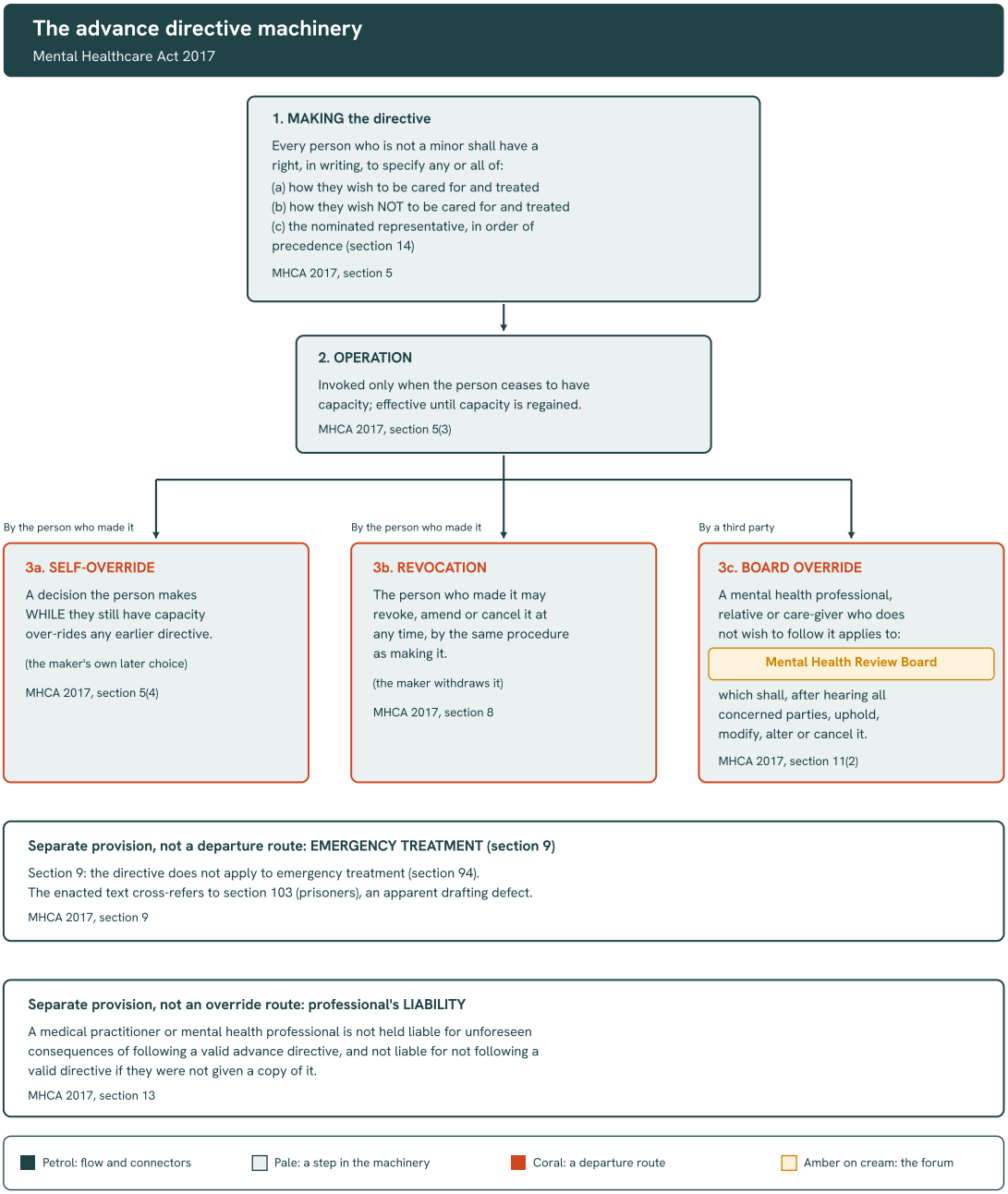


Fig 25.3. The advance directive under the Mental Healthcare Act 2017: every person who is not a minor shall have a right to make one in writing (section 5), it operates only once the person loses capacity (section 5(3)), and can be departed from by the maker's own later capacitous decision (section 5(4)), by revocation at any time (section 8), or by a Board override on the application of a professional, relative or care-giver, which the Board shall dispose of after hearing all concerned parties (section 11(2)). Separately, section 9 says the directive does not apply to emergency treatment; the enacted text cross-refers to section 103, though the Act's emergency-treatment provision is section 94 and section 103 concerns prisoners, an apparent drafting defect. Section 13 separately protects the professional from liability and is not an override route.

5.1 The right to make an advance directive

The right to make a directive is set at section 5. Every person who is not a minor shall have a right to make an advance directive in writing. The verb matters: this is a right conferred in mandatory terms, not a facility the establishment may extend at its discretion. What the directive may specify is stated in the person's own voice - the way they wish to be cared for and treated for

a mental illness; the way they wish not to be cared for and treated; and the individual or individuals, in order of precedence, whom they wish to appoint as their **nominated representative**. That last limb links the directive to the separate machinery of the nominated representative, whose appointment and duties this chapter treats in their own right; here it is enough that the directive is where the person may name, and rank, the people they trust to speak for them.

Beyond its contents, the making carries points that are commonly examined as one-liners. The right to make a directive exists irrespective of any past mental illness or past treatment: a history of illness neither bars a person from making a directive nor weakens one they have already made. The point is more than administrative. It refuses the assumption that a diagnosis, or a past spell of illness, strips a person of the standing to plan their own care; a directive made by someone with a psychiatric history is not thereby suspect, and the fact that a person was once unwell is not, by itself, a reason to look behind what they have set down. And a directive that is contrary to any law in force is **void ab initio** - void from the outset, not merely voidable later - so a directive cannot be used to demand something unlawful, and a clinician confronted with such a clause is not obliged to give it effect.

IN INDIA

Unlike an informal "living will," this is a statutory right of every adult who is not a minor, and it is enforceable: a clinician who sets aside a valid directive without taking the matter to the Mental Health Review Board is acting outside the Act. In day-to-day practice the directive is still newly established and under-used, so the working knowledge that actually protects a patient is simple - a valid, known directive is binding, and it is displaced only in the specific ways the Act allows.

5.2 When the directive operates: the capacity trigger

A directive is not a standing instruction that runs from the day it is signed. It is dormant while the person has capacity and comes alive only at a defined moment. It is invoked only when the person ceases to have the **capacity** to make mental-healthcare and treatment decisions, and it remains in effect until that capacity is regained. The statutory test of that capacity is not restated here - it is taught where this chapter defines mental illness and the capacity to make treatment decisions - but its structural role in this topic is decisive: capacity is the switch. While it is present, the directive is silent; when it is lost, the directive speaks; when it returns, the directive falls silent again.

Holding this clearly is what prevents the errors that follow. If the directive operates only during incapacity, then it cannot bind a person who still has capacity - which is the subject of the self-override rule - and it cannot be a permanent surrender of autonomy, because the person recovers the decision the moment capacity returns. The directive is therefore best understood as a bridge across a period of incapacity, built by the person while they have capacity and dismantled automatically when capacity is regained.

5.3 The self-override rule

The most examined point in the whole topic is that the maker can defeat their own directive simply by having capacity. Any decision made by a person while they have the capacity to make mental-healthcare and treatment decisions shall over-ride any previously written directive by that person. The verb is mandatory: the contemporaneous capacitous decision does not merely compete with the earlier directive, it prevails over it. This is not a loophole; it is the Act being consistent with itself. Autonomy is respected in the present tense, so the wishes a person actually holds while competent must beat the wishes they recorded earlier for a time when they expected not to be competent.

It is worth seeing why the Act declines to treat a directive as an unbreakable pre-commitment against the recovered self. A person may reasonably want to bind their own future - to guard against a relapse in which their judgement is impaired - and the Act honours that wish precisely by giving the directive force during periods of incapacity. What it will not do is let a past self overrule a present competent one. The instant capacity is present, the law treats the person as the best author of their own care, and the earlier document steps aside without ceremony or paperwork. The directive protects the person from their incapacitated future, not from their capacitated present.

TRAP **An advance directive does not bind a person who still has capacity.** Candidates assume a written directive governs from the moment it is signed, and clinicians occasionally invoke it to hold a patient to an earlier refusal. In law the directive operates only once capacity is lost, and even then a decision the person makes while capacitous over-rides it. Applying a directive against the present, capacitous wishes of the patient inverts the very provision it claims to rely on.

5.4 Revocation, amendment and cancellation

Separate from over-riding a directive by a present decision is the maker's formal power to unmake it. **Revocation**, amendment or cancellation of a directive sits at section **8**. A directive may be revoked, amended or cancelled by the person who made it, at any time. The precision that earns the mark lies in the actor and the procedure. The power belongs to the maker alone - not to a relative, not to the treating team, not to the establishment - and it is exercised at any time, which in practice means while the person has the capacity to take such a step. And the procedure for revoking, amending or cancelling shall be the same as the procedure for making a directive: the same formality that created the document is required to change or undo it, so a directive cannot be quietly set aside by an informal note.

It is worth fixing the difference from the previous rule. The self-override is automatic and situational - a capacitous decision simply prevails, with no paperwork - whereas revocation is a deliberate, formal act that alters or ends the document itself. Both are the person's own, and neither needs the Board; that is what separates them from the override route that does.

5.5 The override machinery and the Mental Health Review Board

This is the required core of the topic. Following a valid directive is a duty, not a preference: it is the duty of the medical officer in charge of the mental health establishment and of the treating

psychiatrist to follow a valid directive, and that duty gives way only to the review power described here. The override itself is set at section **11**. Where a mental health professional, or a relative, or a **care-giver** of the person desires not to follow a directive, that person shall make an application to the concerned **Mental Health Review Board** to review, alter, modify or cancel it. The modal verb is doing heavy work: the objector is not permitted to disregard the directive unilaterally; they shall apply. Unilateral departure from a valid directive is not an option the Act leaves open.

On receiving the application, the Board shall, after giving an opportunity of hearing to all concerned parties - expressly including the person whose directive is in question - either uphold, modify, alter or cancel the directive. In deciding, the Board takes into consideration -

- whether the directive was made of the person's free will and free of coercion;
- whether it was intended to apply to the circumstances that have actually arisen;
- whether the person had sufficient information when the directive was made;
- whether the person had the capacity to make the decision at the time the directive was made;
- whether the contents of the directive are contrary to law or to the Constitution.

Read together, the matters the Board weighs form a coherent test of whether the directive genuinely represents the person's authentic, informed and applicable choice. Free will and the absence of coercion go to whether the document is truly the person's own at all. Whether it was meant for the situation that has actually arisen guards against a general instruction being stretched to a case its maker never contemplated. Sufficiency of information asks whether the choice was a considered one rather than an uninformed reflex. Capacity at the time of making tests whether the maker could validly bind their future self in the first place. And the check for legality ensures the Act is not turned into a device to compel what no clinician could lawfully do. The override is therefore not a veto on directives a treating team finds inconvenient; it is a structured examination of whether a directive is authentic, informed, applicable and lawful before it is set aside, and the effort of persuading the Board falls on the party who wishes not to comply, not on the person who made the directive.

The composition and wider functions of the Board belong to this chapter's account of the Mental Health Review Boards; what matters here is its unique position - it is the exclusive first-instance forum that can set aside a valid directive against the maker's wishes, doing so only on application and only after a hearing. Its decision is itself appealable to the relevant High Court under section eighty-three, on application by any person or establishment aggrieved by it, within a prescribed window from the decision.

RULE **A valid advance directive must be followed - subject to the Board's power of review and to the statutory non-application to emergency treatment.** The duty to comply falls on the medical officer in charge and the treating psychiatrist, and outside emergency treatment it yields not to the clinician's own disagreement but only to a Board that has been asked, on application, to uphold, modify, alter or cancel the directive after hearing the parties.

Separate from the Board's review power is a statutory non-application rule. Section nine provides that an advance directive does not apply to emergency treatment. The enacted text describes that carve-out as emergency treatment under section one hundred and three, but the Act's own emergency-treatment provision is section ninety-four, and section one hundred and three in fact concerns prisoners - an internal cross-reference defect in the statute's own text, not a drafting choice for a reader to silently repair. During emergency treatment, therefore, the directive simply does not govern the situation; nothing is displaced by application or hearing, because the directive was never engaged for that treatment in the first place.

5.6 The clinician's liability, and the section that is not the override

The Act protects the clinician on both sides of the decision, and it does so at a section that is frequently misremembered. Liability in relation to a directive is set at section **13**. A medical practitioner or mental health professional shall not be held liable for any unforeseen consequences of following a valid directive; and shall not be held liable for not following a valid directive if he has not been given a copy of it. The symmetry is deliberate: the clinician who does the lawful thing, honouring a directive, is shielded from its unforeseen fallout, and the clinician who fails to honour one is excused only where the directive was never placed in their hands. Ignorance protects only genuine ignorance.

The provision is doing quiet policy work behind that symmetry. By shielding the clinician who follows a directive from its unforeseen consequences, it removes the defensive incentive to second-guess or quietly ignore a patient's recorded wishes. By withdrawing that shield the moment a copy has been supplied, it makes receipt of the directive the event that fixes the duty to act on it. The safe posture for the clinician is therefore an active one rather than a passive hope of never having seen the document: ask whether a directive exists, obtain a copy, and follow it unless and until the Board directs otherwise. A directive that sits unread in a family's possession protects no one, and the clinician who takes trouble to find it is the clinician the section rewards.

PITFALL

A surprisingly common error, repeated even in some question papers, is to name the liability provision as the source of the override power. They are different sections doing different work. The power to review, alter, modify or cancel a directive is the Board's, exercised only on application; the liability provision does something else entirely - it shields the clinician who follows a valid directive and the clinician who was never given a copy. Treating the liability section as the route to override, or telling a family that it lets them set a directive aside, misstates the law.

GOOD TO REMEMBER

At admission, ask whether the patient has made an advance directive and obtain a copy for the record. The liability provision excuses a failure to follow a directive only where no copy was given, so an unlocated directive is at once a clinical and a medico-legal gap: a directive can be honoured only once it is known, and the clinician's protection for not following one runs out the moment a copy reaches them.

5.7 The routes distinguished

The whole topic resolves into a single discrimination: who can change or displace a valid directive, and by what route. Setting the possibilities side by side shows why the section, the actor and the verb must be learned together rather than as a gist.

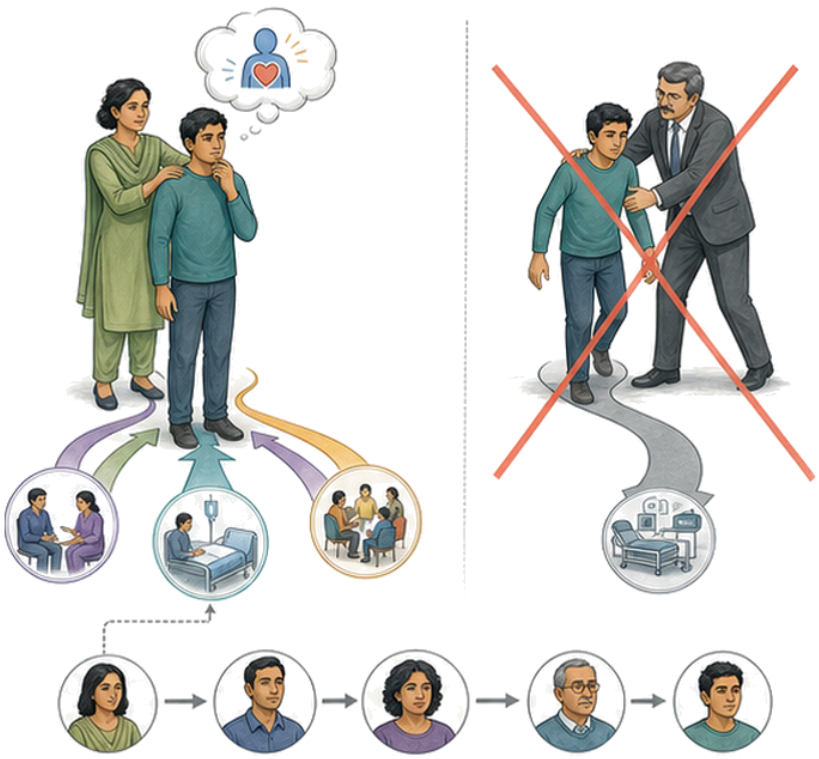
ROUTE	WHO ACTS	WHAT HAPPENS	BOARD NEEDED?
Contemporaneous capacitous decision	the person, while they still have capacity	their present decision over-rides the earlier directive	No
Revocation, amendment or cancellation	the person who made it, at any time	the directive is revoked, amended or cancelled, by the same procedure as making it	No
Review on application	a mental health professional, relative or care-giver who does not wish to follow it	the Board shall, after a hearing, uphold, modify, alter or cancel it	Yes - the only third-party route

Read down the last column and the architecture is clear. The person retains control by two means that need no one's permission - by deciding while capacitous, and by revoking formally. A dissenting third party has a single lawful path, and it runs through the Board, on application, after a hearing. There is no self-help override for a relative or a clinician who simply disagrees. This table covers only the three routes that change or displace a directive; it does not include section nine's separate rule that a directive has no application to emergency treatment at all.

> A valid advance directive governs care only while the person lacks capacity, and not at all during emergency treatment; their own capacitous decision over-rides it, the maker alone may revoke it, and the Mental Health Review Board, on application by a clinician, relative or care-giver, is the exclusive first-instance forum that may override it against the maker's wishes, subject to appeal to the High Court.

6 · Nominated representative (appointment, duties)

Why this earns marks. The **nominated representative** is the Mental Healthcare Act's answer to a hard practical question: when a person with mental illness cannot, for a period, make or communicate their own decisions about care and treatment, who stands beside them and, where necessary, acts on the record - and by what standard must that person reason? The topic is a compact cluster of provisions covering appointment, the default order where no appointment has been made, and the representative's duties, and it threads through almost every other mechanism of the Act: the advance directive names a nominated representative, supported admission is applied for by one, and the person's healthcare rights are exercised with one's support. A candidate who keeps appointment, default and duties apart, and who reads each modal verb exactly, has shown they can work with a statute rather than paraphrase its gist.



- Appointment
- Default order
- Support the person
- Give weight to wishes
- Not a substitute guardian

Fig 25.4 Under the Mental Healthcare Act, the nominated representative supports decision-making and gives weight to the person's own wishes. Appointment, the default order and statutory duties must be kept distinct; the role is not an unrestricted substitute guardianship.

The recurring difficulty is that the office is easily misread as a guardian or a next-of-kin who consents on the patient's behalf. The Act builds something narrower and more demanding. The representative is a supporter, not a substitute: their statutory task is to help the person decide and to give weight to the person's own wishes, not to decide in the person's place. Everything that earns a mark in this topic follows from that single distinction, so it is worth fixing before the mechanics: the appointment provision creates the office and supplies a fallback where none is chosen; the duties provision fixes the standard by which the holder must act.

14	5	17
APPOINTMENT	DEFAULT TIERS	DUTIES

6.1 The right to appoint a nominated representative

The right to appoint sits at section **14**. Every person who is not a minor shall have a right to appoint a nominated representative. The verb is doing real work: this is a right conferred in mandatory terms on the individual, not a facility that the establishment or the family may extend or withhold at its discretion. The appointment is deliberately low in formality so that the right is genuinely usable, but the Act is specific about what a valid one requires:

- it is made in writing, on plain paper, authenticated by the person's signature or thumb impression, and it needs neither a lawyer nor a registrar to be valid;
- the person appointed must be an adult and not themselves a minor;
- the appointee must be competent to discharge the role;
- the appointee must consent, in writing, to act.

Consent matters because the office carries duties, and a person cannot be conscripted into speaking for another without agreeing to do so. Each element is modest on its own, but together they mark the appointment out as a real legal act with a willing, capable holder, rather than a name casually written on a form.

Two points are commonly examined here as one-liners. First, the right belongs to the person and is exercised while they can exercise it: a competent adult sets down, in advance or at the time, whom they trust to support them. Second, the appointment can be undone and remade as the person's circumstances and relationships change, because the right that creates the office is a continuing one and not a single irreversible act. Holding this clearly prevents the error of treating a once-named representative as fixed for life.

IN INDIA

The signature-or-thumb-impression formality is a characteristically Indian piece of drafting: it makes the right real for a population with wide variation in literacy, so that a person who cannot sign is not thereby denied a voice in who supports them. In day-to-day practice the office is still newly established and under-used, and many families arrive at admission with no idea that the appointment is the patient's to make. The working knowledge that actually protects a patient is therefore simple - the choice of representative is the person's own, made informally but in writing, and it is not the hospital's to assign.

6.2 The default order of precedence where none is appointed

Most people never appoint anyone in advance, so the Act cannot let the office stand empty at the moment it is needed. Within the same appointment provision it supplies a default: where no representative has been appointed, the following persons shall be deemed to be the nominated representative, in a fixed **order of precedence**. The deeming verb is mandatory - the law does not merely permit one of these people to step in, it treats them as the representative in turn until an available and willing person is found.

ORDER	WHO IS DEEMED THE NOMINATED REPRESENTATIVE	HOW THEY COME TO THE ROLE
First	The individual the person named in their advance directive	The person's own prior choice, carried across from the directive
Then	A relative	Deemed only if available and willing to act
Then	A care-giver	Deemed only if no relative is available or willing
Then	A suitable person appointed by the concerned Board	Appointed where no relative or care-giver can act
Last	The Director, Department of Social Welfare, or a designated representative	The Board shall appoint this office where no other person is available

Read the column of conditions and the design becomes clear. The order runs from the most personal choice to the most institutional backstop, and it never leaves a person unrepresented: if family and community fail, the concerned Board picks a suitable person, and if even that fails, the Board shall appoint the **Director, Department of Social Welfare**, so that a representative always exists. There is a further safeguard for the gap before the Board can act: a person representing an organisation registered under the Societies Registration Act, 1860, or under any other law, and working for persons with mental illness, may be engaged as the representative pending the Board's appointment. That initial engagement is discretionary. But once the representing person makes a written application to act, the medical officer in charge of the establishment or the psychiatrist in charge of the person's treatment shall accept the application, so the person becomes the temporary representative as a matter of duty, not choice, until the proper appointment is made.

The single most useful thing to carry from the order is that it is a default, displaced entirely by an appointment. An appointed representative, even one who is not a relative, outranks the whole deeming list; a **care-giver** or relative is deemed to hold the office only in the absence of a valid appointment and only in their place in the queue. This is why appointment and default must be learned as two limbs of one provision rather than as a single rule about who speaks for the patient.

PITFALL

A common clinical error is to treat the nearest relative as automatically and always the representative, and to seek that relative's consent as though the office were a matter of kinship. It is not. Where the person has appointed someone, that appointee holds the office whatever the family's wishes; and even under the default, a relative ranks below the person's own advance-directive choice and is deemed to act only if available and willing. Reaching for the nearest relative by reflex can put the wrong person in the role and sideline the patient's own prior choice.

6.3 Appointment implies nothing about capacity

One provision within the same section removes a misunderstanding that would otherwise undo the whole reform. The Act is explicit that appointing, or failing to appoint, a nominated representative does not imply that the person lacks the capacity to make mental-healthcare and treatment decisions. The two questions are kept entirely separate. Naming a representative is a piece of forward planning that a fully capacitous person does precisely because they are thinking ahead; it is not a confession of present incapacity, and it does not lower the person's standing to decide for themselves here and now.

This matters because the older model it replaces ran the other way: to have someone speak for you was to be, in the law's eyes, someone who could not speak. The Mental Healthcare Act breaks that link on purpose. A person may have a representative in place and still make their own valid decisions across most of their care; the representative comes forward only for the decisions the person cannot presently make. The capacity that triggers that hand-over is the treatment-decision capacity defined where this chapter sets out the definition of mental illness and the capacity to make treatment decisions, and it is not restated here; what belongs to this topic is only the negative rule - representation and incapacity are not the same fact, and neither is evidence of the other.

6.4 The duties of the nominated representative

This is the required core of the topic. The standard by which the representative must act is set at section **17**, and its verbs are mandatory throughout. While fulfilling the role, the representative shall consider the person's current and past wishes, their life history, their values, their cultural background, and their **best interests**. The list repays attention because it refuses to collapse into a bare best-interests test. Wishes, history, values and cultural background are placed alongside best interests, not beneath them, so the representative cannot substitute a tidy external judgment of what is good for the person for the harder work of reconstructing what this particular person would want.

The second duty sharpens the first. The representative shall give **particular credence** to the views of the person, to the extent that the person understands the nature of the decisions under consideration. This is a sliding, decision-specific weighting rather than an all-or-nothing switch: the more the person grasps of a given decision, the more their own view must govern it, even during a period when they cannot make the decision unaided. The third duty states the purpose the first two serve - the representative shall provide support to the person in making treatment decisions. The office exists to enable the person's own decision-making wherever it can reach, and to speak in the person's voice, reconstructed from the first duty's materials, only where it cannot.

RULE **The representative's duty is to support the person's own decision-making, not to replace it.** The statute is framed in mandatory terms: the holder shall consider the person's present and past wishes, life history, values and cultural background; shall give particular credence to the person's own views in proportion to how well they understand the decision; and shall provide support in making treatment decisions. Best interests sits within that reconstruction of the person's will, not above it.

Beyond these core duties, the representative is the person the Act turns to at several other points in the patient's journey. The representative may apply for the person's admission and take part in decisions about discharge and discharge planning, may seek information about the diagnosis and the proposed treatment so that support is informed rather than nominal, and gives or withholds consent to research on the person's behalf within the limits the Act sets. The consent role also reaches the regulated treatments, including electroconvulsive therapy, whose consent machinery this chapter treats in its own right and which is not reopened here. The section anchors for these wider functions lie in provisions this topic does not own, so they are named as functions rather than pinned to numbers, but the shape is worth carrying: the representative is not a one-decision proxy but a continuing supporter across admission, treatment, information and discharge.

6.5 Supported decision-making, not substitute/best-interests decision-making

The conceptual heart of the office, and the point most often lost, is the model of decision-making the duties encode. The older tradition of guardianship worked by **substitute/best-interests decision-making**: a guardian decided in the person's place, asking what a reasonable person, or the guardian, would choose. The Mental Healthcare Act adopts **supported decision-making** instead. The representative's job is to furnish the support - information, presence, help in weighing options, and a faithful account of the person's own wishes and values - that lets the person decide as far as they are able, and to carry the person's reconstructed will only for the residue they cannot reach.

AXIS	SUPPORTED DECISION-MAKING (THE REPRESENTATIVE'S STANDARD)	SUBSTITUTE/BEST-INTERESTS DECISION-MAKING (THE OLDER MODEL)
Who decides	The person, supported; the representative fills only the gap the person cannot cross	The proxy, in the person's place
Weight of the person's own view	Given particular credence, in proportion to how far the person understands the decision	Often displaced once a proxy is appointed
Reference point	The person's wishes, history, values and cultural background, and their best interests together	A best-interests or reasonable-person judgment made for the person
Effect of having a representative	No implication that the person lacks capacity to decide	Appointment historically signalled incapacity

The contrast is not academic. It changes what the representative should actually do at the bedside: not announce a decision, but sit with the person, explain the options in terms the person can follow, and decide unaided only what genuinely cannot be reached with support. It also explains why the duties are drafted as they are - the emphasis on wishes, values and particular credence is the machinery that keeps support as the default, so that the representative consents on the person's behalf only where the person needs nearly total support to decide, and even then only as a temporary measure kept under frequent review of the person's capacity.

TRAP **Describing the nominated representative as a substitute decision-maker who consents on the patient's behalf.** Candidates equate the office with a guardian or next-of-kin proxy, and clinicians sometimes obtain the representative's consent as if the patient had dropped out of the picture. The statutory duties point the other way: the holder must give particular credence to the person's own views and provide support in the person's own decision-making. Treating the representative as a routine proxy inverts the standard the section actually imposes.

6.6 Reading the office correctly in practice

Pulling the provisions together, the office resolves into three questions a clinician can ask in order. Is there an appointed representative? If so, that person holds the office, whatever the family's preferences, provided the appointment was validly made and the appointee competent and consenting. If not, who is deemed to hold it under the default order, worked down from the advance-directive choice through relative and care-giver to the Board's appointee and, in the last resort, the Director, Department of Social Welfare? And once the holder is identified, are they discharging the duties the Act imposes - supporting the person's own decisions and giving particular credence to the person's views - rather than deciding in the person's stead? Each question maps onto a limb of the topic, and answering them in that sequence is how the statute is meant to be used.

The office also has to be kept in its lane. It is a healthcare-facing role: it supports the person's decisions within the mental-healthcare system and reaches neither the person's property nor their money, which are the concern of the separate guardianship and property-management machinery this chapter treats elsewhere. Conflating the two offices, so that a representative is asked to sign for an estate or a property manager to consent to treatment, is a standing source of error and a genuine safeguarding risk.

GOOD TO REMEMBER

At every admission and at each major treatment decision, establish who the nominated representative is before you seek anyone's involvement: ask whether the person has appointed one, and if not, walk the default order rather than defaulting to whichever relative is present. Record the answer. Then treat that person as a supporter of the patient's own decision-making, not as a consent-giver who displaces the patient - which is exactly what the duties require, and exactly what a hurried ward routine tends to forget.

Every non-minor has a mandatory right to appoint a nominated representative in writing; where none is appointed the Act deems one in a fixed order, from the advance-directive choice down to the Director, Department of Social Welfare; and the holder's duty is to support the person's own decisions and give particular credence to their views, not to decide in their place.

7 · Admission types (independent, supported admission and discharge procedures)

Why the marks cluster here. Admission is where the Mental Healthcare Act 2017 stops declaring principles and starts issuing procedure, and examiners return to it because it is the

point at which the Act's central idea becomes a set of hard rules a clinician can get wrong. That idea is that the route a person takes into inpatient care follows their capacity to make treatment decisions, not their diagnosis and not the convenience of the service. The Act therefore builds a graded ladder rather than a single admission order: an independent route the person asks for himself, a supported route that another person applies for on his behalf, and an emergency provision that holds a dangerous situation before either can be arranged. Each rung carries its own examiners, its own clock, its own reporting duty and its own modal verb, and the questions that separate a pass from a distinction live in the differences between them.

This section teaches those routes and the discharge procedures that close them. The capacity test itself, what it means to be able to understand, appreciate or communicate a treatment decision, is defined elsewhere in this chapter and is only invoked here. The point to hold is that capacity is the switch, and every provision below is a setting of that switch.

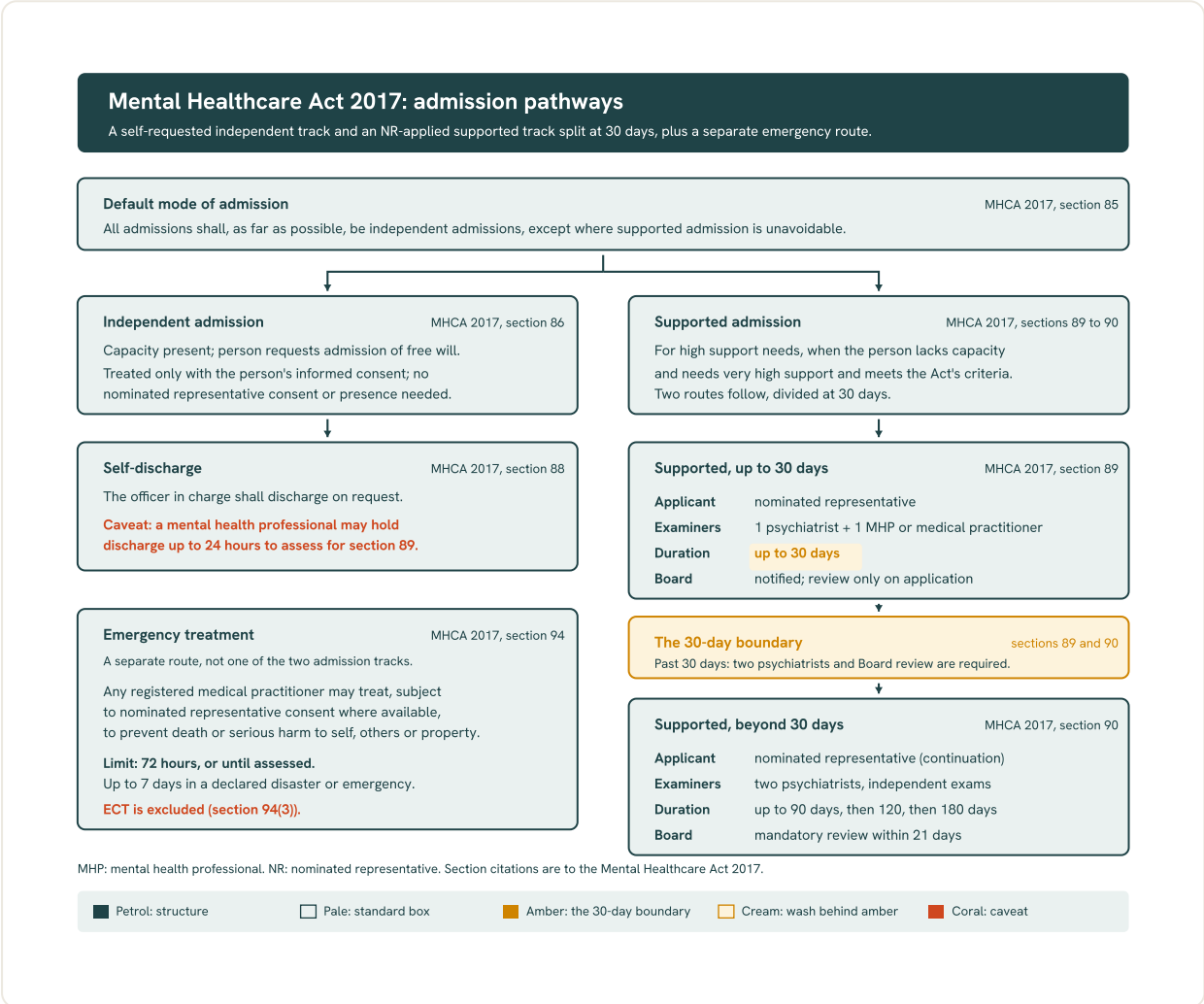


Fig 25.5. Admission under the Mental Healthcare Act 2017 runs on two tracks that differ in who initiates them: a self-requested independent admission (section 86, capacity present, on the person's own request and informed consent, with no nominated representative needed) and a supported admission for high support needs, applied for by the nominated representative, which the 30-day boundary divides into section 89 (one psychiatrist with one other professional; up to 30 days) and section 90 (two psychiatrists examine independently; mandatory Board review within 21 days). Emergency treatment (section 94) is a separate 72-hour route that excludes electro-convulsive therapy.

7.1 The default the Act commands (section 85)

The Act opens its admission scheme by defining the **independent patient** and, in the same breath, by making that status the default. An independent admission is the admission of a person who has the capacity to make his own mental-healthcare and treatment decisions, or who needs only minimal support to make them. The definitional provision does more than label a category. Its second limb lays down a rule of priority: all admissions to a mental health establishment *shall*, as far as possible, be independent admissions, and a supported admission is lawful only where conditions exist that make it unavoidable.

Read that modal verb precisely, because the examiner will. The Act does not say a clinician *may* prefer the independent route; it says every admission *shall* be independent so far as possible. Supported admission is the exception that has to be justified, not a parallel option of equal standing, and it is why the choice of admitting section is never a matter of clinical taste.

RULE **The mode of admission follows capacity, and independent admission is the default the Act mandates.** A supported admission is not an alternative a clinician may reach for out of convenience; it is the exception the statute permits only when the person's decision-making capacity, or a defined risk, makes the independent route unworkable. Every question about which section applies begins by asking what the person can decide, not what he is diagnosed with.

IN INDIA

The 2017 Act rebuilt admission around this default deliberately. For the practising psychiatrist the burden has shifted: the record must show why an independent admission was not possible before a supported admission is used, and a supported admission that could have been an independent one is a departure from what the Act commands, not a neutral choice.

7.2 Independent admission and treatment (section 86)

The operative provision for the independent route is the one under which a person who is not a minor, who considers himself to have a mental illness and who wishes to be treated, *may request* the medical officer or mental health professional in charge to admit him. The request is the patient's own, and the initiative sits with him. On receiving it the officer *shall* admit the person where satisfied that the illness is severe enough to need admission, that the person is likely to benefit from it, that he understands the nature and purpose of the admission and is asking of his own free will, and that he has the capacity to make the decision or needs only minimal support. The duty is expressed as a "shall", but it is a conditional duty: the officer admits if and only if those conditions are met, and refuses if they are not.

Two consequences of independent status are examined repeatedly. First, an independent patient *shall not* be given any treatment without his own **informed consent**. Admission does not import a power to treat, and a capacitous inpatient who refuses a specific intervention keeps that refusal. Second, the establishment *shall not* require the consent or the presence of a nominated representative, a relative or a care-giver in order to admit an independent patient. The person

stands on his own capacity, and inserting a family gatekeeper into an independent admission is not something the Act permits.

7.3 Self-discharge and the twenty-four-hour hold (section 88)

Because the independent patient is admitted on his own capacity, he keeps the key to the door. He *may* discharge himself without the agreement of the officer in charge, a right of **self-discharge** that follows directly from independent status, and on his request the officer *shall* discharge him immediately. This is the ordinary rule: a person admitted on his own decision may reverse that decision.

The provision then supplies the exception that examiners love, because it is a narrow, conditional power that candidates routinely overstate. Notwithstanding the right to self-discharge, a mental health professional *may* prevent the discharge of an independent patient for up to **twenty-four hours**, and for one purpose only: to allow the assessment needed to decide whether a supported admission is warranted. The power arises only where the professional is of the opinion that the person:

- is unable to understand the nature and purpose of his decisions and requires substantial or very high support from his nominated representative;
- has recently threatened or attempted, or is threatening or attempting, to cause bodily harm to himself;
- has recently behaved or is behaving violently towards another person, or has caused or is causing another person to fear bodily harm from him; or
- has recently shown or is showing an inability to care for himself to a degree that places him at risk of harm to himself.

At the end of that window the person *shall* either be admitted as a supported patient under the next provision or be discharged, within that window or on completion of the assessment, whichever is earlier. The hold is a bridge to a decision, not a decision in itself.

> **GOOD TO REMEMBER**
>
> The twenty-four-hour hold is an assessment window, not an authority to treat. It buys time to decide whether a supported admission is justified; it does not, by itself, let you medicate a refusing patient. If treatment genuinely cannot wait for that decision, the question is whether the separate emergency provision applies, not whether the hold has quietly turned into a treatment order.

7.4 Supported admission up to thirty days (section 89)

When the independent route is genuinely unworkable, the Act turns to **supported admission**, the mechanism for a person with **high support needs** who cannot presently make or communicate the admission decision himself. The first supported-admission provision governs shorter admissions, and it is initiated not by the patient but by an application from his nominated representative. The officer *shall* admit the person on that application only once a defined examination has been done: the person must have been independently examined, on the

day of admission or within the preceding **seven days**, by **one** psychiatrist together with a second examiner who is a mental health professional or a medical practitioner. Their task is not merely to confirm illness but to certify that a supported admission is the **least restrictive** option that meets the person's needs. The distinct admission procedure that applies to minors is a separate provision and is not set out here.

The admission this provision authorises *shall* be limited to **thirty days**. That ceiling is the defining feature of the shorter route and the hinge on which the whole supported-admission scheme turns. A reporting duty attaches to it: the officer *shall* report the admission to the concerned Board within **three days** where the patient is a woman or a minor, and within **seven days** for any other person. Note what that reporting is and is not. It informs the Board; it is not a requirement that the Board clear the admission before it takes effect. Under this shorter route the Board's review is not an automatic pre-authorisation, it is triggered when the patient, his nominated representative or a recognised organisation applies for it. That is the crucial contrast with the longer route below.

Finally, the provision carries its own escalation valve. If the officer forms the opinion that the person is likely to need treatment beyond that ceiling, he is duty-bound to *refer* the matter to be examined by **two** psychiatrists for admission beyond that period. The shorter route cannot simply roll over; crossing the ceiling demands a fresh and higher threshold of scrutiny, which is the subject of the next provision.

7.5 Supported admission beyond thirty days (section 90)

The second supported-admission provision is a genuinely different instrument, not a mere continuation, and collapsing the two is one of the commonest ways to lose the mark. It applies when a person already admitted under the shorter route needs continuous admission beyond that ceiling, or is being readmitted soon after a discharge. Several things change, and each of them tightens the test.

First, the examination is heavier. The person must have been independently examined in the preceding **seven days** by **two** psychiatrists, each of whom must independently reach the required conclusion. Second, the risk threshold is worded more stringently: where the shorter route spoke of a person who had *recently* threatened or attempted harm, this provision requires that the person has done so *consistently over time*. A single recent episode that would support the shorter admission does not, on its own, support the longer one.

Why the Board matters here. The third change is the one the examination cares about most: the Board's role turns from reactive to mandatory. The officer *shall* report every admission and readmission under this provision to the concerned Board within **seven days**. The Board then *shall*, within **twenty-one days** of the last admission or readmission, either permit the admission or order the person's discharge. This is not an optional review that someone has to ask for; it is a compulsory adjudication the Board must complete, and it is the real safeguard that separates long-term supported admission from short.

The durations are correspondingly longer and tiered. An admission under this provision *shall* be limited to **ninety days** in the first instance. Beyond that it *may* be extended by a further **one hundred and twenty days** at the first extension, and thereafter by **one hundred and eighty days** on each subsequent occasion. The lengthening intervals are matched to the mandatory Board oversight, so that a longer detention always sits under a heavier external check rather than a lighter one.

TRAP **Board review is automatic only for the longer supported admission, not for the shorter one.** Candidates write that "the Board must approve supported admission", flattening the two provisions into one. Under the shorter route the admission takes effect on the examiners' certificate and the Board is merely notified, reviewing only if someone applies; under the longer route the Board must, within its fixed period, positively permit the admission or order discharge. Always say which route you mean and match the Board's role to it.

7.6 The routes compared

Set against one another, the routes separate cleanly on who initiates them, who examines, how long they last and what the Board does. The accompanying table lays out the axes the examiner tests. Commit the pattern rather than the isolated numbers, because a viva question almost always asks you to move a patient from one column to the next.

AXIS	INDEPENDENT (SECTION 86)	SUPPORTED, UP TO THIRTY DAYS (SECTION 89)	SUPPORTED, BEYOND THIRTY DAYS (SECTION 90)
Who initiates	The patient's own request	Application by the nominated representative	Application by the nominated representative, for continuance beyond **thirty days** or qualifying readmission within **seven days** of discharge
Capacity assumed	Has capacity or needs minimal support	High support needs	High support needs, persisting
Examiners	Satisfaction of the officer in charge	One psychiatrist plus a second examiner	Two psychiatrists, independently
Harm threshold	Not applicable	Recently or currently: self-harm threat or attempt, violence or causing another to fear bodily harm, or inability to self-care at a degree of risk	The same three limbs, but shown consistently over time rather than recently or currently
Duration	Not time-limited by this provision	Capped at **thirty days**	**ninety days** first, then extensions
Board's role	None for admission	Notified, reviews on application	Must permit or order discharge within **twenty-one days**
Exit	Self-discharge on request	On expiry or clinical decision	Board may order discharge

7.7 Emergency treatment before admission (section 94)

Between the moment a crisis presents and the moment a formal admission can be arranged sits **emergency treatment**, and the Act keeps it deliberately separate from the admission provisions. Any registered medical practitioner, not only a psychiatrist, and whether at a health establishment or in the community, *may* provide any medical treatment, including treatment for mental illness, subject to the informed consent of the nominated representative where one is available. The power exists only where treatment is immediately necessary to prevent death or irreversible harm to the person's health, or the person inflicting serious harm on himself or others, or the person causing serious damage to property as a consequence of his mental illness. Emergency treatment in this sense expressly includes transporting the person to the nearest establishment so that a proper assessment can be made.

Two limits define the provision and are examined precisely. First, it is time-bound: emergency treatment is limited to **seventy-two hours**, or until the person has been assessed at a mental health establishment, whichever is earlier; only where the appropriate Government has declared a disaster or emergency may that period extend up to **seven days**. Second, and this is the line candidates miss, nothing in this provision permits the use of electro-convulsive therapy as a form

of treatment. Emergency powers are wide as to who may act and what ordinary treatment may be given, but they stop firmly short of ECT. The clinical technique and consent for ECT itself belong to the ECT and neurostimulation notes and are not taught here; what the admission law fixes is that the emergency route is not a back door to it.

PITFALL

A floridly catatonic or acutely suicidal patient can look like exactly the case for urgent ECT, and a clinician who reaches for it under emergency powers has misread the statute. The emergency provision authorises ordinary treatment to hold a dangerous situation; it excludes ECT outright. Urgent ECT must be routed through its own consent and authorisation machinery, never through the emergency window.

7.8 Discharge, escalation and the shape to memorise

Discharge mirrors admission. The independent patient, admitted on his own decision, is discharged on his own request, subject only to the narrow twenty-four-hour hold examined above. The supported patient's exit is governed instead by time and by oversight: the shorter admission ends when its ceiling is reached unless it has been lawfully escalated, and the longer admission sits under a Board that may order discharge at its mandatory review. Escalation and discharge are therefore opposite directions of the same supervised process, and the examiner's scenarios usually turn on moving a patient correctly from one rung to the next rather than on any single figure.

86	89	90	94
INDEPENDENT ADMISSION	SUPPORTED, SHORTER ROUTE	SUPPORTED, LONGER ROUTE	EMERGENCY TREATMENT

MNEMONIC

Ask, Apply, Escalate, and Bridge

The independent patient **asks** for himself; the shorter supported admission is one the nominated representative **applies** for; the longer supported admission is an **escalation** demanding a second examining psychiatrist and a mandatory Board decision; and emergency treatment is the **bridge** that holds a crisis until one of those routes is settled. The verbs map to the provisions in the order a real case moves through them.

Independent admission is the default the Act commands; supported admission is the justified exception, and it splits into a shorter provision and a longer, Board-supervised one, never collapsing into a single rule.

8 · Mental Health Review Boards (composition, functions)

A charter of rights is only as strong as the forum that enforces it. The Mental Healthcare Act is written, to an unusual degree for an Indian health statute, as a set of promises to the person with mental illness: a right to make an advance directive, a right to a nominated representative,

safeguards on how a person may be admitted and discharged, and a right to live in and be part of the community. A promise on paper is worth only as much as the body a patient can actually move when it is broken, and that body is the **Mental Health Review Board**. It is a standing, quasi-judicial forum, constituted for a district or a group of districts, that reviews involuntary care, holds and revisits advance instructions, appoints nominated representatives to support a person's own decisions and hears grievances against establishments. Examiners return to it because it is the cleanest single test of whether a candidate understands that the Act's rights are enforceable machinery and not a wish-list, and because candidates routinely confuse it with the regulatory Authority that shares the Act.

Read the Board as the hinge between the two halves of the Act. On one side sit the substantive rights and the admission architecture; on the other sits the question every rights instrument must answer, which is who decides when those rights are contested, how quickly, and with what consequence. The Board is that answer, and the Act deliberately places it close to the patient rather than in a distant court. Fix its constitution, its composition and its functions and a whole cluster of short-note and one-mark questions falls into place at once. This section teaches those three things from the primary provisions and marks the discriminations an examiner rewards.

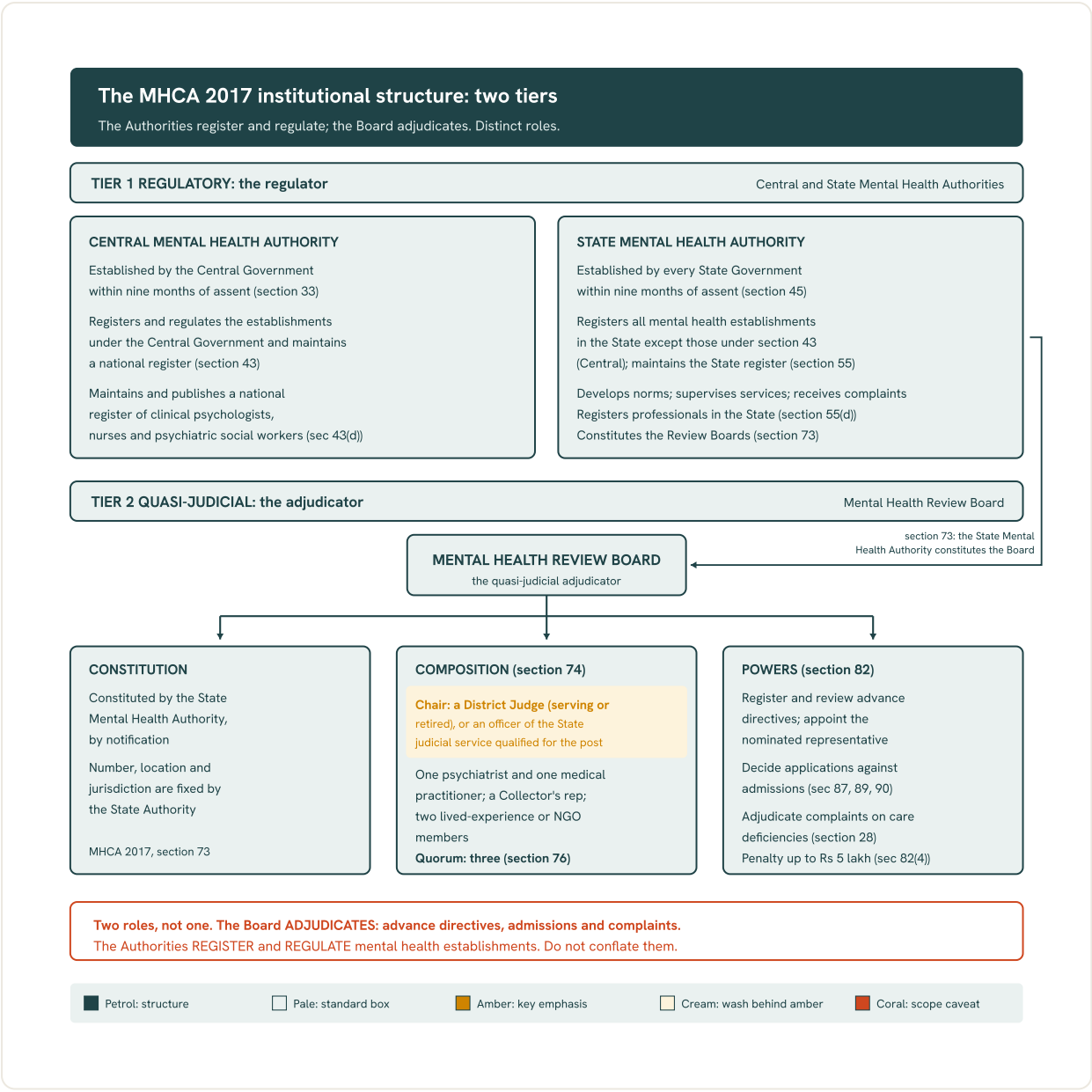


Fig 25.6. The MHCA 2017 divides its institutions into a quasi-judicial adjudicator (the Mental Health Review Board, sections 73, 74 and 82) and regulatory Authorities (Central section 33 and State section 45) that register and regulate mental health establishments; the State Authority constitutes the Board under section 73.

8.1 The rights-enforcement organ of the Act

Every rights statute faces the same design problem. A right that can be vindicated only in the higher courts is, for the person with a mental illness, a right that mostly cannot be vindicated at all, because cost, delay and distance defeat it before it begins. The Act takes the opposite decision and builds a permanent body of its own, for a district or a group of districts, to which a patient or a nominated representative can bring a grievance directly. That is why the Board is best understood not as an administrative add-on but as the enforcement organ without which the rest of the Act would be advisory.

The word that carries the most weight here is quasi-judicial. The Board does not treat patients and it does not manage services; it adjudicates. It receives applications, hears the parties, applies the provisions of the Act to the facts, and issues a reasoned order the parties are bound to obey. That places it in the family of statutory tribunals rather than clinical committees, and almost

every feature that follows, from the judicial officer in the chair to the power to impose a monetary penalty, is a consequence of that character. A candidate who fixes this one idea rarely gets the rest wrong.

RULE **The Board is a tribunal, not a clinical committee.** It is chaired by a judicial officer and it exists chiefly to decide questions of law, rights and compliance under the Act. It does not ordinarily prescribe treatment, but the Act gives it narrow, specific treatment-authorisation powers as well, including permission for ECT in a minor and approval of psychosurgery, which belong to this chapter's account of prohibited and restricted procedures and are not taught here. Its whole design - the judge in the chair, the application-and-hearing procedure, the power to bind and to penalise - follows from its adjudicating character, so sort any question by asking whether it concerns the standing of one patient's rights or the running of a service, and the answer, and the right body, follow.

8.2 Constitution of the Board (section 73)

A Board does not arise on its own, and the provision that creates it repays exact reading because it splits the responsibility across two levels of government. The duty to bring Boards into existence is mandatory and it rests on the State Mental Health Authority: it *shall*, by notification, constitute the Boards for the purposes of the Act. Read the modal verb precisely, because it is a duty and not a discretion; a State that has not notified its Boards is in default of the Act, not merely declining an available option. The requisite number of Boards, their location and their territorial jurisdiction are then specified by the State Authority in consultation with the State Government concerned, which is the mechanism that lets a populous State raise several Boards while a smaller one manages with fewer.

The third limb is the one candidates overlook. The constitution of a Board for a district, or for a group of districts, *shall* be as prescribed by the Central Government. The design is therefore split deliberately between the two levels: the Centre fixes the template and the shape of the body, uniform across the country, while the State decides how many Boards to raise and where to site them. That division buys national consistency in what a Board is and local control over how far a citizen must travel to reach one. Holding those two facts together, a central template with local reach, is what the provision is really testing.

IN INDIA

The choice to pitch the Board at the district is not incidental. A person detained against their will, or a care-giver acting for them, must be able to bring an application without crossing a State line. A body sitting only in the State capital would exist on paper and be unreachable in practice, whereas a tribunal sited within reach, in the district or group of districts it serves, turns the right to challenge a decision into a usable remedy rather than a theoretical one. The Board's authority flows down from the State Authority, but its blueprint is set centrally, and that combination of local access on a national template is a distinctively Indian federal answer to the problem of making rights reachable.

8.3 Composition: a mixed bench by design (section 74)

This is the most heavily examined provision in the group, and it is best learnt as a structure rather than a list. Each Board *shall* consist of four kinds of member, chosen so that the bench carries legal authority, administrative reach, clinical knowledge and the voice of the very people the Act exists to protect. The **chairperson** is a judicial officer, and the accompanying table sets the four seats against what each is there to bring.

SEAT	WHO HOLDS IT	WHAT IT BRINGS TO THE BENCH
Chair	A District Judge, an officer of the State judicial service qualified to be appointed a District Judge, or a retired District Judge	Judicial authority and the discipline of due process
Administrative member	A representative of the District Collector, District Magistrate or Deputy Commissioner	Administrative reach and the link to local government
Medical members	**two** members, one a **psychiatrist** and the other a **medical practitioner**	Specialist and general clinical judgement on the decisions under review
Community members	**two** members who are persons with mental illness, care-givers, or representatives of their organisations or of mental-health non-governmental organisations	Lived experience and civil-society oversight

Read the seats as functions rather than as names. The judicial chair is what makes the body quasi-judicial rather than clinical: it hears the parties, weighs the evidence and passes orders that bind, and it is led by someone trained to do exactly that. The administrative representative ties those orders to the machinery that must carry them out. The medical seats put the clinical facts of an admission or a treatment decision in front of the bench, and the deliberate pairing of a psychiatrist with a general medical practitioner, rather than two psychiatrists, guards against a purely specialist reading of a case. The community seats are the provision's most distinctive feature: by seating persons with mental illness, their care-givers and civil-society representatives on the reviewing body itself, the Act builds its participatory, rights-based ethos into the structure of the forum rather than leaving it to good intentions.

The bench does not need every seat filled to act. Its **quorum** is **three** members, so a validly constituted sitting can proceed with three present. That threshold keeps the Board workable, because a body that could meet only at full strength would stall, while still demanding a genuine plurality rather than a single decision-maker holding a person's liberty in one pair of hands.

MNEMONIC

Judge, Collector, Clinicians, Community

The four member-categories in the order the Act lists them: a **J**udge chairs the Board, the **C**ollector's office is represented, two **C**linicians sit (a psychiatrist and a medical practitioner), and two **C**ommunity members carry lived experience, the care-giver's perspective or a mental-health organisation's voice. Four Cs after the Judge, and the bench is complete.

TRAP **Do not seat a psychiatrist in the chair.** Candidates reflexively make the senior doctor the head of any mental-health body. The chair here is judicial; the psychiatrist is one of the medical members and never the chairperson. The Act deliberately separates the clinical voice from the adjudicating authority, and a script that inverts that has misread the whole design of the bench.

8.4 Powers and functions (section 82)

This is where the Act's rights become remedies. The powers and functions of the Board *shall* include all or any of the following, meaning these are its standing jurisdictions, exercised as cases arise rather than all at once. Taken together they are the mechanisms by which each protection the Act grants elsewhere becomes something the Board can test and enforce.

- to register, review, alter, modify or cancel an **advance directive**, the instrument in which a person records future treatment wishes; how it is made and when it may be overridden are dealt with where this chapter treats advance directives and are not reopened here;
- to appoint a **nominated representative** for a person who has not chosen one, the qualifications and duties of that role belonging to this chapter's account of the nominated representative;
- to receive and decide an application, brought by the person, the nominated representative or another interested person, against a decision on admission or treatment made by the medical officer or mental health professional in charge of an establishment;
- to decide applications about the non-disclosure of information to the person, where part of the record has been withheld and the withholding is contested;
- to adjudicate complaints about deficiencies in the care and services an establishment provides; and
- to visit and inspect prisons and jails.

The pattern across these functions matters more than the list. Somewhere in the Act a person is given a protection, to plan treatment in advance, to have a chosen person speak for them, to be admitted only on lawful grounds, to see their own record, to be cared for to a standard. Each of those protections is then handed a forum with the power to test it against the facts and to order a remedy. That is what converts the Act's language of rights into something a clinician and an establishment can be held to, and it is why the Board, and not the regulatory Authority, is the body a wronged patient turns to. The inspection of prisons and jails is the one function that reaches beyond the establishment; it anchors the Board's protective eye on persons with mental

illness held in custody, while the substantive psychiatry of prisoners and the report a psychiatrist prepares for a court belong to the Forensic ethics, consent and legal procedure notes and are not taught here.

PITFALL

The Board is neither the regulator nor a general grievance desk. Registering establishments and setting service standards sit with the State Mental Health Authority; criminal responsibility and fitness to stand trial sit with the courts. The Board's jurisdiction is the Act's own rights machinery - directives, representatives, admission and discharge, disclosure and standards of care - and a clinician who takes a registration question or a criminal-forensic question to the Board has picked the wrong body and lost time that a patient may not have. A rights complaint about care deficiencies is not automatically misdirected at the Authority either: it follows its own ladder, first to the establishment's medical officer or mental health professional, then to the Board, and only to the State Authority if the complainant remains dissatisfied with the Board's response.

8.5 Orders and enforcement: the Board's teeth

Because the Board adjudicates, it works by application and hearing, and an adjudicator without a sanction is only a suggestion box. The Act does not leave it there. Where a mental health establishment does not comply with the orders or directions of the Authority or the Board, or wilfully neglects them, the Authority or the Board, as the case may be, *may* impose a penalty which *may* extend up to **five lakh rupees** on the establishment. Cancellation of registration is a narrower power: only the Authority may cancel it, acting on its own or on the Board's recommendation, and only after giving the establishment an opportunity to be heard. Every element of that sentence is examinable and each can be dismantled in a stem.

Learn the structure element by element. The trigger is non-compliance with, or wilful neglect of, an order, not any breach at all. The response is discretionary, expressed as a permissive *may* and not a mandatory *shall*, so a script that makes the penalty automatic has overstated the law; this is exactly the modal error that turns a discretionary power into an invented duty. The monetary sanction is capped and not fixed, so the words up to are doing real work and the body is not obliged to levy the maximum. And cancellation of registration is gated behind a hearing, which keeps the enforcement power itself within the discipline of due process. Collapse any one of those - read the discretion as a duty, drop the ceiling, or forget the hearing - and you have described a harsher and different law than the one the Act actually writes.

8.6 The Board in day-to-day practice

Where the treating psychiatrist meets the Board. For the clinician the Board is not an abstraction. It is the body that can be asked to review a decision they have made, and it is also a body a psychiatrist may sit on, so the specialty stands on both sides of the process. When you admit a person on an involuntary, supported basis, that decision is reviewable by the Board on an application from the person, their nominated representative or another interested person, and the quality of your documentation is precisely what will be scrutinised if the decision is challenged. The Board decides on the record that exists, and a decision that was clinically sound

but poorly recorded is hard to defend once it reaches the bench. The same forum is where a contested advance instruction, or a dispute over who should act as a person's representative, is finally resolved, so the Board runs through a great deal of routine practice even when no one is thinking about it.

GOOD TO REMEMBER

If an involuntary admission is likely to be contested, prepare for the Board at the moment you admit, not when the notice arrives. Record the indication, the capacity finding and the less-restrictive alternatives you weighed, and confirm that a nominated representative is identified. Approaching the admission as something you may later have to justify before a judge-led bench, rather than as a purely clinical act, is the single habit that protects both the patient's rights and your own position.

73	74	82
CONSTITUTION OF THE BOARD	COMPOSITION OF THE BOARD	POWERS AND FUNCTIONS

The Mental Health Review Board is the Act's quasi-judicial guardian of the individual patient: constituted by the State Authority on a centrally prescribed template, chaired by a District Judge, a qualified officer of the State judicial service, or a retired District Judge, presiding over a mixed bench of administrative, clinical and lived-experience members, and empowered to hold advance directives, appoint nominated representatives, review involuntary care and enforce its orders by penalty.

9 · Central and State Mental Health Authorities

A statute of rights needs an office to enforce it. The Mental Healthcare Act sets out an ambitious charter - a capacity-based test for treatment decisions, advance directives, admission safeguards and a right to community living - but a charter on paper is only as strong as the administrative body that registers the services meant to deliver it, writes their standards and inspects them. The Act supplies that body in a deliberately two-tier form: a **Central Mental Health Authority** for the Union and a **State Mental Health Authority** in every State. Between them they are the regulatory and administrative spine of the Act, the machinery through which registration, quality norms, supervision, the workforce registers and training are actually delivered.

Marks cluster here for a reason the topic makes plain once you see its shape. There is a mandatory establishment duty with a fixed time-limit; a composition set by statute that seats particular officers and senior professionals, and deliberately seats service users too; a closed list of statutory functions; and, most examinable of all, a clean federal division of registration between the two tiers. None of it is discretionary decoration. The Authority is where the Act's principles are turned into an inspected, registered, standard-bearing system, and a candidate who can separate what the Central body does from what each State body does, and both from the case-by-case work that belongs to another body, has the topic in hand.

9.1 Where the Authorities sit: the regulator, not the adjudicator

The Act creates two quite different kinds of body and it is essential not to blur them. The Central and State Authorities are primarily administrative and regulatory: they register establishments, write the norms those establishments must meet, supervise them, hold the registers of the workforce, and train and advise. The case-by-case, quasi-judicial function - examining whether a particular admission is lawful, reviewing an advance directive, hearing a person's application against a decision made about him - belongs to the Mental Health Review Board, a separate body constituted under the Act and treated in its own right elsewhere in this chapter. That division is not absolute both ways, though: a rights complaint about deficiencies in care can escalate from the Board to the State Authority as the final statutory tier where the complainant remains dissatisfied, and both Authorities also carry their own power to inspect, inquire into and act on rights violations. The Authority builds and polices the system and stands as the last statutory word on a dissatisfied complaint; the Board adjudicates the individual case within it.

The second organising idea is federal. Public health is principally a State subject, but mental-health legislation also draws on the Concurrent List, which is why both the Union and the States can legislate here, and the Act reflects that by mirroring its structure at two levels rather than centralising it. The Central Authority governs the services under the Union's control; each State Authority governs the services within its State. The two are built on the same template - an establishment duty, a fixed composition, a list of functions - so the efficient way to learn them is as one design instantiated twice, with the differences (who chairs, who sits, and above all who registers what) as the examinable delta.

RULE **The Authorities regulate the system; the Review Board adjudicates the individual case.** Registration, norms, supervision, the workforce registers, training and advice are the Authorities' work; deciding whether a particular admission or advance directive is lawful is the Board's. Sort any question first by asking whether it concerns the standing of a service or the standing of one patient's decision, and the right body follows.

TRAP **Naming the Authority where the answer is the Review Board, or the reverse.** Registering a nursing home, framing service norms or maintaining a register of clinical psychologists is Authority territory; reviewing an involuntary admission, examining an advance directive or hearing a patient's application is the Board's. Both are created by the same Act, and under time pressure candidates swap them. State which function is in play and the body chooses itself.

9.2 The Central Mental Health Authority: the establishment duty (section 33)

The Act does not merely permit a Central Authority; it commands one. The Central Government shall, within **nine months** of the Act receiving the assent of the President, by notification establish the Central Authority for the purposes of the Act. Read the modal verb with care, because it is the kind of distinction the whole chapter turns on: the provision says the Government *shall* establish, not that it *may*. This is a positive statutory obligation carrying a fixed outer time-limit, not a discretionary power the executive is free to leave unused.

Two phrases in the provision do quiet work. "By notification" tells you how the body comes into legal existence - it is constituted on publication in the official gazette, not by mere executive

intention - and "for the purposes of this Act" fixes its remit to the Act's own scheme rather than to mental health administration at large. The point to carry is that the existence of the regulator is itself a legal duty with a clock on it. An Act that created rights but left their enforcement machinery optional would be hollow; by making the Authority mandatory and time-bound, the statute guarantees that the body responsible for registering and standardising services must exist, and must exist promptly.

9.3 Composition of the Central Authority (section 34)

Who sits on the Authority is fixed by statute, not left to the Government to compose at will. It is chaired **ex officio** by the Secretary or Additional Secretary in the Department of Health and Family Welfare - that is, the chair is held by whoever occupies that administrative post, by virtue of the office rather than by personal nomination. Alongside the chair sit a set of named ex officio members drawn from the relevant arms of government, and then the nominated members who give the body its professional and lay expertise.

The nominated professional members are the part examiners test. They include a **mental health professional**, a psychiatric social worker, a clinical psychologist and a mental health nurse, each required to have at least **fifteen years** of experience in the field. The seniority bar is deliberate: the people writing service norms and supervising establishments are meant to be seasoned practitioners rather than junior appointees. Just as deliberately, the composition reserves places for representatives of persons who have or have had mental illness, of care-givers and of non-governmental organisations. Seating service users and care-givers on the regulator itself is a design choice, not an afterthought - it is the participatory, rights-based logic of the Act made structural, so that the body standardising services is not composed only of officials and clinicians.

33	43	45	55
CENTRAL AUTHORITY ESTABLISHED	CENTRAL AUTHORITY FUNCTIONS	STATE AUTHORITY ESTABLISHED	STATE AUTHORITY FUNCTIONS

9.4 Functions of the Central Authority (section 43)

The Act sets out what the Central Authority shall do as a defined list of duties, and the verb throughout is mandatory. The functions are best held as a small set of roles the body performs across the services under the Union's control:

- register every **mental health establishment** under the control of the Central Government, and maintain a register of all such establishments in the country;
- develop **quality and service provision norms** for the different types of establishment it oversees;
- supervise those establishments and receive complaints about deficiencies in the services they provide;
- maintain a **national register** of clinical psychologists, mental health nurses and psychiatric social workers;
- train all relevant persons - including law-enforcement officials, mental health professionals and other health professionals - in the provisions and implementation of the Act; and

- advise the Central Government on all matters relating to mental healthcare and services.

Two of these deserve emphasis. The registration function makes the Authority the gatekeeper of legitimate practice: an establishment that is not registered is not lawfully operating, and the register the Authority keeps is the country's ledger of recognised services. The workforce register does the same for people - it is the national list of the allied mental-health professions, distinct from the registration of establishments and serving a different purpose. Both are national in scope, because the Central Authority's job is aggregation and standard-setting across the Union rather than the running of any single facility.

MNEMONIC

TRANS - the regulator's five verbs

The Authority's statutory job is to **T**rain the relevant officials and professionals, **R**egister establishments and keep the workforce register, **A**dvise the Government, set **N**orms of quality and service, and **S**upervise establishments while receiving complaints. Five verbs, one regulator: the letters recover the whole functional remit without adding anything the provision does not itself contain.

GOOD TO REMEMBER

The workforce register is not an abstraction when you build a team. Clinical psychologists, mental health nurses and psychiatric social workers are registered to work as mental health professionals under the Act, and their standing in that role flows from the register. If you are staffing an establishment or referring within a multidisciplinary team, a professional's registration is what places them lawfully in the role the Act recognises.

9.5 The State Mental Health Authority: establishment and composition (sections 45 and 46)

The State tier is built on the same template, and its establishment provision mirrors the Central duty exactly in force. Every State Government shall, within **nine months** of the Act receiving assent, by notification establish a State Authority for the purposes of the Act. Again the verb is *shall*, again there is a fixed window, and again the body is constituted by notification. The obligation lies on every State without exception, so the two-tier system is meant to be complete across the country rather than a Union body with optional State counterparts.

The composition follows the Central pattern with instructive differences. The State Authority is chaired ex officio by the Secretary or Principal Secretary in the State's Department of Health. Its nominated membership again carries senior professionals - a mental health professional, a psychiatric social worker and a clinical psychologist, each with at least **fifteen years** of experience - but it also brings in explicitly clinical and academic weight that examiners like to test. It includes the head of one of the mental hospitals in the State, or the head of the department of psychiatry at a Government medical college, nominated by the State Government, together with one eminent psychiatrist from the State who is not in Government service. Seating both a senior public-sector clinician-administrator and an independent private psychiatrist

anchors the State regulator in the actual service landscape of that State rather than in officialdom alone.

9.6 Functions of the State Authority and the registration split (section 55)

The State Authority's functions parallel the Central body's, and the parallel is exactly where the single most examinable distinction in this topic appears. The State Authority shall register all mental health establishments in the State, and here the operative word is *except*: it registers all establishments in the State except those that fall under the Central Authority's registration mandate, and it shall maintain and publish a register of them, including online. It shall likewise develop quality and service norms, supervise establishments and receive complaints, register clinical psychologists, mental health nurses and psychiatric social workers within the State to work as mental health professionals, and train the relevant officials and professionals.

The registration split is the high-yield line. Put the two registration functions side by side and the federal logic is exact. The Central Authority registers the establishments under the control of the Central Government; each State Authority registers everything else within its borders. There is no overlap and no gap - a given establishment is registered by one Authority or the other, decided by whether it is centrally controlled. The State register carries the added statutory feature of being published, including online, which turns it into a public instrument a patient or family can in principle consult rather than an internal list.

AXIS	CENTRAL AUTHORITY	STATE AUTHORITY
Who must establish it	The Central Government	Every State Government
Establishment duty	Mandatory, within a fixed window from assent	Mandatory, within the same window
Chairperson (ex officio)	Secretary or Additional Secretary, Department of Health and Family Welfare	Secretary or Principal Secretary, State Department of Health
Distinctive members	Senior professional members; representatives of persons with mental illness, of care-givers and of non-governmental organisations	Head of a State mental hospital or of psychiatry at a Government medical college; one eminent non-Government psychiatrist; senior professional members
Which establishments it registers	Those under the control of the Central Government	All other establishments in the State
Register of establishments	A national register of all establishments in the country	A State register, maintained and published (including online)
Register of professionals	Maintains the national register of clinical psychologists, mental health nurses and psychiatric social workers	Registers those professionals within the State

IN INDIA

The practical effect is that no mental health establishment operates lawfully without being registered by the appropriate Authority, and the State register is a published document, available online, rather than a closed file. For a patient or family this is a real safeguard: the recognised services in a State can be identified, and a complaint about deficiencies in a service has a defined statutory destination rather than nowhere to go. For the professions, the workforce registers give the allied mental-health disciplines a formal national footing.

PITFALL

A clinician opening a private psychiatric facility who assumes the Central Authority is the body to register with has misread the split. Unless the establishment is under the control of the Central Government, it is the State Authority that registers it. Taking the application to the wrong tier wastes time and, worse, can leave a service running unregistered in the belief that it has complied. Match the establishment to the Authority by asking one question first: is this a centrally controlled establishment or not?

Both Authorities are mandatory statutory bodies that must be established within a fixed window of assent; the Central Authority registers establishments under Central-Government control while every State Authority registers all other establishments in its State, and both are regulators, distinct from the quasi-judicial Review Board.

10 · Decriminalization of suicide under MHCA Section 115

This is where the law stops treating a survived suicide attempt as a crime and starts treating it as a medical emergency. A person who lives through an attempt on their own life reaches casualty in one of the most fragile states medicine ever encounters, and the older question of whether that same person is also a criminal defendant sat awkwardly on top of the clinical crisis for most of the last century. Section **115** of the Mental Healthcare Act settles that question by statute. It does not merely voice a sentiment about compassion; it lays down a rule of evidence and a public obligation, and the examiner wants that rule stated precisely, with its correct scope and its correct verbs.



Fig 25.7 Section 115 of the Mental Healthcare Act presumes severe stress after a suicide attempt, protects the person from trial and punishment subject to the statutory rule, and places a duty on government to provide care, treatment and rehabilitation. It does not create a right to die.

The marks here are easy to shed because the provision is routinely over-stated. Candidates say the Act legalised suicide, or that the Act itself repealed the offence, and both are wrong. What the section actually does is narrower and more careful: it presumes a mental state, it bars trial and punishment, and it lays a duty of care, all without itself deleting a word of the older criminal law. That older offence, the attempt to commit suicide once punishable under Section **309** of the Indian Penal Code, is the historical provision the section is drafted around; the section decriminalises by presumption and bar rather than by repeal, and the later fate of that older Code is a separate matter taken up at the end of this topic. Holding that distinction is the whole of the question.

115	**309**	**226**
MENTAL HEALTHCARE ACT SECTION, THE OPERATIVE LAW	FORMER PENAL CODE OFFENCE, REPEALED 2024	BHARATIYA NYAYA SANHITA SECTION, THE ONLY CURRENT OFFENCE

10.1 Decriminalisation is not repeal

The single most important idea in this topic is a distinction between two things that sound alike and are not. **Decriminalisation** removes the criminal consequence that would otherwise attach to an act while leaving the underlying prohibition where it stands; **repeal** strikes the prohibition out of the law altogether. The section achieves the first and not the second. It works through a **notwithstanding clause**: the presumption and the bar on trial and punishment operate notwithstanding the older Penal Code offence, which is the legislative device for making a new rule prevail over an existing one without repealing that existing one. At the time the section was enacted the older offence therefore stayed on the book, its operation merely displaced, while a person who had attempted suicide was lifted out of its reach by the presumption the section erects around them.

The reason this matters beyond pedantry is that scope follows from it. Because the section works by decriminalising one specific act and not by rewriting the criminal law wholesale, it reaches exactly as far as its own words carry it, and no further. It lifts the person who has attempted suicide out of trial and punishment; it says nothing about anyone else and nothing about any neighbouring offence. A candidate who reads the reform as a sweeping repeal has, without noticing, claimed that everything the old law touched has fallen away, which both over-states the section and is the source of the classic scope errors examined later in this topic.

RULE **The section decriminalises the attempt; the section itself does not repeal the offence.** A rebuttable presumption and a statutory bar lift the person who has attempted suicide out of trial and punishment, operating notwithstanding the older Penal Code provision rather than striking it out. Reading the section itself as a repeal over-states what it does and misplaces its limits.

10.2 The presumption of severe stress

The first working part of the section is a presumption, and its wording is exact. Any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have **severe stress**, and shall not be tried and punished under the Indian Penal Code. Two features of that sentence carry the marks. First, the verb is mandatory: the person shall be presumed to be under severe stress, and shall not be tried and punished. This is not a discretion the court may exercise; it is a default the law imposes. Second, the presumption is a **rebuttable presumption**, signalled by the words unless proved otherwise. The law starts from the position that the attempt sprang from severe stress, but it leaves open the possibility that this can be displaced by proof to the contrary.

Understanding what a rebuttable presumption does to the burden of proof is what separates a precise answer from a vague one. Ordinarily the person invoking a defence must establish it. Here the statute flips the starting point: severe stress is assumed, so the effort of showing that it was absent falls on whoever wishes to argue that the person should nonetheless be tried. In practical terms this makes trial and punishment the exception rather than the rule, because the ordinary case is presumed into the protected category and stays there unless someone affirmatively proves otherwise. The legislature chose a presumption rather than a blanket, unconditional immunity for a reason: a presumption defaults every survivor into care while preserving a narrow

evidentiary route for the genuinely unusual case, without ever requiring the distressed person to prove their own distress.

One further nuance repays attention. What the section presumes is severe stress, not a diagnosed mental illness. The protection does not wait on a psychiatric label and is not confined to those who can be shown to be mentally ill; a person overwhelmed by circumstance who attempts suicide is presumed into the same protected position as one whose attempt arose from a formal disorder. This keeps the reform broad at the point where it matters, the moment of contact after an attempt, and it is why the section is drafted around stress rather than around illness. The clinician's later judgement about whether a mental illness is present shapes the care that follows, but it does not gate the presumption that shields the person from trial and punishment.

10.3 The duty to provide care, treatment and rehabilitation

The presumption is only half of the section, and a candidate who stops there has answered half the question. The second working part is an affirmative obligation. The **appropriate Government** shall have a duty to provide care, treatment and rehabilitation to a person who has severe stress and has attempted to commit suicide, so as to reduce the risk of recurrence of the attempt. Again the verb is mandatory: this is a duty the Government shall discharge, not a service it may choose to offer. Where the first part shields the person from the criminal process, the second part turns the State toward them, converting the removal of punishment into a positive commitment of care.

The triad the duty names is worth taking apart, because each word points somewhere different in time:

- **Care** is the immediate response, the safe holding and attention the person needs in the acute aftermath of the attempt.
- **Treatment** is the address of whatever underlies the severe stress, whether a mental illness, a crisis of circumstance, or both.
- **Rehabilitation** is the forward-looking limb, the work of restoring the person to a life in which the risk that brought them to the attempt is reduced.

The stated purpose of the duty, to reduce the risk of recurrence, is what ties the triad together and gives the reform its public-health character. The section is not content simply to decline to punish; it reframes a suicide attempt as an event that generates an obligation on the State to intervene therapeutically, precisely because a person who has attempted once carries a raised risk of attempting again. The presumption and the duty are therefore not two unrelated clauses that happen to share a section; they are the negative and positive faces of a single decision to move the survivor of an attempt from the criminal justice system into the care system.

MNEMONIC

Presume, do not try, then provide

The section in three moves. **Presume** severe stress in the person who has attempted suicide; **do not try** - they shall not be tried and punished under the Indian Penal Code; **then provide** - the appropriate Government shall have a duty to give care, treatment and rehabilitation to cut the risk of a repeat attempt.

AXIS	FIRST LIMB - THE PRESUMPTION	SECOND LIMB - THE DUTY
WHAT TRIGGERS IT	An attempt to commit suicide by the person	A person with severe stress who has attempted suicide
STATUTORY VERB	Shall be presumed; shall not be tried and punished	Shall have a duty to provide
NATURE OF THE RULE	A rebuttable presumption of severe stress, displaceable only by proof otherwise	A mandatory obligation, not a discretionary service
WHO IS ACTED ON	The person, who is lifted out of the criminal process	The appropriate Government, on whom the obligation falls
PURPOSE	To remove criminal liability and reframe the attempt as a mental-health event	To provide care, treatment and rehabilitation and reduce the risk of recurrence

10.4 What the section does not reach

Because the reform is so easy to over-read, the examinable core is as much about the section's limits as its content. It decriminalises the attempt by the person, and that is the boundary of what it does. It does not license **assisted dying**: the section speaks to someone who has survived an attempt on their own life, not to any right to be helped to end that life, which is a wholly separate legal and ethical question the section neither raises nor answers. Nor does it disturb the offence of **abetment of suicide**, which remains a distinct crime directed at the person who instigates or aids another's death; the protection runs to the one who attempted, not to a third party who drove them to it.

Stated as the three things the section does not do:

- It does not, by itself, repeal the older attempt-to-suicide offence; it works by presumption and bar, operating notwithstanding that offence rather than striking it out.
- It does not license assisted dying or create any right to be helped to die.
- It does not decriminalise the abetment of suicide, which remains a separate and live offence.

TRAP **The section did not itself repeal the older attempt-to-suicide offence, and it did not legalise suicide across the board.** The commonest examination error is to write that the Act struck out the attempt-to-suicide offence, or that suicide is now lawful. Neither is true of what the section does: a rebuttable presumption bars trial and punishment of the person who attempted, the section operates notwithstanding the older offence rather than deleting it, and abetment of suicide remains a crime. Collapsing a conditional presumption into a blanket repeal loses the mark every time.

PITFALL

Quoting the presumption as though it were absolute. Clinicians and candidates alike drop the words unless proved otherwise and describe the section as an unconditional immunity, so that no attempt could ever be tried and punished. The presumption is rebuttable, its protection is confined to the person who attempted, and it leaves assisted dying and abetment untouched. Stating a presumption without its condition is the same class of error as stating a statutory immunity without its conditions, and both are penalised.

The section raises a rebuttable presumption of severe stress that bars the trial and punishment of the person who attempted suicide, and it lays a mandatory duty on the appropriate Government to provide care, treatment and rehabilitation to reduce recurrence; it decriminalises the attempt by presumption and bar, working notwithstanding the older Penal Code offence rather than by repealing it.

10.5 Receiving the survivor: the clinical frame

The value of the section for a working psychiatrist is that it converts a legal principle into a default posture at the bedside. When a patient arrives after an attempt, the law has already decided, in advance and in mandatory terms, that this is a person under severe stress to be cared for, not a suspect to be processed. The clinician's task is therefore squarely medical: assess the mental state, stabilise the acute risk, identify and treat what underlies the stress, and plan for the follow-through that the rehabilitation limb contemplates. Documentation of that assessment and plan is what demonstrates that the survivor was received into the care pathway the section builds, rather than diverted into a criminal one.

Two practical points follow. First, the reflex of treating every self-harm presentation as a police matter is displaced by the section: the default is clinical care, and the record should show the mental-state assessment and the safety plan that the care pathway calls for. Second, the presumption does not dilute the clinician's own duties of assessment and risk management; if anything it sharpens them, because the person is now unambiguously a patient owed care rather than a suspect to be handed on. The section changes the frame of the encounter, not the standard of the clinical work carried out within it.

IN INDIA

Before this Act, an attempt to commit suicide was itself prosecutable under the Indian Penal Code, so a survivor could in principle be treated as an offender rather than a patient - a position long criticised as compounding distress with the threat of a criminal record. The Mental Healthcare Act reversed that default nationally, moving the survivor of an attempt from the criminal frame into a statutory presumption of severe stress backed by a Government duty of care. The everyday working knowledge that protects a patient is the simple version: the person who has attempted is presumed to be under severe stress, is not to be tried and punished, and is owed care by the State.

GOOD TO REMEMBER

On the ward, the section means the police station is not the first stop for a survivor of an attempt. Frame the encounter as an emergency, treat and document accordingly, and remember that the presumption protects the patient and the abetment law protects against those who might have driven them there - the two are not in tension. Where a case genuinely looks unusual, the burden of displacing the presumption is not yours to discharge and not the patient's to answer.

10.6 Currency, controversy and the limits of the reform

The reform is real but partial, and the exam rewards seeing both. The controversy the section itself raises is the gap between decriminalisation and repeal. When it was enacted the section decriminalised the attempt without repealing Section **309** of the Indian Penal Code; the presumption operated notwithstanding that offence, so the older crime stayed on the book but inoperative for the survivor, and commentators noted that a fuller reform would have removed it outright rather than papering over it with a presumption. The words unless proved otherwise were read by some as a residual doorway, since a presumption that can in theory be rebutted is not the same as an offence that cannot be charged at all.

The second live question is enforceability of the duty. A mandatory obligation on the appropriate Government to provide care, treatment and rehabilitation is only as strong as the services that actually exist to discharge it, and a duty framed in a statute does not by itself build the crisis care and follow-up capacity a survivor needs; the reform's ambition on the care side outruns the machinery available to deliver it. The currency point that now settles cleanly is the fate of the older offence. The Indian Penal Code was repealed and replaced in its entirety by the Bharatiya Nyaya Sanhita, 2023, in force from **1 July 2024**, so the provision the section is drafted around is no longer live law for conduct occurring on or after that date; the section's own text still refers to it, but a textual cross-reference does not keep a repealed offence in force. That repeal is not absolute for what came before it: the Bharatiya Nyaya Sanhita carries its own repeal-and-savings clause, preserving the Penal Code's previous operation, any liability or punishment already incurred under it, and any investigation or proceeding begun under it, to be continued as if the Code had not been repealed, so an attempt committed before that commencement date remains governed by the saved older position read together with this section's presumption and bar, and the law is not silent for that period. The new code did not carry over a general offence of attempting suicide. For conduct on or after that same commencement date, the only criminal

provision that now reaches an attempt is the narrow Section **226** of the Bharatiya Nyaya Sanhita, confined to the person who attempts suicide with the intent to compel or restrain a public servant from discharging his official duty, punishable with simple imprisonment which may extend to one year, or fine, or both, or community service. For the ordinary survivor of an attempt nothing in that provision applies, and the section's presumption and Government duty of care stand as the operative law. What the section itself decides is unambiguous, and that is what the answer should assert without hedging: a presumption of severe stress, a bar on the trial and punishment of the person who attempted, and a mandatory Government duty of care.

11 · Prohibited and restricted procedures (ECT, psychosurgery, restraint, seclusion)

Why the marks are here. The Mental Healthcare Act does not only decide who may be admitted and treated; it draws a hard perimeter around HOW a person with mental illness may be treated, naming a small set of interventions that are either forbidden outright or permitted only through a defined statutory gate. Examiners return to this perimeter because it is where a single modal verb settles the law. A procedure that "shall not" be done is not the same thing as one that "may only" be done on conditions, and a candidate who blurs the two has misread the Act rather than merely forgotten a detail. The territory is narrow, and the marks reward precision rather than breadth.

The scheme lives in a short, consecutive run of provisions. One lists the procedures the Act prohibits, one restricts a single neurosurgical treatment, and one governs the everyday coercive measures of restraint and seclusion. The examinable point is almost always the BOUNDARY between the categories rather than the content of any one rule, so it pays to learn the categories first and hang the detail on them. Read this topic as a small system of law, not as a list of facts to be recited.

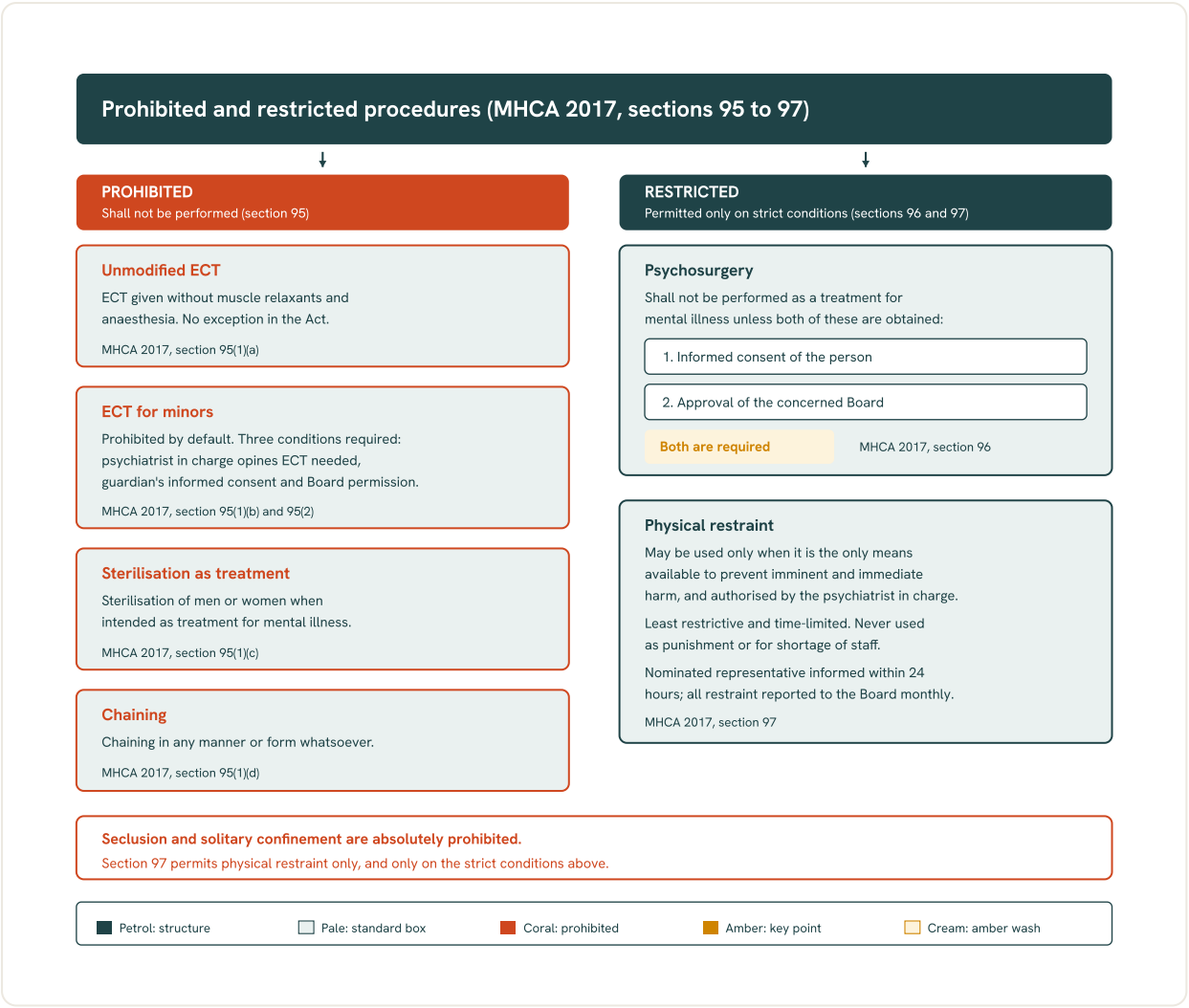


Fig 25.8. The Mental Healthcare Act 2017 separates absolutely prohibited procedures (section 95) from procedures permitted only on strict conditions (sections 96 and 97). Unmodified ECT has no exception, while ECT for minors, psychosurgery and physical restraint each pass only through a defined statutory gate, and seclusion stays barred outright.

11.1 Prohibited versus restricted: the architecture

The Act sorts controlled interventions into two families that must never be run together. A **prohibited procedure** is barred: the statute says it shall not be performed, and the only softening it permits is a single exception written into the statute itself. A **restricted procedure** is lawful, but conditionally: it shall not be performed UNLESS defined requirements of consent and authorisation have first been met. The difference is one of kind, not of degree. A prohibition is a closed door with, at most, one named key; a restriction is an open door with a lock on it, and the whole of the analysis is deciding which door you are standing at.

This architecture is not arbitrary drafting. It follows from the governing idea of the Act, that a person with mental illness keeps the ordinary rights of dignity and bodily integrity, and that any intrusion on those rights must be justified, minimised and supervised by someone outside the treating team. The interventions the Act singles out are procedures with recognised risks of coercion and misuse: given without anaesthesia, imposed on children, used to sterilise, or reached for when a ward is short of staff. Naming them in primary legislation, rather than leaving them to

professional custom, converts a matter of clinical etiquette into a matter of enforceable law that a statutory Board can review after the fact.

RULE **The category fixes the modal, and the modal fixes the law.** A prohibited procedure carries a "shall not": it is barred, and any relief comes only from an exception the statute writes for itself. A restricted procedure carries a "shall not ... unless": it is permitted, but only once the conditions of consent and Board authorisation are satisfied. Deciding which category a procedure belongs to is therefore the whole task, because the operative rule falls straight out of the category.

The accompanying table maps each controlled intervention to its category, its operative modal and the lawful route, if any, that reopens it. Read down the modal column first, because it is the fastest way to see why the same word, ECT, can name both an absolute prohibition and a conditionally permitted treatment.

PROCEDURE	CATEGORY	OPERATIVE RULE AND MODAL	LAWFUL ROUTE, IF ANY
UNMODIFIED ECT, WITHOUT MUSCLE RELAXANTS AND ANAESTHESIA	Prohibited	Shall not be performed	None
ECT FOR A MINOR	Prohibited by default	Shall not be performed	Guardian's informed consent and the Board's prior permission
STERILISATION INTENDED AS TREATMENT FOR MENTAL ILLNESS	Prohibited	Shall not be performed	None, as a treatment for mental illness
CHAINING, IN ANY MANNER OR FORM	Prohibited	Shall not be performed	None
PSYCHOSURGERY	Restricted	Shall not be performed unless conditions met	Person's informed consent and the Board's approval
SECLUSION OR SOLITARY CONFINEMENT	Prohibited	Shall not be imposed	None
PHYSICAL RESTRAINT	Restricted, conditional	May only be used when necessary and authorised	Only means to prevent imminent, immediate harm, authorised by the psychiatrist in charge

11.2 The prohibited procedures

The prohibitions are gathered in section **95**, which opens with a non-obstante clause and then states that the listed treatments shall not be performed on any person with mental illness. The non-obstante wording is doing real work: it makes this rule prevail over everything else in the same Act, so no other machinery, not an emergency, not a substitute decision-maker, not an advance instruction, can be used to authorise what the section forbids. Four interventions sit on the list:

- **unmodified electroconvulsive therapy**, meaning ECT given without the use of muscle relaxants and anaesthesia;
- electroconvulsive therapy performed on a minor;
- **sterilisation** of a man or a woman, where it is intended as a treatment for mental illness;
- **chaining** in any manner or form whatsoever.

Two features of the drafting repay attention. The bar on the unmodified technique is the statutory root of the working rule that ECT may be given in modified form only; the Act does not merely discourage unmodified ECT, it forbids it, and, unlike the position for a minor, it attaches no exception of any kind. Sterilisation, by contrast, is caught specifically when it is intended as a treatment for the mental illness itself, which is the historical eugenic use the clause is written against; it says nothing about surgery undertaken for unrelated reasons, on ordinary consent, in a person who happens to have a mental illness. Reading that qualifier out of the clause is a common way to overstate it.

The technique of ECT itself, its electrode placement, stimulus dosing, seizure threshold and mechanism, belongs to **the ECT and neurostimulation notes**; here the Act speaks only to whether, and on whom, the procedure may lawfully be performed at all. The full consent procedure and eligibility rules for ECT, including the modified-only requirement as an operating standard, are developed where this chapter sets out the Act's ECT provisions. This section fixes only the placement of ECT within the prohibited-and-restricted scheme, and no more.

IN INDIA

The explicit bar on chaining a person in any manner or form is not a theoretical clause. It responds to documented reports of persons with mental illness being chained in Indian homes, custodial settings and faith-healing establishments; how widespread or prolonged the practice was is not itself something section **95** establishes. By naming the practice in primary legislation and placing it among the treatments that shall not be performed, the Act converts what had been tolerated as a family or community coping measure into an unlawful act, and hands inspecting authorities a bright line rather than a matter of degree to argue over.

MNEMONIC

The prohibition list: Unmodified ECT, Minor's ECT, Sterilisation, Chaining

These are the treatments the prohibited-procedures section forbids by default, in the order the Act lists them. The first admits no exception, and neither does the last; a minor's ECT alone reopens, through the proviso that follows, and sterilisation is caught only where it is meant as a treatment for the mental illness itself. If you can rebuild the list, you can rebuild the section.

11.3 The single conditional exception

One item on the prohibition list, and one only, is reopened by the Act. Electroconvulsive therapy for a minor is barred by default, but a proviso to the same section provides that, where the psychiatrist in charge of the minor's treatment is of the opinion that it is required, the treatment

shall be done with the informed consent of the guardian and the prior permission of the concerned Board. The consequence for the taxonomy is the point to carry away here: this is not a flat prohibition like the others but a prohibition with a single, fully conditioned gate, which is exactly why it must be read alongside its proviso and never quoted as an outright ban.

The mechanics of that gate, how the guardian's consent is taken, what the Board must weigh, and the requirement that its permission come before rather than after the treatment, are the province of this chapter's ECT-provisions material, which owns the consent-and-eligibility rules in full; they are named here only to place the exception inside the prohibited category. What this section contributes is the discrimination itself: an absolute bar admits no consent, a conditionally reopened bar admits a defined one, and the two ECT rules sit on opposite sides of that line even though they share a name. A candidate who carries "ECT is prohibited under the Act" as a single fact has flattened two different rules into one.

11.4 The restricted procedure: psychosurgery

Psychosurgery is handled separately, in section **96**, and it is the cleanest example the Act gives of a restricted procedure. **Psychosurgery** shall not be performed as a treatment for mental illness UNLESS two requirements have both been obtained: the informed consent of the person on whom the surgery is to be performed, AND the approval of the concerned Board. The conditions are conjunctive. The patient's consent does not stand in for the Board's approval, and the Board's approval does not stand in for the patient's consent; each is necessary and neither is sufficient alone. That is precisely what makes this a restriction and not a prohibition: the door is open, but it carries two locks and both must be turned.

The scope of the provision is a favourite trap, and it is worth stating flatly. The psychosurgery restriction governs psychosurgery, and psychosurgery only. It does not reach ECT, and there is no separate "ECT machinery" hiding inside it: every ECT rule lives in the prohibited-procedures section and its minor-treatment proviso, not here. A candidate who files ECT under the psychosurgery restriction, or who imports the psychosurgery consent conditions into the ECT analysis, has crossed a boundary the Act keeps deliberately sharp. The two provisions are neighbours in the statute and strangers in their content.

The contrast with the prohibited category is the deeper teaching point. Psychosurgery is not forbidden; a person who retains the capacity to consent may lawfully undergo it, provided the Board agrees. The informed consent the section demands is meaningful only in a person with the capacity to give it, a standard the Act defines where this chapter treats capacity to make treatment decisions, and which is presupposed rather than restated here. That is the whole logic of a restricted category: the Act judges the procedure too grave to leave to consent alone, but not so grave as to bar it outright, and so it inserts an independent gatekeeper between the clinician's proposal and the operating table.

11.5 Restraint and seclusion

The last provision, section **97**, governs the two coercive measures a ward reaches for in an emergency, and it treats them very differently. **Seclusion** and solitary confinement are prohibited

outright: a person with mental illness shall not be subjected to them, with no gate at all. **Physical restraint** is not banned but tightly restricted; it may only be used when it is the only means available to prevent imminent and immediate harm to the person or to others, AND when it is authorised by the psychiatrist in charge of that person's treatment. The modal split is the heart of the section, and it is asymmetric on purpose: seclusion attracts a flat "shall not", while restraint attracts a "may only ... when". Both conditions on restraint, the necessity test and the authorisation, are cumulative; neither alone will do.

Restraint, once permitted, is then hedged by a set of continuing duties that make it an accountable act rather than a clinical convenience:

- it shall not continue for any period longer than is absolutely necessary to prevent the immediate risk of significant harm, and it shall never be used as a punishment or a deterrent, nor reached for merely because the establishment is short of staff;
- the nominated representative shall be informed of every instance within **twenty-four hours**, and every instance shall be included in the establishment's report to the concerned Board on a monthly basis.

Read together, these duties describe restraint as something that must be necessary, proportionate, authorised in a named clinician's own judgement, time-limited to the actual risk, purpose-limited, disclosed promptly to the person's own safeguarder, and audited from outside. The nominated representative named in these duties is the person appointed under the Act to protect the patient's interests; that office is set out where this chapter treats the nominated representative, and is only invoked here rather than defined. The point that examiners press is that the duties survive the emergency: a restraint that was clinically defensible at the moment it began is still a breach of the section if it outlasts the risk, or goes unrecorded, or is never notified.

The clinical craft of managing the violent or highly aroused patient, the graded response of de-escalation, offered medication, rapid tranquillisation and the longer-term plan, is taken up where this chapter addresses the management of the high-risk patient. That clinical decision, however, is bounded at every step by this section. A restraint that is clinically reasonable but exceeds the statutory limits is still unlawful, and seclusion is not available as a de-escalation option at all, however tempting a quiet locked room may look on a stretched ward.

TRAP **Treating restraint and seclusion as one regime, or reversing which of them is barred.** The section does not restrict the two equally. Seclusion and solitary confinement are prohibited outright, while physical restraint is conditionally permitted. A candidate who writes that "restraint and seclusion may be used in an emergency" has merged a flat prohibition with a conditional permission and stated the law of neither correctly. Answer them apart: seclusion is out, restraint is in on conditions.

GOOD TO REMEMBER

For every episode of physical restraint, run the same discipline downstream. Authorise it in your own name as the psychiatrist in charge, stop it the moment the immediate risk has passed, tell the nominated representative within the statutory window, and enter it in the monthly return to the Board. Build these into a standing ward protocol rather than trusting memory in a crisis, because the commonest failures are not of judgement at the bedside but of the notification and reporting duties afterwards. A restraint that was defensible but undocumented is, on the section's own terms, still a breach.

PITFALL

The commonest ward-level error is to treat seclusion as a milder, more respectable step than restraint, a quiet side-room rather than hands on a patient, and to use it as routine behavioural management. The Act does the opposite: it permits physical restraint under tight conditions but prohibits seclusion and solitary confinement outright, with no gate at all. Reaching for a locked room to avoid "restraining" a patient is therefore not the safer choice but the unlawful one, and it is exactly the kind of practice a Board review is designed to surface.

11.6 Reading the perimeter: modal verbs, currency and scope

Where candidates lose the mark. Almost every error on this topic is one of three kinds, and all three come from reading the statute loosely rather than exactly. The first is a modal error: softening a "shall not" into a "may not", or hardening a "may only" into a flat permission. A discretionary power and a mandatory duty are different laws, and the Act chooses its verbs deliberately; the difference between seclusion's "shall not" and restraint's "may only" is the difference between a bar and a licence. The second is a category error: collapsing the prohibited and restricted families into one, so that psychosurgery is misremembered as banned or unmodified ECT as merely restricted. The third is a scope error: reading the psychosurgery restriction as though it covered ECT, or treating seclusion as a permitted lesser form of restraint.

A word on currency, because that is where the real-world pitfalls cluster. These are provisions of the current Act. Any comparison with how the earlier mental health legislation treated unmodified ECT and prolonged institutional restraint is not verified against primary-source grounding here, and should not be quoted as an established statutory contrast. When a viva turns to prohibited and restricted procedures, the safe posture is to name the current provision, state its modal verb exactly, and give any exception WITH its conditions rather than as a headline. A gate stated without its conditions earns no marks in the examination, and on a real ward it is a breach waiting to happen.

Prohibited	Restricted	Seclusion	Restraint
BARRED, WITH ONE NAMED EXCEPTION	LAWFUL ON CONSENT AND BOARD APPROVAL	FORBIDDEN OUTRIGHT	ONLY MEANS, THEN AUTHORISED

Prohibited means never, save the single statutory gate for a minor's ECT; restricted means only with the person's informed consent and the Board's authorisation; and seclusion, uniquely, is prohibited outright while physical restraint is merely restricted.

12 · ECT provisions under MHCA (consent, minors, modified ECT)

A short provision that examiners return to again and again. The Mental Healthcare Act does not leave electroconvulsive therapy to clinical judgement alone. It draws two firm lines around the treatment and places both inside its list of prohibited procedures at section **95**: electroconvulsive therapy given without anaesthesia and muscle relaxation shall not be performed at all, and electroconvulsive therapy in a minor shall not be performed either, save under a single, tightly conditioned exception. Almost everything a candidate is asked to say about ECT and the law follows from reading those two rules exactly, in the verbs the statute itself uses.

What this section governs is **consent and eligibility**: who may lawfully receive ECT, in what form, and on whose authority. It does not govern the technique of the treatment, and it does not lay out the full taxonomy of prohibited against restricted procedures, which this chapter treats in its own place. Hold both boundaries from the outset, because the two commonest ways to lose a mark here are to answer a consent question with a fact about how ECT is delivered, and to soften an outright prohibition into a mere restriction. The value of the topic is that it is small, self-contained and unforgiving of loose wording, which is exactly why it rewards precision.

12.1 The provision: two prohibitions and a proviso

The section is headed **prohibited procedures**, and it opens with a non-obstante clause: the treatments it names shall not be performed on any person with mental illness notwithstanding anything else contained in the Act. That opening does real work and is worth pausing on. A non-obstante clause makes the rule that follows prevail over every other provision of the same statute, so no other machinery in the Act - not emergency treatment, not consent given through a substitute decision-maker, not an advance instruction - can be used to authorise something this section forbids. When it says a treatment shall not be performed, it means the treatment cannot be reached by any other route the Act provides.

Two of the procedures it prohibits concern ECT: ECT given without muscle relaxants and anaesthesia, and ECT for minors. The provision lists other prohibited procedures beside these, among them sterilisation intended as a treatment for mental illness and restraint by chaining, but those belong to the wider classification of prohibited and restricted procedures set out elsewhere in this chapter and are named here only to show the company the ECT rules keep. What matters for this topic is the two-layer shape of the section: a first part that prohibits, and a second part that, opening with its own notwithstanding clause, carves a narrow exception for the minor. A candidate must read the two parts together, because the prohibition on ECT in minors is not the whole of the law; the exception in the second part is the other half, and quoting only the first half over-states the ban.

RULE **The Act permits only modified ECT, and prohibits ECT in a minor except under one fully conditioned exception.** Unmodified ECT shall not be performed at all; ECT in a minor shall not be performed either, unless the treating psychiatrist is of the opinion that it is required and it is done with the guardian's informed consent and the Board's prior permission. Everything else on this topic is an elaboration of those two sentences.

Modified	Minors	Guardian	Board
THE ONLY LAWFUL FORM OF ECT	ECT PROHIBITED BY DEFAULT	INFORMED CONSENT REQUIRED	PRIOR PERMISSION REQUIRED

12.2 Modified ECT only

The first ECT rule is the prohibition on **unmodified electroconvulsive therapy**, that is, ECT given without the use of muscle relaxants and anaesthesia. The verb is mandatory and absolute: such treatment shall not be performed. The immediate legal consequence is the point the examiner wants stated plainly. Because the unmodified form is barred, **modified electroconvulsive therapy** - ECT delivered under general anaesthesia with pharmacological muscle relaxation - becomes the only lawful form of the treatment. Reduced to the position it establishes, only modified ECT may be given.

The reason the legislature took this step is not hard to see, and stating it briefly shows the examiner you understand the rule rather than merely reciting it. Unmodified ECT produces a full motor convulsion, with the injury, indignity and fear that attend it; the modification markedly attenuates the motor convulsion and reduces musculoskeletal injury risk, addressing much of what historically made the treatment feared and misused. The Act converts what had been a standard of good practice into a rule of law with no discretion attached to it. There is, in particular, no emergency dispensation from it: however urgent the clinical situation, the section provides no lawful route to ECT without anaesthetic and relaxant cover. A clinician who cannot arrange modified ECT cannot lawfully substitute the unmodified form.

What this section does not cover. How modified ECT is actually delivered - electrode placement, bilateral against unilateral application, stimulus dosing, the seizure threshold and mechanism of action - is the clinical technique of the treatment, and it belongs to **the ECT and neurostimulation notes**, not here. This provision owns the law of consent and eligibility: it tells you that ECT must be modified and by whom it may be consented to, not how to prescribe or administer it. Keeping the consent question and the technique question apart is itself examinable, and conflating them is a common way to drift off the point.

IN INDIA

The Mental Healthcare Act settled the question nationally by making the modified form the only lawful one and the unmodified form a prohibited procedure. How widely unmodified ECT was practised beforehand, and how the Indian position compares with practice elsewhere today, are historical and comparative questions this note does not verify and leaves as a declared gap rather than an asserted fact. What is settled is the law itself: here the rule is not guidance but statute, and the everyday working version is simply that ECT in India means modified ECT.

PITFALL

Treating direct ECT as a permissible fallback when anaesthetic cover is hard to arrange. In resource-limited settings the temptation is to reason that some ECT is better than none and to give it unmodified in an emergency. The Act allows no such reasoning: the prohibition on unmodified ECT is absolute and carries no emergency exception. The lawful response to unavailable anaesthetic support is to arrange it or to defer the treatment, never to fall back on the prohibited form.

12.3 ECT in a minor: prohibited, then conditionally permitted

The second ECT rule is the one most often mis-stated. By default, ECT for a **minor** - a person who has not attained the age of majority, as the Act defines the term - shall not be performed; it sits in the prohibited list alongside unmodified ECT. But the section does not stop there. Its second part opens with its own notwithstanding clause and creates an exception: if, in the opinion of the psychiatrist in charge of the minor's treatment, ECT is required, then such treatment shall be done with the informed consent of the guardian and the prior permission of the concerned Board. The prohibition and the exception are two halves of one rule, and a precise answer states both.

The exception is **cumulative and conditional**: it is not enough to satisfy one of its requirements, and the requirements are not interchangeable. Three conditions must be met together before ECT in a minor becomes lawful:

- the psychiatrist in charge of the minor's treatment must be of the opinion that ECT is required - a clinical-necessity filter that turns on the treating psychiatrist's judgement, not on any clinician's view and not on the family's wish;
- the **guardian** must give **informed consent** - because a minor cannot give valid consent to the treatment, consent is exercised on the minor's behalf by the guardian, and it must be informed rather than merely obtained;
- the **concerned Board** - the Mental Health Review Board with jurisdiction over the case - must grant its permission, and that permission must be prior, sought and given before the treatment is administered rather than ratified afterwards.

Each condition carries a mandatory verb: the treatment shall be done with the guardian's consent and the Board's permission. The word that trips candidates is prior. The Board's role here is a genuine external check placed ahead of the treatment, not a paperwork step completed later, and an ECT course begun in a minor on the strength of guardian consent alone, with the Board approached afterwards or not at all, is unlawful however sound the clinical indication. The design is deliberate: ECT in a developmentally vulnerable minor is a high-stakes decision, so the law layers three different safeguards - a clinical judgement of necessity, a surrogate's informed consent, and an independent authority's prior sanction - and it requires all three to align before the treatment may proceed.

MNEMONIC

Opinion, Guardian, Board

The three cumulative gates for lawful ECT in a minor, in the order the section sets them. **Opinion** - the psychiatrist in charge is of the opinion that ECT is required; **Guardian** - the guardian gives informed consent on the minor's behalf; **Board** - the concerned Board grants prior permission before treatment begins. Miss any one of the three and the treatment is not lawful.

ECT SCENARIO	POSITION UNDER SECTION 95	STATUTORY FORCE
UNMODIFIED ECT, WITHOUT MUSCLE RELAXANTS AND ANAESTHESIA	Shall not be performed; only modified ECT is lawful	Absolute prohibition, no exception
ECT FOR A MINOR, BY DEFAULT	Shall not be performed	Prohibition
ECT FOR A MINOR, WHERE THE TREATING PSYCHIATRIST IS OF THE OPINION IT IS REQUIRED	Shall be done with the guardian's informed consent and the concerned Board's prior permission	Mandatory conditional exception, all conditions cumulative

TRAP **ECT is not absolutely banned in minors, and guardian consent alone does not make it lawful.** The classic error is to write that the Act forbids ECT in minors outright, forgetting the exception; the near-miss error is to remember the exception but to give only the guardian's consent, omitting the Board's permission. Both lose the mark. The lawful route needs the treating psychiatrist's opinion of necessity, the guardian's informed consent and the Board's prior permission, together and in advance.

12.4 Informed consent for ECT generally

Away from these two special rules, ECT is not a law unto itself; it is subject to the ordinary requirement of informed consent that governs any treatment under the Act. General informed consent applies to ECT as it applies to any other intervention, and the practical shape of the consent question follows the person's capacity and status rather than anything peculiar to ECT. For an adult who has the capacity to make the treatment decision, ECT requires that person's own informed consent, freely given on an adequate disclosure of what is proposed. Where the person's capacity is impaired, the Act's answer is support rather than automatic substitution: consent is worked out with the person through the nominated representative, not simply taken over from them.

The capacity standard itself, the ability to make a mental-healthcare treatment decision, is the Act's general test, and this chapter teaches it in its own place with the definition of mental illness and of capacity; ECT does not carry a special test of its own. Likewise the support-based routes the Act provides, the nominated representative and any valid advance directive, are treated elsewhere in this chapter and are named here only to complete the picture. The point to carry away is that the consent question forks by the person in front of you:

- a capacitous adult consents for themselves;

- an adult who lacks that capacity is supported by the nominated representative in reaching a decision rather than routinely bypassed by it: the representative gives consent on the person's behalf only in the narrow case where the person needs near-total support, and even then the person's capacity is kept under frequent review; a valid advance directive guides how the person is to be treated but does not itself supply the consent, and the making and operation of both are set out separately in this chapter;
- a minor is governed by the special exception in the prohibited-procedures section - the treating psychiatrist's opinion, the guardian's informed consent and the Board's prior permission.

Why the Board sits in the loop for a minor but not for an adult. The asymmetry is instructive. A capacitous adult's own consent is treated as sufficient authority for ECT; a minor cannot consent, the guardian's consent is a surrogate rather than the patient's own, and so the law adds an independent authority to check the decision before it is acted on. The Board's prior permission is the safeguard that compensates for the fact that the person receiving the treatment is not the person consenting to it.

> Only modified ECT may be given, because unmodified ECT shall not be performed; ECT in a minor shall not be performed either, unless the treating psychiatrist is of the opinion that it is required and it is done with the guardian's informed consent and the concerned Board's prior permission.

GOOD TO REMEMBER

Before booking ECT for a patient who is a minor, assemble three things and put each in the record: the treating psychiatrist's documented opinion that ECT is required, the guardian's informed consent (put it in writing as good practice, though the Act does not itself prescribe a written form for it), and the concerned Board's prior permission. Because the Board's permission must precede treatment, build the lead time into the plan; it is not a form to be completed after the first session. For an adult, confirm capacity first: where it is present the person consents for themselves, and where it is impaired the nominated representative's task is to support the person's own decision, giving consent on the person's behalf only where the person needs near-total support and with capacity kept under frequent review, guided by any valid advance directive rather than proceeding on the family's say-so alone.

12.5 Prohibited against restricted: keeping the categories apart

A recurring error on this topic is to blur the category the two ECT rules belong to. Both live among the Act's prohibited procedures, the strongest category, in which the treatment either may not be performed at all, as with unmodified ECT, or may not be performed on the class in question except under a defined exception, as with ECT in minors. That is a different and stronger thing than a restricted procedure, where a treatment is permitted but hedged with conditions. The full account of which procedures are prohibited and which are restricted, and the statutory limits on restraint and seclusion, is given elsewhere in this chapter; the reason to raise it

here at all is that the eligibility of ECT cannot be stated correctly without placing it in the prohibited category and not the restricted one.

The discrimination matters clinically as much as verbally. Calling the ECT rules a restriction implies a general permission subject to conditions, which invites the mistake of treating the conditions as procedural hurdles a determined clinician can work around. Calling them what they are, prohibitions - one absolute and one subject to a single narrow exception - keeps the emphasis where the statute puts it: on what may not be done, and on the exact and cumulative conditions under which the one exception opens.

12.6 Currency, controversy and the examination frame

The examinable heart of this topic is verb discipline. A statute is not a gist; it is an exact rule with an exact modal verb. Here the operative verbs are shall not be performed for the two prohibitions, and shall be done with for the conditions of the minor exception, and both are mandatory. Reading a discretionary may where the Act writes a mandatory shall changes the law: it would turn a prohibition into a matter of clinical choice and the minor's safeguards into optional courtesies. State the verbs as they stand and the answer is secure; soften them and it collapses.

Two honest limits belong in a complete answer. First, the age at which a person ceases to be a minor for the purposes of this section, and the separate provision that carries the Act's general requirement of informed consent to treatment, are matters of definition that this topic points to rather than fixes; where a figure or a cross-section is not certain, the disciplined move is to name the provision and not to invent its number. Second, the boundary with the technique of ECT is a boundary of scope, not of importance: electrode placement, dose and mechanism are as clinically weighty as the consent rules, but they are decided in the ECT and neurostimulation notes, and importing them here answers a different question. What this section decides is narrow and firm, and that is what an answer should assert without hedging: modified ECT only, ECT in minors prohibited save under the three cumulative conditions, and general informed consent for everything else.

13 · Comparison of MHCA 2017 with Mental Health Act 1987

Why the marks are here. A recurring short-note and viva task asks you to set the mental health statute a psychiatrist practises under today against the one it displaced. The examiner is not testing whether you can recite two indexes of provisions; the examiner is testing whether you grasp that Indian mental health law changed its philosophy. The **custodial** statute of **1987** existed to regulate institutions and to manage people the law treated as unable to decide for themselves; the statute of **2017** exists to presume capacity and to restore rights. Almost everything that separates the two Acts follows from that single reorientation, and an answer that names the reorientation earns the marks that a list of differences never will.

It helps to read the comparison as a question about what a mental health law is for. The older Act answered: to protect society and the patient by controlling where treatment happens and who may consent on the patient's behalf. The current Act answers: to protect the person's autonomy

and dignity, treating mental illness as a health condition and not as a legal status that strips the person of a voice. Hold those two purposes side by side and the specific provisions, on capacity, on the patient's forward wishes, on who represents them, on self-harm, on treatments of concern, and on who supervises the system, sort themselves into a single pattern rather than a heap of facts to be memorised.

1987	2017
MENTAL HEALTH ACT, REPEALED	MENTAL HEALTHCARE ACT, IN FORCE

13.1 The law that was replaced

To compare fairly you have to be honest about what the earlier Act was, rather than caricaturing it. The Mental Health Act of 1987 is generally described as itself a reform in its time, one that displaced a colonial lunacy law and added procedural safeguards around admission and discharge that its predecessor had lacked. Its organising idea, though, remained custodial: the statute was built around the licensed institution and around **guardianship** and the management of the patient's property. Mental illness, on this model, sat close to a legal status, a condition that removed the person from ordinary decision-making and put the State, the court and the family in the role of custodian.

Three features of that design, as the 1987 Act is generally described, are worth naming, because each is precisely what the later Act would invert. First, the centre of gravity was the establishment: the law's energy went into licensing and inspecting psychiatric hospitals and nursing homes, so that the regulation of places stood in for the empowerment of persons. Second, decisions were routed away from the patient, whether to a guardian appointed through a court-linked process or to the receiving institution. Third, admission and detention were the pivotal legal events, and the person's own account of what they wanted carried little formal weight. The criticism that gathered against this model was not that its safeguards were absent but that its premise was wrong:

- it equated a diagnosis with an inability to decide, instead of testing the decision itself;
- it gave the person no way to record, in advance, how they wished to be treated in a future episode;
- it left the choice of surrogate to law and family rather than to the patient;
- and it treated confinement as the natural mode of care rather than the exception.

Under the older regime an admission often turned on an order obtained through a magistrate, an institution-centred route that expressed the custodial premise. The detail of those procedures is now of historical interest only, because the Act that contained them has been taken off the statute book entirely, and it is that removal, not any single provision, which the comparison is really about. A caution belongs on the record here: the specific 1987 provisions set against the current Act in this note, including those in the table that follows, are the established historical account of the earlier statute and were not re-verified against the 1987 primary text in this pass, so read that

older column as the standard description rather than as freshly checked primary law; what is firmly grounded is the load-bearing point that the 2017 Act repealed and replaced the 1987 Act.

13.2 The paradigm shift: from custody to capacity

The current Act reorganises all of this around the person's decision-making capacity. Where the older law asked whether a person was mentally ill and, if so, who should decide for them, the newer law asks whether this person can make this particular decision and, if not, how they can be supported to. This is what is meant by calling it a **rights-based** and **capacity-based** framework: rights-based because it begins from the entitlements of the person rather than the powers of the institution, and capacity-based because the trigger for any substituted decision is a loss of capacity for a specific decision, not a diagnostic label. It is expressly aligned with the **UN Convention on the Rights of Persons with Disabilities**, the international standard for how the law should treat persons with disabilities, mental illness among them.

That alignment is the deepest of the differences, because it changes the default. In a custodial statute the default is intervention, and the person must be rescued from it by safeguards; in a rights-based statute the default is the person's own choice, and intervention is what must be justified. Every downstream contrast, the presumed capacity, the forward voice, the chosen representative, is an expression of that reversed default.

RULE **Read the two Acts as two models, not two indexes.** The Mental Healthcare Act 2017 is not the Mental Health Act 1987 with better sections; it is a different theory of what the law is for. Once you see the move from a custodial, institution-centred statute to a rights-based, capacity-based one, every specific difference becomes predictable rather than something to be recalled cold.

IN INDIA

The reform had a specific legal trigger. India is a party to that convention, and a state that ratifies one takes on a duty to bring its domestic law into conformity with it. A statute organised around custody and guardianship could not be squared with an instrument built on legal capacity and autonomy, so the real question was never whether to reform the 1987 Act but whether to amend or replace it, and only replacement could carry a change of premise. This treaty origin is why the current Act reads less like a hospitals-and-services law and more like a charter of rights for persons with mental illness.

13.3 A repeal, not an amendment

The mechanism by which the change was made carries its own teaching point. The 2017 Act does not tinker with the 1987 Act; it **repeals** it outright and puts a new statute in its place, the repeal being effected by an express repealing provision written into the 2017 Act itself. An amendment leaves the parent Act standing and edits it; a repeal-and-replace lifts the parent Act off the statute book completely and starts again. The examiner who asks for a comparison is implicitly asking you to notice this: the earlier Act is repealed for current substantive operation, subject to the extensive transitional savings the repealing provision itself carries.

Why does a repeal rather than an amendment fit a change of paradigm? Because when the organising premise of a law changes, editing individual provisions cannot carry the load. The definitions, the procedures, the bodies and the rights all have to be rebuilt around the new premise, and a patchwork of amendments to a custodial Act would leave the custodial scaffolding standing beneath them. Replacing the whole structure is the only way to make capacity, and not custody, the load-bearing idea. This is also why the answer should never present the two statutes as coexisting alternatives: one has wholly succeeded the other.

The Mental Healthcare Act 2017 did not amend the Mental Health Act 1987; it repealed and replaced it, exchanging a custodial licensing-and-guardianship regime for a rights-based, capacity-based one aligned with the UN disability convention.

PITFALL

Because the whole of the earlier Act went, a provision remembered from the 1987 framework is not a fallback when the 2017 machinery feels unfamiliar. Reaching for an institution-licensing route, or defaulting to a family guardian's consent because that is how one was taught, is to apply a law that no longer exists. When a current mechanism is unclear the answer is the correct 2017 provision, not the repealed predecessor, except for the narrow band of pre-commencement matters the repeal's own transitional savings keep alive; citing a superseded section as though it governs ordinary current practice is the way a presentation slip becomes a factual error.

13.4 The concrete markers of the shift

With the model clear, the specific novelties of the current Act become legible as instances of one move, and each is best learned as a contrast with the position it replaced rather than as a free-standing fact. The Act begins from a **presumption of capacity**, so that a person is taken to be able to make their own treatment decisions unless an assessment of the specific decision shows otherwise; the older law, by contrast, let the diagnosis do the work that a capacity assessment should do. It gives statutory standing to the **advance directive**, a person's recorded instruction about how they wish, or do not wish, to be treated in a future episode when they may be unable to say so, a forward voice the 1987 Act simply did not provide. It replaces the imposed guardian with the **nominated representative**, a person the patient may appoint themselves or, absent an appointment, one identified through the Act's own default order of representatives, to support them and, where needed, to speak for them.

The shift reaches into the treatment of self-harm and of treatments of concern as well. The current Act decriminalises the suicide attempt, directing a person who has attempted suicide towards care rather than prosecution and reversing the older exposure to the criminal law. It prohibits electroconvulsive therapy in its unmodified form, bringing a treatment the earlier statute did not specifically regulate under an explicit statutory bar; the clinical technique of that treatment is not the concern of this comparison and belongs to the ECT and neurostimulation notes. And where the older law licensed and inspected psychiatric hospitals and nursing homes through its licensing authorities, the registration and regulation of establishments now sits with

the Central and State Mental Health Authorities, so that regulatory function passes from one administrative body to its statutory successor rather than disappearing. Separately from that regulatory line, and not as a replacement for it, the current Act adds the **Mental Health Review Boards** as a quasi-judicial rights-review mechanism the 1987 framework had no equivalent of, so the genuinely new element here is the review of rights and not any transfer of the licensing function to a board. Each of these has its own detailed machinery, taught in this chapter where the Act's provisions are set out one by one; here they matter only as the visible edges of the single underlying move.

WHERE THEY DIFFER	MENTAL HEALTH ACT 1987	MENTAL HEALTHCARE ACT 2017
Governing idea	Custodial and institution-centred	Rights-based and capacity-based
Decision-making	Incapacity inferred from the illness	Capacity presumed until assessed otherwise
Patient's forward voice	None provided	Advance directive
Surrogate decision-maker	Guardian set by law and family	Patient-appointed, else statutory default order
Attempted suicide	Exposed to the criminal law	Decriminalised and directed to care
Unmodified ECT	Not specifically regulated	Prohibited
System oversight	Licensing authorities	Central and State Mental Health Authorities

MNEMONIC

DANCER - the six things the 2017 Act brought that the 1987 Act did not

Decriminalised suicide attempt, **A**dvance directive, **N**ominated representative, **C**apacity presumed, **E**CT in its unmodified form prohibited, **R**eview Boards as a new rights-review mechanism. The value of the mnemonic is that every letter is the same move seen once more, from custody towards capacity, so if you recall the theme the six recover themselves rather than having to be held as a list.

13.5 What did not change, and statute against reality

Where the contrast is easy to overstate. A good answer resists the temptation to make the two Acts opposites in every respect. The State's protective role did not vanish. The current Act still allows treatment and admission without the person's contemporaneous consent in defined circumstances, through its supported route, so the power to intervene for a person who cannot presently decide survives. What changed is that the power is now hedged with capacity assessments, a representative, review and time limits rather than exercised as custodial discretion. The continuity is deliberate: a purely libertarian statute that never permitted involuntary care would fail the very people the law exists to protect, and recognising this is what separates a mature answer from a slogan.

The harder continuity is between statute and service. A rights-based law presumes an infrastructure, review boards that actually sit, representatives who are available, directives that are honoured, community services that make non-custodial care real, and that infrastructure is uneven across the country. The most substantial criticism of the current Act is therefore not of its philosophy but of the distance between its promises and the resources on the ground, so that some of its rights remain aspirational in practice. For the exam this is the note to close on: the paradigm shift is real and is the correct headline, but its realisation is a work in progress. On currency, be unambiguous. The current Act is the operative mental health law; the 1987 Act is repealed for current substantive operation and survives only through its own narrow transitional savings, so any statement of the present general law must be drawn from the newer statute.

GOOD TO REMEMBER

The change is not academic at the bedside. A clinician trained under the older frame has to unlearn two reflexes: treating a diagnosis as automatic proof that the patient cannot decide, and treating a family member as the default consent-giver. Under the current Act the starting point is the patient's own presumed capacity, the patient's own advance instructions, and a representative the patient has chosen or, absent that, one identified through the Act's own default order, and the burden sits on the clinician to show why any of these should be displaced.

13.6 Framing the comparison in an answer

Because this topic is examined as a comparison, how you organise the answer matters almost as much as its content. Lead with the paradigm shift stated in a single sentence, then name the repeal-and-replacement so the reader knows the older Act is wholly gone, and only after that deploy the specific differences as evidence for the shift. A short contrast arranged by theme, governing idea, capacity, the patient's voice, the surrogate, self-harm, treatments of concern, oversight, earns its place because it shows understanding, whereas a table set out by section number shows only recall and invites the very error of citing a dead provision. Round off on two honest points: that the current Act is the law, and that its rights are further along on paper than in the services meant to deliver them. An answer built this way reads as an argument about a change of model, which is exactly what is being asked, and not as a memorised inventory of two statutes placed side by side.

TRAP **Answering the comparison as a section-by-section ledger.** Candidates line up provisions of one Act against provisions of the other and produce a table with no argument in it. The examiner wants the paradigm shift stated first and the provisions used as its evidence. A bare ledger also tempts you into citing a repealed provision as if it were current, which turns a presentation weakness into a factual mistake and forfeits marks twice over.

14 · Penalties and offences under MHCA

A right that cannot be enforced is only a wish, and this is the clause that puts teeth behind the whole Act. The Mental Healthcare Act spends most of its length conferring rights, prescribing procedures and constraining what may be done to a person with mental illness, and all of that architecture would be merely hortatory if a breach of it carried no consequence. The

penalties-and-offences machinery is what converts the Act's duties into enforceable law: it names the price of non-compliance and, in doing so, tells a practitioner and an establishment that the Act's procedures are not optional. The examinable core is a single provision, the **general penalty** at section **108**, and the marks are won or lost on stating it precisely, with its correct tiers and its correct verbs.

Two words are worth separating first, because candidates blur them. An **offence** is the prohibited conduct, the doing of what the Act forbids or the failing to do what it requires; the penalty is the consequence the law attaches to that conduct. The general penalty is not a list of forbidden acts but the residual consequence clause standing behind the Act's substantive duties, ready to price a breach wherever a specific penalty has not already been written. Read that way, the topic is small, exact and highly scorable.

14.1 The general penalty clause and what a contravention is

The provision is a general penalty because it is not tied to any one duty in the Act. Its trigger is a **contravention**, and a contravention here reaches three things, not one. A person who breaches any of the following falls within the clause:

- a provision of the Act itself;
- a rule made under the Act;
- a regulation made under the Act.

This breadth is deliberate. The Act operates not only through its own sections but through delegated legislation, the rules the appropriate Government frames and the regulations the Authorities issue, and a penalty confined to the bare text of the Act would leave that delegated layer unenforceable. By reaching provisions, rules and regulations alike, the clause makes the whole regulatory scheme, down to its subordinate instruments, carry the same enforceable weight. It is the safety net beneath the entire statute.

Because it is general, it is also residual. The Act singles out at least one breach for a penalty of its own: running a mental health establishment without **registration** is given a separate, specifically tiered administrative penalty in its own provision rather than being left to the general clause. The mental model is therefore two-layered. Where the Act has written a specific penalty for a specific offence, that specific provision governs; everywhere else, a contravention falls to the general penalty. A candidate who knows only that a penalty exists, without knowing that this one is the residual clause and not the whole penalty regime, has learned half the topic.

14.2 The two-tier ladder: first and subsequent contravention

The measure of the penalty is not flat. The clause escalates, distinguishing a **first contravention** from a **subsequent contravention** and treating the repeat offender more severely. It is best learned as a ladder with two rungs. For each rung the Act sets an imprisonment measure and a fine measure, and for each it leaves the court free to impose imprisonment, a fine, or both rather than forcing a single form of punishment. What changes between the rungs is not only how high

the ceilings sit but whether the fine carries a mandatory floor at all, and that asymmetry is where the marks hide. The accompanying table lays the two rungs side by side.

MEASURE	FIRST CONTRAVENTION	SUBSEQUENT CONTRAVENTION
IMPRISONMENT	up to **six months**	up to **two years**
FINE, MINIMUM	No floor stated; a ceiling only	Not less than **fifty thousand rupees**
FINE, MAXIMUM	up to **ten thousand rupees**	up to **five lakh rupees**
COURT'S OPTIONS	Imprisonment, or fine, or both	Imprisonment, or fine, or both

108	six months	two years	five lakh
ACT'S GENERAL-PENALTY SECTION	FIRST-CONTRAVENTION PRISON CEILING	SUBSEQUENT-CONTRAVENTION PRISON CEILING	SUBSEQUENT-CONTRAVENTION FINE CEILING

The pattern the table makes visible is the point. Moving from a first to a subsequent breach, the imprisonment ceiling rises, the fine ceiling rises steeply, and, uniquely, a mandatory minimum appears on the fine for the repeat offence where none existed before. A first contravention can attract a small fine, a short custodial term, or both, at the court's discretion up to the stated caps. A subsequent contravention cannot be met with a token fine, because the fine, if imposed, must clear the floor the Act sets. The escalation is thus qualitative as well as quantitative: the second time, the law removes some of the court's leniency on the fine.

RULE **The general penalty is residual, tiered and, in its measure, discretionary.** It reaches any contravention of the Act or of a rule or regulation made under it; the quantum escalates from a first to a subsequent contravention; and for each tier the court may impose imprisonment, a fine, or both. Only the subsequent-contravention fine carries a mandatory floor. Every other limit is a ceiling the court may rise to, not a fixed sentence it must pass.

14.3 Reading the verbs: ceilings, a floor and a choice

A statute is an exact rule with an exact verb, and this clause is a small masterclass in why the verb matters. The imprisonment and fine limits are almost all expressed as amounts the punishment may extend to. That phrasing sets a **ceiling**, a maximum the court may not exceed, while leaving it free to impose anything below that maximum, including a nominal penalty, according to the gravity of the breach. It does not fix the sentence. To read a ceiling as the tariff is to misstate the law by promoting a maximum into a mandate.

Against that background, one figure behaves differently, and the difference is the examinable subtlety. For the subsequent-contravention fine, the Act says the fine shall not be less than a stated amount but may extend to a higher one. That first half is a **mandatory minimum**, a floor the court must clear if it fines at all, and it is the single mandatory quantum in the whole provision. The second half is the familiar ceiling. So the repeat fine is bounded on both sides, a floor and a cap, while every other measure in the clause is bounded only above. Holding that one

asymmetry, a mandatory floor on the repeat fine and ceilings everywhere else, is what separates a precise answer from a vague recollection of large numbers.

The third verb worth naming is the connective one. Each tier offers imprisonment, or a fine, or both, a genuine disjunction with an inclusive tail. The court is not compelled to imprison; it may fine instead, and it may do both. This is why the clause is not, as it is often misremembered, a jail provision but a graduated sentencing power in which custody is one option among two.

TRAP **An amount the punishment "may extend to" is a maximum, not a mandatory sentence, and the general penalty is never automatic imprisonment.** Candidates read the imprisonment ceilings as fixed terms and state the penalty as a definite jail sentence, or forget that the court may impose a fine instead of, or in addition to, custody. The one mandatory quantum is the floor on the repeat-contravention fine; treat every other figure as an upper limit and you will not misquote the section.

14.4 A residual clause: general versus specific penalties, and what lies outside

Two boundaries keep this topic honest, and both are scope questions of the kind this chapter tests. The first is internal to the Act. The general penalty is residual: where the Act has written a specific penalty for a specific offence, that specific provision governs and the general clause stands behind it. Treating the residual clause as the whole penalty regime, and stretching it over breaches the Act has priced separately, flattens a two-layer scheme into one.

The second boundary is external, and candidates most often trip over it because the words sound adjacent. The general penalty punishes breaches of this Act. It is a wholly different question from whether a person with mental illness who commits a crime is criminally responsible for it, which the substantive criminal law decides and the criminal-responsibility material addresses. The penalty clause is a regulatory-enforcement provision aimed at those who flout the mental-health statute; the responsibility question is a doctrine of the general criminal law aimed at the mentally ill defendant. They share a chapter and little else, and conflating the enforcement of the Act with the exculpation of the accused is a category error worth guarding against.

The general penalty is also content-blind. It does not itself say which acts are prohibited or which procedures require consent; those substantive requirements live in the Act's other provisions and are taught with the items that own them, and the clinical technique, dosing and mechanism of electroconvulsive therapy belong to the ECT and neurostimulation notes. Its role sits downstream of all of that: once a substantive duty exists somewhere in the Act, whether a rule about admission, a requirement of consent, or a limit on a procedure, this is the clause that prices its breach when no more specific price has been set.

PITFALL

Applying the general penalty to an offence the Act has singled out for its own specific penalty. Running a mental health establishment without registration is not left to the general clause; the Act gives that breach a separate, specifically tiered administrative penalty of its own. Reaching for the general penalty to describe every breach, or quoting one tier's ceiling as though it were a fixed fine, is the scope error that both loses the mark and misstates the clinician's actual exposure.

14.5 In practice: triggering the penalty and how it is enforced

Why this matters at the bedside is quieter than the numbers suggest. What actually brings a clinician or an establishment within reach of the penalty is a concrete breach of the Act's duties, not an abstract one: proceeding without a consent the Act requires, admitting or detaining a person outside the admission procedure, carrying out a procedure the Act prohibits, or operating an establishment without registration. Each of these is a contravention, and the penalty clause does not ask whether harm resulted; it asks whether the Act was followed. That is a more demanding standard than a negligence test: a clinician who caused no injury can still have contravened a procedural requirement, which is why documented compliance, not good outcomes alone, is the real protection.

The reason not to overstate the clause is that its practical bite depends on machinery outside itself: a penalty means nothing until something invokes it. The clause is best understood as the backstop that gives the Act's supervisory bodies their ultimate leverage, not as a threat hovering over routine clinical work. Stated at the height the section itself supports, and no higher, the rule is clean, and that restraint is itself examinable.

IN INDIA

The Act is central law and its penalty clause applies nationally, but a penalty on paper is only as real as the machinery that invokes it. The establishment-registration penalty and the Board's own compliance powers are administrative sanctions, enforced through the State and Central Mental Health Authorities and the Review Boards, while the general penalty alone creates criminal, prosecutable punishment. The working protection for a practitioner is therefore procedural: register the establishment, follow the admission and consent procedures, respect the rights the Act confers, and keep the record that shows you did. The penalty is the backstop, not the daily instrument.

GOOD TO REMEMBER

When you are asked, in a viva or on a ward round, what happens if the Act is breached, resist the urge to name a jail term. The honest answer names the structure: a first contravention and a subsequent contravention are treated differently, the court may fine or imprison or do both, and only the repeat fine has a mandatory floor. If the breach is running an establishment without registration, that has its own specific penalty and is not this clause at all. Getting the shape right matters more than reciting a figure.

The Act's general penalty makes any contravention of the Act, a rule or a regulation punishable, more lightly for a first contravention and more heavily for a subsequent one, with the court free to order imprisonment, a fine, or both, and a mandatory minimum falling only on the fine for a repeat breach.

The Rights of Persons with Disabilities Act 2016

15 · Salient features of RPWD Act 2016

Why the marks are here. Disability law is the point at which psychiatry stops being purely clinical and becomes a matter of enforceable rights, because mental illness is a specified disability in Indian law, and a person with mental illness is a person with a disability once that functional, barriers-based definition is met, and the protections, benefits and certification that follow all rest on a single statute. A candidate is asked for the salient features of that statute because the examiner wants four things placed correctly: what the Act is, where it came from, when it took effect, and what it replaced. Those anchors are the whole of a short-note answer, and they are also the facts most often muddled, because the Act is easy to confuse with the welfare law it superseded and easy to date to the wrong year.

The Act is best read at its origin, meaning its number, its long title, its commencement clause and the legislation it repealed, because every later provision inherits its character from that origin. Read this way it is not a welfare scheme with a few rights attached; it is a rights statute from its first line, written to bring an international convention into Indian law, and grasping why that is so is the difference between a pass-level answer and a good one. The recognised categories of disability, the certification machinery, the benefits and the guardianship reform each have their own detailed treatment elsewhere in this chapter; here the object is the Act as a whole, seen from its foundations.

49 of 2016	27 Dec 2016	19 Apr 2017	1995
ACT NUMBER	PRESIDENTIAL ASSENT	BROUGHT INTO FORCE	ACT IT REPEALED

15.1 The Act, its number and its short title

The Rights of Persons with Disabilities Act reached the statute book as Act No. **49 of 2016**, receiving Presidential **assent** on **27 December 2016**. An Indian statute carries two identifiers a candidate should keep apart: the short title, which names the Act and gives its year, and the official Act number, which fixes it in that year's sequence of central legislation. Both point to the same statute, and quoting either correctly signals that the answer rests on the primary Act rather than on a textbook paraphrase of it.

Section **1** is where the Act names itself and states when it will begin. It gives the short title, the Rights of Persons with Disabilities Act, **2016**, and then sets out the commencement rule. Its **long title**, the formal recital that opens the Act, announces its purpose in a single sentence, and here that sentence does real work: the purpose it declares is not the welfare of the handicapped but giving effect to an international rights convention. The long title is therefore not decoration; it is the interpretive key to everything that follows, and an examiner who asks for salient features is partly asking whether the long title has been read.

15.2 Commencement: assent is not coming into force

The most examinable trap in the whole topic hides in one clause. An Act does not become operative law on the day it is passed, nor even on the day it receives assent; it becomes operative on its **commencement**. The short-title-and-commencement section provides that the Act "shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint." The two modal verbs are doing different jobs and both must survive intact. The coming-into-force is mandatory, because the Act shall come into force, while the choice of the actual date is discretionary, left to the Central Government to appoint. The statute is certain that it will begin; it is deliberately silent about when.

The appointed date arrived by notification: the Act was brought into force on **19 April 2017** through **S.O. 1215(E)**. Between assent and that notification the Act existed on paper but bound no one, a period of dormancy that catches the candidate who dates the Act's operation to the year of its assent. This is not pedantry. Rights become claimable, and duties become enforceable, only from commencement, so any question about when an entitlement first arose, or from when a duty could be enforced, turns on the notified date and not on the date of assent.

TRAP **Assent is not commencement.** The Act received Presidential assent in one year but was brought into force by a separate Gazette notification on a later date. Date the operation of the Act, and the moment any right became claimable or any duty enforceable, to the notified commencement, never to the year of assent. Quoting the assent year as the year the Act "came into force" is an easy mark lost.

15.3 A statute built to give effect to a treaty

The single fact that explains the Act's whole character is that it was written to implement a treaty. Its long title declares it an Act to give effect to the United Nations Convention on the Rights of Persons with Disabilities, the **UNCRPD**, and the Act's preamble records that India ratified that Convention on **1 October 2007**. India follows a dualist tradition, in which ratifying an international convention expresses the State's commitment but does not by itself make the Convention enforceable domestic law. For its guarantees to be claimable in an Indian court, Parliament must legislate, and this Act is that implementing legislation. The interval of several years between ratification and enactment is precisely that dualist step being worked through.

This treaty parentage is why the Act reads as it does. Because it exists to give effect to the Convention, its provisions are construed purposively and in harmony with the Convention's principles rather than read down as narrow welfare measures. Where a later section is ambiguous, the long title and the Convention it serves supply the direction of travel, towards autonomy, inclusion and equal recognition before the law. A candidate who says only that the Act "protects the disabled" has missed the point that it exists to confer rights already recognised in international law, and it is that framing, not the vocabulary of protection, that the salient-features question is testing.

RULE **The Act is treaty-driven and therefore rights-based.** It exists to give effect to the disability Convention, and every provision is read in that light: disability is approached as a question of rights and of the barriers society raises, not as a matter of welfare or charity. State that character first and the salient features fall into place beneath it, because each one is an application of it.

IN INDIA

India ratified the disability Convention several years before it legislated, and turning that ratification into enforceable domestic law is exactly what this Act performs. The practical consequence for the Indian clinician is substantial. The rights of a person with mental illness to non-discrimination, to reasonable adjustment and to the entitlements that follow certification now rest on a rights-based statute carrying the broader UNCRPD social-and-rights model, rather than the narrower, impairment-and-threshold-based regime it replaced. That is a firmer footing from which to advocate for a patient, and it is why the Act, and not merely its schedule of benefits, is worth knowing at the bedside as well as in the examination.

15.4 From welfare to rights: the earlier Act repealed

The Act did not enter an empty field. It **repealed and replaced** the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, **1995**, the country's earlier dedicated disability legislation. The change of name signals a change of philosophy. The earlier Act framed disability as a matter of equal opportunity and protection, a narrower, impairment-and-threshold-based regime, while the new Act frames it as a matter of rights, in which the person is a **rights-holder** owed non-discrimination and the adjustments that make participation possible. That is the move from a medical-and-charity view of disability to a rights-based, socially grounded one, in which disability is understood to arise from the barriers a society erects and not from an impairment considered alone.

Two ideas carry that model into the text and both are worth naming, though their machinery is developed elsewhere. The first is reasonable accommodation, the duty to make the specific adjustments a person needs to exercise rights on an equal basis, a refusal of which is itself treated as discrimination. The second is equal recognition before the law, the principle that a person with disability retains legal standing and decision-making status rather than being displaced by a guardian as a matter of course. The full reform of guardianship that this principle drives is taken up in this chapter's account of benefits, reservations and guardianship under the Act; what matters at the level of salient features is that the Act's paradigm, and not simply its list of benefits, is what changed.

POINT OF CONTRAST	PERSONS WITH DISABILITIES ACT, 1995	RPWD ACT 2016
UNDERLYING MODEL	Welfare and protection; a medical-and-charity view	Rights-based; a socially grounded understanding of disability
LEGAL IMPETUS	Domestic enactment implementing a regional proclamation, not a binding UN treaty	Domestic enactment giving effect to a ratified United Nations convention
STANDING OF THE PERSON	Beneficiary of State provision	Rights-holder owed non-discrimination and accommodation
STATUS TODAY	Repealed and replaced	The disability law now in force

Gathered up, the salient character of the Act is best expressed as the principles it embodies:

- respect for inherent dignity, individual autonomy and the freedom to make one's own choices;
- non-discrimination and equality of opportunity;
- full and effective participation and inclusion in society;
- accessibility, so that the physical and informational environment does not itself disable; and
- reasonable accommodation as an enforceable entitlement rather than a favour.

The RPWD Act is India's rights-based enactment of the UNCRPD, Act No. **49 of 2016**, in force from **19 April 2017**, and the successor to the narrower, impairment-and-threshold-based law of **1995**.

15.5 The architecture of the Act

Asked for the salient features of the RPWD Act **2016**, the strongest answer also maps the Act's structure and knows where the detail of each limb sits. The Act recognises a defined and considerably broadened set of disabilities, bringing within its scope conditions that the earlier law did not, mental illness among them. It establishes a statutory machinery for the assessment and certification of disability. It confers rights and entitlements, including in education, in public employment and in access to benefits. It reforms guardianship along the Convention's lines and connects with the National Trust framework for certain conditions. It designates authorities and commissioners to monitor implementation and to hear grievances, and it creates offences and penalties for contravention and for discrimination. Each of these is a salient feature in its own right, and this chapter takes the recognised categories of disability, the certification route, the benefits and reservations, and the guardianship reform in turn.

What holds the structure together is the origin already set out. Every limb, meaning who is recognised, how they are certified, and what they are owed, is an expression of the same UNCRPD-aligned rights-based commitment that the long title announces, which the narrower, impairment-and-threshold-based 1995 Act did not carry. That is why reading the Act at its origin is not a preliminary to the salient features but the most salient feature of all: the character of the statute determines the reach of every provision built upon it, and an answer that leads with the benefits before the character has quietly inverted the Act.

PITFALL

The commonest real-world error is to keep working within the framework the Act repealed, citing the older statute or advising a patient and family as though disability were still a matter of welfare provision rather than enforceable right. A new certificate, entitlement or complaint must be founded on the current Act; action already taken under the 1995 Act is not thereby erased, since the Act's own savings provision deems it done under the corresponding RPWD provision. Reaching for the superseded legislation is the disability-side equivalent of quoting a criminal provision that a later code has already replaced, and it is marked as an error of currency, not merely of loose citation.

15.6 Why the psychiatrist is examined on it

Where it touches practice. The reason this Act belongs in a psychiatry syllabus at all is that, under it, mental illness is a specified disability, and a person with mental illness is a person with a disability once the Act's functional, barriers-based definition is met. That inclusion pulls psychiatry into the Act's machinery. The recognition of disabilities and the place of mental illness among them, the certification through which that recognition is proved, and the benefits, reservations and guardianship reform that recognition unlocks are each taken up in the discussions that follow, and each rests on the rights-based foundation set out here. Alongside the Mental Healthcare Act, which governs care, treatment and the rights of the person within mental-health services, this Act governs the civil and social standing of the same patient, and in practice the two are read together.

Knowing the Act at origin is therefore not an academic flourish. It tells the clinician which statute is live, on what footing a patient's entitlements rest, and why an assessment of disability is an act with legal consequence and not merely a clinical note. The candidate who can state the Act's number, its treaty purpose, its commencement and the law it replaced has the spine of the topic; everything the later provisions add is flesh on that spine.

GOOD TO REMEMBER

When you assess a patient whose illness limits their functioning over the long term, remember that your clinical opinion can be the gateway to statutory rights and not only to treatment. Because mental illness is recognised as a disability, the psychiatric assessment carries a civil consequence, and framing it as a right the patient holds, rather than a benefit you are kindly recommending, is both more accurate in law and more useful to the family sitting in front of you.

16 · Recognized disabilities and inclusion of mental illness

Why the marks are here. The Rights of Persons with Disabilities Act is the statute that decides who counts as disabled in Indian law, and psychiatry has a direct stake in the answer because mental illness is one of the conditions it recognises. Two questions recur, in the examination and at the bedside. The first is which impairments the Act actually lists, and where mental illness falls among them. The second is what the much-quoted forty-per-cent figure governs, because it is routinely misattached. Both are settled by reading the Act's own definitions and its Schedule

rather than by memory of what a disability certificate looks like, and a candidate who can separate the definition of disability from the benchmark threshold, and place mental illness correctly within the recognised list, has the whole of this topic.

The Act carried Indian disability law from a narrow, medically framed list to a broad, socially framed one aligned with the United Nations Convention on the Rights of Persons with Disabilities. For the clinician this is not academic. Recognition under this statute is the gateway through which a person with a severe and enduring mental illness reaches statutory protections and entitlements, and the psychiatrist is very often the first professional to see that a patient is eligible at all. Knowing exactly what the Act recognises, and on what terms, is therefore part of doing right by the patient, not only part of passing the paper.

40%	21	5
BENCHMARK THRESHOLD	SPECIFIED DISABILITIES	HEADS IN THE SCHEDULE

16.1 Two definitions the Act keeps apart

The single most examinable feature of this Act is that it defines disability twice, and the two definitions do different work. A **person with disability**, at section **2(s)**, means a person with a long-term physical, mental, intellectual or sensory impairment which, in interaction with **barriers**, hinders full and effective participation in society on an equal basis with others. Notice what this definition does not contain: any number. It is deliberately the barriers model, in which disability arises from the meeting of an impairment and a disabling environment, not from the impairment considered on its own. The qualifier long-term is doing quiet work here too, because a transient or short-lived impairment, however severe while it lasts, does not by itself answer the definition.

The definition has three elements a candidate should be able to lift apart cleanly:

- a long-term physical, mental, intellectual or sensory impairment;
- an interaction between that impairment and environmental or attitudinal barriers; and
- a resulting hindrance to full and effective participation in society equally with others.

Against this stands the **person with benchmark disability**, at section **2(r)**, and here a threshold appears. A person with benchmark disability means a person with not less than **40** per cent of a specified disability, where that disability has not been defined in measurable terms; and, where the disability has been defined in measurable terms, a person with disability as certified by the certifying authority. This category is narrower, and it is the one to which the Act pins its heavier positive entitlements, the reservations and the schemes, whose detail is dealt with separately in this chapter's account of benefits, reservations and guardianship under the Act.

Why two definitions, and not one, is the reasoning worth showing rather than reciting. The Act does two different jobs. It protects a broad class of people from discrimination and guarantees them accessibility and equal participation, and for that purpose it wants the widest, most inclusive definition, one with no arithmetic gate at all. Separately, it distributes scarce positive goods, reserved seats, reserved posts and targeted schemes, and for that it needs a narrower,

sharply defined qualifying group. The benchmark definition is that narrower gate. Reading the two definitions as one, or importing the threshold into the general definition, collapses a deliberate two-tier design and is exactly the error the next box warns against.

TRAP **The threshold belongs to benchmark disability, not to disability.** Candidates read the headline figure and conclude that a person must reach it to be a person with disability at all. The general definition carries no percentage; the threshold is a second, higher gate for benchmark-linked entitlements only. A patient can be a person with disability under the Act, protected from discrimination and owed accessibility, and still fall short of benchmark status.

AXIS	PERSON WITH DISABILITY	PERSON WITH BENCHMARK DISABILITY
Threshold in the definition	None; no percentage stated	Not less than the benchmark proportion of a specified disability
Underlying model	Barriers model: impairment in interaction with barriers	Quantified extent of a specified disability
What it establishes	Status, equality and the anti-discrimination protections	The qualifying gate for reservation and benchmark-linked schemes
Role of certification	Not defined by a percentage certificate	Certified by the certifying authority where the disability is measurable

16.2 The Schedule of specified disabilities

What actually counts as a specified disability is not left to clinical opinion; it is fixed by a list. A **specified disability** means, at section **2(zc)**, the disabilities enumerated in the Schedule to the Act. This closed-list technique is deliberate. Certifying authorities, courts and government departments need a fixed, common reference for who is inside the specified-disability class and who is not, and an itemised Schedule supplies a legal certainty that a purely descriptive definition cannot. The Schedule fixes specified disabilities for this certification and benchmark-linked machinery; it does not confine the broader status of **person with disability**, which section **2(s)** defines on its own terms, independently of Schedule membership. The technique has a cost worth naming, however: a genuinely impairing condition the Schedule does not list falls outside the specified-disability machinery until the Schedule is revised to admit it, which is why the recognised list is written to be amendable rather than closed for good. The Schedule also widened the recognised conditions, from the **seven** categories of the earlier disability legislation to **21** specified disabilities, and it is this expansion that first brought several psychiatric and neurodevelopmental conditions squarely within disability law.

The itemised conditions are organised under **five** heads:

- physical disability, covering locomotor disability, visual impairment, hearing impairment and speech and language disability;

- intellectual disability, within which specific learning disabilities and autism spectrum disorder sit;
- mental behaviour, which is mental illness;
- disability caused by chronic neurological conditions and by blood disorders; and
- multiple disabilities, including deaf-blindness.

Two placements are worth holding, because both are tested by asking a candidate to file a condition correctly. Intellectual disability and mental illness sit under different heads, a separation the Act insists on and returns to in its own definition of mental illness. And autism spectrum disorder, together with specific learning disability, sits under intellectual disability rather than under mental illness, which is where an unwary answer tends to place them. The head names are not loose labels. Each condition has a fixed address in the Schedule, and the marks reward the candidate who knows the address and not merely the neighbourhood.

RULE **Recognition is by inclusion in the Schedule, not by severity.** A condition is a specified disability under this Act because it is listed in the Schedule; the broader status of person with disability under section 2(s) is not confined to the Schedule. Severity, expressed later as the benchmark proportion, is a separate question that fixes the level of entitlement, not whether the condition is a specified disability at all. First establish that the condition is scheduled; only then ask how much of it the person carries.

16.3 Mental illness within the Schedule

Where psychiatry enters the statute. Mental illness appears in the Schedule under the mental-behaviour head, and the Schedule gives it its own definition. **Mental illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgement, behaviour, capacity to recognise reality or the ability to meet the ordinary demands of life. The drafting is broad and functional. It turns on gross impairment of everyday functioning rather than on any named diagnosis, and that is precisely what lets a range of severe and enduring psychiatric conditions qualify without the statute having to list each of them. The test the Act sets is disability of function, not the presence of a particular label, which sits comfortably with the wider principle in these notes that a diagnosis is not named to a patient as the currency of their care.

The definition then carries an express carve-out that examiners like to probe. It does not include **retardation**, described as a condition of arrested or incomplete development of mind characterised by subnormality of intelligence. The Act is not denying that intellectual disability is a disability; it recognises it fully, but under the separate intellectual-disability head, not within mental illness. The two are kept apart on purpose, because they call for different assessment and different supports, and folding them under one heading would blur both. For the examination the discrimination to keep ready is short: intellectual disability is recognised, but as intellectual disability, never as mental illness.

IN INDIA

Mental illness was not first recognised as a disability by this statute. The Persons with Disabilities Act of 1995 that it replaced already listed mental illness among the disabilities it recognised; what the present Act does is broaden and reorganise the disability framework, adding conditions and building the benchmark structure onto it, rather than granting mental illness its first statutory footing. The practical significance for the clinician is unchanged: a person with a severe and enduring psychiatric illness is, in principle, eligible for the same order of statutory protection and entitlement as a person with a physical disability. In day-to-day practice the psychiatrist is usually the professional who first recognises that a patient's illness has reached a disabling level, and who sets the patient on the pathway toward a disability certificate. Recognising eligibility early, and saying so plainly, is itself part of good care.

16.4 Recognition, certification and the definition that is not this one

Three boundaries decide whether an answer has understood this topic or has merely memorised the figure. The first is recognition against certification. Being listed in the Schedule makes mental illness a specified disability, not an automatically recognised individual disability; an individual with mental illness becomes a person with disability, and so gains the general rights the Act owes every person with disability, the protection from discrimination and the claim to accessibility and equal participation, only when the section **2(s)** elements are also met, the long-term impairment interacting with barriers to hinder participation, not by diagnosis or Schedule placement alone, and none of which turns on any percentage. What recognition does not by itself confer are the benchmark-linked entitlements. Those, the reservations and the schemes, follow only from a certificate that the person meets the benchmark threshold, and the machinery for assessing and certifying mental illness as a benchmark disability, the instrument used and the certifying authority, is taken up separately in this chapter's account of disability certification and the assessment of mental illness. For those benchmark entitlements recognition is the door and certification is the key, and this topic owns the door.

The second boundary is the benchmark against the benefit. The threshold is the entrance to the benchmark-linked reservations and schemes; separate general schemes open to persons with disability as such, resting on section **2(s)** status rather than on the benchmark proportion, also exist and are not gated by the threshold. The content of the benchmark-linked entitlements, who reserves what and the guardianship provisions that travel with them, belongs to this chapter's account of benefits, reservations and guardianship under the Act. This topic owns the definition of the gate, not the goods that lie beyond it, and a candidate who pours reservation proportions into a recognition answer has quietly answered a different question.

PITFALL

The Rights of Persons with Disabilities Act carries its own definition of mental illness, and it is not the definition used in the Mental Healthcare Act. The two provisions read similarly but sit in different statutes and do different work: one decides recognition as a disability for entitlements, the other governs care, admission and rights under mental-health law. Quoting the disability Schedule's definition when the question is about mental-health-care law, or the reverse, is a common and avoidable error. The Mental Healthcare Act's definition of mental illness is taught with that Act's definitional provisions, and each should be cited to its own statute.

The third boundary is the quietest, and it is the one clinicians actually trip on. Recognition, certification and benefit are three steps, not one, and a patient can be standing at any of them. A patient whose illness is plainly disabling, so that the section **2(s)** elements, the long-term impairment, its interaction with barriers and the resulting hindrance to participation, are met, is a person with disability, and that status already owes the general protections the Act gives every person with disability; what it does not by itself deliver are the benchmark-linked benefits, which wait until a certificate is issued and the entitlement is claimed. Keeping the three steps apart is what lets a clinician be honest with a family about what a diagnosis does, and does not, by itself deliver.

GOOD TO REMEMBER

When a patient with a severe, persistent mental illness asks about disability benefits, the answer comes in two parts. Recognition is not in doubt, because an illness this severe and persistent satisfies the section **2(s)** elements, and mental illness is in any event a specified disability under the Act. What the patient needs is certification, first of the specified disability and then, if the benchmark proportion is met, at the benchmark level, each a separate assessment carried out under its own machinery. The clinician's task is to flag eligibility early and route the patient into the certification pathway, rather than to promise a particular benefit that only certification and the benefits framework can actually confer.

Mental illness is a specified disability recognised in its own right and kept distinct from intellectual disability; the benchmark proportion governs benchmark disability and its entitlements, never the definition of a person with disability.

17 · Disability certification and assessment of mental illness (IDEAS)

Why the marks are here. For a person living with severe mental illness, a disability certificate is the document that turns a clinical fact into a quantified legal entitlement. It is the gateway to the specified-disability status and, once the benchmark is crossed, to the stronger concessions, welfare schemes and reservations the disability statutes pin to that number; the Act's general equality and non-discrimination protections attach to a person with disability independently of any certificate and do not wait on it. The examiner is rarely satisfied by the clinical picture alone. The marks sit on the exact statutory machinery - which provision empowers the guidelines, who is competent to certify, what procedure the applicant passes through - and on the one instrument

by which disability in mental illness is actually measured in this country. Get the chain and the computation right and the answer writes itself; blur a mandatory duty into a discretionary power, or read the percentage off the wrong number, and the mark is gone.

This topic is deliberately self-contained. It is about the DISABILITY certificate and nothing else. It is not the certificate of fitness to resume a job, not the assessment that sits behind a compensation or pension claim, and not the report a psychiatrist prepares for a court. Each of those is a separate certification with a different purpose and a different instrument, and the commonest way to lose the mark is to let one bleed into another. Mental illness is one of the specified disabilities the Act recognises; the recognition and definition of that category are treated separately in these notes, and what follows begins once mental illness is already inside the schedule and asks only how its disability is certified.

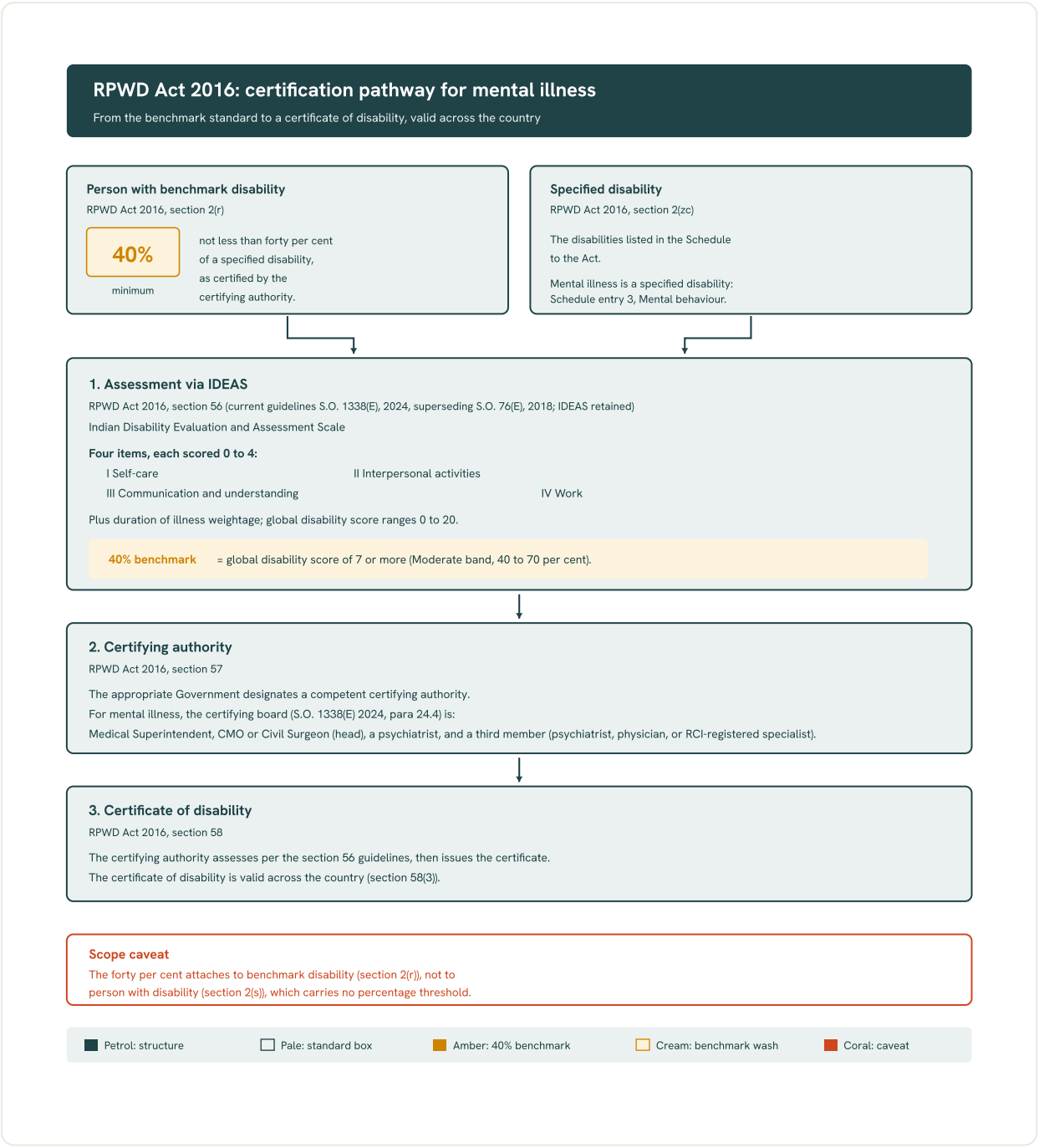


Fig 25.9. The RPWD Act 2016 route to a certificate of disability for mental illness: the benchmark standard of not less than forty per cent of a specified disability (section 2(r)) is measured with IDEAS under the section 56 guidelines, certified by the section 57 authority, and recorded on the section 58 certificate that is valid across the country.

17.1 The statutory chain: from the Act to a certificate

The Rights of Persons with Disabilities Act builds certification as a chain of three provisions, and each link carries an exact modal verb that must be reproduced. The first link is the enabling power at section **56**: the Central Government **shall** notify guidelines for the purpose of assessing the extent of a specified disability in a person. This is a mandatory duty, and it matters because nothing can be certified until those guidelines exist. They are the yardstick against which extent is measured, and a certificate issued against no notified guideline has no legal footing.

The second link, at section **57**, designates who may certify. The appropriate Government **shall** designate persons having the requisite qualifications and experience as **certifying authorities**,

competent to issue the certificate of disability, and shall also notify the jurisdiction within which, and the terms and conditions on which, they perform that function. Both duties are mandatory. A certificate issued by a person who has not been designated, or outside the notified jurisdiction, is not a valid certificate, which is why the identity of the certifying body is itself an examinable fact.

The third link, at section **58**, is the procedure the applicant actually passes through, and here the modal verbs switch deliberately. Any person with a specified disability **may** apply, in the manner prescribed by the Central Government, to a certifying authority having jurisdiction. The application is the citizen's option, never a compulsion. On receipt, the certifying authority **shall** assess the disability in accordance with the guidelines notified under the enabling power, and shall then either issue a certificate of disability in the prescribed form or inform the applicant in writing that he has no specified disability. The assessment is a mandatory duty and its two outcomes are the only two permitted: there is no lawful third option of leaving the application unanswered.

17.2 The assessment guidelines for mental illness

The guidelines the enabling power anticipates were notified by the Central Government in **2018** as gazette notification **S.O. 76(E)**, and they expressly superseded the older mental-illness guidelines of **2002**. For mental illness they lay down that assessment consists of a clinical assessment together with the IDEAS scale and, where it is relevant, an intelligence (IQ) assessment. Those 2018 guidelines also carried a discriminating rule that examiners used to return to: where both an IQ score and an IDEAS score were generated, the score indicating the more severe disability was taken, not an average and not whichever was measured first. That rule does not survive into the current 2024 notification, which instead directs that a person whose intellectual disability and mental-illness disability coexist is classified as having multiple disability and certified through the multiple-disability route, not by picking the worse of the two single-disability scores.

The same guidelines constitute the **certifying board** for mental illness. In outline the board is headed by a senior institutional officer, the Medical Superintendent, Chief Medical Officer or Civil Surgeon, or the equivalent officer a State notifies, and it includes a psychiatrist, who performs the clinical assessment, and a psychologist, who performs the IQ testing. This composition is worth holding, because it is the concrete answer to the section **57** question of who is competent to certify. The current notification is the 2024 **S.O. 1338(E)**, which superseded the 2018 **S.O. 76(E)**, and IDEAS is retained as the instrument, so the computation set out below is the tool a candidate must know. The 2018 notification is now historical. Its 2024 successor was not verbatim-verified for these notes, so the precise medical-board composition and the certificate-validity rules it sets are a declared gap: read the board as constituted per the current notification, but treat the exact 2024 designations, including that of the psychologist, as to be confirmed against the primary rather than settled here.

17.3 IDEAS: the instrument and its four domains

The Indian Disability Evaluation and Assessment Scale, **IDEAS**, is the instrument by which disability in mental illness is quantified for certification. It was developed by the Rehabilitation

Committee of the **Indian Psychiatric Society** and then adopted, with modifications, as the official tool. Its logic is important: it does not rate symptoms, it rates the disability that illness produces in everyday functioning. A florid mental state and a disabling one are not the same thing, and it is the second that the law compensates. IDEAS makes that judgement across **four** domains:

- **Self-care** - hygiene, grooming, bathing, toileting, dressing, eating and looking after one's own health.
- **Interpersonal activities (social relationships)** - initiating and maintaining interactions with others in a contextually and socially appropriate way.
- **Communication and understanding** - producing and comprehending spoken, written and non-verbal messages.
- **Work** - functioning in the domain of employment, housework or education.

Each domain is scored from **0 to 4**, the lowest step recording no disability in that area and the highest recording profound disability, a complete inability to perform. The rater's task is to convert clinical observation into these four graded judgements, which is why inter-rater consistency and a structured interview matter as much here as anywhere in the mental state examination.

MNEMONIC

Some Individuals Can Work

The four IDEAS domains in order: **S**elf-care, **I**nterpersonal activities, **C**ommunication and understanding, and **W**ork.

IN INDIA

Disability in mental illness is not certified on a free clinical impression but on a gazette-notified, home-grown instrument. IDEAS grew out of the Indian Psychiatric Society's own rehabilitation work and was then modified and notified by the Ministry of Social Justice and Empowerment, which is what makes it the official yardstick and also makes its items, scoring and computation government-open, free to reproduce with acknowledgement of the gazette notification. For an Indian candidate this is the answer that a Western disability scale would get wrong: the tool the law names is IDEAS.

17.4 Computing the score: total, duration weightage and global score

The four domain scores are added to give a total disability score, which therefore runs from **0 to 16**. IDEAS then does something distinctive that candidates routinely omit: it adds a weightage for the **duration of illness**. The reasoning is that chronicity compounds disability. The same symptom burden carried for a decade is more disabling than the same burden carried for a month, because it erodes the roles, skills, employment and social capital that do not quickly return once lost. The weightage is graded by how long the illness has run:

DURATION OF ILLNESS	WEIGHTAGE ADDED
under 2 years	**+1**
2 to 5 years	**+2**
6 to 10 years	**+3**
over 10 years	**+4**

The total disability score plus the duration weightage gives the **Global Disability Score**, which runs from **0 to 20**. It is this global figure, and not the raw four-item total, that is carried forward to the percentage. The distinction is small on the page and decisive in the exam and in the clinic, because the same four-domain profile can land in two different percentage bands depending only on how long the person has been ill.

4	0-16	0-20	40%
IDEAS DOMAINS	ITEM TOTAL	GLOBAL SCORE	BENCHMARK CUT-OFF

TRAP **Mapping the percentage from the four-item total.** The item total and the global score are different numbers, and only the global score carries the percentage band. Candidates score the four domains, read straight off to a percentage, and silently drop the duration-of-illness weightage. The weightage is added first, every time; the global disability score is what the percentage table responds to.

17.5 From global score to percentage and the benchmark

Where the number becomes an entitlement. The global disability score maps onto a severity band and a percentage of disability, and it is the percentage that the rest of the statutory world responds to. The banding is fixed by the notified guidelines, so it is read, not judged:

GLOBAL DISABILITY SCORE	SEVERITY	PERCENTAGE DISABILITY
0	No disability	**0%**
1 to 6	Mild	**below 40%**
7 to 13	Moderate	**40 to 70%**
14 to 19	Severe	**71 to 99%**
20	Profound	**100%**

The single figure to hold is the cut-off. The line that defines a **benchmark disability**, and that gates the Act's benchmark-linked reservations and schemes rather than every welfare measure, is **40%**, which is reached at the moderate band, that is at a global disability score of **7** or more. Below it, an applicant is still a person with disability who retains the Act's general rights, but does not cross the line to which the stronger, benchmark-linked concessions and reservations are pinned. The benchmark, in other words, is not merely a descriptor of severity; it is the switch that turns those entitlements on.

RULE **The percentage is a statutory computation, not a clinical impression.** The certificate rests on the IDEAS global disability score defined in the notified guidelines. A clinician's global sense that a patient is "severely ill" has no legal standing until it is expressed as that computed score and its percentage band, which is precisely why the instrument, the duration weightage and the banding must be applied as written rather than approximated.

PITFALL

Treating IDEAS as an intelligence test, or certifying from IDEAS alone when a coexisting intellectual disability is present. IDEAS is the instrument for mental illness; intellectual disability is assessed on IQ. Under the superseded 2018 guidelines a clinician who generated both scores took the more severe of the two; under the current 2024 notification, a person whose intellectual disability and mental-illness disability coexist is instead classified as having multiple disability and certified through the multiple-disability route. A clinician who still defaults to the old take-the-worse-score rule, or to IDEAS alone, is applying superseded guidance and under-certifies the very patient the safeguard was written for.

GOOD TO REMEMBER

Because the score is anchored to current functioning and to the duration of illness, it moves as the patient does. A certificate is a snapshot, not a life sentence. An applicant whose global score sits just under the benchmark today may cross it after a relapse and a longer illness course, and one certified during a severe episode may fall below the band after sustained recovery. Re-assessment when the clinical picture changes materially is part of using the instrument honestly, and it protects both the patient's genuine entitlements and the integrity of the certificate.

In mental illness the disability percentage is read off the IDEAS global disability score, and **40%** is the benchmark that opens the statutory entitlements reserved for benchmark disability.

17.6 The certificate: its reach, appeal and boundaries

Two features of the issued certificate are heavily tested. First, its reach: the certificate of disability **shall** be valid across the country. This pan-India validity is a deliberate reform of the unique-disability-identity era, replacing a patchwork of State-bound certificates with a single document a person can carry and use anywhere in the country. Second, its challengeability: the Act provides an appeal against the certifying authority's decision to an appellate authority the State designates, so a wrongly refused or wrongly graded applicant is not left without remedy. A candidate who names both the country-wide validity and the existence of an appeal shows the whole shape of the procedure, not just its front end.

Finally, the boundary that keeps this topic clean. The disability certificate is one of several psychiatric certifications and must not be confused with the others. It is not the certificate of fitness to resume a job, nor the assessment behind a workmen's compensation or disability-pension claim, nor the certificate or report a psychiatrist prepares for a court, which belongs to the Forensic ethics, consent and legal procedure notes. Each answers a different legal question

with a different instrument, and IDEAS and the benchmark threshold belong to this certification alone; they should not be borrowed to answer a fitness-to-work or a compensation question. Equally, the entitlements this certificate unlocks - the reservations, concessions, benefits and the guardianship framework of the disability statutes - are taken up in a separate section of these notes. Here the work ends at the certified percentage, which is exactly where the law means it to end and the next topic to begin.

18 · Benefits, reservations and guardianship under RPWD and National Trust Act

Why the marks are here. Guardianship is the point where disability law stops being about entitlements and starts being about a person's legal capacity to decide for themselves. Two Indian statutes govern it, and a candidate is expected to keep them apart. The Rights of Persons with Disabilities Act rebuilt guardianship around a rights-based, supported model; the National Trust Act built a separate, committee-appointed route for a defined group of developmental disabilities. Both create a machinery for a supporting or substitute decision-maker, both use the word guardianship, and by a quirk both place that machinery at the same-numbered section of their own Act, which is exactly why answers confuse them. The examiner is testing whether you know which statute reaches which person, and what kind of guardianship each actually confers.

The benefits-and-reservations half of this topic flows from the same rights-based logic. The Rights of Persons with Disabilities Act converts disability from a welfare category into a set of enforceable entitlements in education, employment and public schemes. The stronger of those entitlements attach to a person certified as having a benchmark disability, and how that certification is done, its instrument and its threshold, is taken up separately in this chapter's account of disability certification and is not reconstructed here. What follows is the guardianship framework in full, and the shape of the entitlements it exists to support.

> RPWD guardianship defaults to a limited, supported, decision-specific guardian appointed by a court or designated authority; the National Trust Act runs a separate, committee-appointed guardianship for its named developmental disabilities, and the two must never be merged.

Two	Limited	Committee	Support
PARALLEL STATUTES	THE RPWD DEFAULT	THE NATIONAL TRUST ROUTE	NOT SUBSTITUTION

18.1 From substituted to supported decision-making

The older Indian frameworks treated a person of unsound mind as globally incapable and installed a guardian to decide in their place. That is **substituted decision-making**, and its guardianship is **plenary guardianship**: a standing, all-purpose authority over the person and often their property. The Rights of Persons with Disabilities Act rejects this as the default. It begins from the presumption that capacity is retained, it offers support first, and it turns to a guardian only where a person, even after adequate and appropriate support, still cannot take legally binding decisions. This is **supported decision-making**, and the statute gives it a specific

legal form, **limited guardianship**, in which the guardian assists a decision rather than overriding it.

Why this shift matters clinically is easy to lose behind the vocabulary. A person's capacity to decide is rarely all-or-nothing: it is specific to a decision and it can change over time. A guardianship that removes decision-making wholesale, once and for all, mismatches that reality, disempowers the person, and invites abuse of the arrangement. A guardianship built to fit the decision that is actually in difficulty, and to expire when it is no longer needed, matches the clinical facts and keeps the person at the centre of their own life. That is the design intent the Act writes into law.

RULE **Guardianship under the RPWD Act is support, not substitution.** The default is a limited guardian who decides jointly with the person, for a defined decision and a defined period, in line with the person's own will; total support, subject to review, is the exception the court must specifically justify, never the starting point.

18.2 RPWD guardianship: the limited guardian

The reform is codified at section **14** of the Rights of Persons with Disabilities Act, headed Provision for guardianship. The trigger is deliberately narrow. Where a district court, or a **designated authority** notified by the State Government, finds that a person with disability who has already been given adequate and appropriate support is still unable to take legally binding decisions, that person may be provided the further support of a limited guardian to take legally binding decisions on their behalf, and to do so in consultation with the person. The modal verb matters: the court may provide this support, it is not bound to, and it enters only after ordinary support has already been tried and has not sufficed.

What limited means is defined inside the section, and it is the examinable core. Limited guardianship is a system of joint decision resting on mutual understanding and trust between the guardian and the person, and it carries these mandatory features:

- it shall be confined to a specific period, not granted as an open-ended status;
- it shall be confined to a specific decision or situation, not extended to the person's life at large; and
- it shall operate in accordance with the will of the person with disability, so the guardian gives effect to the person's own choice rather than displacing it.

The section also builds in an escape valve and a mandatory overlay. By its proviso, the court or designated authority may grant total support where the person genuinely requires it, or where limited guardianship would otherwise have to be granted repeatedly, subject to review, so the default is limited but total support, subject to review, remains available on the facts and under scrutiny. Separately, under **14(2)**, every guardian appointed for a person with disability under any other law is deemed to function as a limited guardian on and from commencement, an overlay that is not confined to appointments made before the Act and continues to catch guardians appointed under other laws afterward. Where the designated authority has appointed

the guardian, an appeal against that decision lies to an appellate authority notified by the State Government. Read together, these provisions make limited guardianship the rule, total support the justified exception, and the person's own will the standard the guardian is held to.

18.3 The National Trust Act route: the Local Level Committee

Running parallel to the RPWD scheme is the guardianship route under the National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, **1999**. This route is confined to the **four** conditions named in the Act's own title, and it is administered not by a court but by a **Local Level Committee** constituted under the Act. Its guardianship provision sits at section **14**, headed Appointment of guardianship, and its whole character is different from the RPWD instrument.

Two kinds of applicant may approach the committee. A parent of a person with disability, or a relative, may apply for the appointment of a person of their own choice to act as guardian. A **registered organisation** may also apply in the prescribed form, but here the Act adds a safeguard: no such application shall be entertained unless the consent of the person's existing guardian is also obtained. In deciding an application the committee shall consider two matters:

- whether the person with disability actually needs a guardian; and
- the purposes for which the guardianship is required.

The committee receives, processes and decides these applications and sends the particulars onward, and it also retains the power to remove a guardian it has appointed. The committee appoints the guardian for a defined group of developmental disabilities and orients the arrangement to the person's continuing care; but like every guardian appointed under a law other than the RPWD Act, that guardian is also deemed to function as a limited guardian under **14(2)** of the RPWD Act, so the committee supplies the appointing forum while the RPWD Act supplies the guardianship's limited, supported character. That is why families of children with autism or cerebral palsy are so often directed to the committee rather than to a court, and why the two statutes cover genuinely different ground even though the resulting guardian's authority is the same limited kind.

> **PITFALL**
>
> Do not route every guardianship request to the Local Level Committee. That door is open only for the conditions the National Trust Act names. A person whose disability is a mental illness lying outside those conditions falls under the Rights of Persons with Disabilities Act, before a court or a State-notified designated authority, and steering such a family to the wrong body costs them months they often cannot spare.

18.4 Two statutes, two guardianships, one confusion

Because the two Acts place guardianship at the same section number and use the same word for it, the commonest examination error is to describe one route with the features of the other. The way to protect the mark is to hold the axes apart and answer across all of them. The accompanying table sets out the discriminations an examiner tests.

AXIS	RPWD ACT, LIMITED GUARDIANSHIP	NATIONAL TRUST ACT ROUTE
Appointing body	District court, or a State-notified designated authority	Local Level Committee constituted under the Act
Default model	Limited, supported, joint decision-making	Committee-appointed for continuing care, but deemed a limited guardian under RPWD **14(2)**
Whom it reaches	Any person with disability under the Act's broad definition, not confined to the Schedule of specified disabilities	Only the developmental conditions the Act names
Who initiates	Follows a finding that support has not sufficed; done in consultation with the person	A parent, a relative, or a registered organisation applies
Scope and tenure	Confined to a specific decision and a specific period; total support only by justified exception	Appointment of a guardian for the person, removable by the committee
Underlying philosophy	Rights-based; capacity presumed; least restriction	Welfare and continuing care of a defined group

TRAP **Both provisions carry the same section number and the same label, yet they are different laws.** A candidate who memorises the guardianship section as one undivided fact loses the mark the instant the stem names a condition or an appointing body. The RPWD provision is limited and court-led and reaches any person with disability under the Act's broad definition, not merely the Schedule's specified disabilities; the National Trust provision is committee-led and confined to the conditions its Act names. Name the statute before you name the section, and the features fall into place.

GOOD TO REMEMBER

When a family asks you about guardianship, two questions settle the route before any form is filled: does the person's condition fall within the ones the National Trust Act names, and is a standing, total arrangement really needed, or would a limited guardian for a specific decision suffice? Reach for the least restrictive option that will work, and record why anything more was necessary, because both the statute and any later review will ask you exactly that.

18.5 Benefits and reservations, and where guardianship fits

Where the law bites in practice. The Rights of Persons with Disabilities Act does more than forbid discrimination; it creates positive entitlements. It reserves opportunities in higher education and in government employment for persons with benchmark disability, and it directs government to frame benefits and welfare schemes touching the education, health, livelihood and social security of persons with disability generally. The structural point the examiner wants is that the more substantial of these entitlements attach to a person recognised as having a **benchmark disability**, which is the qualifying category the Act uses to target its stronger

reservations and benefits. The precise proportions reserved, and the section numbers that carry them, belong to the salient-features treatment of this Act and are not asserted here.

How that recognition is assessed and certified, including the instrument used and the threshold that fixes a benchmark disability, is dealt with separately in this chapter's account of disability certification, and it should not be rebuilt in a guardianship answer. What matters for the present topic is the join between the two halves. A person may need a guardian precisely because a disability that affects decision-making is also what qualifies them for these entitlements, and a guardian, above all a limited guardian working in consultation with the person, is frequently the one who helps give those entitlements effect, from an educational place to a pension to enrolment in a scheme. The general civil-law machinery for managing the property and affairs of a person with mental illness sits outside both disability statutes and is taken up separately in these notes.

IN INDIA

Section **14(1)** gives the district court and any State-notified designated authority concurrent jurisdiction over a guardianship application, so a family may go to the district court whether or not an authority has been notified; in States that have not notified an authority, the district court remains the readily identifiable forum, so families meet very different waiting times from one State to another. The National Trust route, by contrast, is built to be reached locally through its committees, which is one reason it remains the practical first stop for parents of children with the developmental disabilities it covers, even though its guardianship is the less rights-forward of the two models. A psychiatrist who knows which door opens for which person, and can say so plainly to a family, saves them a great deal of avoidable delay.

In the examination this topic rewards the candidate who leads with the supported-decision reform, keeps the two guardianship routes cleanly apart, matches each modal duty to its correct statute, and treats benefits and reservations as entitlements gated by a certification taught elsewhere. Say those things in that order, name both Acts, and the answer reads as the work of someone who has understood the law rather than only memorised its headings.

Substance and narcotics law

19 · NDPS Act 1985 (salient provisions, classification of substances)

Why the classification carries the marks. The Narcotic Drugs and Psychotropic Substances Act, 1985, the NDPS Act, is India's principal criminal-control statute for drugs of abuse, and in an examination almost every mark it yields sits in two places: how the Act defines the substances it governs, and how it grades an offence by the quantity involved. This is not a pedantic point. How heavily an act is punished, and whether a route out of the criminal process toward treatment is open, follow substantially from which statutory class a substance occupies and in what amount it was held; but class and quantity alone do not decide whether the act is an offence at all, since the Act carries its own exception for medical or scientific dealing conducted within its rules, orders

and an applicable licence, permit or authorisation, and a treatment route further depends on addiction, voluntariness, a qualifying institution and the treatment being undergone. Get the class wrong and every conclusion built on top of it is wrong.

The discipline this topic really teaches is to read the Act as a lawyer reads it, from the primary text and by the Act's own definitions, rather than as a pharmacologist reads it. The statute does not ask what a molecule does in the brain; it asks where the law has placed that molecule. The clinical face of substance use, the dependence syndromes, withdrawal states and de-addiction pharmacology, sits outside this frame and is developed in the Substance use disorders notes; here the object is narrower and sharper, the law of classification itself.

Named	Listed	Notified	By statute
NARCOTIC DRUG, NAMED IN THE ACT AND EXTENDABLE BY NOTIFICATION	PSYCHOTROPIC SUBSTANCE, FIXED BY THE SCHEDULE	QUANTITY BANDS, SET BY THE CENTRAL GOVERNMENT	CLASS FOLLOWS THE LAW, NOT PHARMACOLOGY

19.1 Two classes, and a scheme graded by quantity

The Act builds its control in two central moves. It first names the things it governs, and for classification of controlled drugs the two principal statutory classes are narcotic drugs and psychotropic substances, distinct from the separate controls the Act carries elsewhere for precursor or controlled substances and for specified plants. It then criminalises the operations carried out around those two classes, the production, manufacture, possession, sale, purchase, transport and warehousing, together with the financing and harbouring that support them, subject to the Act's own exception for medical, scientific and otherwise licensed dealing conducted within its rules, orders and authorisations. On top of that prohibition it lays a graded scheme of punishment for many of its principal offences, in which the severity of the sentence tracks the quantity involved rather than the identity of the drug alone; several other offences under the Act carry offence-specific penalties independent of that quantity scheme. The examinable salient provisions are therefore not scattered across the Act; they gather at the front, in the definition clauses that fix the two classes, and in the quantity definitions that drive the sentence for the offences that turn on them.

Everything in the topic hangs off one organising idea, and it is worth stating before any single definition is opened: under this Act, what a substance is is a question answered by the statute, not by pharmacology. The Act works by naming and by listing, and a substance is controlled because the law has placed it in a controlled category, not because of what it does to the nervous system. This is the point a well-drilled candidate returns to whenever a definition looks counter-intuitive.

RULE **Classification under the NDPS Act is statutory, not pharmacological.** A substance falls within the Act because the Act's text names it or its Schedule lists it, not because of how the substance behaves in the body. Reason from the definition outward; reasoning inward from a drug's action is the single most reliable way to place a substance in the wrong class.

19.2 The narcotic drug: a means-and-includes definition

The Act's definition of a **narcotic drug** sits at section **2(xiv)**, and its drafting rewards close reading because the structure is itself examinable. The definition operates by **means and includes**: it first means a short, named set of substances, and then includes a further category on top. The named substances are:

- coca leaf;
- cannabis, in the sense the Act gives to hemp;
- opium; and
- poppy straw.

To that closed list the definition then adds its inclusion: it takes in all manufactured drugs as well. The means half is a fixed enumeration; the includes half opens the class to the category of manufactured drugs, which the Act defines separately on its own terms in another of its definition clauses. Read together, a narcotic drug is whichever of the named plant-derived substances the Act lists, together with the manufactured drugs the Act separately brings in, a closed list plus an inclusion, not an open description that a court is left to fill in.

Two features of that definition carry marks. First, the enumeration combines the closed list of four named source materials with a further inclusion for manufactured drugs, and a candidate should be able to recite the named heads rather than assume every manufactured drug is simply a derivative of one of them, since the Central Government can itself notify further substances into the manufactured-drug limb without touching the named list. Second, and more importantly, membership does not depend on pharmacology at all, and that is exactly where the classic error lives.

TRAP **Reading narcotic drug as a pharmacological category, and so excluding cannabis.** The everyday medical meaning of narcotic is a sedating opioid-type agent, and a candidate who imports that meaning reasons that cannabis, not being pharmacologically narcotic, must fall outside the definition. The statute says the opposite: cannabis is named in the enumeration and is a narcotic drug in law. Narcotic here is a legal label the text attaches, not a pharmacological description of the drug.

PITFALL

Trusting a secondary source for the exact words of the definition. The operative closing words of the narcotic-drug definition are all manufactured drugs. A widely used online case-law source reproduces the final word as manufactured goods, which is a transcription slip; the primary Gazette text of the Act reads drugs. When the precise word matters, and in a criminal statute it always does, verify the wording against the primary text of the Act rather than an aggregator, because one wrong noun quietly changes what the class contains.

19.3 The psychotropic substance: defined by the Schedule

The second class is built on a different mechanism, and the contrast between the two mechanisms is the heart of the topic. A **psychotropic substance** is defined at section **2(xxiii)**

not by naming particular drugs in the body of the Act, but by reference to a list. It means any substance, natural or synthetic, or any natural material, or any salt or preparation of such a substance or material, that is included in the list of psychotropic substances specified in the **Schedule** to the Act. Put plainly, a substance is psychotropic for the purposes of this Act if, and only if, it appears in that Schedule.

The definition is deliberately wide in one direction and narrow in another. It is wide in reach: it sweeps in natural and synthetic substances, raw natural materials, and any salt or preparation of them, so that a controlled substance cannot slip out of the class simply by being presented as a derivative or a formulation. It is narrow in gate: however broadly those words describe candidate substances, none of them is a psychotropic substance in law unless the Schedule actually lists it. The breadth describes what can be controlled; the Schedule decides what is.

This is the practical significance of a list-based definition. Because the controlled class is whatever the Schedule contains, the Act's reach over psychotropics can be extended by adding a substance to the Schedule, without reopening and rewriting the parent definition each time a new drug of abuse appears. The definition supplies the frame; the Schedule supplies the current contents. It is precisely this that separates the two classes in their primary mechanism: a narcotic drug's named list sits fixed in the Act's own enumeration, though its manufactured-drug limb can itself be widened by further Central Government notification, while a psychotropic substance is fixed entirely by the Schedule the Act carries with it.

19.4 Narcotic drug versus psychotropic substance

Because the two classes are defined by different machinery, a direct contrast is the examiner's favourite way into the topic. Setting them side by side on shared axes makes both the difference and its consequence easy to hold under pressure.

AXIS	NARCOTIC DRUG	PSYCHOTROPIC SUBSTANCE
WHERE THE CLASS IS FIXED	Enumerated in the body of the Act itself	Listed in the Schedule the Act carries
FORM OF THE DEFINITION	Means a named set and includes manufactured drugs, a closed list plus an inclusion	Means any substance, material, salt or preparation included in the Schedule, a gate by listing
WHAT IT TAKES IN	Coca leaf, cannabis, opium, poppy straw and manufactured drugs	Whatever the Schedule specifies, natural or synthetic, and their salts and preparations
RELATION TO PHARMACOLOGY	None: membership is by name, not by drug action	None: membership is by listing, not by drug action
HOW THE CLASS GROWS	By naming more in the Act itself, or by Central Government notification widening the manufactured-drug limb	By adding entries to the Schedule

MNEMONIC

Narcotics are Named; Psychotropics are Placed

Two words fix the whole contrast. A **Named** class: narcotic drugs are named in the Act's own enumeration. A **Placed** class: psychotropic substances are whatever has been placed in the Schedule. Hold which class is Named and which is Placed, and you can reconstruct both definitions and their key consequence, that a new psychotropic arrives by way of the Schedule while the named narcotic list sits in the Act itself. Qualify the mnemonic before relying on it: the manufactured-drug limb of the narcotic-drug definition can itself be widened by Central Government notification, so a narcotic drug is not confined only to what the Act names in so many words.

19.5 Classification by quantity: the graded scheme

The second axis of classification is amount, and it is what turns one prohibited act into a minor matter and another into a grave one. Once a substance is within either class, the Act does not punish every dealing with it identically: for many of its offences it grades the offence by the quantity involved, and it does so through two further definitions. A **commercial quantity**, at section **2(viia)**, is any quantity greater than the amount specified for that substance by the Central Government by notification in the Official Gazette. A **small quantity**, at section **2(xxiiia)**, is any quantity lesser than the amount similarly specified. Between the two lies an intermediate band, more than small but less than commercial, and the three bands attract punishment of ascending severity:

- a small quantity, drawing the lowest tier of punishment;
- an intermediate quantity, more than small but less than commercial, drawing the middle tier; and
- a commercial quantity, drawing the highest tier.

The structural point, and the one the exam rewards, is where the actual thresholds live. The Act does not fix the numbers. It defines the small and the commercial quantity by reference to amounts the Central Government specifies, substance by substance, in a Gazette notification, and the executive can revise those amounts without amending the Act. That is why an answer should state the scheme and its mechanism and should never attempt to recite thresholds from memory: the operative figures do not sit in the Act at all, they sit in delegated legislation, and they differ for every substance.

IN INDIA

The load-bearing feature of the Indian scheme is that the small-quantity and commercial-quantity thresholds are set by Central Government notification in the Official Gazette, not written into the Act. This keeps the classification responsive, because a threshold can be added or revised for a substance administratively, but it also means the operative numbers live outside the statute, in delegated legislation that a practitioner has to consult separately. The quantity seized, measured against the notified figure for that particular substance, is what fixes the band, and with the band the gravity of the charge.

The small-versus-commercial line does more than scale a sentence; for the individual relief provisions it also marks an outer limit, and that limit sits at small quantity itself, so an intermediate-quantity offence, more than small but below commercial, already falls outside that relief and not only a commercial-quantity offence does. The relief the Act extends to a qualifying addict is confined to the Act's consumption offence or to another offence involving a small quantity, not to offences sorted loosely into personal-consumption versus trafficking labels, and it does not reach an intermediate or commercial-quantity offence; a separate, systemic power the Act carries for the Government to establish treatment centres is not gated by offence-quantity at all. The full machinery of that individual relief, who qualifies, on what conditions, and how it sits against prosecution, is a distinct provision developed separately in these notes on the treatment and de-addiction side of the Act; what matters here is only that the quantity classification is part of the gate through which any such relief must pass.

GOOD TO REMEMBER

For the treating psychiatrist the quantity line is not an abstraction. Whether a dependent patient found with a substance faces the heaviest tier of the Act, or is instead eligible for the treatment-oriented route the Act reserves for consumption or small-quantity cases, turns on the class and the amount together. Knowing that the thresholds are notified rather than fixed in the Act, and that they differ by substance, is what keeps a clinician from either falsely reassuring a patient or overstating the jeopardy when the family asks what a seizure means.

Under the NDPS Act classification is a statutory question and not a pharmacological one: a narcotic drug is enumerated in the body of the Act, a psychotropic substance is whatever the Schedule lists, and for many of its offences the gravity is graded across small, intermediate and commercial quantities whose thresholds the Central Government fixes by notification rather than the Act.

20 · Treatment and de-addiction provisions, immunity for addicts under NDPS

Why the marks sit here. The Narcotic Drugs and Psychotropic Substances Act is remembered as a punitive statute, and for the trafficker it is exactly that. For the dependent user it also carries a reformative limb, and it is that limb the examiner probes, because answering well forces a candidate to separate three different powers that all point toward treatment yet operate at

different stages of the criminal process and under different modal verbs. One provision bars prosecution without requiring a finding of guilt. One lets a convicting court divert an offender into treatment instead of prison. One empowers the State to build the treatment system itself. Each is conditional, and reciting the headline without its conditions is how the mark is lost.

The idea that ties the limb together is that the law treats dependence as a condition to be treated rather than only an offence to be punished, but for the two individual routes below, that grace extends only to the consumption offence and to offences involving small quantity. The moment an offence involves more than small quantity, including the intermediate band below commercial, those two reformative routes fall away and the punitive machinery applies in full; the third, systemic provision carries no equivalent offence-quantity threshold, because it is a power to build the treatment system rather than an individual defence. Holding that boundary in mind keeps the two individual routes below in their correct scope, and the reader who wants the classification of quantities and substances that sets those bands will find it developed separately in these notes on the salient provisions of the Act. Here the object is narrower: the treatment, de-addiction and immunity provisions themselves.

Pre-conviction	Post-conviction	Systemic
IMMUNITY FOR THE ADDICT WHO VOLUNTEERS	RELEASE FOR TREATMENT IN PLACE OF SENTENCE	POWER TO ESTABLISH DE-ADDICTION CENTRES

20.1 Immunity from prosecution for the addict who volunteers

The reformative limb opens with a pre-conviction protection at Section **64A**, which grants **immunity from prosecution** to a dependent user who comes forward for treatment, without requiring a finding of guilt, and even while a prosecution against him is already pending. The provision reaches only a person who is an **addict**, which the Act defines as a person who is dependent on any narcotic drug or psychotropic substance. The immunity is not a pardon and it is not automatic; it is a conditional bar that attaches only when a defined set of facts is present, and the examiner rewards the candidate who can state those facts rather than the slogan.

The conditions must be read together, because the failure of any one of them dissolves the protection:

- the person is an addict within the meaning of the Act;
- he is charged with the offence of consumption of a narcotic drug or psychotropic substance, or with an offence involving only a **small quantity** of such substances, so that the bar does not extend to an offence involving more than small quantity, whatever that offence is labelled;
- he **voluntarily** seeks to undergo medical treatment for de-addiction;
- the treatment is at a hospital or institution **maintained or recognised** by the Government or a local authority; and
- he actually undergoes that treatment.

Where those conditions are satisfied the Act provides that he **shall not be liable to prosecution** for the consumption offence, or under any other section, for offences involving a small quantity.

The verb is mandatory. Once the addict has genuinely volunteered and undergone treatment at a qualifying institution, the bar operates as a matter of right, and the prosecuting agency has no discretion to insist that he nonetheless be tried. This is the design choice worth understanding: the State is prepared to forgo the prosecution of a consumption or small-quantity offence in exchange for the offender placing himself in treatment, because a treated dependent user serves the Act's purpose better than a punished one, while an offence involving more than small quantity, whatever it is called, is deliberately left outside; the boundary the Act draws is quantity, not the informal label of trafficking.

RULE **The bar on prosecution is mandatory; its withdrawal is discretionary.** The Act says the qualifying addict shall not be liable to prosecution, but the accompanying proviso says the immunity may be withdrawn if he does not undergo the complete treatment for de-addiction. The two halves of the same provision carry different modal verbs, and that split is the whole point. Protection is guaranteed to the one who completes; only the failure to complete reopens the door to prosecution, and even then the reopening is a discretion to be exercised, not an automatic consequence.

PITFALL

The provision is routinely recited as blanket immunity for a drug offence. It is nothing of the kind. It is confined to the consumption offence and to offences involving small quantity; a person whose offence involves more than small quantity, whatever it is labelled, gains nothing by volunteering for treatment. Equally, the immunity presupposes that the treatment was at a maintained or recognised institution and that it was actually undergone. Stating the immunity without its scope, or without those preconditions, is the commonest way the rule is misapplied at the bedside and in the exam alike.

20.2 Release for treatment in place of a sentence

Where the immunity route requires no finding of guilt, the second lever operates only after conviction. Section 39 gives the court a power of release on **probation** for treatment. When an addict is found guilty of the consumption offence, or of an offence relating to a small quantity, the court **may**, instead of sentencing him at once to any imprisonment, and **with his consent**, direct that he be released to undergo medical treatment for **de-toxification** or de-addiction. This is a judicial discretion, not an entitlement of the offender: the modal verb is permissive, and the offender's consent is a precondition, so the court may decline the course and the offender may refuse it.

The discretion is structured rather than open. The court exercises it having regard to the age, character, antecedents, or physical or mental condition of the offender, and only where it is of the opinion that it is expedient to do so. Release is then conditioned on the offender entering into a bond, with or without sureties, to appear and furnish a report on the result of his treatment within a period **not exceeding one year**, and meanwhile to abstain from any offence under the Act's substantive offences chapter. The treatment must be at a hospital or institution maintained or recognised by the Government; unlike the immunity provision, this route has no local-

authority alternative, so the two routes are close but not identical in the class of facility they accept.

The provision then looks past the treatment episode. After considering the report on the result of the treatment, the court **may** direct the release of the offender after due admonition, on his entering into a further bond to be of good behaviour and to abstain from the substantive offences for a period **not exceeding three years**. The structure is therefore a supervised pathway that runs from conviction, through a treatment episode reported back to the court, to a probationary discharge on good behaviour, the whole of it turning on the offender's consent and on the treatment report he furnishes to the court, rather than on incarceration.

> **GOOD TO REMEMBER**
>
> When an addict has been diverted under this power, the psychiatrist's report on the result of treatment is the very document the court acts on. Recording that the patient presented, engaged with treatment, and the outcome of that engagement is what the report conveys to the court; the further, good-behaviour release turns on that report being furnished and considered, not on a defined course being completed, though a report showing non-engagement leaves the court free to fall back on sentence. The clinical content of that de-addiction course, the pharmacology of detoxification and relapse prevention, belongs to the Substance use disorders notes; what the statute needs from the clinician is an accurate account of engagement and outcome.

20.3 Building the treatment system: establishing de-addiction centres

The first two provisions presuppose that a qualifying institution exists to treat the addict; the third supplies the power to create one. Section **71** empowers the Government to build the de-addiction infrastructure. In its current, amended form it provides that the Government **may** establish, recognise or approve as many centres as it thinks fit, and it names the purposes those centres serve:

- identification, treatment and management of addicts;
- education, after-care and rehabilitation;
- **social re-integration** of addicts; and
- supply of narcotic drugs and psychotropic substances to addicts registered with the Government, and to others where such supply is a **medical necessity**.

The verb is again permissive. This is an enabling power the Government may exercise, not a duty to place a centre in every district, and a second limb allows the Government to make rules for the establishment, maintenance, management and superintendence of such centres and for the supply of the controlled substances from them. It is that controlled-supply purpose that distinguishes the provision from an ordinary health-service enabling clause: the section enables the concerned Government, subject to such conditions and in such manner as may be prescribed, to supply narcotic drugs and psychotropic substances to registered addicts and where supply is a genuine medical necessity. It is not itself a licence, and it does not by itself legalise a centre's or clinician's own supply; compliance with the Act, its rules, orders and any applicable authorisation

remains necessary before supervised substitution or maintenance services can rest on firm ground.

One point of currency is examinable here. Older textbooks quote the original wording, under which the Government might, in its discretion, establish such centres; the current text broadened that to establish, recognise or approve, and expressly added management and social re-integration to the list of purposes. The modern provision should be cited in its amended form, and an answer that reproduces the older discretion-only wording as though it were the current law dates itself.

IN INDIA

The reformative limb only works if a qualifying institution is actually within reach, which is why this provision matters in Indian practice as much as the immunity itself. The two individual routes each require treatment at a qualifying institution, though the qualifying class differs slightly: the immunity route accepts recognition by the Government or a local authority, while the release-for-treatment route requires recognition by the Government alone. The crucial practical question for a clinician asked to support a claim of protection under either route is whether the treating facility carries the recognition that route requires. A course completed at an unrecognised facility does not answer the statute, however good the care. The centres provision is different in kind: it is the power by which Government establishes, recognises or approves such centres and, subject to prescribed conditions, supplies controlled substances through them; it is not itself an individual eligibility condition, and it does not licence a centre's or clinician's own supply. The clinical work delivered inside such a centre lies beyond the statute.

20.4 Reading the provisions correctly: stage, consent and the modal verbs

Where candidates come unstuck. The three provisions are easy to blur into a single sentence to the effect that the Act lets addicts get treatment instead of punishment, and that blur costs marks because it hides the very distinctions being tested. The two treatment routes for an individual differ in the stage at which they operate, in whose power they are, and in what triggers them; the third provision is not a route for an individual at all but a systemic enabling power. Setting the two individual routes side by side on shared axes makes the differences easy to hold under pressure.

AXIS	IMMUNITY ROUTE (PRE-CONVICTION)	RELEASE-FOR-TREATMENT ROUTE (POST-CONVICTION)
STAGE	Without a finding of guilt; can operate even while prosecution is pending	After a finding of guilt, in place of sentencing
WHOSE POWER	Operates for the addict as of right once the conditions are met	A discretion of the convicting court
STATUTORY VERB	Shall not be liable to prosecution, a mandatory bar	The court may direct release, a permissive power
CONSENT	Implicit in the act of volunteering for treatment	Express consent of the offender is required
ONGOING CONDITION	May be withdrawn if the complete treatment is not undergone	Bond to furnish a treatment report, then a good-behaviour bond
ELIGIBLE OFFENCES	Consumption and small-quantity offences only	Consumption and small-quantity offences only

The shared floor of the two routes is as instructive as their differences. Both are confined to the consumption and small-quantity end of the Act, both require the offender's willing participation, and both are conditioned on treatment at a recognised institution, though only the immunity route's proviso turns on that treatment being completed; the release-for-treatment route turns instead on a report on the treatment being furnished and considered. What separates them is only the moment at which the law intervenes and the identity of the actor whose choice controls the outcome: before any finding of guilt the choice and the benefit belong to the addict, while after conviction the choice belongs to the court and is exercised only with the offender's agreement.

TRAP **Collapsing the pre-conviction immunity and the post-conviction release into one provision.** They share a purpose and a scope, but one is a mandatory bar that prevents prosecution without requiring a finding of guilt, and can operate even while prosecution is pending, belonging to the addict once he qualifies, while the other is a permissive judicial power exercised only after conviction and only with the offender's consent. A candidate who describes the immunity as the court's discretion, or the release as an automatic entitlement of any addict, has swapped their essential features and forfeits the discrimination the question is testing.

The immunity provision bars prosecution of the addict who voluntarily undergoes complete de-addiction at an institution maintained or recognised by the Government or a local authority, for the consumption offence or an offence involving small quantity; the bar is mandatory, and only his failure to complete treatment may reopen it, and then at the authority's discretion.

Criminal responsibility and forensic assessment

21 · McNaughton rules and Section 84 IPC (insanity defence)

Where the criminal law admits a mind can be too disordered to blame. The insanity defence is the point at which the criminal law concedes that a person may perform the forbidden act and still not be a criminal, because the mind that produced the act was too disordered to carry responsibility for it. It is the oldest of the forensic questions and the most heavily examined, and in an Indian paper it now carries a second, sharper demand: the candidate must show that the substantive law has changed. The unsound-mind exception has moved out of the Indian Penal Code and into the Bharatiya Nyaya Sanhita (BNS), and the rule that fixes who must prove what has moved out of the old evidence law and into the Bharatiya Sakshya Adhiniyam (BSA). The two moves answer different questions: which insanity provision governs turns on the date of the alleged offence, while which evidence law governs turns separately on whether the proceeding was already pending when the Adhiniyam came into force. An answer that recites the old penal-code section as the live law forfeits the currency mark even when the doctrine it states is otherwise sound.

Behind the statute stands one common-law inheritance. Both the superseded Indian provision and the one that replaced it are codifications of the **McNaughton rules**, the answers the English judges gave when asked when madness should excuse. Everything examinable here is an unpacking of that lineage: what the rules require, how the Indian code recast them, what changed on the appointed date and what deliberately did not, and where the law places the burden of proof. It is also the criminal-responsibility face of a wider idea running through the chapter, that capacity is decision-specific and time-specific, one question seen from many legal angles, and its synthesis is drawn together elsewhere. The concern here is the one capacity a court asks about after a crime: whether the accused, at the instant of the act, could know what the law required him to know.

22	84	108	1 July 2024
CURRENT EXCEPTION, BHARATIYA NYAYA SANHITA	HISTORICAL EXCEPTION, PENAL CODE	BURDEN OF PROOF, SAKSHYA ADHINIYAM	RECODIFIED LAW IN FORCE

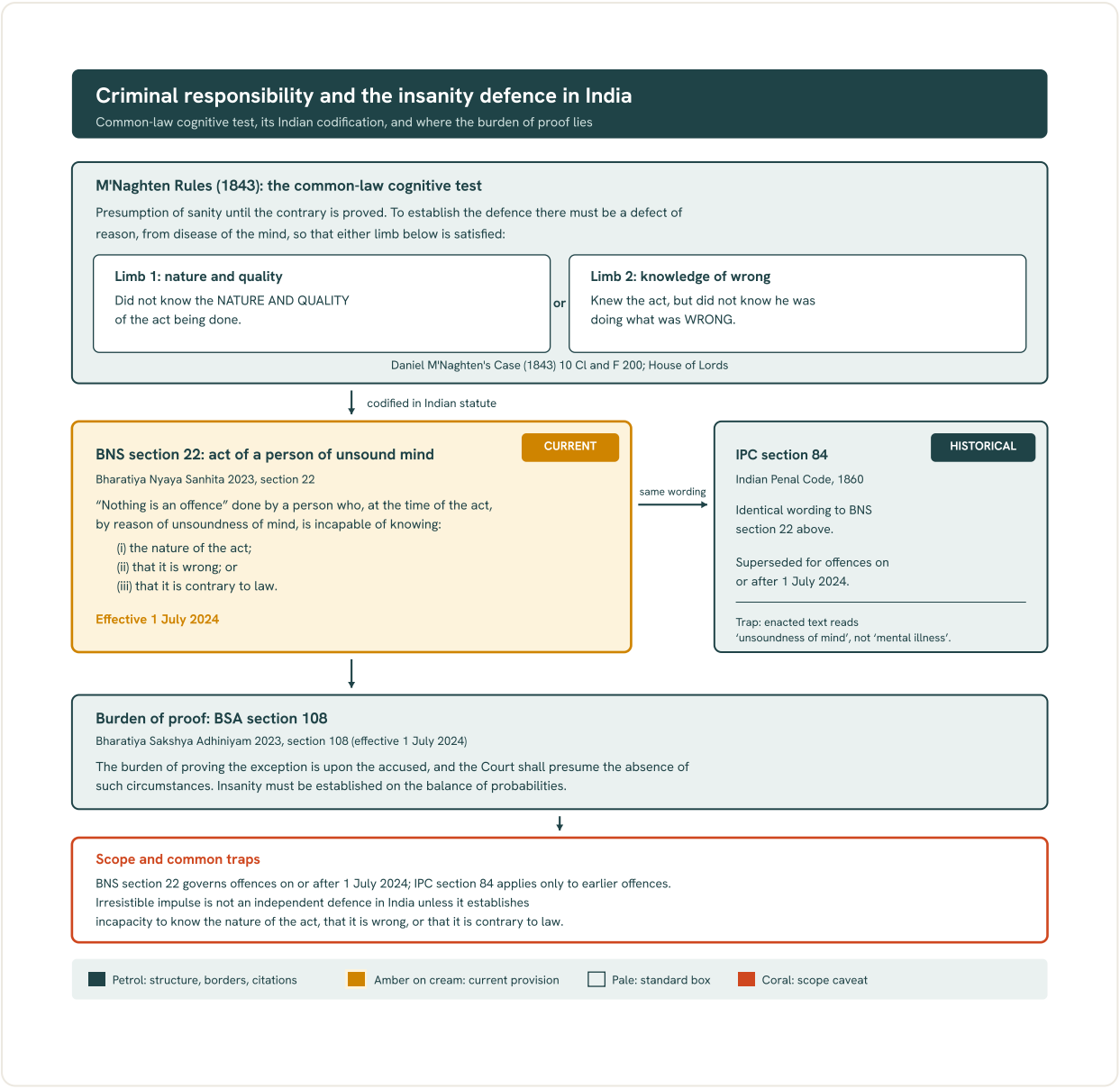


Fig 25.10. Criminal responsibility for the mentally ill offender in India: the two M'Naghten cognitive limbs are codified in BNS section 22 (current, effective 1 July 2024), which reproduces verbatim the wording of the now-historical IPC section 84, while BSA section 108 places the burden of proving the exception on the accused, to the balance of probabilities.

21.1 The McNaughton rules: the common-law origin

The rules take their name from Daniel M'Naghten, tried for a killing carried out under a paranoid delusion and acquitted on the ground of insanity. The acquittal caused enough public disquiet that the House of Lords put questions to the judges, and their replies, offered as an advisory statement of the law rather than as a decision in the case, became the formulation the common-law world has relied on ever since. The defendant's surname is spelled several ways across the reports, M'Naghten and McNaughton among them, and nothing of substance turns on the spelling; what matters is the test the judges set out in **1843**.

Two elements frame the rules before the test proper. The first is a starting position: every person is presumed sane, and to displace that **presumption of sanity** the defence must be clearly proved. The second is a threshold condition: the accused must have been labouring under a **defect of reason** arising from a **disease of the mind**. Ordinary confusion, ignorance or strong

emotion will not do; only a genuine failure of reasoning grounded in mental disease opens the door to the test.

The test itself has two limbs, set in the alternative so that either alone will suffice. At the time of the act, and as a consequence of the defect of reason, the accused either did not know the nature and quality of the act he was doing, or, if he did know that, he did not know that what he was doing was wrong. The whole enquiry is pitched at knowledge, which is why the rules are described as a purely **cognitive test**: they ask what the accused was able to know, not whether he could govern himself. A man who knew precisely what he was doing and knew it to be wrong, yet was driven to it by an urge he could not master, falls outside the rules as framed. That deliberate narrowness is the origin of every later objection to the test, and the alternative formulations devised in answer to it are examined elsewhere in this chapter; the Indian codes, as the following sections show, retained the McNaughton frame rather than discarding it.

21.2 Codification in India: the historical penal-code exception

When the general criminal law of the country was first codified, the McNaughton rules were written into the Penal Code as its general exception for the person of unsound mind, at section **84**. That provision was the Indian insanity defence for well over a century, and it governed the question until the recent recodification. It rendered the common-law test into a single sentence: nothing is an offence which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is incapable of knowing the nature of the act, or that he is doing what is either wrong or contrary to law.

Two features of that recasting repay attention, because both are examined. The drafters kept the legal phrase **unsoundness of mind** rather than any clinical term, holding the exception broad and legal rather than pinned to a diagnosis. And where the English rules spoke only of not knowing the act was wrong, the code opened that single limb into two, wrong or contrary to law, recognising a wider set of cognitive failures than the common-law wording named. Both points are taken up below.

The status of this section is the first thing to state and the easiest to get wrong. It applied before the general criminal law was recodified and it continues to govern offences committed while it was the law in force; it is not the current provision. Naming it as the source of the Indian test is correct; naming it as the live exception for a present-day offence is precisely the currency error this topic exists to catch.

21.3 The current provision, and the date that switched it on

The recodification replaced the Penal Code, and the insanity exception moved across to BNS Section **22**. The Sanhita states the rule in words identical to the historical section, down to the phrase unsoundness of mind and the same set of cognitive incapacities: it reproduced the old exception verbatim and did not modernise it. The doctrine did not change; only the statute book that carries it did.

The examinable pivot is the date. The Sanhita did not fix its own commencement; it left the appointed date to the Central Government, to be notified in the Official Gazette, and the date so

appointed was **1 July 2024**. From that date the Sanhita's exception is the governing substantive provision, and the historical penal-code section recedes to the offences committed before it. The two never compete: which applies is settled entirely by when the alleged act was done, so an opinion that has not first fixed that date may be reasoning under a statute that does not apply to the case.

Note the grammatical force of the provision, because it is not a discretion. It declares that nothing is an offence in the stated circumstances; where the exception is made out the act is simply not a crime, not an offence the court may excuse as a matter of leniency. That declaratory character is what makes the exception a true answer to liability rather than a plea in mitigation.

AXIS	HISTORICAL PROVISION (PENAL CODE)	CURRENT PROVISION (BHARATIYA NYAYA SANHITA)
STATUS	The pre-recodification insanity exception, now superseded	The substantive insanity exception in force
OFFENCES IT GOVERNS	Offences committed before the appointed date	Offences committed on or after the appointed date
WORDING OF THE TEST	Unsoundness of mind; incapable of knowing the nature of the act, or that it is wrong, or that it is contrary to law	Reproduced word for word, without amendment
PAIRED BURDEN STATUTE	Not fixed by this axis. The evidence statute, and so the burden provision, follows the pendency of the proceeding when the Adhiniyam commenced, not the date of the offence: a proceeding already pending continues under the former evidence law, and a proceeding not then pending takes the Bharatiya Sakshya Adhiniyam.	

21.4 Reading the exception: the incapacities, and legal versus medical insanity

The substance of the exception lies in what the accused must have been incapable of knowing, and there are three such incapacities. It is enough that, by reason of unsoundness of mind at the time of the act, the accused was incapable of any one of them:

- that he could not know the nature of the act, its physical character and immediate consequences;
- that he could not know the act was wrong, in the moral sense the law attaches to wrongdoing; or
- that he could not know the act was contrary to law, that it was forbidden by the legal order.

The relation between the second and the third is the fine point examiners reach for. The common-law rules spoke only of not knowing the act was wrong; the Indian code split that into wrongfulness and unlawfulness, so incapacity as to either suffices. The effect is an exception a little wider than the single English word would allow, and a candidate who folds the two back together has quietly narrowed the section its drafters opened.

MNEMONIC

Could not know: the Nature, the Wrong, the Law

The three cognitive incapacities the exception recognises: at the time of the act, and by reason of unsoundness of mind, the accused was incapable of knowing the **N**ature of the act, or that it was **W**rong, or that it was contrary to **L**aw. Any one of the three suffices, and every one of them is about knowing, never about being able to resist.

Legal insanity is the name the courts give to what the section demands, and it is not the same thing as a psychiatric diagnosis. A person may carry a severe mental illness and remain criminally responsible if, at the moment of the act, that illness did not deprive him of the capacity to know the nature of the act, or its wrongfulness, or its unlawfulness. What exempts is not the presence of disease but the specific cognitive incapacity the section describes, assessed at the instant of the act. This distinction between legal insanity and mere medical illness is the most productive discrimination in the topic, and it is why a bare diagnosis, however grave, never on its own makes out the defence.

RULE **Legal insanity, not medical illness, decides the defence, and the test is wholly cognitive.** The exception exempts only the accused who, by reason of unsoundness of mind at the time of the act, was incapable of knowing the nature of the act, or that it was wrong, or that it was contrary to law. It asks nothing about whether he could control his conduct, and it is not satisfied by the presence of a diagnosis, however severe.

AXIS	THE MCNAUGHTON RULES (ENGLISH COMMON LAW)	THE INDIAN CODIFIED TEST
THRESHOLD CONDITION	A defect of reason from disease of the mind	Unsoundness of mind
FIRST LIMB	Did not know the nature and quality of the act	Incapable of knowing the nature of the act
WRONGFULNESS LIMB	Did not know the act was wrong	Incapable of knowing it was wrong, or that it was contrary to law
CHARACTER OF THE TEST	Cognitive; about knowing, not controlling	Cognitive; no volitional limb was added

TRAP **Importing an irresistible-impulse limb the Indian law does not contain.** The exception exempts only the accused who could not know the nature of his act, or its wrongfulness, or its unlawfulness; it says nothing about an inability to resist a known and wrongful impulse. Candidates read a volitional test into the section, or treat any grave diagnosis as automatically exculpatory, and both misstate what is a narrow cognitive rule.

IN INDIA

Indian courts decide the defence on legal insanity, not medical insanity, and they give real weight to the conduct surrounding the act. Evidence of planning, of concealment or of flight after the act tends to show that the accused knew the nature and the wrongfulness of what he did; it may weigh against the exception, but does not by itself defeat it, however unwell he may be. The corollary for the psychiatrist is that the opinion must speak to the accused's capacity to know at the moment of the act, reconstructed from the whole record, and not merely to the diagnosis he carried before or after it.

21.5 Who must prove it: the burden and the presumption

Establishing the defence is not the same as raising it, and the difference is fixed by the law of evidence. The **burden of proof** for the insanity exception, as for every general exception, sits at section **108** of the Bharatiya Sakshya Adhiniyam. Its rule is that when a person is accused of an offence, the burden of proving the existence of circumstances that bring the case within a general exception is upon him, and the court shall presume the absence of such circumstances. The accused therefore does not merely raise the possibility of insanity; he must prove it, and the court begins from the presumption that he was sane.

The standard he must meet is lighter than the one the prosecution carries. The prosecution must still prove the offence beyond reasonable doubt, and that general burden is not displaced; but the accused establishes the exception on the balance of probabilities, the civil standard, which is why an insanity defence can succeed on evidence that would fall short of a conviction. Holding the two standards apart is the examinable core, and the presumption of sanity is what the accused must overcome to reach the exception.

This mirrors the common-law rules, which already required insanity to be clearly proved from a presumption of sanity; the modern evidence statute reproduces the burden rule of the law it replaced, so the allocation did not change with recodification, only the statute that houses it. A candidate must state without hedging that the burden lies on the accused, that the court shall presume its absence, and that the standard resting on him is the balance of probabilities.

For an act done on or after the appointed date the insanity exception is the Bharatiya Nyaya Sanhita provision, which reproduces the old penal-code section word for word; the test is purely cognitive, and the accused must establish it on the balance of probabilities while the court presumes his sanity.

21.6 The psychiatric assessment, and the questions that are not this one

What the psychiatrist decides, and what only the court decides. Because the exception turns on a mental state at one past moment, the assessment is retrospective and functional. The task is to reconstruct, from contemporaneous records, the accounts of the act, the person's own narrative and the known course of any disorder, whether at the time of the act the accused was capable of knowing the nature of the act and its wrongfulness or unlawfulness. The psychiatrist supplies a medical opinion on that capacity; the conclusion of law, that the accused was legally

insane and so not criminally responsible, belongs to the court alone, which reaches it on the whole case and never on the diagnosis alone.

Several neighbouring questions are constantly confused with this one, and each is answered by its own law rather than by the insanity exception:

- whether the accused can be tried at all turns on his mental state at the time of the trial, not the time of the act, so a person may be fit to be tried for an act committed while insane, or unfit to be tried although he was fully responsible when he acted; that trial-time capacity is taken up separately in this chapter;
- whether an abnormality that fell short of the exception can still lower the grade of a killing, and whether an act done without conscious control is answerable at all, are the questions of diminished responsibility and of automatism, treated in their own place in this chapter and not by restating this exception;
- the criminal responsibility of a child, exempted by reason of age rather than of unsoundness of mind, belongs to the Child psychiatry: assessment, treatment, services and protection notes, and not to the insanity defence at all.

The manner in which the opinion is finally put before the court, the form of the report, the certification of the expert to give evidence and the conduct of the testimony, is not part of this substantive law and belongs to the Forensic ethics, consent and legal procedure notes.

GOOD TO REMEMBER

Before writing a line of opinion, fix the date of the alleged act, because that date decides which insanity provision applies to the case; the burden statute is decided separately, by whether the proceeding was already pending when the Bharatiya Sakshya Adhiniyam commenced. Then anchor the opinion to the accused's capacity to know at the moment of the act rather than to the diagnosis he happens to carry, and say plainly where the record cannot support a firm view. The legal label is the court's to attach; your work is the mental state and its bearing on knowing.

PITFALL

Citing the superseded penal-code section as the live insanity provision in a real medico-legal report. For an offence on or after the appointed date the governing exception is the Bharatiya Nyaya Sanhita provision, and a report resting on the old section invites the other side to point out that it relied on a law no longer in force. The wording is identical, so the doctrine survives the slip, but the citation does not, and a discredited citation weakens the witness. Fix the date first, then cite the statute that the date makes applicable.

22 · Other tests of criminal responsibility (Durham, irresistible impulse, ALI)

The insanity defence is not one rule but a family of them. The M'Naghten test that governs the Indian courtroom asks a single, cognitive question: did the accused, by reason of unsoundness of mind, fail to know the nature of his act, that it was wrong, or that it was contrary to law? That narrowness is deliberate and it is taught in full under the McNaughton rules elsewhere in this

chapter, but it leaves two familiar figures outside the door. One is the defendant who knew perfectly well that his act was wrong and yet, driven by illness, could not stop himself. The other is the defendant whose crime seems to pour directly out of a disease process. Anglo-American courts spent a long stretch of the modern era building tests to catch those cases, and the three that recur in every forensic viva are the volitional supplement known as irresistible impulse, the causal Durham or product test, and the two-limbed test of the American Law Institute. The examiner wants three things: the exact formulation of each, where each sits against the M'Naghten baseline, and the point that decides most answers, which is that none of them is Indian law.

Understanding why these tests were built, and why they were then narrowed or abandoned, is worth more than memorising their words. Each was an attempt to fix a perceived defect in the cognitive test, each overcorrected in a different direction, and the arc of American doctrine over the last several decades is essentially the story of the courts finding the right width. India watched that experiment and kept its cognitive frame. A candidate who can narrate that arc, and place the Indian position at the end of it, has the whole topic.

22.1 The cognitive limit that produced the alternatives

Every alternative test is a reaction to the same feature of the M'Naghten rule: it is pitched wholly at knowledge. It asks what the accused was able to know at the moment of the act, and it asks nothing about whether he could govern his conduct once he knew. That leaves a real clinical population unaddressed, the patients whose illness spares cognition but wrecks control, and it was pressure from those cases that drove the reform. Each successor test loosens exactly one constraint and no more, which is why the comparison between them is so clean.

The first line of attack adds a faculty. If a man can know an act is wrong and still be unable to resist it, then a test confined to knowing is incomplete, and the volitional element must be admitted alongside it. The second line of attack abandons the enumerated faculties altogether and asks only about origin: never mind whether he knew or could resist, did the illness cause the act? The third line of attack keeps both faculties but attacks the threshold, replacing total incapacity with a partial one and replacing bare knowledge with a fuller grasp. These are the only three moves available, and the three examinable tests are one each.

RULE **Each alternative broadens the insanity defence along one axis and no more.** Irresistible impulse adds the volitional faculty to a test that had asked only about knowledge; the product test discards the faculties and substitutes causation; the American Law Institute test keeps both faculties but softens the threshold from total to partial incapacity. Identify which axis a test moves and you have understood it.

22.2 The irresistible impulse test

The earliest and most modest departure from the cognitive rule is the **irresistible impulse** test, which does not replace M'Naghten but supplements it. It concedes the cognitive question and then adds a volitional one: the accused may be excused even though he could tell right from wrong, if a diseased mental condition deprived him of the power to resist the impulse to act. Its

classic wording comes from **Smith v. United States**, a District of Columbia decision later quoted in full in the leading product-test judgment. An accused may be excused only where, although able to distinguish right from wrong, his reasoning powers were so far dethroned by a diseased mental condition as to deprive him of the will power to resist the insane impulse to commit the act, though he knew it to be wrong.

Several features of that formulation are worth fixing, because examiners test the discriminations rather than the slogan:

- It presupposes that the cognitive test has been failed on its own terms; the accused did know the act was wrong, so the excusing element is loss of control, not loss of knowledge.
- The impotence of will must be the product of a diseased mental condition, not of ordinary rage, jealousy or intoxication, which is what keeps the test from swallowing every crime of passion.
- It works only as a gloss on M'Naghten, a volitional limb bolted to a cognitive frame, never as a free-standing code of its own.

The objection to the test is evidential rather than logical. No examination distinguishes an impulse that genuinely could not be resisted from one that simply was not resisted, and a court is left accepting an expert's inference about a capacity that leaves no external trace. That difficulty is why the jurisdictions that adopted the test confined it to cases where the collapse of self-control was close to total, and why later reformers preferred a formulation that spoke of degrees of capacity rather than of a single, unprovable moment of surrender.

22.3 The Durham or product test

The boldest experiment swept both the cognitive and the volitional questions aside and asked one thing only. In **Durham** v. United States, decided by the District of Columbia Circuit in **1954**, the court held that an accused is not criminally responsible if his unlawful act was the **product** of mental disease or mental defect. This is the broadest of all the tests: it names no symptom, ties the jury to no particular faculty, and makes the whole enquiry one of causation. It was modelled on an older **New Hampshire rule** that had similarly refused to reduce insanity to a fixed legal formula and had left the question of mental disease to the jury as a matter of fact.

Its breadth was both its appeal and its undoing. By asking only whether the crime issued from illness, the product test allowed the full clinical picture to come before the court and freed psychiatry from having to force its findings through the narrow language of knowing and resisting. But the same breadth cut loose the legal question from any workable standard. With no definition of mental disease and no symptom for the jury to look for, the determination drifted toward whatever the expert witnesses asserted, and the phrase mental disease itself proved unstable as diagnostic fashions shifted. Critics charged that the test surrendered a question of moral and legal responsibility to clinical opinion. The verdict was delivered by the very court that had created the rule: in United States v. **Brawner** it abandoned the product test and adopted the American Law Institute formulation in its place. The product test survives in the examination

chiefly as the cautionary extreme, the demonstration of what happens when the insanity enquiry is made too wide.

22.4 The American Law Institute Model Penal Code test

Between the rigidity of M'Naghten and the formlessness of Durham sits the considered compromise, the test drafted for the **Model Penal Code** at section **4.01**. Its wording restores both faculties while lowering the bar for each. A person is not responsible for criminal conduct if, at the time of the conduct, as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality, or wrongfulness, of his conduct, or to conform his conduct to the requirements of law. The cognitive and the volitional questions are set in the alternative, joined by an "or", so that a failure of either capacity suffices.

Two changes of language carry the whole reform, and both are examined:

- The test asks whether the accused could **appreciate** the wrongfulness of the act, not merely whether he could know it. Appreciation implies an emotional and rational grasp of meaning, deeper than the bare intellectual awareness the older word demanded, and it admits the defendant who could recite that an act was forbidden without truly understanding what that meant.
- The test requires only that the accused lack **substantial capacity**, not that he be wholly incapable. This deliberately abandons the all-or-nothing quality of the older tests and lets the law recognise the partial impairments that clinical reality actually presents.

The drafters also closed the obvious loophole. The formulation expressly excludes an abnormality manifested only by repeated criminal or antisocial conduct, so that a diagnosis resting on the offending record itself cannot be used to bootstrap the defence; the habitual offender cannot convert his history of crime into evidence of the disease that excuses it. Taken together, the test spread across most of the American federal circuits as the settled middle path, until the volitional half of it fell out of favour after a notorious acquittal. The Insanity Defense Reform Act of **1984** removed the volitional prong from federal law, returning the federal test to an appreciation-of-wrongfulness standard and leaving the two-limbed version to those states that retained it.

TRAP **Presenting the product test or the Model Penal Code volitional prong as the current American standard.** The product test was abandoned by the same court that devised it, the District of Columbia Circuit, in Brawner, not by American courts generally, and the volitional limb was struck out of federal law by statute, though state rules still vary and some states retain a volitional element of their own. Write each as a landmark in a doctrinal arc, not as the rule in force everywhere, and never carry either into a statement of what every American court would apply today.

22.5 Reading the tests against one another

The examiner's favourite exercise is to set the tests side by side, and the discriminations are cleanest when each is measured against the M'Naghten baseline on two axes: the faculty it interrogates and the breadth it allows. The accompanying comparison arranges them so, from the narrowest cognitive rule to the widest causal one, with the compromise between.

MNEMONIC

Will, Cause, Both

The alternatives in one line: irresistible impulse tests the **will**, the product test tests **cause**, and the Model Penal Code test restores **both** faculties at a lower threshold. Set against M'Naghten, which tests knowledge alone, this fixes the whole family in memory and tells you at once what each one adds.

TEST	FACULTY IT INTERROGATES	CORE QUESTION	BREADTH AND CURRENT STANDING
M'NAGHTEN (THE BASELINE)	Cognition alone	Could he know the nature of the act, or that it was wrong?	Narrowest; the frame retained in India, taught in full elsewhere in this chapter
IRRESISTIBLE IMPULSE	Volition, added to cognition	Though he knew it was wrong, could he resist the impulse?	A gloss on the cognitive test, never free-standing; not accepted as such in India
DURHAM OR PRODUCT	Neither; causation only	Was the act the product of mental disease or defect?	Broadest; abandoned by the D.C. Circuit in Brawner, not nationwide
MODEL PENAL CODE	Cognition and volition	Did he lack substantial capacity to appreciate wrongfulness or to conform his conduct?	The middle path; the volitional half later dropped in federal law

1954	1962	1972	1984
DURHAM DECIDED	MODEL PENAL CODE TEST FRAMED	PRODUCT TEST ABANDONED	VOLITIONAL PRONG DROPPED, US FEDERAL

22.6 Why India keeps the M'Naghten frame

The alternatives are foreign-law history, not defences you can run here. The Indian insanity defence remains the cognitive right-and-wrong test. The current unsound-mind exception and the historical provision it replaced are set out in full under the McNaughton rules in this chapter, and what matters at this point is what they exclude. India never adopted the product test and never adopted the Model Penal Code standard, and its courts have generally not accepted irresistible impulse as a free-standing defence. Loss of control, by itself, does not answer the question the statute asks. It becomes relevant only where it can be shown to amount to an incapacity to know the nature of the act, that it was wrong, or that it was contrary to law, at which point it has stopped being a separate volitional test and has collapsed back into the cognitive one the Indian codes already contain.

The reasoning behind this conservatism is coherent rather than merely traditional. The cognitive test asks a question that can be reconstructed from evidence, whether the accused knew, and courts can weigh planning, concealment and flight against that claim. A volitional or causal test

asks a question that leaves no external trace and that the same reasoning cannot police, which is precisely the evidential objection that eventually narrowed the American tests too. India, in other words, reached the destination the American arc was travelling toward and simply never left it.

IN INDIA

An accused who knew his act was wrong but says he could not resist it does not, on that ground alone, satisfy the Indian test; a defence pitched purely on loss of control has no statutory footing here, and neither does one pitched on the act being a product of illness. The practical corollary is that an Indian forensic opinion is built around the accused's capacity to know the nature of the act, that it was wrong, or that it was contrary to law, at the material time, and the volitional and causal formulations enter, if at all, only as they bear on that cognitive question.

No alternative test is Indian law: India retains the M'Naghten cognitive frame, and its courts admit irresistible impulse only where it amounts to an incapacity to know the nature of the act, that it was wrong, or that it was contrary to law.

22.7 The alternatives in an Indian medico-legal opinion

The tests matter to the clinician chiefly as a discipline of drafting. A psychiatrist who has absorbed the Western literature naturally reaches for its vocabulary, and it is easy to write an opinion in language a foreign court would recognise but an Indian one cannot use. The examiner rewards the candidate who keeps the clinical description and the legal conclusion apart: describe the illness and its bearing on control and causation as fully as the record allows, then translate that description into the only question the Indian court is empowered to answer.

PITFALL

Offering, as the operative conclusion of a report for an Indian court, that the act was a "product" of the illness or that the accused acted on an "irresistible impulse". However accurate the clinical observation, the court has no test into which those words fit, and the opinion gives the judge nothing on which to decide. The error is one of scope rather than of assessment, and it is the counterpart on this topic of citing a superseded section as the live law.

GOOD TO REMEMBER

Describe volitional impairment and the illness-to-crime link freely in the clinical body of the report, because that is genuine and useful evidence, but anchor the conclusion to the question the law actually asks: at the material time, could the accused know the nature of the act and that it was wrong? Frame loss of control as bearing on that cognitive capacity, not as a test in its own right. The form of the report itself and the certification of the expert to give evidence belong to the Forensic ethics, consent and legal procedure notes.

23 · Fitness to stand trial (criteria, assessment)

A criminal trial is a contest the accused is meant to take part in. The adversarial process presumes a defendant who can hear the charge against him, follow the evidence as it unfolds, and

give his lawyer the instructions from which a defence is built. When mental disorder takes that ability away, to press on would be to try a person who cannot answer the case, which offends the most basic requirement of a fair hearing. So the law asks, before the trial begins and again if the question arises once it is under way, whether the accused can be tried at all. This is **fitness to stand trial**, the same idea the older courts called **fitness to plead**.

The marks gather here because the topic is small, self-contained, and constantly confused with a larger one. The words "unsound mind" appear and candidates reach at once for the insanity defence, answering a question no one asked. Fitness is about the present: can this person be tried now, and it is procedural. Criminal responsibility is about the past: what was his state of mind when he did the act, and it is substantive. Hold those two apart and the topic is clean; blur them and the whole answer slides off the point.

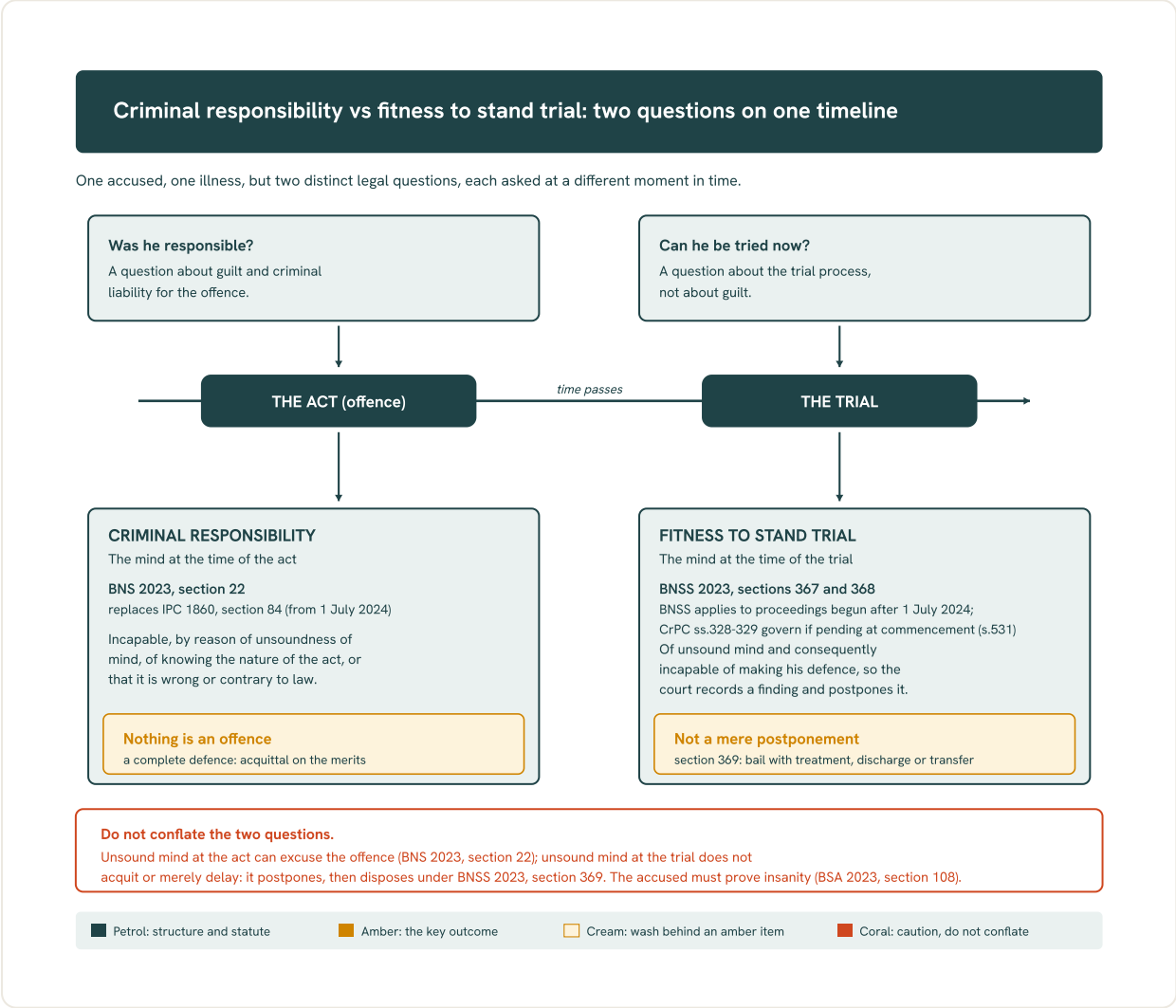


Fig 25.11. Criminal responsibility asks about the accused's mind at the time of the act (BNS 2023, section 22, replacing IPC 1860, section 84); fitness to stand trial asks about his mind at the time of the trial (BNSS 2023, sections 367 and 368). The first can excuse the offence. The second does not acquit and does not merely postpone the trial: on a finding of unfitness the court records the finding, postpones the proceedings, and then makes a disposal under BNSS 2023, section 369, which may release the accused on bail with out-patient treatment, order supervised treatment where bail is refused, discharge the accused on sufficient security, or transfer the accused to a residential facility.

23.1 What fitness to stand trial means

Fitness is the capacity to take part in one's own trial. It is not a measure of general mental health and it is not intelligence; it is a functional, task-specific competence, judged against what the trial actually asks a defendant to do. The statute does not grade the illness. It poses a consequence question: is the accused, by reason of **unsoundness of mind**, rendered **incapable of making his defence**. Two limbs have to be satisfied, and they are joined by the word "consequently": there must be a mental condition, and that condition must be the reason the accused cannot mount a defence. A severe diagnosis that leaves the defendant able to understand the charge, follow the proceedings and instruct counsel does not make him unfit; a less dramatic condition that dismantles those abilities does.

The reason the law insists on this threshold is not therapeutic but a matter of justice. A verdict reached against a defendant who could not understand the proceedings or contribute to his own defence is not a safe verdict, because the process that produced it was not one he could engage with. Fitness protects the integrity of the trial itself, which is why it is examined as a preliminary matter and can be raised at any stage the illness first shows itself, whether at the outset or midway through the hearing.

RULE **Unsoundness of mind bears on fitness only where it makes the accused incapable of making his defence.** The test has two limbs and the second decides it. Establish a mental condition and you have done the first half; what settles fitness is the functional bridge from that condition to the specific abilities a defence requires. A diagnosis, however grave, is not by itself a finding of unfitness, and the absence of florid symptoms is not by itself a finding of fitness.

23.2 Fitness set against criminal responsibility

This is the discrimination the topic is really testing, and it is worth stating in full because so many answers lose their footing on it. The two questions differ on their timeline, their purpose and what a finding does. Fitness looks at the accused as he is at the time of trial and asks whether he can participate; a finding of unfitness suspends the proceedings but says nothing about guilt. Criminal responsibility looks back to the time of the act and asks whether the accused should be held liable for what he did; it is a defence to the charge, decided at trial as part of the verdict. Whether unsoundness of mind at the moment of the offence exempts the accused from liability is governed by the substantive criminal law, now recast in the Bharatiya Nyaya Sanhita in place of the Indian Penal Code, and is taken up elsewhere in this chapter under the insanity defence. It is not restated here.

Because the two run on different axes, they can appear in any combination, and this is what makes them genuinely independent rather than two names for one idea. A defendant may be perfectly fit to stand trial and still argue that he was insane at the time of the act; another may have been fully responsible when he offended but become unfit, through illness arising afterwards, by the time the case reaches court. The first is tried and runs his defence, insanity included; the second cannot be tried at all until he is well enough, and the question of his responsibility simply waits for him. Confusing the two collapses this structure and produces an answer that assesses the wrong moment and the wrong issue.

TRAP **Describing the insanity defence when the question was about fitness.** The shared phrase "unsound mind" lures candidates into reciting the tests of criminal responsibility. But fitness is present-state and procedural and has nothing to do with the mental state at the time of the offence. If your answer is dating the accused's mind to when he acted, you have drifted into the wrong topic and will be marked on a question you were not asked.

Fitness to stand trial asks whether the accused can make his defence now and is decided by the court on medical and other evidence; criminal responsibility asks about his mind at the time of the act. They sit on different timelines and neither answers the other.

23.3 The criteria: what making a defence requires

The statute states the test as incapacity to make a defence and leaves the content of that phrase to be worked out in practice. Unpacked, making a defence calls for a cluster of abilities, each tied to a real demand the trial places on the defendant:

- to understand the charge he faces and what is being alleged against him;
- to understand the nature and object of the proceedings and their possible consequences;
- to follow the course of the evidence as it is given;
- to instruct and communicate rationally with his lawyer, giving the account from which a defence can be run;
- to make the decisions a defendant must make, including how to plead and whether to challenge the conduct of his trial.

These are abilities, not attainments: the law asks whether the accused can do these things, not whether he does them well or wisely. A defendant may make an unwise choice and remain fit, because unwisdom is not incapacity. Common-law systems have distilled the same cluster into named judicial standards, but those formulations are the property of other jurisdictions and are not set out here; what matters for the Indian answer is the functional content behind the statutory phrase, tested ability by ability against the disorder in front of you.

It helps to see how different conditions defeat fitness by different routes, because the assessment turns on the route, not the diagnosis. Acute psychosis may make it impossible to follow proceedings or to give a rational account; a severe mood or thought disorder may disorganise communication with counsel; intellectual disability or an acquired cognitive disorder may block understanding of the charge and its consequences; a profound disturbance of memory or attention may prevent the accused from tracking the evidence. The threshold itself, though, is participation rather than sophistication: the law wants a defendant who can engage with his trial, not one who could conduct it as a lawyer would. Setting the bar too high, so that only a mentally robust defendant counts as fit, misreads the standard as badly as setting it too low.

23.4 The statutory procedure: at inquiry and at trial

The code reaches the question both before and during trial, and gives each stage its own provision. At the inquiry stage, while a Magistrate is still examining whether a case should

proceed, section **367** governs. When the Magistrate has reason to believe the person before him is of unsound mind and consequently incapable of making his defence, he shall inquire into the fact of that unsoundness, and shall cause the person to be examined by the **civil surgeon** of the district or such other medical officer as the State Government may direct, examine that officer as a witness, and reduce the examination to writing. The provision continues an arrangement already present in the amended older law: where the civil surgeon finds unsoundness, the person is referred to a psychiatrist or clinical psychologist of a Government hospital or medical college for care, treatment and prognosis, with a right of appeal to a **Medical Board**.

Once the trial itself is under way, section **368** applies. If it appears to the Magistrate or Court of Session that the accused is of unsound mind and consequently incapable of making his defence, the court shall, in the first instance, try the fact of that unsoundness and incapacity; and if, after considering such medical and other evidence as is produced, it is satisfied of the fact, it shall record a finding to that effect and shall **postpone further proceedings**. Both provisions took effect on **1 July 2024**, replacing the corresponding sections of the former Code of Criminal Procedure.

The choice of verb is the whole of the duty. In both provisions it is expressed as "shall", not "may". The court is not given a discretion to try a defendant it suspects is unfit and settle the point later; the moment unfitness is genuinely in issue, it must be tried first, as a preliminary fact, on medical and other evidence, before the substantive trial can go any further. This ordering, the fact of unfitness decided ahead of the question of guilt, is the structural point candidates most often lose, and it is why an answer that reduces the duty to a discretionary power misstates the provision.

FEATURE	INQUIRY STAGE	TRIAL STAGE
When it operates	During the Magistrate's inquiry, before the trial proper	Once the trial is under way, before a Magistrate or Court of Session
What triggers it	The Magistrate has reason to believe the person is of unsound mind and incapable of making his defence	It appears to the court that the accused is of unsound mind and incapable of making his defence
Mandatory medical step	Shall cause examination by the civil surgeon or a directed medical officer, examine him as a witness and reduce it to writing, with onward referral to a psychiatrist or clinical psychologist and an appeal to a Medical Board	Shall first try the fact of unsoundness and incapacity on medical and other evidence
Effect of a positive finding	The fact is recorded and the person is directed to care, treatment and prognosis	Shall record a finding of unsoundness and incapacity and postpone further proceedings

367	368	1 Jul 2024
INQUIRY STAGE	TRIAL STAGE	SANHITA IN FORCE

IN INDIA

This topic runs on the Bharatiya Nagarik Suraksha Sanhita for proceedings instituted after the sanhita's commencement, and on the former Code of Criminal Procedure for any trial, inquiry or other proceeding pending immediately before that commencement, which the sanhita's own savings clause keeps alive as governing law. The machinery is distinctly Indian and the two stages take separate routes: at the inquiry stage the first medical opinion comes from the civil surgeon of the district or a medical officer the State Government names, with onward referral of a person found to be of unsound mind to a psychiatrist or clinical psychologist of a Government hospital or medical college for care, treatment and prognosis, and a route of appeal to a Medical Board; at the trial stage the court instead refers the accused directly to a psychiatrist or clinical psychologist, not through that same civil-surgeon-first sequence. Neither the referral to a psychiatrist or clinical psychologist nor the Medical Board appeal is a sanhita innovation: both continue an arrangement the amended older code already carried. A candidate who cites the old code's section numbers as the governing law is right where the proceeding was pending immediately before commencement, and wrong only where it was instituted afterward.

23.5 Assessing fitness: the psychiatrist's task

The referral you receive is narrower than it first looks. The court does not want a global opinion on the accused's mental health; it wants to know whether a mental condition is present and, if it is, whether it strips him of the particular abilities that making a defence requires. The assessment therefore runs on two tracks at once: a clinical evaluation to establish diagnosis and current mental state, and a functional evaluation that tests each defence ability against that state. Can he tell you what he is charged with. Can he follow what is happening in court and why. Can he give a coherent account to his lawyer and take part in decisions about his own case. The opinion is built from the answers, ability by ability, with the disorder linked explicitly to any incapacity found rather than assumed from the label.

Two features of the judgement are easy to forget. Fitness is present-state and can change: a person who is unfit in acute illness may become fit with treatment, so an opinion is a snapshot and may need revisiting as the condition moves. And the determination is ultimately the court's, not the clinician's. The statute has the court decide the fact on medical and other evidence, which places the psychiatrist as an expert witness supplying one input to a judicial finding, not as the person who makes it. Overstating the role, and writing an opinion as though it were the verdict, is a common way for a report to exceed its proper reach.

PITFALL

The commonest clinical error is to let the diagnosis do the work, certifying a psychotic or intellectually disabled accused unfit because he is unwell, without asking whether the illness actually disables the tasks of making a defence. Fitness is task-specific: a person with a serious disorder may still understand the charge, follow the evidence and instruct counsel, while another whose diagnosis looks milder may be unable to do any of these. Assess the abilities, not the label, and show the link between them.

GOOD TO REMEMBER

When you are asked to opine on fitness, build the report around the defence abilities themselves, understanding of the charge and the proceedings, the ability to follow evidence, and the ability to instruct counsel and decide on a plea, and state, for each, how the disorder does or does not impair it. Keep in view that you supply medical evidence and the finding is the court's to make. The form the report or certificate takes for the court, and the ethics of giving expert evidence, belong to the Forensic ethics, consent and legal procedure notes.

23.6 After a finding of unfitness

A finding of unfitness stops the trial; it does not end the case, and it is not a single order that merely freezes the clock. The court's first duty is to try the fact of incapacity itself, and once incapacity is found the disposal forks rather than defaulting to postponement. Where the evidence produced discloses no prima facie case for the accused to answer, he is discharged rather than held; where a prima facie case remains, the court records the finding of unsoundness and incapacity and postpones further proceedings so that treatment can begin. Postponement is therefore one branch of the disposal, not the whole of it, and the accused who is postponed stands neither acquitted nor convicted, the trial suspended and waiting for him. The sanhita's orientation is treatment and restoration rather than indefinite removal: at the inquiry stage the person is routed to care, treatment and prognosis, and the object is to restore fitness so that the trial can resume and the substantive questions, including responsibility for the act, can finally be answered by a defendant able to meet them.

What becomes of the accused once he is found incapable is set out separately. Where a person is found under section **367** or section **368** to be incapable of making his defence, section **369** governs his disposal, and it offers a graded set of outcomes rather than bare custody. On medical opinion the court may release him on bail where his condition does not require in-patient treatment and a relative or friend undertakes to secure regular out-patient psychiatric treatment and to prevent harm; where bail cannot be granted or no such undertaking is given, it orders him kept in a place where regular psychiatric treatment can be provided. Weighing the nature of the act committed and the extent of the unsoundness of mind or intellectual disability, the court then determines whether release can be ordered at all: it may discharge him on sufficient security, or, where discharge cannot be ordered, transfer him to a residential facility for care and training. Release on bail with an out-patient undertaking, supervised treatment where bail is refused, discharge on sufficient security and transfer to a residential facility are the real branches after a

finding of unfitness; the topic is not, as candidates too often write it, a single order that only postpones the proceedings.

The harder cases are those where fitness may never return. Postponement assumes restoration, but a defendant with a progressive dementia or a fixed cognitive deficit may remain permanently unable to be tried, and the law must then balance the public interest in a trial and the protection of others against the injustice of holding an untried person indefinitely. How the system resolves that tension turns on the disposal choices just described, weighed against the nature of the act and the extent of the disorder, but the clinician should recognise the problem, because a prognosis on the likelihood and timescale of restored fitness is often the most useful thing the psychiatric opinion can offer the court.

The one matter left open here is the mechanism by which proceedings are taken up again once fitness returns, which is set out in further provisions of the sanhita not detailed in these notes. One route in particular should not be confused with fitness at all: the preliminary assessment of a child in conflict with the law, which decides whether a juvenile is dealt with as an adult, is a different determination under a different statute and belongs to the Child psychiatry: assessment, treatment, services and protection notes, not to the law of fitness to stand trial.

24 · Diminished responsibility and automatism

Why the marks are here. Once a court accepts that a defendant performed the physical act, it can still be asked whether the mind behind that act was whole enough to carry the full weight of the charge. Two doctrines press exactly at that seam. **Diminished responsibility** is the claim that a mental abnormality, without excusing the killing, was serious enough to lower its grade; **automatism** is the stronger claim that the act was performed with no conscious control at all. An Indian paper examines the two together because the Indian answer to each is not the English textbook one: a candidate who reaches for the familiar Western framework describes a defence that does not exist here and misses the one that does.

The disciplined way to hold this whole topic is to see that Indian criminal law keeps no separate compartment for either idea. It does not grade criminal responsibility on a sliding scale, and it does not name automatism as a defence in its own right. Instead it feeds each question into a category it already possesses: the grade of a homicide can be softened on a mental ground through provocation, and an act said to be involuntary is answered through the unsound-mind exception where that exception's cognitive-incapacity test is actually met, though that exception is not the sole route by which an alleged involuntary act is examined. This routing, provocation for the grade of a killing and the unsound-mind exception for an involuntary act, is the long-established position of Indian criminal law, and these notes state it on that footing; the precise section of the recodified penal code, the Bharatiya Nyaya Sanhita, that now carries the grave-and-sudden-provocation exception has not been reconfirmed against the primary statute in preparing these notes, so it is named here without its number. Everything that follows is an unpacking of that single structural fact.

India has no diminished-responsibility defence; grave and sudden provocation is the partial defence nearest in effect to it, reducing murder to culpable homicide not amounting to murder, and automatism is answered through the unsound-mind exception when it arises from a disease of the mind.

1957	three	two
ENGLISH HOMICIDE ACT	AUTOMATISM STATES	INSANE OR SANE

24.1 Diminished responsibility: the partial defence India did not adopt

Diminished responsibility originated in Scots law and was introduced into England and Wales by the English Homicide Act of **1957**; there, it is a partial defence to murder alone. It concedes that the accused killed unlawfully, but argues that an abnormality of mental functioning, arising from a recognised medical condition, substantially impaired the capacity to understand the conduct, to form a rational judgement, or to exercise self-control, and provides an explanation for the killing, and so reduces the conviction from murder to the lesser homicide offence with its wider sentencing range. This current test followed the Coroners and Justice Act 2009 amendment to the 1957 device, and its defining feature is that it works on the grade of the offence rather than on guilt: the defendant is neither acquitted nor treated as fully responsible, but left in an intermediate position.

Indian law contains no equivalent. Its general exception for unsoundness of mind operates as a complete defence or as none at all, so there is no statutory instrument that recognises impaired-but-not-abolished capacity and lowers the charge on that account. A defendant whose disorder clouded but did not extinguish the relevant mental capacity falls outside the mental exception altogether, because that exception, whose test and current penal-code provision are set out elsewhere in this chapter where the insanity defence and the McNaughton rules are discussed, is written in all-or-nothing terms. Such a disorder may still weigh in mitigation when the judge fixes sentence, but that is judicial discretion applied after conviction, not a defence that alters the verdict. The absence of the intermediate rung is deliberate, and it is examined precisely because candidates assume the English ladder is present.

24.2 Grave and sudden provocation: the nearest partial defence to murder

The one place where Indian law does soften a killing on something like a mental ground is provocation. Where the accused is deprived of the power of self-control by provocation that is both grave and sudden, and in that state causes the death of the person who gave the provocation, or of another person by mistake or accident, the offence is brought down from murder to **culpable homicide not amounting to murder**. The exception is lost on any of three provisos: where the accused sought or voluntarily provoked the provocation as an excuse for killing or causing harm, where the provocation was given by something done in obedience to the law or by a public servant acting lawfully within the powers of that office, or where the provocation was given by something done in the lawful exercise of the right of private defence. Whether the provocation was in fact grave and sudden, and whether the accused acted while actually deprived of self-control, is a question of fact for the court on the circumstances of each

case. This is the true counterpart to diminished responsibility in the Indian scheme, because it is a genuine partial defence: it does not acquit, it re-grades. The comparison the examiner wants is that both doctrines lower a murder charge without excusing it, but they rest on entirely different foundations.

Grave and sudden provocation is not a defence of mental incapacity. The accused is treated as responsible, and the law makes a limited concession to ordinary human frailty rather than to illness. Its logic carries both an objective and a subjective element: the provocation must be grave enough that it could deprive a reasonable person of self-control, and it must in fact have deprived this accused of self-control at the moment of the act. The requirement that it be sudden weighs heavily against the exception where a real interval allowed the passions to cool, but the point is not automatic: whether the exception is made out remains a question of fact, and if it fails, on this or any other ground, the remaining ingredients of murder and any other applicable exception must still be established before a murder conviction follows. The psychiatrist's role here is narrow and easily overstated: an opinion on temperament or a co-existing condition may be sought, but the defence itself is a legal construct the court applies, not a psychiatric plea.

FEATURE	DIMINISHED RESPONSIBILITY (THE ENGLISH PARTIAL DEFENCE)	GRAVE AND SUDDEN PROVOCATION (THE INDIAN PARTIAL DEFENCE)
What it rests on	An abnormality of mental functioning that substantially impaired a relevant capacity	Loss of self-control caused by provocation, in a person treated as responsible
Effect on the charge	Reduces murder to the lesser homicide offence	Reduces murder to culpable homicide not amounting to murder
Nature of the concession	To mental illness or abnormality	To human frailty, not to illness
Available in Indian law	No such free-standing defence exists	Yes, as a recognised exception to murder

24.3 Automatism: the concept and the states behind it

Automatism is the assertion that the body acted while the mind was not consciously directing it, so that the movement, though it caused harm, was not a willed act of the person at all. It bites deeper than any partial defence because it attacks the voluntariness a criminal act presupposes: if the conduct was truly involuntary, the guilty act and guilty mind the law requires, analysed elsewhere in this chapter where mens rea and actus reus are set out, are simply not made out. The plea is therefore about absence of conscious, voluntary control at the material time rather than about impaired judgement.

Clinically it is raised by a small set of transient states in which awareness and volition are genuinely suspended:

- the post-ictal state that can follow a seizure, with confused, automatic behaviour;
- a hypoglycaemic state, in which falling glucose disorganises conscious control;

- a somnambulistic state, in which complex acts are carried out during **somnambulism** without waking awareness.

The trap for the clinician is to think the diagnosis settles the law. It does not. The legal category is not the medical label but the answer to two prior questions: was conscious voluntary control actually absent when the act was done, and what caused its absence. A further variant, automatism attributed to voluntary intoxication, is governed by the separate law on intoxication rather than treated as automatism proper, and the clinical management of substance use itself belongs to the Substance use disorders notes.

24.4 Insane versus sane automatism: the internal and external divide

English common law sorts automatism not by its clinical name but by its cause: this internal/external classification is the comparator, not enacted Indian law. Where the involuntary act springs from a **disease of the mind**, an internal cause, English law classes it as **insane automatism** and deals with it as insanity is dealt with; where the involuntary act springs from a purely external cause, English law classes it as **sane automatism**, which if accepted there points toward an ordinary acquittal. India has no separately codified automatism defence carrying either label. A disease-linked involuntary act reaches the unsound-mind exception only where that exception's cognitive-incapacity test is actually met; where it is not, or where the alleged cause is external, the Indian court must assess voluntariness, the ingredients of the charged offence and any applicable statutory exception directly, without a promised codified acquittal.

The pivot, disease of the mind, is a legal construct and not a psychiatric one, and English courts have read it broadly, turning on whether the cause is internal to the person and liable to recur. The reason English law works so hard at this line is that its two branches lead to opposite destinations there: insane automatism, treated as unsoundness of mind, leads not to freedom but to the disposal that follows a successful mental exception, with its provision for detention and treatment; sane automatism, if made out, ends in a clean acquittal. India draws no equivalent guarantee for either branch: an Indian court reaches the insanity disposal only where the unsound-mind exception's own test is met, and has no codified route promising sane automatism an acquittal, so it works from voluntariness, the offence's ingredients and any applicable exception rather than from the common-law label. Because releasing a person whose brain may repeat the act carries a public-protection cost, English courts are cautious about the external-cause branch and readier to route a recurring internal condition through the insanity route.

MNEMONIC

Inside the mind, insane; outside the mind, sane

An internal cause, a disease of the mind, makes the automatism the insanity question and sends it into the unsound-mind exception; an external cause makes it sane automatism, a common-law route to acquittal that Indian statute does not separately codify. Sort by where the cause sits, not by the diagnosis on the chart.

AXIS	AUTOMATISM FROM A DISEASE OF THE MIND	AUTOMATISM FROM AN EXTERNAL CAUSE
Common-law label	Insane automatism	Sane automatism
Where the cause lies	Internal to the person, liable to recur	External to the person
Route in Indian law	Answered through the unsound-mind exception, only where its cognitive-incapacity test is met	Not a separately codified Indian route; the court assesses voluntariness, offence ingredients and any applicable exception directly
Direction of outcome	Toward the insanity disposal, with detention and treatment, where the exception is made out	Under the common-law comparator, toward an ordinary acquittal; Indian law promises no codified route to that outcome

RULE **Neither doctrine is a free-standing Indian defence; each is routed into a category the law already holds.** A killing is down-graded on a mental ground through grave and sudden provocation, the nearest analogue to diminished responsibility rather than the only exception that reduces murder to the lesser offence, and an act said to be involuntary that stems from a disease of the mind is justiciable through the unsound-mind exception where its test is met, though that exception is not the sole route by which an alleged involuntary act is examined. Automatism from an external cause survives as a common-law idea that Indian statute does not separately name, and an Indian court assesses such a case directly on voluntariness, the offence's ingredients and any applicable exception.

24.5 The forensic assessment, and the errors it invites

What the psychiatrist actually supplies. Because both questions turn on a mental state at a past instant, the assessment is functional and almost always retrospective. The task is to reconstruct, from contemporaneous records, witness accounts of the act itself, the person's own account and the known pattern of the condition, whether conscious voluntary control was present or absent at the material time, and to form a view on the likely cause and whether it amounts to a disease of the mind. What the psychiatrist supplies is a medical opinion; the legal category, whether the automatism is insane or sane, and whether responsibility stands, is the court's to decide. An honest report says where the contemporaneous evidence is thin and frames its conclusion as an inference, because a bare diagnosis neither proves nor disproves that the act was involuntary. The conventions for putting that opinion before a court, and the certification of an expert to testify, are not part of this substantive law and belong to the Forensic ethics, consent and legal procedure notes.

GOOD TO REMEMBER

Anchor the opinion to the moment of the act and its cause, not to the label. Ask whether conscious voluntary control was present when the act occurred and whether the cause is internal and recurrent, because that placement, not the name of the condition, decides which legal route the automatism takes. Where the records will not support a firm view, say the evidence is insufficient rather than fill the gap with an impression.

IN INDIA

In practice a referral labelled as automatism is, more often than not, the insanity question in another dress, because the internal-cause states that reach a court, such as post-ictal or somnambulistic behaviour, are the ones the law treats through the unsound-mind exception. The useful Indian report translates the clinical picture into terms the law can act on, points the recurring internal condition toward that exception, and does not offer a diminished-responsibility verdict Indian law cannot receive.

TRAP **Answering as though India had a diminished-responsibility defence, or treating automatism as a distinct Indian plea.** The marks come from knowing that India routes both questions through existing categories: provocation for the grade of a homicide, and the unsound-mind exception for automatism that arises from a disease of the mind. Importing the English partial defence, or presenting sane automatism as a codified Indian defence, is the classic way to lose an answer that structure would have secured.

PITFALL

Writing the wrong law into a real medico-legal report. Offering "diminished responsibility" as an available Indian plea, or citing the superseded penal code as the live provision, does not merely lose an examination mark; it discredits the report and the witness, because the opposing side need only point out that the doctrine or section relied upon is not the law in force. Frame the opinion in the categories Indian law actually uses, and leave the legal conclusion to the court.

25 · Mens rea, actus reus and legal concepts of intent

Where forensic psychiatry enters the criminal law. When a court asks whether a mentally ill person can be convicted of a crime, it is really asking about two building blocks the law has used for centuries: was there a prohibited act, and was there a guilty mind behind it. Almost every forensic-psychiatric opinion in a criminal matter, whether it concerns the insanity defence, diminished responsibility, automatism or fitness to plead, is in the end an argument about one of these two blocks, and most often about the second. Grasping **actus reus** and **mens rea** is therefore not abstract jurisprudence for the candidate; it is the grammar in which the psychiatrist's evidence has to be written if it is to be admissible and useful.

The marks reward the candidate who keeps the legal categories and the clinical ones apart: a diagnosis is not a defence, and a symptom is not the absence of intent. The disciplined witness translates a psychiatric finding into the language of the mental element and stops there, leaving the verdict to the court.

25.1 The two elements of a criminal offence

An ordinary criminal offence is built from **two** elements that the prosecution must establish together: a prohibited act and the guilty mind that accompanies it. The external element is the *actus reus*, the conduct the law forbids; the internal element is the *mens rea*, the blameworthy state of mind with which that conduct is done. Neither is sufficient on its own. A person who forms a murderous wish but does nothing has no act and commits no offence; a person who

causes harm by pure accident, without any of the mental states the law demands, has done the act but without the guilty mind. Only where both are present, proved to the criminal standard, can a conviction follow.

MNEMONIC

Actus non facit reum nisi mens sit rea

"An act does not make a person guilty unless the mind is also guilty." The single line encodes the whole topic: the forbidden **act**, the guilty **mind**, and the requirement that the two belong to the same event. Every criminal-responsibility defence works by attacking one half of it.

AXIS	ACTUS REUS	MENS REA
What it is	The external, prohibited element: conduct, its surrounding circumstances and, for result crimes, its consequence	The internal, blameworthy element: the state of mind accompanying the act
What the law asks	Did the accused do the forbidden thing, and do it voluntarily?	With what intention, knowledge or awareness of risk was it done?
How it can be missing	An involuntary movement, or conduct the law does not in fact prohibit	Accident, mistake, or a mind the law treats as incapable
Where psychiatry usually bears	Rarely, automatism being the exception	Commonly, the psychiatric opinion speaking to the capacity for the required mental state

RULE **The act and the guilty mind must coincide.** It is not enough that each existed at some point; they must meet in the same transaction, the mental element present at the moment the prohibited act is done. This concurrence principle is why timing dominates a forensic opinion: the evidence must fix the mental state to the material time, not to the assessment carried out months later, because a disturbance that arose only afterwards leaves the offence intact.

A crime needs both a forbidden act and the particular guilty mind the law specifies for it, present together at the same moment; prove one without the other and there is no offence.

2	both
ACT AND GUILTY MIND	MUST CONCUR

25.2 The actus reus: the external element

The actus reus is more than a bodily movement. It is usually analysed as up to three things the prosecution may have to prove: the conduct itself, the surrounding circumstances that make that conduct criminal, and, for offences defined by their outcome, the proscribed consequence. In a homicide the conduct is the assault, the circumstance is that the victim was a living person, and the consequence is the death.

- **Conduct** - the act, or in defined cases a failure to act.

- **Circumstances** - the facts that give the conduct its criminal character.
- **Consequence** - the proscribed result, for those offences defined by their outcome.

Two further ideas complete the external element. First, the conduct must be **voluntary**: the law attributes an act to a person only when it was a willed movement of the body. A reflex, a convulsion or a movement during a state of clouded consciousness may be legally involuntary, and this is the doorway through which automatism enters, a plea set out elsewhere in this chapter where diminished responsibility and automatism are discussed. Second, liability can arise from an **omission**, but only where the law imposes a duty to act, as a parent owes a child, so that the failure to discharge that duty becomes the forbidden conduct. For result crimes the prosecution must also prove **causation**, that the accused's act was in fact and in law the cause of the proscribed consequence; an intervening cause may break that chain. The psychiatrist is seldom the witness on causation, but should place it on the act side rather than the mental one.

25.3 The mens rea and the ladder of fault

Mens rea is not a single state but a graded ladder of culpability. The law recognises several mental states, and each offence specifies which one it requires; broadly, the graver the offence, the higher the fault demanded. Running from the most to the least blameworthy, the familiar forms are intention, knowledge, recklessness and negligence. **Intention** is the aim or purpose to bring about the prohibited result. Knowledge is awareness that a circumstance exists or that a consequence is practically certain to follow. **Recklessness** is the conscious taking of an unjustified risk, the accused having foreseen the possibility of harm and gone on regardless. Negligence is a failure to meet the standard of care a reasonable person would show; it is inadvertent, and it is judged against an external standard rather than against what the accused actually foresaw. In Indian usage, a rash act is not a synonym for a negligent one but a distinct alternative: rashness carries awareness of the risk, the accused proceeding in the hope or belief that the harmful consequence will not occur, so it sits closer to conscious risk-taking than to negligence's inadvertence.

FAULT STATE	WHAT THE ACCUSED'S MIND IS DOING	HOW IT IS TESTED
Intention	Aims at the result, or acts in order to bring it about	Subjective: what this accused meant
Knowledge	Is aware the result is practically certain, or that the circumstance exists	Subjective: what this accused knew
Recklessness	Foresees the risk and unreasonably runs it	Subjective foresight of the risk
Rashness	Foresees the risk and proceeds, hoping or believing the harm will not occur	Subjective: the accused's own awareness of the risk
Negligence	Fails to advert to a risk a reasonable person would have seen	Objective: the reasonable-person standard

Why the ladder matters to the witness. A mental illness does not act uniformly on every rung. A disorder may leave a person able to intend an act at the level of bare purpose while destroying the higher-order appreciation that it was wrong, or leave intention untouched and bear only on the judgement of risk. Mapping the clinical picture onto the specific fault state the charge requires, not onto culpability in general, is the discipline that turns a diagnosis into evidence a court can use.

25.4 Legal concepts of intent

Intent in law is narrower and more technical than in ordinary speech, and several distinctions earn marks. Direct intention is the straightforward case, where the consequence is exactly what the accused wanted. Courts also recognise a form sometimes called oblique or indirect intention, where the accused did not desire the result but foresaw it as a virtually certain side effect of what they did set out to do, and from such foresight a court may infer intention. A second concept, **transferred intent**, applies where the accused directs a criminal intent at one target but the harm falls on another: the intent is carried across to the actual victim, so that aiming at one person and killing a bystander is still an intentional killing. And because intention is a fact about a person's mind, it is almost never proved directly. It is inferred from conduct and circumstance, on the common-sense premise that a person ordinarily intends the natural consequences of their acts, which is a presumption of evidence and not a rule that fixes the mind against contrary proof.

TRAP **Confusing motive with intention.** **Motive** is the reason behind the act, such as jealousy, gain or revenge; intention is the decision to do the prohibited act itself. Motive is generally irrelevant to guilt: a mercy killing and a killing for money share the same intention to cause death, and a benign motive does not erase mens rea. Candidates lose marks by arguing that a sympathetic motive negates intent. Motive can help to prove or disprove intention as a piece of evidence, but it is not itself the mental element.

25.5 When the guilty mind is dispensed with, or treated as absent

The requirement of a guilty mind is displaced in two very different ways, and the candidate should not run them together. At one end sit **strict-liability** offences, where the law dispenses with proof of mens rea for some or all elements of the act; the prosecution need only show that the accused did the prohibited thing. These are typically regulatory or public-welfare offences, where the social interest in deterrence is thought to justify convicting without an inquiry into fault. They are the exception, not the rule, and the graver the offence and its penalty, the more strongly the courts resist reading the mental element out of it. At the other end sits the **insanity exception**, and here the candidate should resist collapsing it into a mens-rea-negating device. The current Indian provision is a complete statutory General Exception in its own right, analytically distinct from the prosecution's separate obligation to prove the offence-specific mental element, not a rule that simply deems mens rea absent. An accused can form the intention to perform the physical act and still fall within the exception, because it asks a different question: whether unsoundness of mind removed the capacity to know the act's nature, or that it was wrong or contrary to law. Insanity evidence can also, independently of the exception, raise a reasonable doubt about an offence's own mental element; the two routes carry different burdens

and are not to be run together. That overlap without identity, not a straightforward negation of the mental element, is the conceptual bridge from psychiatry to the criminal law. Its full statement, the governing test, the current Indian substantive provision and the burden of proof, is developed elsewhere in this chapter where the insanity defence is set out; what matters here is that the exception may overlap with, but is not the same thing as, an absence of mens rea.

IN INDIA

Indian penal law does not leave the guilty mind to a single overarching doctrine. It writes the fault element into each offence through defined mental-state words, such as voluntarily, dishonestly, fraudulently, with intent, knowingly, rashly or negligently, and the statutory definitions of those words do much of the work the common law leaves to the maxim. The courts read a presumption of mens rea into an offence unless the statute clearly excludes it, while accepting genuine strict-liability offences in regulatory fields. The forensic implication is practical: identify the exact fault word the charge uses, because the opinion must speak to that mental state and no other.

25.6 The forensic psychiatrist and the mental element

For the psychiatrist, the framework defines both the question and its limits. The court does not want a diagnosis; it wants to know whether, at the material time, the accused had the capacity for the mental state the charge requires. The opinion should reconstruct that mental state as it was when the act was done, from history, contemporaneous records and the phenomenology, and relate it to intention, knowledge, awareness of risk or knowledge of wrongfulness, as the charge demands.

GOOD TO REMEMBER

Frame the report around the mental element, not around the verdict. Say what the illness did to the accused's capacity to intend, to know or to appreciate wrongfulness at the time of the act, and let the court draw the legal conclusion. Anchoring every statement to the material time, and separating what the illness explains from what it might excuse, is what makes the evidence admissible and hard to shake under cross-examination. The manner of putting that opinion before a court, and the certification of an expert to testify, belong to the Forensic ethics, consent and legal procedure notes.

PITFALL

Treating a diagnosis as though it were the absence of mens rea. A person can carry a serious mental illness and still have formed the intention, or possessed the knowledge, the offence requires; illness and an intact fault element routinely coexist. The clinical error is to reason from "the accused was psychotic" straight to "the accused had no guilty mind", skipping the step the law actually cares about, which is what the specific illness did to the specific mental capacity at the specific moment of the act. The report that names the disorder and stops has answered a medical question the court did not ask.

26 · Narcoanalysis, brain mapping and polygraph (deception detection, legal status)

Why the marks are here. Every so often an investigating agency, faced with a suspect who will not confess, reaches for a technique that claims to read the truth directly from the body or the brain. Three such techniques recur in the forensic setting - **narcoanalysis**, the **polygraph** and **brain mapping** - and together they make up the field of **deception detection**. The examiner is not testing the wiring of the machines. The marks are for three separate things a candidate must keep apart: what each technique actually measures, why its scientific standing is disputed, and, decisive for a court, whether the law permits it to be used at all and on what conditions. A candidate who can hold the technique and its admissibility apart answers the whole question; one who fuses them loses it.

These are investigative aids, not clinical tests. None of them makes a diagnosis, and none delivers a verdict of truthful or lying that a judge can simply adopt. Two neighbouring topics must be held off at the outset. The clinical detection of feigned or exaggerated illness, malingering, is a distinct skill and is set out elsewhere in this chapter; it borrows these instruments but does not own their legal status. And the professional-ethics questions the tests raise - consent for a purpose that is not the subject's own treatment, the psychiatrist acting for the investigator rather than the patient, and the report eventually placed before a court - belong to the Forensic ethics, consent and legal procedure notes. What this section owns is the trio of techniques and, above all, their legal position in India, which is settled and frequently examined.

26.1 The three techniques and what each claims to do

Narcoanalysis rests on a pharmacological idea. A sedative-hypnotic drug is given slowly into a vein and titrated to a drowsy, disinhibited, half-hypnotic state, on the theory that a person whose higher control is loosened can no longer sustain the effort of a deliberate lie and will let the truth slip out. The clinical reality is close to the opposite. The same disinhibition that is meant to release the truth also makes the subject highly suggestible and prone to confabulation, so that what emerges is an unstable mixture of memory, suggestion and invention. The account a subject gives under the drug is therefore not a faithful record of fact, and its value, where it has any, is as a lead to be independently verified rather than as evidence in itself.

The polygraph works on a physiological idea rather than a pharmacological one. It records several channels of autonomic arousal continuously while the subject answers a structured sequence of relevant and comparison questions, and the examiner infers deception from the pattern of reactivity, not from the words of the answer. The channels typically recorded are:

- respiration, its rate and depth;
- electrodermal activity, the sweat-gland or galvanic skin response;
- cardiovascular activity, the blood pressure and pulse.

The inference is only as strong as its central assumption, that lying reliably raises arousal more than truthful answering does, and that assumption is where the method is most exposed. Brain mapping, in the Indian forensic setting, refers specifically to the **Brain Electrical Activation**

Profile, an electroencephalographic method that presents the subject with crime-related probe stimuli and looks for the electrical brain response that signals recognition. Its logic differs from both the others: it does not claim to catch a lie but to detect experiential knowledge, that is, whether the brain treats a specific detail of the offence as already familiar, as it would be to a person who was present and not to an innocent stranger.

TECHNIQUE	WHAT IS RECORDED	INFERENCE DRAWN	PRINCIPAL WEAKNESS
Narcoanalysis	Speech produced in a drug-induced disinhibited state	That a disinhibited subject discloses withheld truth	Suggestibility and confabulation; the content is not reliable fact
Polygraph	Autonomic arousal across respiratory, electrodermal and cardiovascular channels	That deception raises arousal on the relevant questions	Arousal is non-specific; open to anxiety, countermeasures and examiner bias
Brain mapping	Electrical brain responses to crime-related stimuli	That the brain recognises a familiar detail of the offence	Detects recognition, not guilt; reliability disputed

26.2 Why the scientific standing is disputed

The reason all three are described as techniques of contested scientific validity is the same in each case: none of them measures deception itself. Each measures a proxy and then reasons backward from that proxy to a conclusion about truthfulness, and every step of the backward reasoning can fail. It is worth setting the criticisms out on principle, because the examiner rewards a candidate who can say why the methods are weak rather than merely assert that they are.

- the signal is indirect - pharmacological disinhibition, autonomic arousal, or stimulus recognition - and none of these is unique to lying, so an innocent explanation is always available for the same reading;
- the reading is examiner-dependent and defeatable: an anxious but honest subject can generate exactly the arousal that is scored as deception, a prepared subject can defeat the test with deliberate countermeasures, and interpretation is hard to standardise or replicate;
- there is no agreed, validated error rate for any of them that a court could weigh against the strength of the other evidence.

Narcoanalysis carries an additional and specific hazard, that its central mechanism is also a mechanism of false memory: the disinhibition that is supposed to lower the guard on the truth simultaneously lowers the guard on suggestion, so a leading question can plant an answer the subject then reports with conviction. The polygraph and brain mapping avoid that particular trap but share the deeper one, that a physiological or electrical correlate of arousal or familiarity is not the same thing as a lie. The distance between the correlate and the conclusion is precisely where an innocent person can be caught and a guilty one can slip through, and no amount of instrumental precision closes it, because the gap is one of logic and not of measurement.

26.3 The constitutional bar on compulsion

Where the examinable law sits. The Constitution guarantees, in Article **20(3)**, the **right against self-incrimination**: no person accused of an offence shall be compelled to be a witness against himself. The settled reading of that guarantee turns on a distinction between two kinds of evidence. A person may be compelled to furnish physical or material evidence - a fingerprint, a specimen, a handwriting sample - because giving it does not require the accused to speak from their own mind. A person may not be compelled to give testimonial or communicative evidence, evidence whose source is the content of the accused's own mind, because that is precisely to make them a witness against themselves.

The results of narcoanalysis, the polygraph and brain mapping fall, on this analysis, on the protected side of the line. Each extracts a communication from the subject's own mental processes - a spoken account, an autonomic reaction to a question, an electrical sign of recognition - so compelling the subject to undergo the test is compelling them to become a witness against themselves. In **Selvi v State of Karnataka (2010) 7 SCC 263** the Supreme Court held that the compulsory, involuntary administration of these techniques violates that right, and also the right to life and personal liberty under Article **21**, and that it amounts to cruel, inhuman or degrading treatment. The bar is thus doubly grounded: in the specific protection against self-incrimination and in the broader protection of personal liberty and dignity.

RULE **Compulsory administration is unconstitutional.** Forcing a subject to undergo narcoanalysis, the polygraph or brain mapping violates the right against self-incrimination and the right to life and personal liberty, and amounts to cruel, inhuman or degrading treatment. The prohibition attaches to the compulsion, not to the technique: what the Constitution forbids is extracting the mind's contents against the subject's will, whatever the instrument used to do it.

26.4 Consent, and the safeguards on a voluntary test

The consequence of the constitutional bar is a rule that is easy to state and easy to get subtly wrong: no such test may be conducted without the subject's **consent**. But consent is necessary, not sufficient. Compulsory testing is prohibited outright, and a voluntary request remains subject to judicial consideration and authorisation and the prescribed safeguards; consent alone creates no right to testing. In Amlesh Kumar v State of Bihar, the Supreme Court held that an accused has no indefeasible right to narcoanalysis, and that the court must weigh voluntariness, the safeguards and the totality of circumstances before authorising it. A subject who genuinely and freely agrees is not being made a witness against themselves, but that agreement does not by itself entitle them to the test; a subject who is pressured, tricked or ordered is being made one.

Consent, however, does not turn the product of the test into free evidence. Even a result obtained voluntarily, and any information later discovered by following up on that result, are governed by the National Human Rights Commission Guidelines of **2000**. Two things follow. First, a voluntary result is not automatically admissible as substantive proof of guilt merely because the subject agreed to the test; its use is constrained by the safeguards that framework imposes. Second, and less obviously, the protection does not reach the derivative material. A fact or physical object subsequently discovered with the help of a voluntary test may be proved under

section 27 of the Evidence Act, the discovery rule, so that although the voluntary result is not itself admissible against the subject, the physical evidence or fresh lead it throws up can be admitted against them. Stating the consent rule without this second half is the commonest way it is misremembered.

20(3)	21	2000
SELF-INCRIMINATION BAR	LIFE AND DIGNITY	NHRC GUIDELINES

TRAP **Reading the leading judgment as a total ban on these techniques.** It is not. What was struck down is the compulsory, involuntary administration of narcoanalysis, the polygraph and brain mapping; the voluntary, consented route survives, subject to the National Human Rights Commission safeguards. A candidate who writes that the tests are simply "banned in India" has stated the law too widely and thrown away the distinction the question is built to test. The accurate sentence names compulsion as the thing prohibited, and consent as necessary but not by itself sufficient: a voluntary request still needs judicial consideration and authorisation before it may proceed.

PITFALL

Conducting or lending clinical cover to one of these tests without valid, documented consent, on the assumption that an investigator's request or a court's involvement supplies the authority. It does not. What the law requires is the subject's own free consent, and its absence makes the administration unconstitutional however the request was routed. A psychiatrist asked to perform or supervise such a test should confirm consent independently, record it, and decline where consent is absent or coerced.

26.5 The psychiatrist's role and its limits

The clinician drawn into this area, whether asked to administer a test, to be present during one, or to interpret its result, works within tight boundaries. The first is scientific: the result is not a diagnosis and not a determination of truth, and it must never be presented to an investigator or a court as if it settled whether the subject is lying. At most it is one indirect and disputed datum. The second is legal: the psychiatrist cannot supply the consent the subject has not given, and no institutional request substitutes for it. The third is a matter of role, because the psychiatrist here is acting for the justice system rather than treating a patient, and the duties that flow from that shift - disclosure, the limits of confidentiality, the form of the eventual report - are the province of the Forensic ethics, consent and legal procedure notes and are not resolved by clinical instinct.

Kept in its place, the topic is straightforward. The examiner wants a candidate who separates three questions and answers each on its own terms: does the technique measure what it claims, which is doubtful; is its output reliable enough to act on, which it is not without independent corroboration; and may it lawfully be used, which it may, but only with consent and within the National Human Rights Commission framework. Confusing the three - treating a legal permission as a scientific endorsement, or a scientific criticism as a legal prohibition - is the very error the whole topic is constructed to expose.

GOOD TO REMEMBER

Before going near any of these tests, confirm and document the subject's own consent, and treat its absence as a bar rather than an obstacle to be worked around. Never present the output as a diagnosis or as proof that the subject is truthful or lying; confine any report to what was observed and defer the truth-question to the court. If asked to rely on a result, say plainly that it corroborates nothing on its own and would need independent verification to carry any weight.

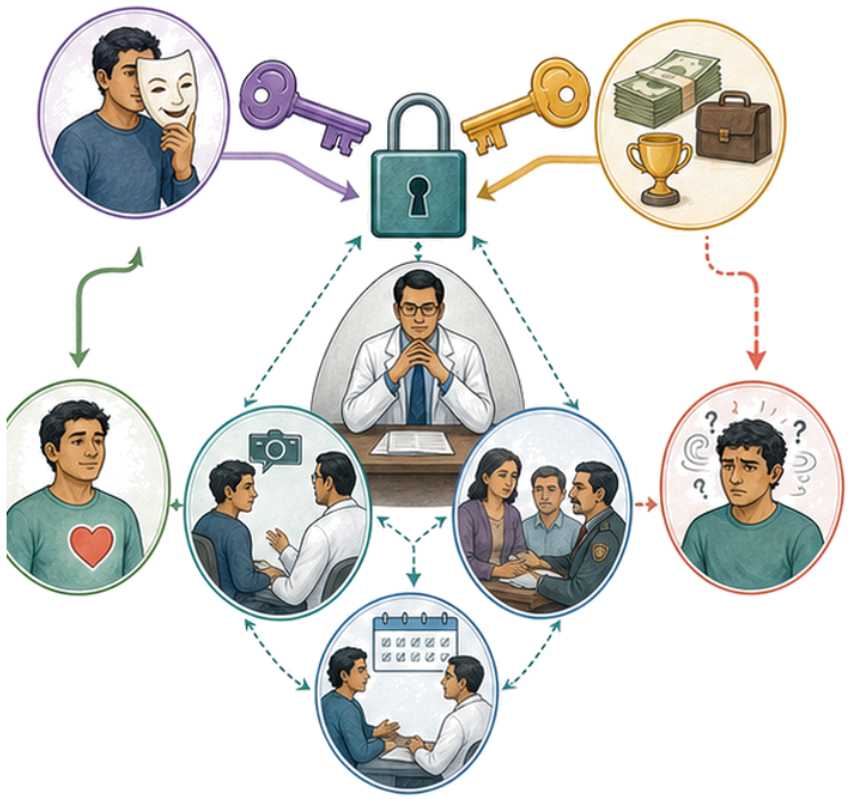
IN INDIA

The Indian position is settled and practical. Brain mapping in its Brain Electrical Activation Profile form, together with narcoanalysis and the polygraph, is still sought at the investigation stage, but none of the three has independent evidentiary value, and consent alone creates no right to testing: a voluntary request remains subject to judicial consideration and authorisation, and for an accused seeking the test the appropriate stage is ordinarily when defence evidence is led at trial, not an automatic consent-based investigation-stage route (Amlesh Kumar v State of Bihar). Voluntary results and anything derived from them are handled under the National Human Rights Commission Guidelines, so a psychiatrist asked to conduct or interpret a test should treat consent as the threshold question and the guidelines as the operating limit, and should resist any suggestion that a test result can stand in for evidence a court would otherwise require.

No deception-detection test may be conducted without the subject's consent; compelling narcoanalysis, the polygraph or brain mapping violates the right against self-incrimination and amounts to cruel, inhuman or degrading treatment.

27 · Malingering and detection in forensic settings

Why the marks are here. A forensic opinion is only as good as the honesty of the person being examined, and in exactly the settings where a psychiatric report carries the most weight - a criminal charge, a compensation claim, a plea that the accused is too unwell to be tried - the examinee has the clearest possible reason to shape what the examiner sees. **Malingering** is the deliberate manufacture of illness for a payoff that lies outside the illness itself, and the psychiatrist who cannot recognise it is left in one of two failing positions: deceived into a false opinion, or, having learned to distrust, so quick to see feigning that the genuinely ill are disbelieved. The topic is examined because it sits at the precise point where clinical skill meets medico-legal consequence, and because the discriminations it demands - conscious from unconscious, external reward from internal need - are the ones candidates most often blur.



- Intentional production
- External incentive
- Look for inconsistency
- Use collateral evidence
- Do not diagnose from suspicion alone

Fig 25.12 Malingering requires both intentional production or gross exaggeration of symptoms and an external incentive. Detection integrates observed inconsistencies, collateral records and structured assessment; suspicion alone is not a diagnosis.

The single organising idea is that malingering is defined by two things at once: the symptom is produced or grossly amplified on purpose, and the reason for producing it lies outside the person, in some tangible gain the illness is meant to secure. Take away either half and it is no longer malingering. That double test is what separates it from every neighbouring presentation, and it is also what tells the examiner where to look, because a motive that is external and instrumental tends to leave external and instrumental traces.

> Malingering is the intentional production or gross exaggeration of symptoms for an external incentive; it is not a mental disorder but a condition warranting clinical attention, and it is established by positive, converging evidence of feigning, never inferred from an unwelcome diagnosis alone.

2	3	4
HINGE QUESTIONS	THE DIFFERENTIAL	EVIDENCE FAMILIES

27.1 What malingering is, and why it is not a diagnosis

To malinger is to feign. The examinee either produces a symptom that is not there or takes a real complaint and pushes it into **gross exaggeration**, and does so knowingly, in the service of a goal that the sickness is only a means to reach. The goals are worldly and specific: escaping a criminal trial or its punishment, evading a duty such as work or service, or securing money through a compensation or disability claim. This is what is meant by an **external incentive**. The reward is a change in the person's outward circumstances, not anything internal to their psychology, and it is the externality of the motive that gives the concept its shape and its detectability.

It follows from this that malingering is classified not as an illness but as a **condition warranting clinical attention**, something that may become the focus of an assessment without itself being a disorder with its own psychopathology, course and treatment. The distinction is not pedantry. A disorder is something the patient has and the clinician treats; malingering is something a person does and the clinician must detect and describe. Recording it in a report is therefore an assertion about conduct and motive, not about pathology, and it must be justified by evidence of the same order that any serious accusation demands. The examiner who forgets this drifts into using the word as a term of disbelief rather than as a finding, which is where reports go wrong.

27.2 The three-way differential: two questions that sort it

The heart of the topic is a differential across three presentations, and it resolves cleanly if two questions are asked in order. First, is the symptom produced deliberately, or does it arise outside the person's conscious control. Second, if it is deliberate, what is the incentive - something tangible in the outside world, or the internal satisfaction of occupying the role of a patient. The three presentations answer these two questions in three different combinations, and the combination is the diagnosis.

Malingering answers both: deliberate, for an external reward. **Factitious disorder** shares the first answer but not the second - the symptoms are produced deliberately, yet the motive is internal, the psychological need to be seen and treated as sick, what is classically called **the sick role**, with no external payoff in view. **Conversion** and the other unconsciously produced presentations answer the first question differently altogether: the symptom is genuine to the person and not deliberately made, so no question of incentive in the malingering sense even arises. The examiner who collapses these three - who calls a factitious patient a malingerer, or treats a conversion symptom as feigned - has made the single commonest error in the area, and it is an error about the two questions, not about the symptoms themselves.

AXIS	MALINGERING	FACTITIOUS DISORDER	CONVERSION AND OTHER UNCONSCIOUS PRESENTATIONS
How the symptom is produced	Deliberately produced or grossly exaggerated	Deliberately produced	Not deliberate; outside conscious control
The incentive behind it	External and tangible: escape trial or duty, gain compensation	Internal: to occupy the sick role	No conscious incentive; the symptom is experienced as real
Standing as a disorder	Not a disorder; a condition warranting clinical attention	A recognised mental disorder	A recognised mental disorder
The clinician's task	Detect the feigning and describe the evidence	Diagnose and manage the disorder	Diagnose and treat the disorder

MNEMONIC

Conscious for a prize, malinger; conscious for the role, factitious; not conscious at all, conversion

The two hinge questions compressed into one line. Deliberate production plus an external, tangible reward is malingering; deliberate production for the internal reward of the sick role is factitious disorder; a symptom that is not deliberately produced at all is conversion or another unconsciously generated presentation. Fix the awareness and the incentive, and the label follows.

TRAP **Equating malingering with factitious disorder because both involve deliberate symptoms.** The two part on the incentive, and its direction is the whole point: malingering runs on an external, tangible gain, factitious disorder on the internal need to be a patient. A candidate who defines malingering as "producing symptoms deliberately" and stops there has described both conditions and distinguished neither. The examiner is testing whether you can name the external incentive as the discriminator, so make that the sentence you write first.

27.3 Detecting malingering: converging evidence, not a single sign

Because the motive is external, the feigning tends to leave marks that honest illness does not, and detection is the disciplined business of looking for them and requiring several to point the same way before any conclusion is drawn. No single finding is proof, and the strength of the method lies entirely in convergence: one anomaly raises a question, several independent anomalies pointing at the same feigned presentation begin to answer it. Four families of evidence carry most of the weight, and it helps to understand why each one works and where each one fails.

- **Inconsistency between reported and observed function.** The examinee describes a level of impairment that their spontaneous behaviour, when they are not being formally tested, does not support: a memory said to be gone that works when the person is distracted, a weakness that eases when attention moves elsewhere, a distress that lifts in the waiting room. It works because sustaining a fabricated deficit across every unguarded moment is hard; it fails when the genuine condition itself fluctuates, so the gap must be marked, not fleeting.

- **Symptom patterns that are atypical or over-endorsed.** The feigned picture tends not to follow the natural shape of the disorder it imitates. Symptoms are affirmed too readily and too broadly, rare and improbable complaints are endorsed, and the presentation is often a lay caricature of illness rather than its true form. It works because a person mimicking a disorder cannot know its fine internal grammar; it fails where the examinee has real clinical knowledge or genuine partial illness that lends the account authenticity.
- **Poor effort on validity testing.** Structured tasks can be built so that even a severely impaired but honest person performs well, so that failure below that floor points away from illness and toward withheld effort. It works because it separates capacity from cooperation; it fails when it is over-read, since a single poor score in a distressed or poorly engaged examinee is a question, not a verdict.
- **Corroboration from collateral sources.** Records, informants and observation across time and across settings test the self-report against something the examinee does not control. It works because the story a person tells and the record others keep are hard to align if the story is invented; it fails only when collateral is thin, which is precisely when the examiner must say so rather than fill the gap.

RULE **Malingering is established by positive, converging evidence of feigning, never by exclusion and never from one sign.** A single failed test, an unlikeable examinee, or a diagnosis the person happens to want are not grounds; what is required is several independent lines - inconsistency, atypicality, poor effort and collateral - agreeing that the presentation is manufactured for a gain. Treating malingering as a diagnosis of exclusion, reached when nothing else seems to fit, inverts the logic and is how the genuinely ill come to be wrongly disbelieved.

27.4 Validity testing and the instrumental methods

Two kinds of structured testing formalise the effort question, and the exam rewards knowing that they ask different things. One asks whether the person is over-reporting symptoms, endorsing more, and more improbable, complaints than any real syndrome generates; this is the logic of **validity testing** applied to what the examinee says. The other asks whether the person is genuinely trying on a cognitive task, typically through forced-choice formats where even severe honest impairment leaves performance near the level that chance alone would give. Performing consistently below that level is a powerful single indicator, because doing worse than random guessing implies the examinee knew the correct answer and steered away from it, an effort that only a person controlling their own responses could produce.

AXIS	SYMPTOM VALIDITY: OVER-REPORTING	PERFORMANCE VALIDITY: POOR EFFORT
What it asks	Is the person reporting more, and more improbable, symptoms than a real syndrome produces	Is the person genuinely trying on the task
What flags feigning	Atypical, rare and over-endorsed symptoms	Effort below what severe genuine impairment or chance would give
What genuine illness looks like	A coherent pattern that fits the disorder's natural shape	Impairment that still shows real, sustained effort

Beyond the interview and these tests lie the instrumental methods of deception detection - narcoanalysis, brain mapping and the polygraph. They belong to the malingering conversation because they too claim to separate truthful from feigned or concealed report, but their reliability and, above all, their legal admissibility are contested, and that question is set out elsewhere in this chapter, where narcoanalysis, brain mapping and the polygraph are discussed. The malingering examiner should know these methods exist, should treat a positive instrumental result as neither necessary nor sufficient to establish feigning, and should defer the question of when they may lawfully be used to that discussion. The distinct ethical problem of subjecting an unwilling examinee to a procedure designed to catch them out belongs to the Forensic ethics, consent and legal procedure notes and is not settled here.

IN INDIA

The Indian settings that generate external incentives are the ones that generate malingering: criminal referrals in which an accused may feign illness to claim the unsound-mind exception or to be found unfit to plead, both of which are taken up elsewhere in this chapter, and compensation, disability and fitness-to-work assessments in which a certificate carries money or a livelihood. Well-standardised symptom and performance measures are often not to hand in routine practice, so the Indian assessment leans hardest on the two tools that are always available - careful documentation of observed against reported function, and collateral gathered from records and informants. The instrumental methods sometimes pressed for by investigating agencies sit under a contested legal position covered elsewhere in this chapter, and a psychiatrist asked to rely on them should keep that limit clearly in view.

27.5 The forensic assessment and its dangers

How the examination is actually conducted. Because the whole question is whether a self-report can be trusted, the assessment is built to test consistency rather than to take the account at face value. The examiner moves from open, unstructured enquiry to specific probing, re-examines the same ground at different times to see whether the story holds, and observes the examinee outside the formal interview where the effort of maintaining a fabricated deficit relaxes. Collateral is gathered before the interview, not after, so that the account can be checked against something independent while the person is still in the room. Throughout, the stance is neutral: malingering

is detected and documented, not confronted, because an accusation across the desk yields defensiveness and loses the observational advantage without adding evidence.

The hardest discipline is to hold two truths together. A person can be both malingering and genuinely ill, so a finding that some symptoms are exaggerated does not establish that the person is well, and detecting feigning never closes the separate question of real illness underneath it. Feigning is also a matter of degree rather than a switch, ranging from mild embellishment of a real complaint to wholesale fabrication, and the report should say where on that range the evidence places the presentation. What the psychiatrist supplies is a description of the evidence and the reasoning from it to a conclusion, framed as an inference of a stated strength; the report certifies findings, not a motive it cannot evidence, and the conventions for putting such an opinion before a court belong to the Forensic ethics, consent and legal procedure notes.

GOOD TO REMEMBER

Gather the collateral before you interview, not after, so the account can be tested against something independent while the person is in front of you. Keep the stance neutral, because malingering is detected rather than confronted, and hold on to the fact that feigning and genuine illness coexist, so exaggeration in part never proves wellness in whole. Describe the observed against the reported, let the convergence carry the weight, and where the evidence supports only doubt, write doubt and name what further information would settle it.

PITFALL

Committing the word "malingerer" to a medical record or a court report on an impression rather than on convergent evidence. The label is an accusation of deliberate fraud; asserted without the positive findings to support it, it is clinically wrong, because it forecloses a genuine illness that may coexist, and medico-legally reckless, because the opposing side needs only to show that the conclusion rested on suspicion for the whole report to fall. If the evidence supports only doubt, record doubt; a defensible report never reaches further than its findings allow.

28 · Psychiatric aspects of homicide and filicide

Why the marks are here. Killing is the point at which psychiatry and the criminal law meet most sharply, and the questions a court then puts to the psychiatrist - was this person responsible, what drove the act, could it have been foreseen and prevented - all turn on the mental state at the moment of the offence. **Filicide**, the killing of a child by a parent, concentrates these questions further, because it forces the assessor to hold together parental psychopathology, the safety of any surviving children and a society that finds the act almost unthinkable. This topic is examined less for its epidemiology than for two things a candidate must produce cleanly: the recognised classification of these killings, and the specific clinical contexts in which the risk is real.

The foundation is a base-rate fact that must be stated with care, because getting it wrong in either direction is a failure of both scholarship and fairness. Homicide committed by a person with mental illness is uncommon, and the great majority of people with even severe mental illness are never violent. What raises the risk is not the diagnostic label but the active symptomatic state:

lethal violence is over-represented in florid psychosis carrying persecutory or command features, and in acute substance intoxication. Holding both halves of that sentence together - the rarity and the specific high-risk state - is what separates a defensible answer from a stigmatising one.

Homicide by a person with mental illness is uncommon but is over-represented in active psychosis with persecutory or command features and in substance intoxication; filicide is classified by the parent's motive, neonaticide is a separate category tied to concealed pregnancy in a young mother, and postpartum psychosis is a recognised high-risk context for infanticide.

5	first day
RESNICK FILICIDE MOTIVES	NEONATICIDE WINDOW

28.1 Homicide in the context of major mental illness

The link between psychosis and homicide is real but narrow, and understanding its shape prevents both complacency and over-prediction. Risk rises when psychotic symptoms directly engage a potential victim: a **persecutory** delusional system that casts a specific person as a lethal threat, or hallucinations that **command** the patient to act, convert a private illness into a danger to others. The mechanism is one of subjective self-defence or of felt compulsion: the patient acts not on ordinary motive but within a delusional reality in which the act feels necessary or unavoidable. Substance intoxication is the second and independent amplifier - it disinhibits, distorts perception, and in combination with psychosis is a far stronger driver than either state alone.

The features that should raise concern in an acutely psychotic patient are worth holding as a short set:

- persecutory delusions that name or locate a specific persecutor, rather than a diffuse sense of threat;
- command hallucinations to harm, particularly where the patient shows early compliance or feels unable to resist them;
- delusions of passivity or control, in which the patient experiences their own actions as imposed from outside;
- comorbid substance intoxication, which lowers the threshold for acting on any of the above.

These are state markers, not a general risk formulation. The systematic taxonomy of static and dynamic risk factors, and the structured tools that weigh them, are developed elsewhere in this chapter; the point here is narrower - that lethal violence in mental illness is bound to the active symptomatic state, which is why it is often reversible with treatment and why the assessment of any homicide case begins with a disciplined reconstruction of the mental state at the time of the act. Where that reconstruction establishes that the act arose from an illness meeting the legal threshold, the matter becomes one of criminal responsibility, the insanity defence, taken up in full elsewhere in this chapter; short of that threshold, India has no diminished-responsibility

defence, so the mental abnormality may instead bear on proof of an offence-specific mental element or on sentence, or engage the grave-and-sudden-provocation exception where its own conditions are independently established, matters taken up in full elsewhere in this chapter.

28.2 Filicide and its classification by motive

Filicide is the killing of a child by a parent, and the single most examinable fact about it is that it is classified by the parent's motive, not by the method or the age of the child. The most widely used scheme is **Resnick**'s, which separates the killings into motivational groups. Learning them as motives rather than as a bare list is what makes them clinically useful, because the motive is what predicts the mental state behind the act and the way the law is likely to treat it.

In **altruistic** filicide the parent kills out of a distorted belief that death spares the child suffering - the severely depressed mother who can see no future for herself or her child, or the psychotic parent convinced the child is doomed. It is the category most strongly associated with serious affective or psychotic illness and with maternal suicide, the killing forming part of an extended suicide. **Acutely psychotic** filicide is killing driven directly by psychosis, by command hallucinations or delusions, without the coherent if deluded protective logic of the altruistic type; here the act may be bizarre and, in any ordinary sense, unmotivated. The **unwanted-child** type is the killing of a child the parent regards as an obstacle or a burden, classically where the child is genuinely unwanted and the parent unsupported. **Fatal maltreatment**, sometimes called accidental filicide, is death resulting from cumulative abuse or neglect rather than from an intention to kill, and it is the category that sits at the interface with child protection. The **spouse-revenge** type, the rarest, is the killing of a child in order to inflict suffering on the other parent.

RULE **Filicide is classified by the parent's motive, not by the act.** The same outcome, a dead child, can arise from profound depressive illness, from florid psychosis, from an unwanted pregnancy or from cumulative neglect, and it is the motive that fixes the likely mental state, the risk to any surviving children and the legal disposal. An answer that catalogues methods or injuries has missed the axis the examiner is testing.

RESNICK CATEGORY	CORE MOTIVE	TYPICAL MENTAL STATE	FORENSIC AND CLINICAL EMPHASIS
Altruistic	To spare the child suffering	Severe depression or psychosis; risk of extended suicide	Strongest link to major mental illness; assess the parent's own suicidality
Acutely psychotic	No rational motive; act driven by symptoms	Active psychosis, command hallucinations, delusions	Reconstruct the symptoms operating at the time of the act
Unwanted child	Child experienced as a burden or obstacle	Often no major mental illness; situational	Social adversity, support, and safeguarding of future children
Fatal maltreatment	No intent to kill; death from abuse or neglect	Variable; personality, substance use, stress	Interface with child protection and surviving siblings
Spouse revenge	To make the other parent suffer	Often personality pathology rather than psychosis	Rarest; focus on the parental relationship

28.3 Neonaticide as a distinct category

Neonaticide, the killing of a newborn within **the first day of life**, is commonly treated as a special, age-defined subtype of filicide, analysed separately because its perpetrator profile is different. It is classically committed by a young mother who has denied or concealed the pregnancy, often frightened, unsupported and without antenatal care, who delivers alone and disposes of the newborn in a state of panic or dissociation. Major mental illness is usually absent; what dominates is denial, immaturity and social desperation rather than psychosis or depression. Because both the psychopathology and the social setting differ so completely from the filicide motives, neonaticide is analysed on its own terms, and folding it into the motive list for older children is a standard and costly error.

TRAP **Neonaticide is a special, age-defined subtype of filicide, and it is not usually a mental-illness case.** Candidates absorb the first-day killing into the motive classification and reach for psychosis or depression to explain it. The prototypical picture is the opposite: a concealed pregnancy in a young, unsupported woman, a solitary delivery, and a dissociative or panic-driven act, with no major mental illness at all. The discriminator the examiner wants is the perpetrator profile, not a motive.

28.4 Postpartum psychosis and the risk of infanticide

Standing apart from both the situational neonaticide and the diverse filicide motives is the killing that arises out of **postpartum psychosis**, a recognised high-risk context for infanticide. Puerperal psychosis is a psychiatric emergency: it can arise abruptly in the early period after delivery, it is frequently affective in colour, and it can carry delusions concerning the infant - that the baby is defective, evil, or better off dead - together with command phenomena. The lethal danger is that these beliefs generate exactly the altruistic and acutely psychotic mechanisms described above, now directed at a wholly dependent newborn who cannot protect itself. This is

why the condition is treated as an emergency regardless of how settled the mother appears in the intervals between disturbance.

GOOD TO REMEMBER

A mother with postpartum psychosis should never be assumed safe to be the sole carer of her infant on the strength of a calm interview. Ask directly about intrusive or command-driven thoughts of harming the baby, arrange urgent review and admission, and keep mother and infant together only under supervision. The decision to admit jointly or to separate is a safeguarding decision as much as a treatment one.

Treatment is urgent, and where the illness is severe or life is at risk it may include physical treatments whose clinical technique and consent framework belong with the ECT and neurostimulation notes; the forensic point here is only that recognition and containment of the risk must come first.

28.5 The psychiatric assessment of the parent or perpetrator

What the psychiatrist actually does. The psychiatric contribution to a homicide or filicide case is a careful reconstruction of the mental state at the time of the act and a formulation of the motive, because these determine everything that follows: the availability of the insanity defence or a partial defence, the risk to any surviving children, and the treatment the perpetrator needs. The assessment gathers the person's account of the act, the pre-offence history and mental state, collateral and documentary evidence, and screens specifically for the depressive, psychotic and intoxication states that carry the risk. In a parent, it must always extend to the safety of other children in the household.

PITFALL

The dangerous clinical error is to hear a depressed mother say her children would be better off without her, or better off coming with her, as if it were ordinary depressive worthlessness. In a parent, the thought that a child would be better off dead is altruistic-filicide ideation until proven otherwise, and it must be asked about as directly and as specifically as suicidal ideation, with the same threshold for protective action. Missing it because it was heard as routine rumination is how a preventable death is not prevented.

IN INDIA

In Indian practice the evaluation of a mother who has killed her infant or newborn usually turns on reconstructing the perinatal mental state and screening for postpartum psychosis and severe depression, because the legal disposal runs through the general criminal law and the defences taken up elsewhere in this chapter. The classic neonaticide setting, a concealed pregnancy in a young and unsupported woman, is a recurring feature of casework, and it calls for a social and safeguarding response as much as a psychiatric one.

Two boundaries frame the work and should be named rather than absorbed. The formal examination for the court, the expert report, and the ethics of acting where treatment meets

evidence belong with the Forensic ethics, consent and legal procedure notes. Where fatal maltreatment or the safety of surviving children brings child-protection law into play, the governing statutes are set out in the Child psychiatry: assessment, treatment, services and protection notes. The forensic psychiatrist names these frames and works within them, but the assessment itself remains what it has always been: a disciplined reconstruction of a mind at the moment it did something almost unbearable to contemplate.

Civil law, capacity and family law

29 · Testamentary capacity (criteria and assessment)

Why the marks are here. A will speaks only after its maker is dead, at the one moment when the person who could explain it can no longer be asked, so the law insists that the mind behind it was sound when the document was made. Disputes about that soundness are common - a late will that cuts out one child, a large gift made in the shadow of dementia, a bequest a family says was the product of illness - and the court that must resolve them turns to the psychiatrist for an opinion on capacity. The examiner rewards the candidate who treats **testamentary capacity** as what it is: a functional, decision-specific and time-specific test, governed by a statute that says who may make a will and by a classic common-law authority that says what a sound mind for that particular purpose actually involves. A bare diagnosis is not the answer to any of it.

Two sources hold this topic together, and the disciplined answer keeps both in view at once. The Indian Succession Act supplies the statutory frame: it names who is competent to make a will and, through a short set of Explanations, tells us what soundness of mind means for this act and when it is measured. The common law supplies the anatomy of that soundness through the case every examiner expects by name, which breaks the "sound mind" of the statute into the concrete faculties a testator must actually exercise. Learn the two together and the wrong-statute traps that cluster around this topic fall away.

59	1925	1870	4
MAKING A WILL	INDIAN SUCCESSION ACT	BANKS V GOODFELLOW	LIMBS OF SOUNDNESS

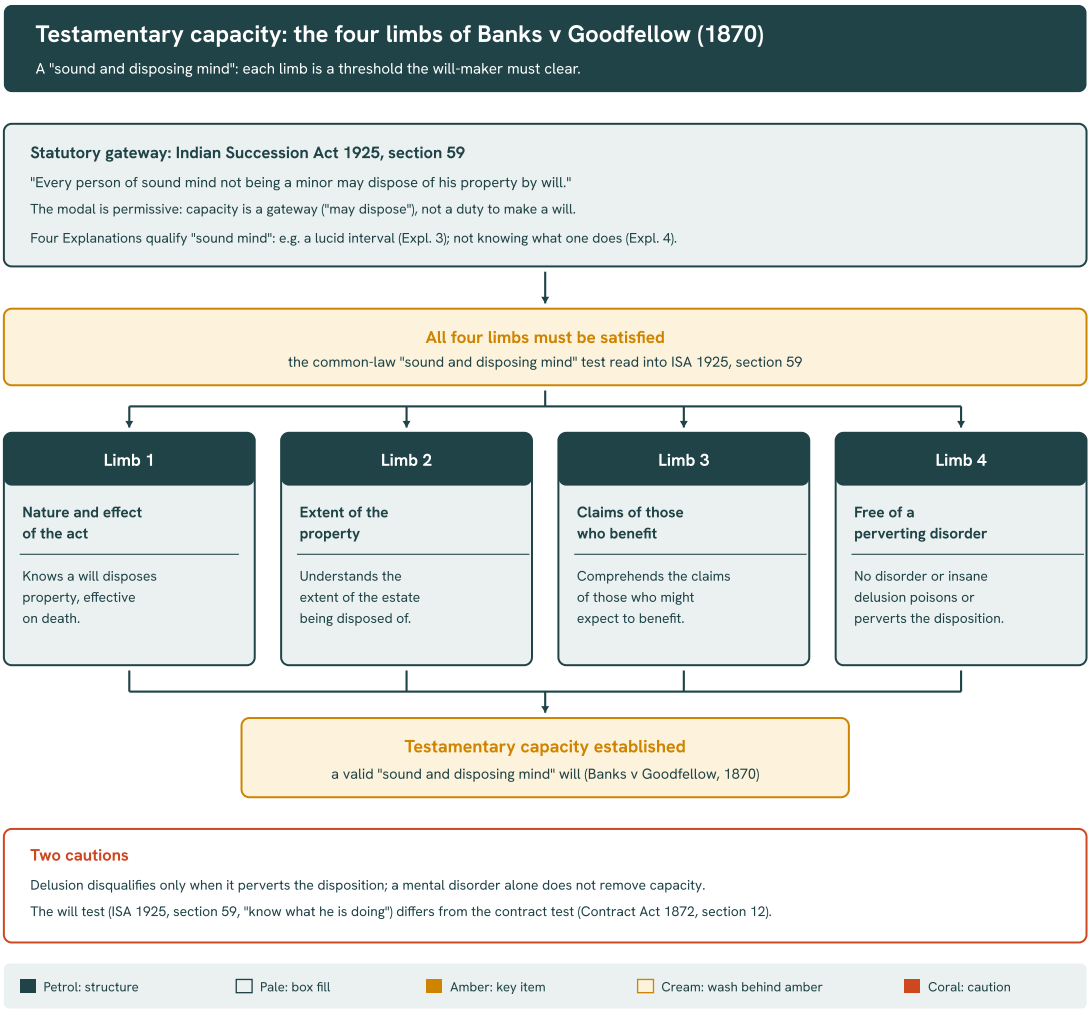


Fig 25.13. The four limbs of testamentary capacity from Banks v Goodfellow (1870), read into the permissive gateway of Indian Succession Act 1925, section 59. All four thresholds must be cleared for a "sound and disposing mind"; a mental disorder or delusion disqualifies only when it perverts the disposition.

29.1 Who may make a will

The starting provision sits in the Indian Succession Act of **1925**, at section **59**, and its opening words set both the standard and its character: every person of **sound mind** not being a minor may dispose of property by will. Two features of that sentence repay slowing down on. The first is that the operative verb is permissive - the section says such a person may make a will, conferring a power rather than imposing a duty. It is an enabling provision, naming who is free to dispose of their estate rather than commanding that anyone must. The second feature is that competence is stated as the pairing of two requirements, soundness of mind and majority, joined so that a sound-minded child cannot make a valid will and neither can an adult whose mind is not sound at the material time.

For the psychiatrist the majority limb is not our concern - age is a matter of record the court establishes for itself - and the whole clinical enquiry lives in the words "sound mind." That phrase is the hinge of the topic. It is not used in its loose everyday sense; the Act gives it content through

the Explanations that follow the main provision, and it is those Explanations, not a diagnostic label, that the examiner wants reproduced and applied.

29.2 What soundness of mind means for a will

The provision qualifies "sound mind" through **four** Explanations, and together they convert a vague adjective into a set of workable rules. The first preserves the will-making power of a married woman over any property she could dispose of by her own act during her life; it is a rule about legal personality rather than about psychiatry, and it does not turn on any mental state. The remaining Explanations are the ones that matter clinically, because each fixes a relationship between a mental state and the power to make a will.

The second Explanation is a caution against equating a sensory or communication impairment with incapacity: persons who are deaf or dumb or blind are not, on that account, incapacitated from making a will, provided they are able to know what they do by it. The condition attached is the whole of the rule: the impairment does not disqualify so long as the person can understand what the act of making the will achieves. The third Explanation is the one candidates most often reach for: a person who is ordinarily insane may make a valid will during an interval in which he is of sound mind, the **lucid interval** in which the standing illness has, for the time being, lifted. The rule is permissive and it is real: an established diagnosis of chronic mental illness does not bar a will made in a genuine window of clarity.

The fourth Explanation states the outer bound in the negative and in absolute terms: no person can make a will while he is in such a state of mind, whether arising from intoxication or from illness or from any other cause, that he does not know what he is doing. The modal force here is worth marking, because it is the mirror of the third: this is not a "may not" that admits of exception but a flat "cannot," and it is deliberately cause-neutral, reaching any state, however it is arrived at, that robs the person of knowing what the act of willing is. The through-line of those clinical Explanations is a single test seen in different situations - the will stands or falls on whether, at the moment of making it, the person knew what they were doing by it.

Held as a single picture, the four Explanations read as follows.

THE SITUATION	WHAT THE WILL-MAKING PROVISION SAYS
A married woman	May dispose by will of any property she could alienate by her own act during her life
A person who is deaf, dumb or blind	Is not thereby incapacitated, provided able to know what they do by the will
A person who is ordinarily insane	May make a will during an interval in which he is of sound mind - a lucid interval
Any person whose mind is disordered by intoxication, illness or any other cause	Cannot make a will while in a state in which he does not know what he is doing

29.3 The common-law test: a sound and disposing mind

The statute tells us that soundness is required and, through the third and fourth Explanations, that it is judged at the moment of making the will, but it does not itself spell out the faculties that soundness comprises. That anatomy comes from the common law, from **Banks v Goodfellow** of **1870**, in which Cockburn CJ set out the test of the **sound and disposing mind** that Indian courts continue to apply. The judgment identifies **four** things a testator must be able to do. The testator must understand the nature of the act of making a will and its effects - that this document directs who will take the estate after death. The testator must understand the extent of the property being disposed of, in broad terms rather than to the last rupee. The testator must be able to comprehend and appreciate the claims of those who might expect to benefit, the persons who have a natural call on the testator's bounty, whether or not the testator chooses in the end to provide for them. And, negatively, no disorder of the mind must poison the affections or pervert the sense of what is right so as to distort the disposition itself.

The understanding limbs are cognitive and specific to the act of testation: they ask what the person can grasp and weigh about this will, this estate and these potential beneficiaries. The final limb is different in kind. It is not a further thing to understand but a negative condition, a requirement that no mental disorder reach into and distort the very choices those limbs describe. That structure is why the test can be satisfied by a person who is far from mentally well, and can fail in one whose cognition on formal testing looks intact: the four limbs ask not whether the mind is healthy but whether it was, for this act, sound and disposing.

MNEMONIC

Deed, Extent, Claims, Delusion

The four limbs of the sound and disposing mind, in order: understand the **Deed** - the nature of making a will and its effect; grasp the **Extent** of the property being given; comprehend and appreciate the **Claims** of those who might expect to benefit; and be free of any disorder or delusion that perverts the disposition. The understanding limbs are faculties the testator must have; the delusion limb is a distortion they must not have.

RULE **A valid will needs a sound and disposing mind at the moment of execution.** The statute sets the standard - soundness of mind together with majority - and the common-law test unpacks soundness into the four faculties the testator must exercise: understanding the act and its effect, the extent of the estate, and the claims of those who might benefit, with no disorder of the mind perverting the disposition. It is a capacity for this decision at this time, not a global verdict on the person or a certificate of mental health.

29.4 Disorder, delusion and the survival of capacity

Capacity survives a diagnosis. The single most discriminating feature of the test lives in its fourth limb, and it runs against intuition. A testator may carry a serious mental disorder, and may even hold frank delusions, and still have testamentary capacity; the presence of illness does not, by itself, defeat the will. What defeats it is narrower and more specific: an **insane delusion** counts only when it is one that influences the disposition, poisoning the testator's natural affections or

their sense of who has a claim, and so bringing about a gift that a sound mind would not have made.

The distinction is best held with a pair of examples. A testator who harbours a fixed, unfounded belief about some matter wholly unconnected with the estate - a delusion about a neighbour, or about events long past - may still make a perfectly valid will, because that belief plays no part in how the property is divided. Contrast the testator who believes, against all reason and evidence, that a devoted child is an enemy conspiring against them, and who disinherits that child precisely for that reason: here the delusion has reached into the disposition and perverted it, and capacity fails. The question the assessor must answer is therefore not "is this person deluded" but "did a delusion shape this will," and only the second defeats it. This is why testamentary capacity can be partial and disposition-specific rather than all-or-nothing.

None of this is a historical curiosity. The sound-and-disposing-mind test remains the governing common-law standard for testamentary capacity, applied and reaffirmed in modern probate litigation, including the recent English authority of **Hughes v Pritchard** - the live framework the assessment must be built around, not a nineteenth-century relic to be recited and set aside.

TRAP **Assuming that a mental disorder, or a delusion, automatically destroys testamentary capacity.** It does not. A testator may have a diagnosis, or even hold delusions, and still make a valid will; capacity fails only where a delusion actually influences the disposition. Writing that the testator "was psychotic and therefore lacked capacity" answers the wrong question and loses the mark, because the examiner is looking for the causal link between the delusion and the terms of the gift, not the mere co-existence of illness and a will.

Testamentary capacity is decision-specific and time-specific: a valid will needs a sound and disposing mind at the moment of execution - the testator understanding the act, the extent of the estate and the claims upon it - and a mental disorder defeats it only when a delusion actually perverts the disposition.

29.5 Assessing and recording testamentary capacity

Because the test is functional and fixed to a moment, the assessment must be functional and, very often, retrospective. Two quite different referrals arise. In the contemporaneous referral the psychiatrist assesses a living testator - typically elderly or seriously ill - at or near the time the will is made, so that a record of capacity exists should it later be contested. In the retrospective referral, the commoner one, the testator has died and the mental state at execution must be reconstructed from whatever survives: the clinical record, the notes of the person who took instructions and prepared the will, informant accounts of the testator's conduct at the time, and the terms of the will itself. In neither case is the task to certify a diagnosis or to pronounce the person globally capable or incapable; it is to map the limbs of the test onto this particular will.

In practice the enquiry tracks the limbs of the test:

- Does the testator understand that they are making a will, and what a will does - that it directs who receives their property after death?

- Do they have a realistic grasp of the nature and extent of the property they are disposing of?
- Can they identify and weigh the claims of those who might expect to benefit, family and dependants, even where they choose in the end to exclude them?
- Is there a mental disorder present, and if so, is any delusion influencing the disposition, or is the illness irrelevant to the choices actually made?

Two habits separate a useful opinion from a dangerous one. The first is to record the testator's actual reasoning - the words in which they described the estate, named the family, and explained the exclusions - rather than a bare conclusion, so that the court can see how each limb was met or failed. The second is candour about the evidence: where the contemporaneous record is thin the psychiatrist should say so and frame the view as an inference, because an overstated report both misleads the court and destroys the witness's credibility under challenge. Good practice, though not a statutory command, is to arrange a capacity assessment whenever an aged or gravely ill person makes a will. The form in which the opinion is finally put before a court, the expert report and the certificate for the court, is not testamentary law and is treated in the Forensic ethics, consent and legal procedure notes.

GOOD TO REMEMBER

Assess and record the testator's grasp of three things against the actual will - the act of making it, the extent of the estate, and the claims of those with a call on their bounty - and ask specifically whether any delusion is shaping the gift. Where a testator is elderly or seriously ill, a capacity assessment made at the time the will is executed is worth far more than any reconstruction attempted after death, once memory has hardened into partisanship.

IN INDIA

Wills are governed by the Indian Succession Act, and its provision on who may make a will supplies the statutory soundness standard that the courts read together with the Banks v Goodfellow limbs. The psychiatrist advises and the court decides, since testamentary capacity is ultimately a finding of fact for the judge. In everyday practice the referral is civil and usually retrospective, arising from a contested will, and the useful report is the one that tracks the limbs of the test against the particular will and testator rather than offering a diagnosis or a blanket judgement on the deceased.

29.6 Keeping the will test apart from its neighbours

Testamentary capacity is one of a family of legal capacities, each with its own standard and its own governing text, and the examiner's favourite move is to run them together. The capacity to make a binding agreement - contractual capacity - is governed by its own provision in the Indian Contract Act, with its own definition of soundness of mind, and it is taken up as its own topic in this chapter; its test is not the will test and must not be borrowed for one. The capacity to make a mental-healthcare or treatment decision has its own statutory test under the Mental Healthcare Act and is likewise treated elsewhere in this chapter. What these capacities share is a common structure, not a common test: each is decision-specific and time-specific, so the assessor must first

identify which decision the law has actually raised, reach for the right standard, and apply that standard's own limbs.

India retains these as distinct, separately worded tests rather than a single all-purpose capacity, and for the careful examinee that is a help rather than a burden. The discipline is simply to pair the decision with its own test - a will with the sound and disposing mind, a contract with the contract-law definition of soundness, a treatment decision with the mental-health-law test - and never to answer one capacity question with another's wording or another's statute. The candidate who keeps the acts, the standards and the limbs paired loses nothing to the confusion the paper is built to induce.

PITFALL

Answering a will question with the wrong statutory test. Soundness of mind for a contract has its own definition in the Indian Contract Act, and it is not the standard for a will; a testator's capacity is measured against the Indian Succession Act's soundness requirement and the Banks v Goodfellow limbs, at the moment of execution. Lifting the contract-law soundness test - or a standing "of unsound mind" label from the case notes - across to a disputed will is a scope error that produces the wrong answer even when every clinical fact in the report is correct.

30 · Contractual capacity and competence

Why the marks are here. A psychiatrist is pulled into contract law the moment a family disputes a gift, a sale, a loan or an agreement signed by a relative who was, or is said to have been, mentally unwell. The court does not ask whether the person carried a diagnosis; it asks a narrower and far more answerable question - was this particular person, at the particular moment of the transaction, able to understand what they were doing and to judge its effect on their own interests. Contractual capacity is therefore a functional and time-bound test, and the examiner rewards the candidate who can name the governing sections precisely, reproduce their exact wording, and keep this test cleanly apart from the neighbouring tests of testamentary capacity and of capacity to make a treatment decision.

The whole topic sits in two short sections of one old statute, and the discipline the examiner is testing is statutory rather than clinical: can you say who the law treats as competent, what it means by soundness of mind, and at what instant that soundness is measured. Each of those is a separate provision with its own wording, and the difference between a discretionary "may" and a mandatory rule is exactly the kind of detail the paper is built to find. A candidate who paraphrases the gist loses marks a candidate who quotes the limbs keeps.

11	3	12	2
COMPETENCE	CUMULATIVE CONDITIONS	SOUND MIND	SOUNDNESS LIMBS

30.1 Who is competent to contract

The law of who may enter a binding agreement is set out in the Indian Contract Act of **1872**, at section **11**. It treats a person as **competent to contract** only when **three** conditions hold together, joined in the text by "and" and therefore strictly cumulative: the person is of the **age of**

majority according to the law to which they are subject; is of sound mind; and is not disqualified from contracting by any law to which they are subject. Because the conditions are cumulative, the failure of any single one defeats competence. A mentally sound adult who happens to be disqualified by some other statute is not competent, and neither is a mentally sound person who is below the age of majority.

The age limb is why a minor cannot bind themselves. An agreement made by a minor is not merely unenforceable against them; it is **void ab initio**, void from the very beginning, the position long settled in the **Mohori Bibee** line of authority. This void-from-the-outset position is settled for a minor's agreement specifically, and it should not be read across to the other two limbs as though incompetence from any source produced the identical result. The consequence of an agreement made by a person who was not of sound mind is left to the statutory provisions taken up below and is not asserted here.

The third limb, that the person is not disqualified by any other law, is a reminder that soundness of mind is only one of the doors that must be open. Various statutes disqualify particular persons or particular kinds of transaction, and where they bite, competence fails regardless of how lucid the person was. For the psychiatrist this is a useful boundary: the remit is the sound-mind limb, and it is neither necessary nor appropriate to opine on age or on legal disqualifications, which the court establishes for itself. The clinical question is confined to the one limb the law actually refers to a mental state.

MNEMONIC

Age, Mind, No-bar

The three cumulative requirements of the competence section, in order: **Age** of majority, sound **Mind**, and **No** legal **bar** - not disqualified from contracting by any law to which the person is subject. All three must hold at once; the failure of any one defeats competence.

30.2 What "sound mind" means for a contract

Soundness of mind is not left to ordinary usage; it is given its own definition, for this purpose alone, at section **12**, and this is the provision the psychiatrist is really being asked about. A person is of **sound mind** for the purpose of making a contract if, at the time of making it, they are capable of two things together: understanding the contract, and forming a **rational judgement** as to its effect upon their interests. The test therefore has **two** limbs - comprehension of the transaction, and rational appraisal of what it will do to one's own position - and both must be present for the mind to count as sound.

The two limbs are worth pulling apart, because they fail in different ways. The first is cognitive and specific to the deal: does the person grasp the nature and the terms of this transaction, what is being given and what is being received. The second is evaluative and self-referential: can the person weigh the consequences of the bargain against their own interests, seeing that a sale below value depletes their estate, or that standing surety exposes them to another's debt. A person may

understand the mechanics of a contract in the abstract and still be unable, through illness, to appraise its effect on themselves; it is the pairing of the two capacities that the section demands.

A functional test, not a diagnostic one. Nothing in this definition turns on a label. A person may carry a serious psychiatric diagnosis and still satisfy both limbs for a given transaction, and a person with no diagnosis at all may fail them in a state of acute confusion. The statute asks what the mind could do at the moment, not what condition it bears. This is why a bare certificate that the person "suffers from a mental illness" answers the wrong question: the court needs to know whether, for this transaction, the person could understand it and reason about its effect on their own interests, which a diagnosis alone can neither establish nor exclude.

RULE **A contract needs a competent mind at the moment it is made.** Competence is the cumulative package of the competence section - majority, sound mind, and no disqualification - and soundness of mind for this purpose is the capacity, at the time of contracting, to understand the agreement and to form a rational judgement of its effect on one's own interests. Both the standard and the timing are set by statute, not by the assessor's general impression of the person.

30.3 Soundness is judged at the moment of contracting

The most examined feature of the definition is its timing. Soundness is assessed at the instant the contract is made, not as a standing trait, and the statute spells out what that means through two situational rules that cut in opposite directions. A person who is usually of unsound mind, but occasionally of sound mind, may make a contract when they are of sound mind: the recognised illustration is the **lucid interval**, in which an otherwise incapacitated person contracts validly during a genuine window of clarity. The mirror rule is stricter and is the one candidates forget: a person who is usually of sound mind, but occasionally of unsound mind, may not make a contract while they are of unsound mind, so the ordinarily capable person who signs while delirious or intoxicated is, for that transaction, outside the section's protection.

The reason the section is built this way is evidential as much as conceptual. If capacity can flicker, then what governs a disputed deal is the mental state at the material time, and contemporaneous evidence of that state - the notes of the day, the observations of those present, the person's own conduct around the transaction - becomes decisive. Conditions that wax and wane, such as delirium or intoxication, make the timing the whole question, because the same person may be within the section one hour and outside it the next. The two rules together say that neither a usual incapacity nor a usual capacity settles the matter; only the state at the moment does.

The two situational rules are best held as a single picture, since a candidate who remembers one half routinely forgets that it works both ways.

USUAL BASELINE	STATE AT THE MOMENT OF CONTRACTING	EFFECT ON THIS CONTRACT
Usually of unsound mind, occasionally sound	Sound - a genuine lucid interval	May make the contract
Usually of sound mind, occasionally unsound	Unsound - for example delirium or intoxication	May not make the contract

Contractual capacity is transaction-specific and time-specific: the only question is whether, at the moment of the deal, the person could understand it and form a rational judgement of its effect on their own interests.

30.4 Assessing and reporting contractual soundness

Because the statutory test is functional and tied to a moment, the assessment must be functional and, very often, retrospective. By the time a dispute reaches a psychiatrist the transaction is usually months or years past, so the opinion is reconstructed from contemporaneous records, the person's own account, informant histories, and any independent evidence of the mental state around the material time. The psychiatrist is not certifying a diagnosis and is not declaring the person globally capable or incapable; the task is to map the two statutory limbs onto the specific agreement in question, and to say, as far as the evidence allows, whether they were met when it was signed.

In practice the enquiry follows the section's own structure:

- Did the person understand the nature of this transaction - what was being given, received or promised, and on what terms?
- Could they form a rational judgement as to its effect on their own interests, weighing the benefit against the cost or the risk?
- Was that capacity present at the time the contract was made, allowing for fluctuation and for genuine lucid intervals?
- Is the opinion documented with the person's actual reasoning, rather than a bare conclusion, so that a court can see how each limb was met or failed?

The honest retrospective opinion is careful about its own limits. Where the contemporaneous record is thin, the psychiatrist should say so and frame the view as an inference rather than a certainty, because the burden of persuading the court sits with the party challenging the transaction and an overstated report does that party's work while damaging the witness's credibility. The manner in which the opinion is finally put before a court - the form of the report, the psychiatrist's duties as an expert, and the certificate for the court - is not contract law and is treated in the Forensic ethics, consent and legal procedure notes; here the point is only that the clinical content of the opinion is dictated by the two statutory limbs and by the moment at which they must be shown.

GOOD TO REMEMBER

Assess and record the person's understanding of the particular deal and their reasoning about its effect on their own interests, at the material time. A global label - "of unsound mind" - is not what the court can act on; the demonstrated grasp of this transaction is. Where the records will not support a firm view, say the evidence is insufficient rather than filling the gap with an impression.

IN INDIA

The governing standard is statutory: the Indian Contract Act fixes the definition of soundness, and the psychiatrist advises rather than decides, since competence is ultimately a finding for the court. In everyday practice the referral is civil and retrospective, arising from a contested gift, property transfer, sale or agreement, and the useful report is the one that tracks the two statutory limbs against the specific transaction rather than offering a diagnosis or a blanket verdict on the person.

30.5 Keeping the contracting test apart from its neighbours

Contractual soundness is one of a family of legal capacities, each with its own test, and the examiner's favourite error is to run them together. The capacity to make a valid will - testamentary capacity - is governed by a different provision, in the Indian Succession Act, and by a different standard; it is taken up as its own topic in this chapter and must not be answered with the contracting definition. The capacity to make a mental-healthcare or treatment decision has its own statutory test under the Mental Healthcare Act and is likewise treated elsewhere in this chapter. What these capacities share is a boundary rather than a common test: because each has its own statutory standard, the contracting definition cannot be lent to a will dispute or to a treatment-refusal question, and the psychiatrist must answer the exact capacity the court has actually raised.

India retains these as distinct, separately worded tests rather than a single all-purpose capacity, and that is a strength for the careful examinee: the discipline is simply to identify which act is in issue, reach for the right statute, and apply its limbs. The contracting test measures understanding and rational judgement of a bargain's effect on the maker's interests; a will and a treatment decision each ask something with its own wording and its own moment. The candidate who keeps the acts, the statutes and the limbs paired loses nothing to the confusion the paper is trying to induce.

TRAP **Answering a will or a treatment-refusal question with the contracting test.** The soundness-of-mind definition for contracting is a distinct statutory test. Testamentary capacity lives in the Indian Succession Act under its own standard, and treatment-decision capacity under the Mental Healthcare Act; quoting the contract definition for all three, or naming the wrong statute, is the classic way to lose an otherwise easy mark.

PITFALL

Treating a diagnosis as though it settled the matter. A standing diagnosis of mental illness, dementia or intellectual disability does not by itself void a contract, and a person may hold a serious diagnosis yet retain soundness for a particular deal, or regain it in a lucid interval. Reading soundness as a global, once-and-for-all status rather than a transaction-specific and time-specific finding is how a clinician's report overreaches what the statute actually asks - and it cuts the other way too, since an ordinarily well person can lose soundness for a transaction signed while acutely confused.

31 · Marriage, nullity and mental illness (Hindu Marriage Act, Special Marriage Act)

Where the marks sit. Mental capacity at the time of the marriage decides whether a ground for nullity exists, not whether the parties are married at all: a defect present at the wedding leaves the marriage standing until a court acts on it, and the governing Act decides whether that route is annulment of a voidable marriage or a declaration that the marriage was void. When mental illness is said to have been present at the moment the marriage was contracted, the question the court is really asking is one of formation - was this a good marriage in the first place - and the answer is nullity, not divorce. The psychiatrist is drawn in to speak to the state of a party's mind at the wedding, not at some later crisis, and the marks reward the candidate who keeps a formation defect apart from a dissolution ground and who can reproduce the exact statutory wording rather than gesture at its gist.

Two statutes carry this in the personal law a candidate must know. The Hindu Marriage Act governs marriages between Hindus, and the Special Marriage Act governs a civil, secular form of marriage irrespective of religion, subject to the section 4 conditions and the current law; each sets a mental-capacity condition for a valid marriage in near-identical words, but the two Acts part company on what a breach of it does to the marriage. Under the Hindu Marriage Act a breach makes the marriage voidable and open to annulment by a decree of nullity; under the Special Marriage Act the same breach makes the marriage void. The discipline the paper tests is statutory: the right section, the right limb, the right modal verb, and the clean line between void and voidable, which here runs between the two Acts themselves.

5	12	4	24
HINDU CONDITIONS	HINDU VOIDABLE	CIVIL CONDITIONS	CIVIL VOID

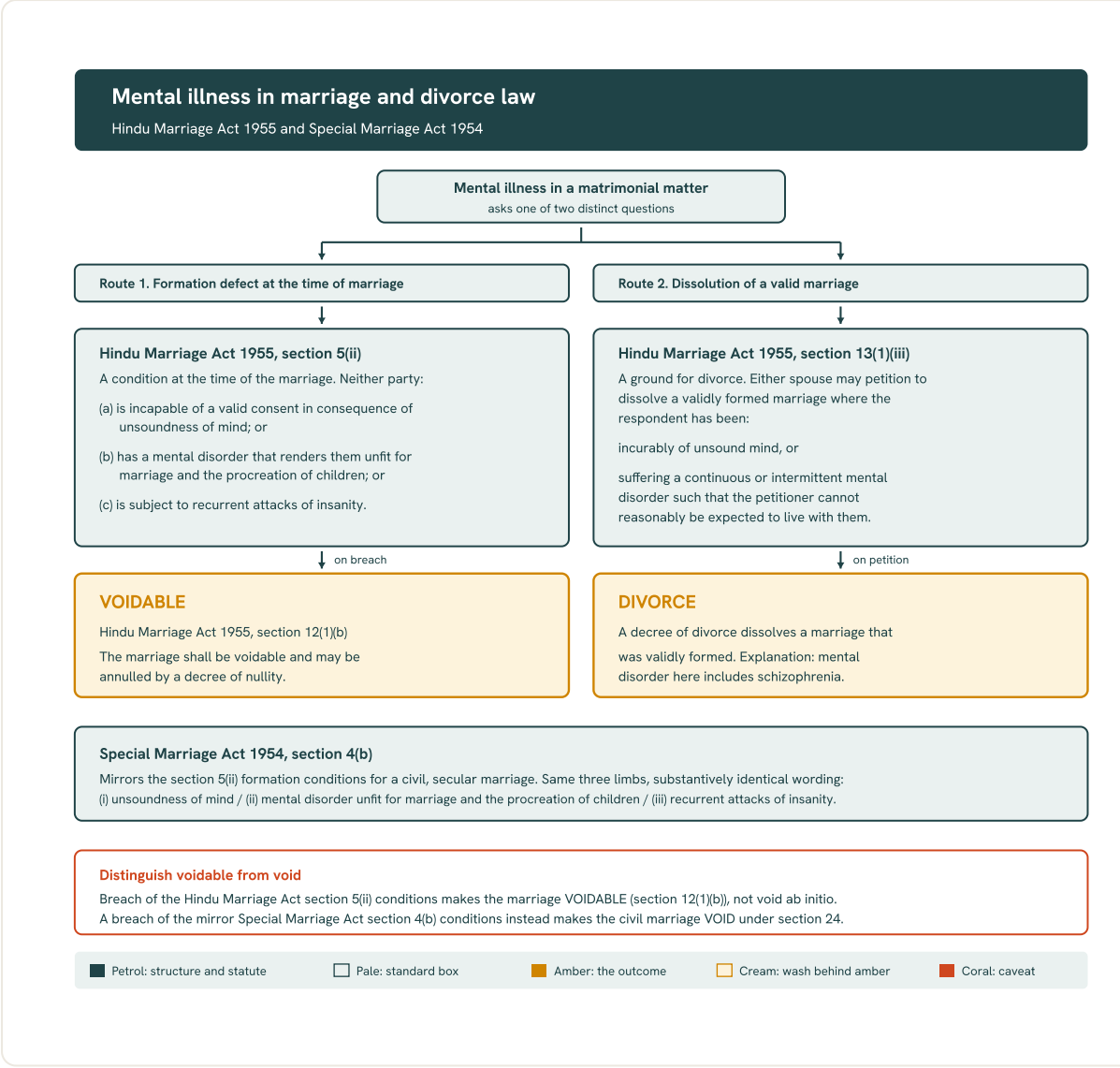


Fig 25.14. Mental illness reaches a marriage by two distinct routes. A formation defect under Hindu Marriage Act 1955 section 5(ii) makes the marriage voidable (section 12(1)(b), annulled by a decree of nullity), while section 13(1)(iii) is a ground to dissolve a validly formed marriage by divorce; the Special Marriage Act 1954 section 4(b) mirrors the formation conditions, but a breach of them makes a civil marriage void under section 24, not voidable.

31.1 The mental-capacity condition for a valid Hindu marriage

The conditions for a valid Hindu marriage are set out in the Hindu Marriage Act of **1955**, and the mental-capacity condition among them is clause (ii) of section **5(ii)**. The Act permits a Hindu marriage to be solemnised only where the conditions in that section are fulfilled, so this is a **formation condition**: it looks at the parties as they were at the time of the marriage and asks whether the marriage was well made, and it is indifferent to anything that befalls either of them afterwards. That temporal anchor is the whole of the topic. A condition that speaks to the moment of formation cannot be satisfied or defeated by a later illness, and a later illness cannot be crammed into it; that is what separates this ground from the neighbouring divorce ground and is where most candidates lose the mark.

The condition is breached if, at the time of the marriage, either party falls within any one of three alternative situations:

- is incapable of giving a valid consent to the marriage in consequence of unsoundness of mind;

- though capable of giving a valid consent, has been suffering from mental disorder of such a kind or to such an extent as to be unfit for marriage and the procreation of children; or
- has been subject to recurrent attacks of insanity.

The clause in its present form is not original to the Act as first enacted. It was substituted by **Act 68 of 1976**, the reform that recast the mental-capacity requirement into the three-limbed shape now examined. Reading the current text as though it were the Act as first enacted is a small but common error, and the wording the paper tests is the substituted wording, not what stood before it.

31.2 Reading the three limbs apart

The three situations are alternatives, not a cumulative test: any one of them, present at the time of the marriage, breaches the condition, and they are worth separating because they weigh quite different things. The first turns on consent. Here the disturbance is grave enough that the person is **unsoundness of mind** incapable of giving a valid consent to the marriage at all; the defect is in the very act of agreeing, so the marriage rests on a consent the law does not recognise. The second limb assumes the opposite starting point. The person can give a valid consent, and does, but carries a mental disorder of such a kind or to such an extent as to render them **unfit for marriage and the procreation of children**. This is a fitness test rather than a consent test, and its threshold is one of gravity: a diagnosis is not enough, the disorder must reach the kind or the extent the clause names. The third limb is the person **recurrent attacks of insanity**, and it captures a relapsing course rather than a settled state, using the archaic statutory word that the substituted clause retained.

The middle limb is the one that repays care, both because its threshold is a matter of degree and because its procreation-linked wording sits awkwardly with the modern rights-based understanding of mental illness and disability; a candidate should reproduce the clause as it stands while recognising that the phrase has drawn sustained criticism. Note too that the clause speaks of "mental disorder", a term the Act defines for the purpose of its divorce ground; that definition belongs to the topic on dissolution and is not restated here, and it should not be read across uncritically to the formation condition. What the formation limbs share is the moment they examine: each asks about the mind at the time of the marriage, and none is concerned with what the illness does to the marriage years later.

MNEMONIC

Consent, Fitness, Freedom

The three alternative situations of the mental-capacity condition, in order: incapacity of **Consent** through unsoundness of mind; a mental disorder that defeats **Fitness** for marriage and the procreation of children despite valid consent; and the absence of **Freedom** from recurrent attacks of insanity. Any one, present at the time of the marriage, breaches the condition.

31.3 The Hindu Marriage Act consequence: voidable, not void

The consequence of breaching the mental-capacity condition is the second half of the topic, and it is stated precisely at section **12(1)(b)**. A marriage in contravention of the condition in clause (ii) of the conditions section shall be **voidable** and may be annulled by a **decree of nullity**. The two modal verbs are doing exact work and must be preserved. The marriage *shall be* voidable, which fixes the category the defect falls into; a party *may* then seek annulment, which is discretionary in the sense that it depends on a party bringing the petition and on the court granting a decree. A voidable marriage is not the same thing as no marriage. It is valid and fully effective for every purpose until a party obtains a decree, and if no one ever petitions it stands. That is the opposite of a **void ab initio** union, which the law treats as never having been a marriage at all and which needs no decree to be a nullity.

Why the distinction bites. It is not academic. It decides who can act, when the marriage ends, and from what point. Because a Hindu Marriage Act mental-capacity breach yields a voidable marriage, the union survives until it is set aside at the instance of a party, and children and property questions are answered against a marriage that existed in law up to the decree.

AXIS	VOID MARRIAGE	VOIDABLE MARRIAGE
What the law treats it as	never a valid marriage at all	a valid marriage until it is annulled
Status before any decree	a nullity from the outset	valid and fully effective
Who ends it, and how	no decree is needed to treat it as a nullity, though one may be sought	only a party may petition, and the court may annul by a decree of nullity
Where a Hindu Marriage Act mental-capacity breach sits	not here	here - contravention of the clause (ii) condition

RULE **Under the Hindu Marriage Act, a mental-capacity defect at the wedding makes the marriage voidable, not void.** Breach of the formation condition renders the marriage liable to be set aside on a party's petition; until a decree of nullity is granted the marriage is valid for all purposes. The Hindu Marriage Act says the marriage shall be voidable and may be annulled, and the candidate must keep both verbs and must not upgrade this ground to a void marriage. The Special Marriage Act runs the other way: there the same breach is void, so the void-or-voidable answer turns on which Act governs.

31.4 The Special Marriage Act: same condition, void not voidable

The civil, secular route to marriage is the Special Marriage Act of **1954**, a form of civil marriage open irrespective of religion, which the parties may solemnise in whatever form they choose since the Act does not require a religious ceremony, subject to the Act's conditions and to the current law. This is the Act's solemnisation chapter, and it is this chapter, not the Act's separate provision for registering a marriage already performed in some other form, that carries the mental-capacity condition examined here. Its mental-capacity condition is clause (b) of section **4(b)**, and its three limbs are substantively identical to the Hindu Act's: incapacity of valid consent through unsoundness of mind; a mental disorder of such a kind or extent as to be unfit for

marriage and the procreation of children despite capacity to consent; and recurrent attacks of insanity. The same clinical test therefore serves both statutes, so the psychiatric opinion does not change with the Act. What changes, and this is the discrimination the paper rewards, is the consequence of a breach. Under the Hindu Marriage Act a breach of the mental-capacity condition renders the marriage voidable under section **12(1)(b)**, valid until a party has it annulled; under the Special Marriage Act a marriage solemnised under that chapter with the same breach is **null and void** under section **24**, a nullity from the outset that a party may have declared by a decree of nullity. A civil marriage solemnised under this chapter that fails the mental-capacity clause is therefore void, not merely voidable, and this void-versus-voidable split between the two Acts, on identical clinical facts, is the examined point. Registration of a marriage already performed in some other form is a separate current route under the Act, carrying its own condition on the parties' mental state at registration and its own, milder consequence for breach, namely that the registration rather than the marriage may be declared of no effect; that registration route is not restated here. The practical work is to cite the Act that governs the marriage in front of you and the consequence that Act attaches to a breach. That section also sets the Act's other conditions for a valid civil marriage, including that neither party already has a living spouse and that each has reached the minimum age the Act fixes for a bride and a groom; those are named here only to place the mental-capacity clause within its section, and are not the psychiatric ground.

IN INDIA

The clinical opinion is identical across the two statutes; what changes is the governing Act, and with it the section cited and the void-or-voidable consequence a breach carries. A marriage solemnised under Hindu personal law is tested against the Hindu Marriage Act, while a civil or inter-faith marriage is tested against the Special Marriage Act, and comparable mental-capacity conditions run through the other personal-law statutes with wording of their own. Match the governing Act to the parties before framing the report, because quoting the wrong statute for the right facts is an avoidable and much-penalised slip in a viva.

31.5 Nullity is a formation defect, not a divorce ground

The title of this topic pairs marriage with nullity, and the trap the paper sets is the line between nullity and divorce. Nullity, the route owned here, rests on a defect present when the marriage was formed: the mind was not fit to marry at the wedding, so the marriage was defective at its formation and may be unravelled by a decree. Divorce is the opposite premise. It is the **dissolution** of a marriage that was validly formed and subsisting, brought to an end for a reason that matters now, and where mental illness is the reason it operates as a ground of divorce with its own threshold. That dissolution ground is taken up as its own topic elsewhere in this chapter and is not restated here; what this section owns is the formation defect and the nullity that follows from it.

The reason the distinction earns marks is not that a single variable, the timing of the illness, sorts the same facts into one route or the other. Nullity and divorce ask different questions of those facts. Nullity asks whether the mental-capacity condition in section **5(ii)** stood breached at the

time of the marriage; if it did, the marriage is voidable under section **12(1)(b)** and may be annulled, whatever course the illness took afterwards. Divorce under section **13(1)(iii)** asks a different question: it presupposes a validly formed and still subsisting marriage and turns on whether the illness now meets the statutory severity threshold that ground sets, irrespective of when the disorder first began. Timing is therefore decisive for one question only, whether the section **5(ii)** condition was breached at solemnisation, and it does not by itself fix which remedy the facts will support: a disorder that predated the wedding can found a nullity petition if it breached the condition then, and can equally found a divorce if the marriage was validly made and the dissolution threshold is now met. This is why the psychiatric history should still fix onset against the date of the marriage as precisely as the records allow, but as evidence going to the formation condition, not as a switch that routes the whole case.

TRAP **Reading a formation defect as a divorce ground, or the reverse.** Facts that show incapacity or unfitness at the time of the marriage answer the nullity question; facts that show a grave illness arising within a valid marriage answer the divorce question. Citing the dissolution ground for a defect present at the wedding, or the formation condition for an illness that developed later, answers the wrong question and forfeits the mark.

PITFALL

Two currency-and-scope errors recur in practice. The first is treating a voidable marriage as if it were void from the outset, and advising a family that "there is no marriage" when in law the marriage stands until a party obtains a decree. The second is conflating the formation ground with the divorce ground, so that a clinician frames an opinion about a spouse's current illness as though it bore on the validity of the wedding years earlier. Both overstate what the statute allows and mislead the very people who have come for guidance.

31.6 The psychiatrist in nullity proceedings

Because the condition is anchored to the moment of the marriage, the assessment is almost always retrospective and is functional rather than diagnostic. By the time a nullity petition reaches a psychiatrist the wedding may be long past, so the opinion is reconstructed from contemporaneous records, informant accounts and any independent evidence of the party's mental state around the date of the marriage. The task is not to certify a diagnosis or to pronounce the person globally sound or unsound, but to map the statutory limbs onto that moment, and the enquiry follows the section's own structure:

- the diagnosis, and how securely it can be made for the relevant period;
- the mental state at the time of the marriage, reconstructed as far as the evidence allows;
- whether, on the first limb, the person could give a valid consent to the marriage;
- whether, on the second limb, a disorder reached the kind or extent that makes for unfitness for marriage and the procreation of children;
- the course of the illness, and whether it ran in the recurrent pattern the third limb describes.

The burden of establishing the ground rests on the party seeking nullity, and the ground must be proved on the whole admissible evidence; medical evidence is ordinarily important, especially where available, but is not an invariable statutory prerequisite, so the quality of the reconstruction frequently decides the case. That makes candour about the limits of a retrospective opinion a professional duty rather than a weakness: where the contemporaneous record is thin, the honest report says so and frames the view as an inference, since an overstated opinion does the petitioner's work while damaging the witness. How the opinion is finally put before a court, the form of the expert report and the duties of the expert witness, is not family law and is treated in the Forensic ethics, consent and legal procedure notes; here the content of the opinion is dictated entirely by the limbs and by the moment at which they must be shown.

GOOD TO REMEMBER

Pitch the opinion to the wedding, not to the clinic today. Set out the diagnosis, the mental state at the time of the marriage, and whether the person could consent or was rendered unfit, and tie each finding to the limb it bears on. Resist a global "of unsound mind" verdict, which is not what the court can act on, and where the historical evidence will not support a firm view, say the evidence is insufficient rather than filling the gap with an impression.

The mental-capacity condition for a valid marriage is judged at the time of the marriage, and its breach is a defect of formation, never a ground of divorce; under the Hindu Marriage Act that breach makes the marriage voidable and annullable by a decree of nullity, while under the Special Marriage Act the same breach makes the marriage void from the outset.

32 · Divorce and annulment on grounds of mental illness

Where the marks sit. A marriage can end in law in more than one way, and the psychiatrist is drawn in whenever mental illness is said to be the reason. The route addressed here is divorce - the dissolution of a marriage that was validly contracted and subsisting - on the ground that the other spouse is mentally ill. Under the Hindu Marriage Act of **1955** this ground lives at section **13(1)(iii)**, and it is worded with a precision the examiner rewards: it is not enough that a spouse carries a psychiatric diagnosis. The section asks a question about severity, endurance and curability, and it leaves the final decision to the court.

Most of the marks turn on keeping divorce apart from nullity, and a diagnosis apart from a legal ground: dissolving a valid marriage is a different legal act from declaring one void or voidable for a defect present when it was formed, and naming a disorder is not the same as satisfying the statutory threshold. Keep those distinctions clear and the topic is secure.

32.1 A dissolution ground, and its pedigree

Divorce is the **dissolution** of a subsisting, validly formed marriage: the union existed in law and is now brought to an end by a **decree of divorce**. Holding that firmly is the key to placing this ground correctly, because the same clinical facts can be argued along a quite different legal route. Under the Act a marriage "may ... be dissolved" on the mental-illness ground, and the verb is

doing real work: dissolution is discretionary and judicial, so even where the clinical picture is made out the court is asked to grant a decree, not compelled to. The petition may be presented by either the husband or the wife, and the ground looks throughout to the other party's condition, so a petitioner cannot found the case on their own illness. The mental-illness ground sits among the Act's other grounds of divorce, but it is the one that turns squarely on psychiatric evidence, which is why the clinical case the section needs falls to the psychiatrist to build rather than to the lawyer.

The clause in its present form is not original to the Act as first enacted. It was substituted by **Act 68 of 1976**, the reform that recast several of the fault grounds and, importantly, attached a statutory Explanation defining what "mental disorder" means for this purpose. Reading the current wording as though it were the original provision is a common slip; the definitions that make the ground workable were a later addition, and it is those definitions the examiner most often tests.

1955	13(1)(iii)	1976
HINDU MARRIAGE ACT	MENTAL-ILLNESS GROUND	EXPLANATION ADDED

32.2 The alternative limbs of the ground

The section gives the petitioner alternative ways of making out the same ground, set down as one or the other and not as a single combined test. The first is that the respondent has been **incurably of unsound mind**. Here the operative words are unsoundness and, decisively, its incurability: a disturbance that can be cured, however severe while it lasts, does not answer this limb. The second is that the respondent has been suffering, continuously or intermittently, from **mental disorder** of such a kind and to such an extent that the petitioner cannot reasonably be expected to live with the respondent. This limb says nothing about cure; its test is one of gravity and of the effect of that gravity on married life.

The phrase "continuously or intermittently" in the second limb is deliberate and clinically apt. A relapsing and remitting illness that returns in episodes is not taken outside the ground merely because the respondent is well between them; what the limb asks is whether the disorder, taken as it actually runs, reaches the kind and extent that makes cohabitation unreasonable. The limbs are worth pulling apart because they weigh different things: the first asks whether the condition can be cured, the second asks whether, cure or no cure, the disorder is grave enough that continued life together cannot reasonably be expected of the petitioner. In clinical terms the hard work usually lies in the first limb, because incurability is a strong and unforgiving word - a prognosis of persistent, treatment-refractory illness is a very different assertion from a diagnosis, and it should be offered only where the course genuinely supports it. A candidate who runs the limbs together, importing incurability into the second or dropping the cohabitation test from it, has misread the clause.

AXIS	FIRST LIMB: INCURABLE UNSOUNDNESS	SECOND LIMB: GRAVE MENTAL DISORDER
Statutory core	the respondent "has been incurably of unsound mind"	a "mental disorder ... of such a kind and to such an extent" that cohabitation cannot reasonably be expected
What must be shown	unsoundness of mind, and that it is incurable	a qualifying mental disorder of sufficient kind and extent
Does curability decide it	yes - incurability is itself the threshold	no - severity and its effect on married life are
Course of the illness	a settled, enduring unsoundness	may be continuous or intermittent
The question for the court	can the condition be cured	can the petitioner reasonably be expected to live with the respondent

32.3 What the Act means by "mental disorder"

The reason this ground is examinable, and not merely a gesture at illness, is that the Act refuses to leave "mental disorder" to ordinary usage. The Explanation to the clause defines it, and defines it broadly. For this purpose "mental disorder" is stated to mean:

- mental illness;
- arrested or incomplete development of mind;
- **psychopathic disorder**; or
- any other disorder or disability of mind;
- and it is expressly stated to include **schizophrenia**.

Two features of the definition repay attention. It is a broad means-and-includes definition: the defined categories are exhaustive at category level, but one category, "any other disorder or disability of mind", is itself a wide catch-all, and "arrested or incomplete development of mind" brings intellectual disability within the term rather than confining it to psychotic illness. The express naming of schizophrenia is the detail candidates remember, and it is a real feature of the provision - the most litigated diagnosis was put beyond argument as to whether it can, in principle, count.

The Explanation also defines psychopathic disorder in its own right: a persistent disorder or disability of mind, whether or not it includes sub-normality of intelligence, that results in abnormally aggressive or seriously irresponsible conduct on the part of the respondent, and it holds whether or not the condition requires or is susceptible to medical treatment. That last clause is easily missed and worth stressing: a psychopathic disorder can found the ground even if it is untreatable or needs no treatment, because the definition turns on the resulting conduct, not on treatability. The breadth of the definition has a practical consequence worth carrying into the witness box: a psychiatric label will rarely take a genuine condition outside "mental disorder", so

the real contest in almost every case is not whether the condition counts but whether it reaches the threshold the limbs set.

32.4 A threshold, not a diagnosis

The crux of the topic. Because the Act names disorders and even singles out schizophrenia, it is tempting to read the ground as satisfied the moment a diagnosis is made. It is not. The definition of "mental disorder" tells you which conditions are capable of founding the ground; it does not tell you that every instance of them does. Each limb imposes a further test that is about degree rather than label - incurability on the first, and a kind and extent that makes cohabitation unreasonable on the second. A stable, treated illness, or a diagnosis that leaves the person able to sustain married life, meets neither.

Consider a respondent whose illness is well controlled between relapses and who functions in the marriage for long stretches. The diagnosis is not in doubt, yet neither limb may be made out: the first is defeated by treatability, and the second by the absence of the required gravity. The section's questions are answered by the course and the consequences of the illness, not by its name in the case notes. This is where the clinical and the legal part company - the diagnosis is a clinical fact the psychiatrist can supply, but whether it reaches the statutory threshold is a mixed question the court decides on the whole of the evidence.

RULE **The ground is a threshold, not a diagnosis.** The Act asks how grave the condition is and, on the first limb, whether it is incurable, not merely what it is called. Naming a disorder, schizophrenia included, establishes only that it is capable of founding the ground; the petitioner must still prove the incurability, or the kind and extent, that the section actually demands.

PITFALL

Asked whether a spouse's illness "is a ground for divorce", a clinician may answer yes on the strength of the diagnosis alone, encouraged by the Act expressly listing schizophrenia. The express inclusion only makes a disorder capable of founding the ground. Treating the diagnosis as though it settled the legal question overstates what the clinical evidence can carry and steps into the court's role of applying the statutory test.

32.5 Divorce is dissolution, not nullity

The title of this topic pairs divorce with annulment, and that pairing is exactly where candidates come to grief. Divorce dissolves a marriage that was validly formed and subsisting, and it operates from the date of the decree forward. **Nullity**, or annulment, rests on the opposite premise: it is a finding that the marriage was void, or voidable and then set aside, because something was wrong at its very formation. Mental illness can feature in both routes, but it enters through different doors. As a divorce ground it speaks to a condition that makes the continued marriage unsustainable; as a nullity ground it speaks to a defect of capacity or consent that was present when the marriage was contracted.

The consequences differ, which is why the distinction is not merely formal. A decree of divorce accepts that a marriage existed and brings it to an end; a decree of nullity treats the marriage as

never having been valid, or unravels it from the outset. In practice the same clinical picture can be pleaded along either route, but what selects the route is whether the marriage was validly formed, not when the illness began: the divorce ground presupposes a valid, subsisting marriage and asks only whether the condition reaches the threshold, so an illness that predated the wedding can still found a divorce where the marriage was validly contracted and the severity test is met. Onset relative to the marriage bears on the nullity question alone, whether a disqualifying condition existed at solemnisation and so vitiated the formation, so the psychiatrist should record onset for that inquiry without treating a pre-marital start as evidence against divorce. The formation conditions, the void and voidable categories and the nullity procedure are taken up as their own topic, in the account of marriage and nullity elsewhere in this chapter, and are not restated here; what this section owns is the dissolution ground and its threshold.

TRAP **Reading a formation defect as a divorce ground, or the reverse.** Facts that show unsoundness or want of capacity at the time of the marriage point to nullity, because they go to how the marriage was formed. Divorce, by contrast, dissolves a validly formed and subsisting marriage whenever the respondent's condition meets the statutory threshold, whether or not the illness began after the wedding. Citing the dissolution ground for a genuine formation defect is one error; treating a pre-marital onset as by itself a bar to divorce, when the marriage was validly contracted and the threshold is met, is the other.

32.6 The psychiatrist in matrimonial proceedings

In practice the psychiatrist is brought in to examine the respondent, or to comment on the records, and to give the court an opinion pitched to the statutory limbs. The burden of proving the ground rests on the petitioner, and the mental-illness ground is proved on the whole of the legally admissible evidence, medical evidence being ordinarily important, especially where available, but not an invariable statutory prerequisite, so the quality of the psychiatric opinion frequently decides the case. What the examination should capture follows the section's own structure:

- the diagnosis, and how securely it can be made;
- the current mental state and its severity;
- the course, whether continuous or intermittent;
- the prognosis, and specifically whether the condition is curable;
- the functional impact on the capacity for married life.

The opinion is then framed to the section: address curability squarely where the first limb is in play, and kind and extent where the second is, and leave the ultimate question of whether the marriage should end to the court. That opinion is often retrospective and always partial, since the examiner may be meeting the respondent long after the events pleaded, so it should be pitched with candour about its limits, because an overstated report does the petitioner's work while weakening the witness. How the psychiatrist actually gives that evidence - the form of the expert report, the duties of the expert witness and the conduct of testimony - is not family law and is

treated in the Forensic ethics, consent and legal procedure notes; here the point is only that the clinical content is dictated by the limbs and by the thresholds each of them sets.

IN INDIA

Indian courts have read the qualifying threshold strictly: neither a bare diagnosis nor a spell of psychiatric treatment establishes the ground by itself, and the petitioner must show on the evidence that the statutory test, incurability or a disorder of the required kind and extent, is actually met. Comparable mental-illness grounds run through the other personal-law statutes and the secular marriage law, though their wording and their thresholds differ, so the governing provision must be matched to the parties before the clinical opinion is shaped.

GOOD TO REMEMBER

When you examine a spouse for matrimonial proceedings, keep the opinion clinical: set out the diagnosis, severity, course, prognosis and curability, and the impact on the capacity for married life, and map each to the limb it bears on. Resist being drawn into whether the marriage should be dissolved, which is the court's question and not the clinician's, and where the evidence is thin, say so rather than filling the gap with an impression.

The divorce ground for mental illness dissolves a valid marriage only where the petitioner proves incurable unsoundness of mind, or a mental disorder so grave that cohabitation cannot reasonably be expected; a diagnosis alone, schizophrenia included, is never enough.

33 · Child custody and psychiatric evaluation

Why the marks are here. A custody question reaches the psychiatrist because a court has to decide something it cannot observe for itself: which arrangement will let a particular child grow up safe, stable and well. When one parent has, or is alleged to have, a mental illness, the court needs someone to translate that illness into what it actually means for the day to day care of the child. The examiner is testing three things at once - that you lead with the principle the whole area turns on, that you will not mistake a diagnosis for the answer, and that you understand the limits of your own role. Get those three right and the rest of the answer writes itself.

State the governing idea before anything else, because every later step serves it. In an Indian custody matter the **welfare of the child** is the paramount consideration, standing above the claims of either parent. The **Guardians and Wards Act 1890**, which applies across communities, and the **Hindu Minority and Guardianship Act 1956**, which applies to Hindus, both make the child's welfare the decisive test. The psychiatric evaluation exists to inform that test, and nothing more.

In an Indian custody dispute the child's welfare is the paramount test; a parent's mental illness counts only through its effect on parenting capacity and on the child, and the psychiatrist informs the decision without making it.

Welfare	Function	Informs	Both
THE PARAMOUNT TEST	NOT THE DIAGNOSIS	THE COURT STILL DECIDES	PARENTS AND CHILD ASSESSED

33.1 The welfare principle and the statutory frame

Custody is decided by the court acting as **parens patriae**, the guardian of those who cannot protect their own interests. This is why the parents' wishes, their relative wealth, and even the ordinary preferences written into personal law are all subordinate to a single question: what does this child need. It helps to separate two ideas that candidates routinely blur. Custody is the day to day care and control of the child; guardianship is the wider legal authority over the child's person and property. A parent may hold custody while the framework of guardianship sits elsewhere, and the welfare test governs both.

Both governing statutes point the same way. Where a personal law names one parent as the preferred natural guardian, that preference *yields* the moment it collides with the child's welfare, because welfare, not lineage and not gender, is the criterion the court is bound to apply. In practice the court weighs the age and sex of the child, the continuity and stability of the child's existing environment, the character and capacity of each parent, the child's own ascertainable wishes, and any threat to safety. None of these is applied mechanically; they are balanced against one another, and the psychiatric evaluation feeds several of them at once.

RULE **Custody turns on the child's welfare, not on a parent's label.** The statutes make welfare the decisive test, so the evaluation exists to translate any parental illness into its concrete effect on care and on the child, and to stop precisely there. An opinion that says more than that has stepped outside the psychiatrist's remit and into the court's.

33.2 From status to function: why a diagnosis does not decide

The single most important clinical and legal move in this area is the shift from status to function. A diagnosis is a status; parenting is a set of functions. A parent's mental illness is not, by itself, disqualifying. What the law asks is whether, and how, the illness affects the parent's capacity to care for this child and the welfare of the child, never the name of the condition on the certificate. This is also the posture the modern rights-based framework of disability law expects: a person is not defined, and must not be written off, by a diagnostic label.

Worked through, the discrimination is straightforward. A parent whose illness is well treated, who has insight, who adheres to treatment and who has a supportive network may parent perfectly well, and a diagnosis alone neither proves nor disproves that. An illness becomes relevant only through its functional consequence: active psychosis with command phenomena that concern the child, a manic episode with reckless endangerment, a depression so severe that a young child is left unfed or unsupervised, or disorganisation that removes basic protection. In each of those the concern is what the parent cannot currently do for the child, not the diagnostic heading under which it falls. The evaluator's job is to make that functional link explicit, or to say clearly that no such link exists.

TRAP **Treating a diagnosis as automatic unfitness.** Candidates write that a parent with schizophrenia or bipolar disorder should lose custody. The law asks for the effect of the illness on parenting and on welfare, not for the diagnosis; a well-treated, insightful, supported parent may care for a child perfectly, and a label on its own decides nothing. Answer with function, and the mark follows.

33.3 Parenting capacity: what the evaluation actually assesses

The core of the psychiatric evaluation is an assessment of **parenting capacity**: not whether a parent is ill, but whether the parent can meet this particular child's needs, now and in the foreseeable future. It is a functional, here-and-now and forward-looking judgement, and it is best broken into domains that can each be observed, described and, where necessary, defended under cross-examination:

- basic care and physical safety - feeding, supervision, medical needs, and protection from harm;
- emotional availability and warmth - the capacity to attune to the child and to respond to distress;
- consistency, structure and boundaries - predictable routines and reliable containment;
- a realistic understanding of the child's developmental and emotional needs;
- the capacity to place the child's needs above one's own, including during adult conflict;
- willingness to support the child's relationship with the other parent rather than obstruct it.

The last domain matters more than trainees expect. A parent who actively works to poison the child's bond with the other parent is displaying a parenting deficit, whatever their diagnostic status, and a parent with an illness who nonetheless protects that bond is showing real capacity. Capacity is established not by assertion but by method: an interview and mental state examination of each parent, a developmental and psychiatric history, and, above all, direct observation of each parent interacting with the child. What a parent describes and what a parent does with the child in the room are different data, and the evaluation needs both.

MNEMONIC

Parent, Child, Fit, Risk

A custody evaluation moves through the **parent** (the parenting capacity of each caregiver), the **child** (developmental needs, attachments and age-weighted wishes), the **fit** between them (how well each parent meets this particular child's needs), and the **risk** to the child's safety. The four run in the order a careful assessment actually follows, and none of them is the diagnosis.

33.4 The child's side: attachment, needs and age-weighted wishes

An evaluation that examines only the parents has done half the work. The child is assessed in their own right. The quality and security of the child's **attachment** to each caregiver, and the continuity of care the child has actually experienced, carry real weight, because welfare is a matter of relationships and stability rather than an idealised parent chosen in the abstract.

Developmental needs shift with age, and an arrangement that serves an infant well may fail an adolescent; the evaluation is always about this child at this stage, not a generic child.

The child's own voice. The child's wishes are ascertained and given weight according to age and maturity - the more developmentally mature the child, the more their stated preference counts, without it ever becoming the sole determinant. Here the evaluator must tread carefully. A child's stated preference can be authentic, or it can be coached, or it can reflect a wish to placate the more frightening parent or to protect the more fragile one. Eliciting the child's voice sensitively and alone, and interpreting it against the whole picture rather than taking it at face value, is a skill the examiner expects you to name explicitly. The child is heard; the child is not asked to choose.

33.5 Risk to the child within the evaluation

Safety is the threshold that sits inside welfare: no arrangement can be in a child's interest if it exposes the child to harm. The evaluation therefore screens actively for risk - domestic violence, substance misuse, neglect, and physical, sexual or emotional abuse - as well as for danger arising directly from untreated parental psychopathology. **Parental alienation**, in which one parent systematically corrodes the child's relationship with the other, is itself a form of emotional harm to the child and belongs squarely in the risk formulation rather than being dismissed as ordinary post-separation hostility.

Where abuse of a child is alleged or suspected, the matter stops being a purely private custody dispute and engages the statutory child-protection machinery. The child-protection statutes, and the systems that assess and safeguard children at risk, are set out in the Child psychiatry: assessment, treatment, services and protection notes; the custody evaluator's task is to recognise the threshold, document the concern accurately, and route it into that machinery, not to adjudicate the abuse allegation itself. Confusing the two - trying to prove or disprove abuse within a custody opinion - is how an evaluator exceeds both competence and remit.

33.6 Method and the limits of the psychiatrist's role

A defensible custody opinion rests on more than one voice. The evaluator interviews and examines each parent, observes each parent together with the child, sees the child sensitively and alone, and gathers **collateral information** from school, treating clinicians, and documentary records. Triangulating these sources is precisely what protects the opinion from a single parent's partisan account, and it is the difference between an assessment and an endorsement.

The most important boundary is the one written into the nature of the task: the psychiatric evaluation informs the court's welfare determination, it does not make it. The evaluator describes parenting capacity, the child's needs and attachments, and any risk, and shows the reasoning that connects them; the choice of custody arrangement remains the court's alone. Staying inside that boundary is not diffidence, it is the correct forensic posture, and it is what keeps the opinion admissible and useful. The wider ethics of acting as an expert - confidentiality in the forensic setting, the avoidance of a mixed treating and evaluating role, and the certification of a report or

opinion for the court - are the subject of the Forensic ethics, consent and legal procedure notes, and are named here rather than taught.

PITFALL

Forming a view from one parent's account without ever observing the child, seeing each parent together with the child, or gathering independent collateral. A custody opinion built on a single, interested informant is unsafe, it tends to import that informant's bias unexamined, and it rarely survives cross-examination.

GOOD TO REMEMBER

Write your opinion as parenting capacity and welfare, never as a verdict on the parent. Say what each parent can and cannot do for this particular child and why, flag any risk plainly, and leave the arrangement itself to the court. An opinion framed this way is both more useful to the judge and far harder to discredit.

33.7 The components at a glance, and how it is examined

Set out side by side, the evaluation separates cleanly on what each part examines and how each part goes wrong. The accompanying table lays out the axes an examiner tests; commit the structure, because a viva question almost always asks you to reason across the whole assessment rather than recite one piece of it.

AXIS	WHAT IT EXAMINES	WHY IT MATTERS	COMMON ERROR
The parent	Parenting capacity: safety, warmth, consistency, insight, the ability to prioritise the child, support for the other parent's contact	Determines whether care will be adequate and stable	Reading the diagnosis instead of the function
The child	Age, developmental needs, attachments, and age-weighted wishes	Anchors the decision in this child's actual needs	Ignoring the child's voice, or over-weighting a coached wish
The fit	How well each parent meets this particular child; continuity of care and environment	Welfare is about a relationship, not a parent in isolation	Assessing parents in the abstract
The risk	Violence, substance misuse, neglect, abuse, alienation, illness-driven danger	Safety is the threshold within welfare	Missing risk by focusing only on capacity

IN INDIA

Indian courts decide custody as guardians of the child, and the welfare test cuts across community and personal law: even where personal law names a preferred natural guardian, that preference gives way to the child's welfare. Custody of a child of **tender years** is often, though never automatically, entrusted to the mother on a welfare rationale rather than by a fixed rule. Because custody usually arises within divorce or judicial-separation proceedings, the psychiatrist is generally asked for an opinion in a matrimonial context in which feelings run high and each side may try to recruit the evaluation to its own case. The welfare test, however, is distinct from and outlives the question of whether the marriage itself survives, and the evaluation should be framed to serve the child even when the adults are framing it to serve themselves.

In the examination this topic rewards the candidate who leads with the welfare principle, refuses to be drawn into equating a diagnosis with unfitness, describes a structured multi-source evaluation, and states plainly that the psychiatrist informs but does not decide. Say those four things clearly, name the two governing statutes, and the answer reads as the work of someone who has actually stood in the witness box rather than only read about it.

34 · Guardianship and management of property of mentally ill

Why the marks are here. When mental illness erodes a person's ability to look after money, land and everyday affairs, the law is asked to do two things at once: shield the person and the estate from loss and from exploitation, while intruding on their autonomy no more than the situation demands. The mechanism it reaches for is the guardianship of property and the appointment of someone to manage the estate. For the examiner this is less a topic than a discrimination. Mental illness can trigger several distinct legal offices, and candidates routinely fold them into one. The task is to hold the property-management route apart from the healthcare-facing office and from treatment-decision capacity, and to know that the framework a psychiatrist works inside today is not the custodial one the older textbooks were built around.

34.1 From custody of the estate to management of it

The oldest Indian machinery for the property of the mentally ill treated the ill person as a ward to be taken in charge. Under the colonial lunacy law the emphasis was custodial: the state, through the court, assumed control of the estate of a person found to be of unsound mind and installed someone to hold it. That **custodial guardianship** of the estate has been superseded. The modern posture begins from the presumption that legal capacity is retained, treats impairment as specific to particular decisions rather than a global forfeiture of legal personhood, and asks for the least intrusion that will protect the person and the property. The rights-based reworking of guardianship for the disabilities it covers, under the disability-rights statute and the National Trust legislation, is set out with the account of benefits, reservations and guardianship elsewhere in these notes. What remains here is the ordinary statutory route, the residual position where no statute fits, and how property management differs from the healthcare offices around it.

PITFALL

The commonest real-world error is to describe property guardianship in the vocabulary of the repealed lunacy law, as though a finding of unsoundness still stripped a person of legal personhood wholesale and handed a relative standing, all-purpose control. It does not. An opinion or an application written on that assumption over-reaches the patient's rights and invites the court to reject it. Anchor the reasoning to the current, least-restrictive frame, not the custodial one it replaced.

34.2 The ordinary statutory route, and the residual jurisdiction

The ordinary route today runs through statute. Because mental illness is itself a specified disability, a person whose illness erodes decision-making is reached by the **disability-rights statute's limited guardianship**, a supported, joint model named and taught with the reform statutes elsewhere in these notes; where its covered conditions apply, the National Trust legislation runs its own committee-appointed guardianship. What there no longer is, is a free-standing, nationwide civil-court power to appoint a guardian of the person and a manager of the estate at large. The property-management machinery of the old Mental Health Act 1987, the judicial inquisition and management of the estate through the district court, was repealed with that Act and not re-enacted by the present mental-health legislation. Beyond the disability statutes, then, the position is a legislative vacuum: where no statutory route fits, the only residual power is the exceptional parens patriae jurisdiction of the chartered High Courts, derived from Clause XVII of their Letters Patent and recognised in recent Bombay High Court authority. That jurisdiction is territorially and institutionally limited, confined to those courts and their territory, and is not a general civil court supplying property management to all. These notes therefore do not assert a nationwide civil-court manager route, because none is grounded; what precisely fills the vacuum for a person outside the disability statutes and outside a chartered High Court's reach is unsettled, and is flagged here as a gap rather than invented. The psychiatrist's contribution is the same throughout: the medical evidence, a reasoned opinion framed to the particular affairs at issue, that the person's illness presently deprives them of the capacity to manage them.

Because a guardian's or manager's authority is tied to the person's incapacity, a restoration of soundness or an increase in capacity is a ground to review, reduce, dismantle or terminate the arrangement through the applicable statutory or judicial mechanism, not a universal automatic discharge. Guardianship of property is therefore a contingent trust, not a permanent status conferred by the diagnosis, and it is administered for the benefit of the ill person under the appointing forum's continuing supervision rather than handed over as ownership.

RULE **Guardianship of property is a protective trust, not a transfer of ownership or a global loss of legal personhood.** The manager administers the estate for the ward's benefit under the appointing statutory or judicial forum's supervision, which is continuing judicial oversight only where a court has made and retained that supervision; recovery or increased capacity is a ground to review, reduce, dismantle or terminate the arrangement through the applicable statutory or judicial mechanism, not a ground for automatic surrender.

34.3 Where the reform statutes take over

These statutory routes are where the ordinary work is done. For the disabilities they cover, two rights-based statutes supply the guardianship, and a candidate must be able to name them and say which person each reaches, even though their machinery is taught elsewhere in these notes. The disability-rights legislation offers a **limited guardianship** built on joint and **supported decision-making**, in which the guardian shares decisions with the person instead of displacing them. The National Trust legislation runs a separate, committee-appointed guardianship for the developmental and intellectual disabilities named in it. Both express the same instinct that runs through the modern law: support before substitution, and no more control than the person's situation needs. The practical question a psychiatrist answers is which of these doors a given patient goes through, and what medical evidence the chosen forum will want.

34.4 Property guardian versus the healthcare nominated representative

The discrimination that carries the marks separates the office that governs property from the office that supports healthcare decisions. The mental-health legislation appoints a **nominated representative** to help a person exercise and protect their rights within the mental-healthcare system. That representative is emphatically not a property guardian: they do not manage the estate, cannot deal with the person's land or money, and take no authority over civil affairs from the role. The traffic does not run the other way automatically either. A guardian or manager appointed to handle property acquires property powers, and that property appointment alone carries no power to consent to or refuse psychiatric treatment, which belongs to the separate machinery of treatment-decision capacity and its supports, discussed with the mental-health statute's capacity test elsewhere in these notes. The same person can nonetheless separately hold treatment-related authority through that statute's own nominated-representative office, most concretely for a minor, whose legal guardian is that statute's default nominated representative unless directed otherwise; that authority comes from the nominated-representative role, never from the property appointment itself. Keeping the two offices conceptually apart, while checking in a given case whether they have in fact come to be held by the same person, is both the examiner's favourite trap and a genuine clinical safeguard.

OFFICE	WHAT IT GOVERNS	WHO APPOINTS	DECISION MODEL
Limited guardian (disability-rights and National Trust routes; the ordinary statutory route)	Defined affairs of a person with the covered disability	A court or designated authority, or the National Trust committee	Supported and joint, least-restrictive
Parens patriae of the chartered High Courts (residual, exceptional)	Property and affairs where no statute fits	The chartered High Courts only, under Clause XVII of the Letters Patent	Managed for the person, court-supervised; territorially and institutionally limited
Nominated representative (mental-health legislation)	Healthcare and mental-healthcare rights only	As the mental-health law provides	Supports the person's own treatment decisions

TRAP **Treating the nominated representative as a property guardian.** Because both are triggered by mental illness and both sound protective, candidates merge them. They are different offices with different appointers, domains and decision models: the nominated representative supports healthcare choices and touches neither land nor money, while the property guardian or manager controls property but has no say over consent to treatment.

Property and money are run by a guardian or manager of the estate; healthcare is supported by the nominated representative - two separate offices, and neither reaches into the other's domain.

IN INDIA

The Indian answer is layered rather than single. The disability-rights and National Trust statutes supply the ordinary route, a modern supported guardianship for the disabilities they cover, which include mental illness; the old Mental Health Act 1987 property-management mechanism was repealed and not re-enacted, so beyond those statutes only the chartered High Courts hold a residual, exceptional parens patriae jurisdiction rather than any general civil court; and the mental-health legislation supplies the healthcare-facing nominated representative. A psychiatrist asked to help is really being asked which of these frames fits this patient, and what medical evidence the chosen forum needs to see.

34.5 Assessing capacity to manage property and affairs

What the psychiatrist actually assesses. The clinical task is a functional capacity assessment, not the pinning of a diagnosis. **Capacity to manage property and affairs** asks whether, at the relevant time, the person can understand what property they have and its broad extent, appreciate the claims of those who depend on them, weigh the choices involved in keeping or disposing of it, and communicate a decision. It is decision-specific and time-specific. A person may lack capacity for a complex commercial transaction yet retain it for ordinary spending, and capacity lost in an acute episode may return with remission. This is why the office is contingent and why recovery is a ground to review or discharge it. It also means the test is about the quality of the decision-making, not the wisdom of the outcome: a person who retains capacity is entitled to make an unwise or eccentric use of their money, and an imprudent choice on its own is no ground to displace them. What justifies intervention is an inability to carry out the reasoning, traced to the illness, and not merely a decision the family would have made differently. The same functional logic underlies the capacity to make a will and the capacity to enter a contract, each taken up on its own terms elsewhere in these notes; but they are judged against different tasks, and none of them is settled by the psychiatric label alone.

GOOD TO REMEMBER

Write the opinion as decision-specific and time-specific, tie it to the particular affairs in question, and record the prospect of recovery. State plainly that being under a property-management order does not by itself authorise anyone to consent to the patient's treatment, and that a return of capacity should trigger review of whether the management is still needed. That is what keeps the report useful to the court and protective of the patient.

35 · Fitness for job and certification of mental fitness

Why the marks are here. A psychiatrist is asked to certify fitness for a job far more often than to give evidence in any court, and it is quiet, everyday medicolegal work that the examiner likes precisely because candidates underprepare it. An employer wants to know whether a person can start a post, or return to one after illness, and turns to the treating or an assessing psychiatrist for a signed opinion. The task looks administrative, but it sits on a genuine question of capacity - can this person, in their current mental state, do this particular job safely and effectively - and it is bounded by employment law that has changed in the person's favour. The marks reward the candidate who can say exactly what such a certificate asserts, what it does not, and how it differs from the two documents it is most often confused with.

The whole difficulty of the topic is discrimination between look-alikes. A one-line signature that a person is "fit" or "unfit" can, depending on which document it belongs to, decide an appointment, unlock a statutory benefit, or sway a legal case, and the same clinician may be asked for all three about the same patient. Keeping them apart is the intellectual content the paper is testing, so it is worth taking the three certifications one at a time before turning to what a fitness opinion should actually contain.

3	3
CERTIFICATIONS TO SEPARATE	DEFINING FEATURES

35.1 Three certifications that must not be conflated

The commonest error in this area is to treat every request for a "mental fitness certificate" as one thing. It is not. The first is the **fitness-for-duty certificate**, an occupational opinion that states whether a person's current mental state permits safe and effective performance of a specified role, with any accommodations or restrictions that make that possible. It answers a forward-looking, work-focused question, and it is the document this topic owns. The second is the **disability certificate**, which does something entirely different: it quantifies impairment so that a person can access certification-linked entitlements, reservations and schemes, and its instrument, its certifying authority and its benchmark threshold are taught with the disability-certification topic in this chapter and are not to be borrowed here. The third is an **expert report or certificate for a court**, prepared as expert testimony to assist legal proceedings; that document, and the psychiatrist's duties in producing it, belong to the Forensic ethics, consent and legal procedure notes.

What separates the three is not the clinical examination, which may be similar, but the question each answers and the legal machinery each feeds. A fitness certificate is about a job; a disability certificate is about entitlement; a court report is about a legal decision. Reaching for the wrong instrument - answering a fitness-to-work request with a disability threshold, or dressing a treatment opinion as a fitness certificate - is how a clinician gives an authoritative-sounding answer to a question nobody asked.

CERTIFICATION	THE QUESTION IT ANSWERS	WHAT IT IS FOR	WHERE ITS DETAIL BELONGS
Fitness-for-duty certificate	Can this person safely and effectively do this role now?	Occupational fitness for a specified job, with accommodations or restrictions	This topic
Disability certificate	How much impairment, for statutory entitlement?	Quantifying impairment for certification-linked entitlements, reservations and schemes	The disability-certification topic in this chapter
Expert report or certificate for a court	What is the clinical opinion for these proceedings?	Assisting a legal decision as expert evidence	The Forensic ethics, consent and legal procedure notes

A fitness-for-duty certificate answers one narrow, current, role-specific question - can this person safely and effectively do this job now, and with what adjustments - and it is neither a disability certificate nor a report for a court.

35.2 What a fitness-for-duty certificate actually asserts

A sound occupational-fitness opinion has three defining features, and each is a guard against a way the certificate is misused. It is role-specific: it speaks to the demands of one named job, not to the person's general worth or employability, so a person may be fit for a desk-based role and not for one that requires night driving or the carriage of a firearm, and the certificate must say which. It is time-limited: it certifies a current state, valid for a stated review period, because a mental state is not a fixed attribute and a fitness opinion given today cannot vouch for the person indefinitely. It is evidence-based: it rests on an actual assessment of the present mental state and the specific occupational demands, not on a diagnostic label carried in the notes.

These three features are why a bare "fit" or "unfit" is a poor certificate. "Unfit", without a role, without a time frame and without a basis, tells the employer nothing they can act on lawfully or safely, and it invites them to read a temporary limitation as a permanent exclusion. The useful document names the role, states the period, and gives enough of the reasoning that the employer can see what the restriction is protecting against.

MNEMONIC

Which role, until when, on what evidence

The three features of a defensible fitness-for-duty certificate: it is **role**-specific (fit for which job, with what accommodations), **time**-limited (a current opinion with a review date, not a standing verdict), and **evidence**-based (grounded in an assessment of the present mental state against the actual demands of the post, not in a diagnosis on the file).

RULE **Fitness is a judgement about a role at a moment, not a verdict on a person.** The certificate certifies that a specified individual can, as they are now, meet the demands of a specified job safely and effectively, with any stated accommodations or restrictions, for a stated period. Every one of those qualifiers - the person, the job, the moment, the adjustments, the review date - is part of what is being certified, and dropping any of them turns a lawful, useful opinion into an over-broad label.

35.3 The functional assessment: matching the person to the role

Because fitness is defined by the job, the assessment begins with the job. The psychiatrist has to understand the actual demands of the role - its cognitive load, its interpersonal and supervisory content, its safety-critical elements, its shift pattern, its access to hazards or to vulnerable people - and then ask whether the person's current mental state allows those demands to be met. This is a **functional assessment**, not a diagnostic one: the question is what the person can do in this post, not what condition they carry, and the two do not map onto each other neatly, since a person with a serious diagnosis may be entirely fit for many roles and a person with none may be temporarily unfit for a demanding one.

Where a limitation exists, the opinion should reach for adjustment before exclusion. A **reasonable accommodation** - a modified duty, a graded return, an altered shift, a temporary reassignment away from a safety-critical task - often converts an "unfit for the role as it stands" into a "fit with these adjustments", and that is usually the more accurate as well as the more humane answer. Restrictions are the mirror image: the specific tasks the person should not perform for now, named narrowly so that everything not restricted remains open. A defensible certificate therefore records several things together rather than a single word:

- the specific role and its demands the opinion is addressed to;
- whether the person's current mental state meets those demands, and where it does not;
- the accommodations that would make the role workable, and the restrictions that should apply meanwhile;
- the period for which the opinion holds and the point at which it should be reviewed.

GOOD TO REMEMBER

Start from the job description, not the diagnosis. Ask what this post actually requires and whether the person can meet it now, then default to graded return and specific accommodations rather than a blanket "unfit". Name the restrictions narrowly and time-limit the whole opinion, so the employer knows precisely what is being protected against and for how long.

35.4 The employment-rights frame the certificate sits inside

A fitness opinion is no longer written in a vacuum in which an employer may do as they please with it. Disability, including mental illness where it amounts to a disability, is a protected ground in employment, and the certificate operates inside that protection rather than around it. This changes the clinician's posture: the default is inclusion with support, and a limitation has to be genuine, job-specific and no wider than the evidence requires, because a loosely worded exclusion can become an unlawful act when the employer relies on it.

The Indian frame. The reform is statutory, and the psychiatrist should know which way it cuts.

IN INDIA

The **Rights of Persons with Disabilities Act** protects against discrimination in employment on the ground of disability, so a psychiatric diagnosis is not a lawful reason to refuse or remove a person from a post by itself. Fitness certification therefore runs alongside a duty of non-discrimination and an expectation of reasonable accommodation, and the useful certificate is the one that supports a person into work with the right adjustments rather than one that hands an employer a broad "unfit" to exclude on. The separate disability certificate that unlocks statutory benefits, with its instrument and threshold, is a different document dealt with elsewhere in this chapter, and the two should never be run together.

PITFALL

Issuing a global or open-ended "unfit for duty" instead of a role-specific, time-limited opinion. A sweeping certificate misinforms the employer, forecloses accommodation, and can convert a temporary or partial limitation into an unlawful exclusion on the ground of disability. The clinical error is treating fitness as a standing property of the person rather than a current judgement about a particular role, and it does real harm in both directions - it can shut a capable person out of work, and it can wave through a person into a safety-critical task the evidence did not actually support.

35.5 Scenarios, boundaries and the limits of the task

The request reaches the psychiatrist in a few recurring shapes. Pre-employment screening asks whether a person can take up a post; **fitness to resume duty** asks whether a person can return after a period of illness or treatment, often the commonest referral and the one where a graded plan is most useful; and periodic re-certification arises in posts, especially **safety-critical roles**, where a standing requirement of demonstrated fitness applies. Each is the same functional question against a different backdrop, and each is answered role by role and moment by moment rather than once and for all.

Two boundaries keep the task honest. The first is confidentiality: the certificate should convey only the conclusion and the work-relevant restrictions and accommodations, not the clinical detail behind them, because the employer has no freestanding entitlement to a person's mental-health information; disclosure needs the person's informed consent or another lawful basis, and only the minimum necessary detail should be released, never a transcript of the consultation. The second is scope: the fitness certificate is an occupational document, and the moment the same clinical picture is wanted as evidence for a court, the exercise becomes expert testimony governed by different duties and treated in the Forensic ethics, consent and legal procedure notes. Likewise, questions of compensation or a disability pension for a work-related psychiatric condition are a distinct assessment with their own purpose and are taken up separately in this chapter; a fitness opinion neither answers them nor should be stretched to.

The honest fitness opinion is modest about what it can promise. It certifies a present capacity for a defined role, hedged by the accommodations that make it workable and by a review date, and it declines to guarantee the future or to pronounce on the person's worth. That restraint is not weakness; it is the whole discipline of the certificate, and it is what keeps a routine signature from doing more legal work than the assessment behind it can bear.

TRAP **Answering a fitness-to-work question with a disability instrument, or vice versa.** The occupational-fitness certificate, the disability certificate that quantifies impairment for benefits, and the expert report for a court are three separate documents with three separate purposes. Borrowing the disability assessment's instrument or threshold to answer whether a person can do a job, or offering a fitness opinion where a court report is wanted, is the classic way to lose an easy mark by producing an authoritative answer to the wrong question.

36 · Workmen compensation and disability pension (psychiatric)

Why the marks are here. A psychiatrist is drawn into compensation and pension work because the law asks a question medicine cannot answer on its own. It does not want to know what the diagnosis is; it wants to know how far the ability to earn has been reduced, and by an injury or illness that some employer or the State is answerable for. This is where clinical description has to be re-expressed in the vocabulary of a statute, and candidates lose marks by answering the medical question when the legal one was asked. The workplace-injury route in India now runs through Chapter VII of the Code on Social Security, which since November 2025 has repealed the Employee's Compensation Act, **1923**, originally the Workmen's Compensation Act and the source of this topic's older name; rights and proceedings that had already accrued under the repealed Act continue under the Code's repeal-and-savings provisions. A disability pension runs through the various service and pension frameworks instead. Employee's compensation centrally uses the statutory concepts of disablement and **loss of earning capacity**; a disability pension uses whatever metric the applicable service or pension scheme prescribes and cannot be assumed to turn on the same idea.

The examinable content is a discipline of translation. The same florid diagnosis can attract a large award or a negligible one depending only on what it does to the person's capacity to work, and

the same clinical picture is weighed differently under a compensation statute, a benefits statute and a pension scheme, because each defines the loss it is buying in different terms. The candidate who can carry a symptom into the language of earning capacity, and keep the three assessments apart, has the marks; the candidate who signs a diagnosis and stops has not.

36.1 The compensable question is loss of earning capacity

The Act does not compensate injury as such. It compensates the economic consequence of injury, the reduction in what the worker can earn, and a diagnosis is only the raw material from which that reduction is worked out. Two employees with the same illness may attract very different awards if one returns to full earning and the other cannot; conversely a modest-looking condition that removes one specific vocational capacity can be economically catastrophic, as when a locomotive driver develops a psychotic illness or a surgeon a disabling tremor. The psychiatric opinion therefore has to end in a statement about the capacity to earn, not in a list of symptoms, and the reasoning that connects the two is the substance of the work.

RULE **Compensation follows the loss of earning capacity, not the diagnosis.** The statute buys the economic consequence of the condition, measured against the work the person could do at the time of the accident. A florid label with preserved earning power attracts little; a contained condition that destroys a particular earning capacity may attract a great deal. The clinician's task is to value the loss, not to name the illness.

36.2 Partial and total disablement under the Act

What follows is now historical law: it describes the repealed Employee's Compensation Act, 1923, retained here because claims and rights that had already accrued before the repeal continue to be decided under it. The repealed Act framed the injury as **disablement** and graded it in two dimensions at once: by how much of the person's working life it removes, and by whether it is temporary or permanent. **Partial disablement**, defined at section **2(1)(g)**, is disablement that, where it is temporary, reduces earning capacity in the employment the person was engaged in at the time of the accident, and, where it is permanent, reduces earning capacity in every employment the person was capable of undertaking at that time. **Total disablement**, defined at section **2(1)(l)**, is disablement, whether temporary or permanent, that incapacitates the person for all work he was capable of performing at the time of the accident. The pivot between the two is the breadth of employment affected, not the visible severity of the injury.

Two deeming provisions convert scheduled injuries into a grade without a fresh enquiry into earning capacity. An injury specified in the second part of the Act's Schedule of injuries shall be deemed to result in permanent partial disablement. Permanent total disablement shall be deemed to result from an injury in the first part of that Schedule, or from a combination of the listed injuries whose loss of earning capacity totals **100%** or more. Outside those deemed cases the grade must be assessed on the facts, and it is precisely there, where no Schedule entry decides the matter, that the psychiatric opinion does its work.

1923	Part I
EMPLOYEE'S COMPENSATION ACT, REPEALED	SCHEDULE I INJURIES, DEEMED PERMANENT TOTAL

The table below sets out the repealed Act's grading structure, retained for historical and pre-commencement reference:

GRADE AND NATURE (REPEALED ACT)	EARNING CAPACITY THAT IS LOST	HOW THE GRADE ARISES
PARTIAL, TEMPORARY	Reduced in the employment the person was engaged in at the time of the accident	Assessed on the facts
PARTIAL, PERMANENT	Reduced in every employment the person was then capable of undertaking	Assessed on the facts, or deemed for an injury in the Schedule's second part
TOTAL, TEMPORARY	Incapacitated for all work the person was then capable of performing	Assessed on the facts
TOTAL, PERMANENT	Incapacitated for all such work on a lasting basis	Assessed on the facts, or deemed for the Schedule's first part or a qualifying listed combination

TRAP **Partial and total are not grades of severity.** They describe the breadth of employment the incapacity spans, not how bad the injury looks. Partial disablement reduces earning capacity in the employment engaged in, or in every employment the person could undertake; total disablement incapacitates for all work the person could then perform. A total disablement can be temporary, and a severe-looking condition can still be only partial. The candidate who reads total as meaning permanent and catastrophic has misread the definition.

The current law replaces this two-by-two structure. Under the Code on Social Security, permanent partial disablement and permanent total disablement are each separately defined and graded, with temporary disablement as its own distinct category rather than a temporary/permanent split within partial and total. The deeming machinery for scheduled injuries and occupational diseases now sits in the Code's own Schedules rather than in the repealed Act's Schedule I, and disputes are decided by a competent authority appointed under the Code rather than by the Commissioner for Employees' Compensation named under the repealed Act. The exact provision numbers are not reproduced here; see the note at the end of this fragment.

36.3 Fitting a psychiatric condition into the framework

The difficulty here is structural rather than clinical. The Act's Schedule was built around visible, measurable physical injury and a list of occupational diseases; it does not enumerate psychiatric conditions or assign them a deemed percentage. A psychiatric sequela, whether a depressive or post-traumatic disorder after a workplace accident, an organic syndrome after a head injury, or an illness said to be occupationally precipitated, therefore almost always falls to be assessed on the general earning-capacity test rather than read off the Schedule. That throws the whole weight of the question onto the clinical opinion and onto its translation into economic terms, which is why this is genuinely psychiatric work and not a clerical signature.

IN INDIA

Because the Schedules assign no deemed figure to a mental illness, a psychiatric claim is decided on the general earning-capacity test, and the dispute over grade and quantum is adjudicated by the competent authority appointed under the Code on Social Security (historically, for claims decided under the repealed Act, the Commissioner for Employees' Compensation). The clinician's report is evidence before that authority, so it has to speak the statute's language, grade of disablement and effect on earning capacity, and not stop at a diagnostic label. A report that names a condition but never reaches earning capacity leaves the adjudicating authority with nothing to convert into an award.

What the report must actually do. A usable opinion carries the reasoning from symptom to earning capacity in steps the adjudicating authority can follow:

- the diagnosis and its expected course, stated plainly and without jargon;
- the specific functional deficits the condition produces, in attention, stamina, reliability, judgement and interpersonal capacity;
- how those deficits bear on the work the person actually did, and on other work they were capable of doing;
- whether the disablement is temporary or permanent, and partial or total, in the statute's sense;
- the causal link between the workplace event and the condition, on which entitlement ultimately depends.

36.4 Impairment, earning capacity and keeping certificates apart

The recurring clinical error is to answer with an **impairment** figure. Impairment measures the loss of function of the person as a whole; loss of earning capacity measures what that impairment does to the ability to work and earn. They are related but not the same, and the Act asks for the second. A hand injury that is a small whole-person impairment is a large loss of earning capacity for a pianist; a psychiatric condition that looks impairing may leave earning capacity in the person's actual field largely intact. The psychiatrist is asked to bridge from the first to the second, using knowledge of the person's occupation, not to hand over a bare percentage of impairment and let the authority guess at its economic meaning.

PITFALL

Certifying a whole-person impairment percentage, or importing the benchmark meant for the disability-rights benefits certificate, when the Act wants an opinion on loss of earning capacity. The two figures are not interchangeable: a benefits threshold answers a different statutory question, and lifting it into a compensation report both overstates and understates the wrong thing. The honest report reasons its way to an earning-capacity opinion rather than borrowing a number designed for another purpose.

Three quite different certificates are commonly conflated, and keeping them separate is half the topic. The statutory disability certificate issued for benefits, reservations and welfare entitlements

under the disability-rights law uses its own instrument and its own benchmark, and certifies disability, not earning loss. The certificate of fitness to resume duty answers whether the person can safely and competently do a job, a forward-looking occupational question. The compensation assessment values a loss of earning capacity already suffered, and a pension assessment values whatever metric, often disablement or impairment attributed to service rather than earning capacity, the applicable scheme prescribes. Each is owned by a different statute and none can be substituted for the others; and where the same clinical picture is wanted as expert evidence for a court or tribunal, that report and the ethics of giving it belong with the Forensic ethics, consent and legal procedure notes.

GOOD TO REMEMBER

Before writing, decide which statutory question you are answering, benefits, fitness to work, or compensation and pension, and use that framework's language throughout. The commonest reason a psychiatric report is sent back is that it answers a different question from the one the form was designed for, and no amount of clinical detail rescues a report aimed at the wrong target.

36.5 Disability pension: a different metric

A **disability pension** is the periodic counterpart to the largely lump-sum compensation of the Act: a recurring benefit for a person whose capacity has been reduced by disability, paid under government service rules, armed-forces rules and various organised-sector schemes rather than under the compensation statute. It raises two psychiatric questions. The first is **attributability**, whether the mental illness is attributable to, or aggravated by, the conditions of service, as opposed to a constitutional illness that would have arisen anyway. The second is the degree of disablement to be recognised. Here the metric often shifts away from loss of earning capacity toward a percentage of disablement or impairment attributed to service, which is why a pension assessment and a compensation assessment of the same patient can reach different figures for entirely defensible reasons.

The precise eligibility thresholds, the rounding conventions, the rules governing attributability and aggravation, and the scheme-specific percentages are fixed by each individual pension framework and are not reproduced here. What the candidate must hold is that these schemes exist, that they turn on a different metric from the compensation statute, and that a compensation percentage must never be carried across into a pension answer, or the reverse. Naming the metric correctly, and refusing to import a figure from the wrong scheme, is what a careful assessment looks like when the exact numbers are set elsewhere.

In any compensation or pension question, translate the psychiatric condition into how far it reduces the capacity to earn, or, for a pension, the degree of disablement attributable to service, and state the grade of disablement, not the label of the illness.

37 · Adoption law and psychiatric fitness of adoptive parents

Why the marks sit here. Adoption pulls the psychiatrist into family law to answer one narrow, statutorily framed question: whether a person proposing to adopt is fit, in mind and in function, to raise a child. Indian law does not leave that fitness to sentiment. It writes it into the eligibility conditions a prospective parent must satisfy, so an examiner can ask for the exact standard, the instrument that sets it, and the clinician's part in evidencing it. The topic belongs with civil and family capacity because adoptive fitness is assessed like any other decision-specific capacity: functionally, at the point of placement, as the ability to take on and sustain the parenting of a particular child, and not as a global verdict on the person's worth.

India runs two parallel routes into a lawful adoption, and what follows covers only one of them in full. Under the Juvenile Justice route, two texts carry the whole of the assessable law. The primary statute is the Juvenile Justice (Care and Protection of Children) Act 2015, whose adoption chapter fixes the fitness conditions for prospective adoptive parents; the working detail is supplied by the Adoption Regulations 2022, framed by the Central Adoption Resource Authority (**CARA**), which turn that standard into concrete eligibility criteria. The Act's own savings clause preserves the second route: an adoption may still proceed under the Hindu Adoptions and Maintenance Act 1956 for a Hindu adopter, and that Act sets its own capacity condition, that the adopter be of sound mind and not a minor, on terms this section does not reproduce. The wider machinery of the Juvenile Justice Act, its care-and-protection provisions, children in conflict with law and the juvenile board, is the province of the Child psychiatry: assessment, treatment, services and protection notes and is not taught here. What belongs to family-capacity law, and to this section, is the fitness of the adopting adult under the JJ Act/CARA route, with the Hindu-law route's own conditions flagged where they diverge from it.

37.1 The statutory architecture: one Act, one delegated code

The reason there are two texts, and the reason examiners test the relationship between them, is that Indian adoption law is built as primary legislation resting on delegated legislation. The Act lays down the mandatory fitness standard for adoptive parents and then, in the very provision that permits a single or divorced person to adopt, defers the operational detail to the adoption regulations framed by the Authority. That Authority is CARA, and those regulations are the Adoption Regulations 2022. The two must therefore be read together: the Act sets the standard and the enabling frame, and the Regulations supply the eligibility gate that a placing agency actually applies. A candidate who quotes one without the other has read only half the law.

IN INDIA

Adoption of a child in need of care and protection runs through the Central Adoption Resource Authority and its recognised specialised adoption agencies, so the fitness standard a psychiatrist may be asked to support is the working gate of that system rather than an abstract test. It is applied in practice through a social investigation and home-study of the prospective parents before a placement is proposed. A psychiatric opinion therefore enters an established administrative process and should be framed to serve it, addressing the statutory conditions directly rather than offering a free-standing character assessment.

37.2 The fitness threshold for adoptive parents (section 57)

The Act's eligibility provision states the core standard in four limbs. A **prospective adoptive parent** *shall* be physically fit, financially sound, **mentally alert** and **highly motivated** to adopt a child for providing a good upbringing. Read the modal verb with the care the examiner will apply. The provision does not say a prospective parent should preferably be mentally alert; it says they *shall* be. This is a mandatory threshold condition of eligibility, not a desirable attribute a placing agency may weigh and waive, and mistaking it for advisory guidance is the fastest way to misstate the law.

Of the four limbs, the psychiatrically load-bearing one is mental alertness, and it is the peg on which a psychiatric opinion is usually hung. The Act deliberately frames it as an active, functional attribute rather than as the absence of any diagnosis. Physical fitness and financial soundness are matters for other assessors; the psychiatrist speaks to whether the person is mentally alert and highly motivated in the sense the statute intends, which is a capacity to engage with and sustain the task of parenting.

MNEMONIC

Fit, Solvent, Alert, Motivated

The four limbs of the eligibility threshold in order: physically **fit**, financially sound (**solvent**), mentally **alert**, and highly **motivated** to give the child a good upbringing. All four are joined by a mandatory "shall", so none is optional.

37.3 The operational eligibility criteria (Regulation 5)

The Regulations sharpen the Act's four adjectives into criteria a placing agency can test. A prospective adoptive parent *shall* be physically, **mentally, emotionally and financially capable**, and two further conditions attach, each carrying its own modal force:

- they *shall* be physically, mentally, emotionally and financially capable of raising a child, which restates the Act's standard as an affirmative capability;
- they *shall not* have any **life-threatening medical condition**, the Regulation's own mandatory wording, read subject to CARA's operational qualification below; and
- they *should not* have been convicted of any criminal act of any nature, nor stand accused in any case of child rights violation.

Note that the modal is not uniform across the three, and the discrimination is examinable. Capability is a mandatory "shall" and the life-threatening-condition clause is a mandatory "shall not", but the conviction-and-accusation clause is worded as a "should not". Reproduce each as the Regulations do rather than levelling them all to a single verb. Read the "shall not" alongside CARA's own standing instructions before calling it an unconditional individual bar: in a couple's application, the Adoption Committee is directed to reject on this ground only where both applicants are affected, weighing medical advice and the other applicant's willingness and capacity to parent, and a controlled lifestyle condition is not on its own a rejection ground; a single applicant's position is assessed on the same functional footing rather than as an automatic exclusion.

RULE **Adoptive-parent fitness is a mandatory statutory condition, not a clinical preference.** Both the Act and the Regulations use the language of duty: the prospective parent must clear the fitness bar for a placement to be lawful. The standard is functional capability to parent, evidenced across the physical, mental, emotional and financial domains, together with the absence of a life-threatening condition, rather than the mere presence or absence of a psychiatric label. The psychiatrist's role is to speak to that functional standard, not to certify normality.

37.4 Who may adopt: consent, couples and the single applicant

Eligibility is not confined to married couples, and the rules on marital status are a favourite of the viva. Where a married couple adopts, the consent of both spouses *shall* be required, so a placement on the wish of one spouse alone is not lawful. A couple is further held to a minimum of relationship stability: no child *shall* be given in adoption to a couple unless they have at least **two years** of **stable marital relationship**, except in the case of relative or step-parent adoption. State that condition with its exception, because the exception is the part candidates drop.

Single applicants are eligible on defined terms. A single or divorced person *may* also adopt, subject to the adoption regulations, and here the enabling verb matters: the law permits it, it does not compel any placement. Within that, a single female *may* adopt a child of any gender, whereas a single male *shall not* be eligible to adopt a girl child. The accompanying table sets the applicants against the rule and its statutory force so the pattern, rather than any isolated phrase, is what is committed.

APPLICANT	ELIGIBILITY RULE	STATUTORY FORCE
Married couple	Consent of both spouses; a minimum period of stable marriage, except in relative or step-parent adoption	Mandatory (*shall*)
Single or divorced person	Permitted to adopt, subject to the adoption regulations	Enabling (*may*)
Single female	May adopt a child of any gender	Enabling (*may*)
Single male	Not eligible to adopt a girl child	Prohibition (*shall not*)

TRAP **Adoption is not restricted to married couples, and a single person is not barred, though the single-male bar is not universal.** Candidates routinely write that only a couple may adopt, or that single applicants are excluded. Under the JJ/CARA route, the law permits a single or divorced person to adopt, and a single female to adopt a child of any gender; the only categorical bar on a single applicant under that route is that a single male shall not adopt a girl child. That bar does not hold across all of Indian adoption law: under the Hindu Adoptions and Maintenance Act, a male may adopt a female child, subject, among the Act's other conditions, to an age gap of at least twenty-one years between them. Flatten either route into "single people cannot adopt", or the JJ/CARA bar into a universal one, and the mark is gone.

37.5 The psychiatric fitness assessment in practice

When a psychiatrist is asked to speak to whether a prospective parent is mentally alert, or mentally and emotionally capable, the question is functional rather than nosological. The statute is not asking for a certificate that the person has never had a mental illness; it is asking whether the person can, in a sustained way, meet the demands of raising the particular child proposed. A stable, treated condition that does not impair parenting is not a statutory disqualifier. The real concern is an untreated or unstable condition that would foreseeably interrupt the safety and continuity of a child's care, which is exactly what the life-threatening-condition exclusion is reaching towards on the physical side.

A useful opinion therefore addresses function and stability, not a label, and covers:

- the applicant's current mental state and its stability over time, rather than a diagnosis considered in isolation;
- the capacity to understand and sustain the demands of parenting the specific child proposed;
- insight, treatment adherence and the support system that maintains stability; and
- any condition that would foreseeably interrupt safe, continuous care.

GOOD TO REMEMBER

A diagnosis is not a verdict. An applicant with a well-controlled mood or anxiety disorder who is stable, adherent and well supported can meet the statutory fitness standard, and writing "unfit" on the strength of a label alone is both poor practice and poor law. Say what the person can do and how reliably, tie it to the mental, emotional and functional criteria the statute names, and reserve an adverse opinion for an impairment that genuinely threatens the child's care.

37.6 Currency, scope and the interface with the court

Two boundaries keep an opinion safe. The first is currency: for the JJ/CARA route, the live framework is the Juvenile Justice Act and the Adoption Regulations 2022 operating through CARA, and Indian adoption regulation has been revised more than once, so an assessment resting on an older adoption guideline is resting on superseded law. The second is scope: the fitness of the adopting adult is the family-capacity question this section owns, while the broader child-protection and juvenile-justice provisions of the same Act, together with the child-protection statutes generally, are taught in the Child psychiatry: assessment, treatment, services and protection notes and should not be folded into the fitness opinion. In the JJ/CARA route,

that opinion feeds an administrative process, not a courtroom one: the adoption order itself is passed by the District Magistrate, not by a court. Court-facing reports arise only where separate litigation, or the parallel Hindu-law route, brings the matter before a judge; the craft of a certificate or report for that setting, its form, duties and confidentiality, belongs to the Forensic ethics, consent and legal procedure notes. Here the psychiatrist supplies the fitness content, not the procedure of whichever forum eventually receives it.

PITFALL

The commonest real-world error is anchoring an opinion to a superseded adoption code, or letting it drift outside the fitness question into the wider child-protection and juvenile-justice provisions that are governed elsewhere. Both make the opinion unsafe. Tie the assessment to the current Act and its Regulations, keep it to the fitness of the adult, and hand the courtroom-certification craft to the notes that own it.

57	5	Two years
JJ ACT: PARENTS' FITNESS	CARA: ELIGIBILITY CRITERIA	COUPLE'S MINIMUM MARRIAGE

Adoptive-parent fitness is a mandatory statutory "shall", set as functional capability to parent and operationalised through CARA's eligibility criteria; the psychiatrist evidences function and stability at the time of placement, never converting a diagnosis into a disqualification.

Violence risk and dangerousness assessment

38 · Concepts of dangerousness and violence risk in psychiatry

Why the marks are here. Few forensic questions reach the psychiatrist as often as the risk of violence. It is asked when a court seeks an opinion before sentence or release, when a review board weighs continued detention, when a ward team decides whether a patient may take leave, and, in ordinary inpatient work, whenever an involuntary admission turns on the harm a person might do to himself or to others. The examiner builds a whole band of questions around it because this is where candidates slip: they answer as though the task were to label a person, when the discipline has spent decades learning that it is not. This section teaches that conceptual footing. It sets out what the older idea of **dangerousness** claimed, why it was abandoned, and what replaced it.

Keep the boundaries of the section in view. The structured instruments that operationalise the modern model, the actuarial tools set beside them, the taxonomy of factors they weigh, and the management of a patient once risk is judged high are each taken up separately in these forensic notes. Here the work is only to get the idea right, because every one of those downstream tasks inherits its logic from the shift described below. A candidate who understands the shift can reconstruct the rest; one who does not will misuse even a good instrument.

38.1 What "dangerousness" meant

The older construct treated the propensity to harm as a fixed personal trait, a stable disposition carried inside the individual and revealed, rather than created, by circumstance. On this view a person either was or was not dangerous, much as he might be tall or short; the environment merely gave the trait its opportunity to show. The idea was legally attractive precisely because it delivered a binary status a court could act on. If dangerousness were a settled attribute of the person, then detaining or releasing him followed cleanly from a single categorical finding, and the psychiatrist could be asked to supply that finding as a matter of expertise.

The construct rested on features that each, in turn, became a reason it fell. It was *dichotomous*: the output was a verdict, dangerous or not, with nothing in between. It was *decontextualised*: because the trait lived in the person, the situation the person was in was treated as incidental. And it was *enduring*: a trait, once present, was assumed to persist, so a finding made today was taken to speak to conduct far into the future. Under this model the clinical task was framed as prediction. The clinician was to forecast whether the individual would be violent, as though violence were an attribute waiting to express itself and the only question were whether the expert could read it in advance. That framing is the one the modern field rejects, and knowing why is the substance of the marks.

38.2 Why the construct failed

The empirical case against dangerousness was blunt. When clinicians predicted it, they were wrong far more often than right, and wrong in a consistent direction: they over-predicted. Cohorts detained as dangerous who were later released by order of a court, and then followed up, went on to serious violence in only a minority of cases, so that most of those held on a dangerousness finding would never have caused the harm the finding forecast. The error was not random noise but a systematic bias toward seeing danger that was not there.

The reason is structural and worth being able to state, because it recurs whenever any rare event is predicted. Serious violence has a low **base rate** in almost any population a clinician assesses. When the event to be predicted is uncommon, even a rule that is accurate most of the time generates a large number of **false positives**, because the handful of people who will truly act are swamped by the many who share the same warning features and will not. A test can look impressive on its hit rate and still, applied to a low-base-rate outcome, flag mostly people who pose no real threat. This is arithmetic, not pessimism, and it does not improve with clinical confidence.

The false positives were not costless. Each was a person detained, stigmatised or denied liberty for a harm he would not have caused, and over-prediction became a respectable-looking route to indefinite preventive detention. There was a second, quieter failure that mattered just as much for practice. Because the danger was located inside the person, the model looked past the circumstances that actually shape conduct, and because it named a fixed trait it offered nothing to do: assessing an unchangeable attribute yields a label and no lever, and gives the clinician no purchase on reducing the very outcome it claims to foresee. The construct thus failed at once

empirically, in its over-prediction; ethically, in the liberty that over-prediction cost; and practically, in the levers a fixed trait denies.

38.3 The reframing: from a trait to a risk

Modern practice replaced the trait with **violence risk**. The change is not merely terminological. Instead of asking whether a person is dangerous, the clinician asks how likely a particular harm is, to whom, how soon, and under what conditions. The newer construct differs from the old in its very form. Risk is *probabilistic*: it is a likelihood, never a certainty, and is properly expressed as a matter of degree rather than a yes or no. It is *contextual*: it is a judgement about a person in a situation, so the same individual may pose a high risk in one set of circumstances and a low one in another. And it is *dynamic*: it rises and falls with time, symptoms and circumstance, so it is a state that fluctuates rather than a settled feature of the person. This single move, from a fixed attribute to a variable, conditional judgement, is the conceptual pivot on which the whole band rests.

RULE **Risk is a state, not a trait.** Violence risk is a probabilistic, contextual and dynamic judgement about a behaviour occurring in a situation, not a fixed property of the person; and because it is a state, the clinical task becomes to assess and manage it, not to predict a status. Every downstream tool and every management plan is an attempt to do that assessment and management well, which is why getting the concept right is prior to getting any instrument right.

The two models can be laid side by side on the axes the examiner tests. Learn the pattern rather than any one row, because viva questions turn on moving from the left column to the right, or on catching an answer that has quietly slid back into the language of the left.

AXIS	DANGEROUSNESS (THE OLDER IDEA)	VIOLENCE RISK (MODERN PRACTICE)
Nature of the construct	A fixed personal trait	A probabilistic, contextual state
Form of the judgement	Dichotomous: dangerous or not	Continuous: a likelihood, along dimensions
Locus	Within the person	The person within a situation
Time course	Static and enduring	Dynamic, varying with time and circumstance
Clinical task	Prediction of a status	Assessment and management of a probability
What it yields	A label or verdict	A formulation with conditions and a plan
Stance to modifiable factors	Nothing to act on	Identifies targets that lower risk

38.4 The anatomy of a risk judgement

Because risk is a probability rather than a verdict, it has structure, and a competent statement makes that structure explicit. A risk judgement is described along **four** dimensions: its nature, meaning the kind of harm feared; its magnitude, meaning how serious that harm would be; its

imminence, meaning how soon it might occur; and its frequency, meaning how often or how repeatedly it is likely to arise. A single global adjective collapses them all into one word and loses the information a decision actually needs, which is why "he is dangerous" tells a court almost nothing while a statement that specifies each dimension tells it a great deal.

What	How bad	How soon	How often
NATURE OF HARM	MAGNITUDE	IMMINENCE	FREQUENCY

The missing element is the condition. Those dimensions describe the harm, but risk is conditional, and the conditions are where the clinical value lies. The same person may carry a high risk under one set of circumstances and a low one under another, so a formulation that omits the circumstances has described only part of the judgement. This is why the modern output is a **risk formulation** rather than a score: it ties the estimated harm to the situations that raise it and the situations that lower it, and it names what follows. A usable risk statement therefore sets out, together:

- the specific behaviour feared, not violence in the abstract;
- the likely target or victim, where one can be identified;
- the circumstances under which the risk rises;
- the circumstances under which it falls; and
- the interventions that follow from the two.

38.5 From prediction to assessment and management

The reframing does more than sharpen language; it changes the job. When risk is understood as a dynamic state, some of what drives it can change over time, and what can change can be targeted. This is why the newer model treats the clinical task as **risk assessment and management** rather than the prediction of a fixed attribute. The point of assessing risk is not to file a forecast but to find the levers, and a construct that admits levers is one a clinician can act on.

The distinction that makes this possible is between the **static** and the **dynamic** drivers of risk. Static considerations are historical and settled, and they anchor the baseline level; dynamic considerations are current and modifiable, and they are what a treatment plan works on. It is the dynamic component that turns a dead-end prediction into a live management task: assess the level and the pattern, identify the modifiable drivers, intervene on them, and reassess, because the estimate is expected to move. The full taxonomy of these factors, static and dynamic, and how they are grouped, is developed separately in these notes and is not rebuilt here; the conceptual point is only that a state, unlike a trait, contains things that can be changed.

The shift also reframes method. The old dangerousness judgement was in practice an unstructured clinical guess, a single expert's global impression, and its poor accuracy was inseparable from its lack of structure. Modern practice replaced that guess with structured approaches, whether the **actuarial** instruments that combine fixed predictors by rule or the **structured professional judgement** that guides the clinician through a defined set of considerations without reducing the decision to a formula. Those methods, and the debate

between them, belong to the separate treatment of risk instruments in these notes; naming them here matters only because they are the machinery through which the reframing is carried out. The management of the violent and high-risk patient, the acute and longer-term plan that acts on the dynamic drivers, is likewise its own section.

38.6 Communicating and acting on risk

A risk opinion is a communication, and its usefulness depends as much on how it is expressed as on how it was reached. The form the modern model demands is conditional and time-limited: it states the assumptions it rests on, ties the estimate to circumstances, gives it a horizon rather than treating it as permanent, and says what would change it. An opinion written that way can be acted on and revisited; a bald categorical label cannot, and it invites exactly the over-detention that discredited the older construct.

GOOD TO REMEMBER

Write a risk opinion the way you would want to read one. Name the specific harm and the circumstances that drive it, put a time horizon on the estimate, and state what would raise or lower it and what you are doing about the modifiable part. "Risk of serious assault is high in the days around contact with his estranged partner and low while that contact is prevented" is a working opinion; "he is dangerous" is a dead end that a court can only over-read or ignore.

IN INDIA

Indian mental health law frames its thresholds in the language of risk of harm to self or to others, not in the older language of dangerousness, and it makes the presence of such a risk a condition for the involuntary route into inpatient care, whose provisions are set out separately in this chapter. The practising psychiatrist meets the concept in two everyday places: in supporting or resisting an involuntary admission, and in medico-legal opinions where a court or authority asks about risk. In both, the reframing is the safeguard, because it obliges the clinician to state a conditional, time-bound judgement rather than to pronounce a person permanently dangerous.

PITFALL

The commonest real-world error is to give a court or a board a categorical verdict, "he is dangerous" or "he is not dangerous", instead of a conditional risk formulation. The first over-detains, because a permanent-sounding label resists any later release; the second falsely reassures, because it strips away the circumstances under which the risk is in fact high. Either way the opinion has smuggled the discredited trait model back in under a modern heading, and it does so most easily when the clinician is asked a yes-or-no question and answers it in kind.

TRAP **Treating "dangerousness" and "violence risk" as interchangeable synonyms.** Candidates use the two words as though they named the same thing and lose the mark the question is testing. They name two different models: one predicts a fixed attribute of the person, the other assesses a probabilistic, contextual and changeable state. An answer that predicts the person rather than the risk-in-context, or that offers a yes-or-no verdict where a conditional judgement is wanted, has answered the older question and earns nothing.

The ethical weight of all this sits just outside the section and should be named, not taught here. A risk opinion can justify preventive detention, and a clinician who learns of a specific, credible threat to an identifiable person may owe a duty that reaches beyond the consulting room; those questions of ethics, confidentiality and the limits of the expert's role belong to the Forensic ethics, consent and legal procedure notes. What this section fixes is the concept those duties operate on.

> Dangerousness asks whether a person is dangerous; violence risk asks how likely which harm is, to whom, how soon and under what conditions, and what changes it. Modern practice, and the examiner, want the second question.

39 · Structured violence risk assessment (HCR-20)

What the marks reward here. Structured violence risk assessment is the discipline of enquiring into the risk of future violence in a fixed, evidence-guided way rather than by global impression, and the examiner who sets this topic almost never wants the internal scoring of any single instrument. What earns the mark is understanding how such an instrument is built, what it is for, and how you would defend the way you used it. The most frequently examined member of the family is the **HCR-20**, and it is the worked example this section is built around. The conceptual groundwork of why a probabilistic, contextual notion of risk replaced the older idea of dangerousness is set out with the account of dangerousness and violence risk in this chapter, and is only leaned on here.

The family is built on a shared shape. First, the assessment is anchored to a fixed list of empirically supported factors, so the clinician cannot simply attend to whatever is salient in the room and quietly overlook a predictor the literature has established. Second, and this is where the methods divide, there is the question of how those listed factors become a conclusion: an actuarial instrument combines them by a fixed statistical rule, while the approach this instrument belongs to keeps the clinician's judgement in charge. Everything that follows turns on that second choice.

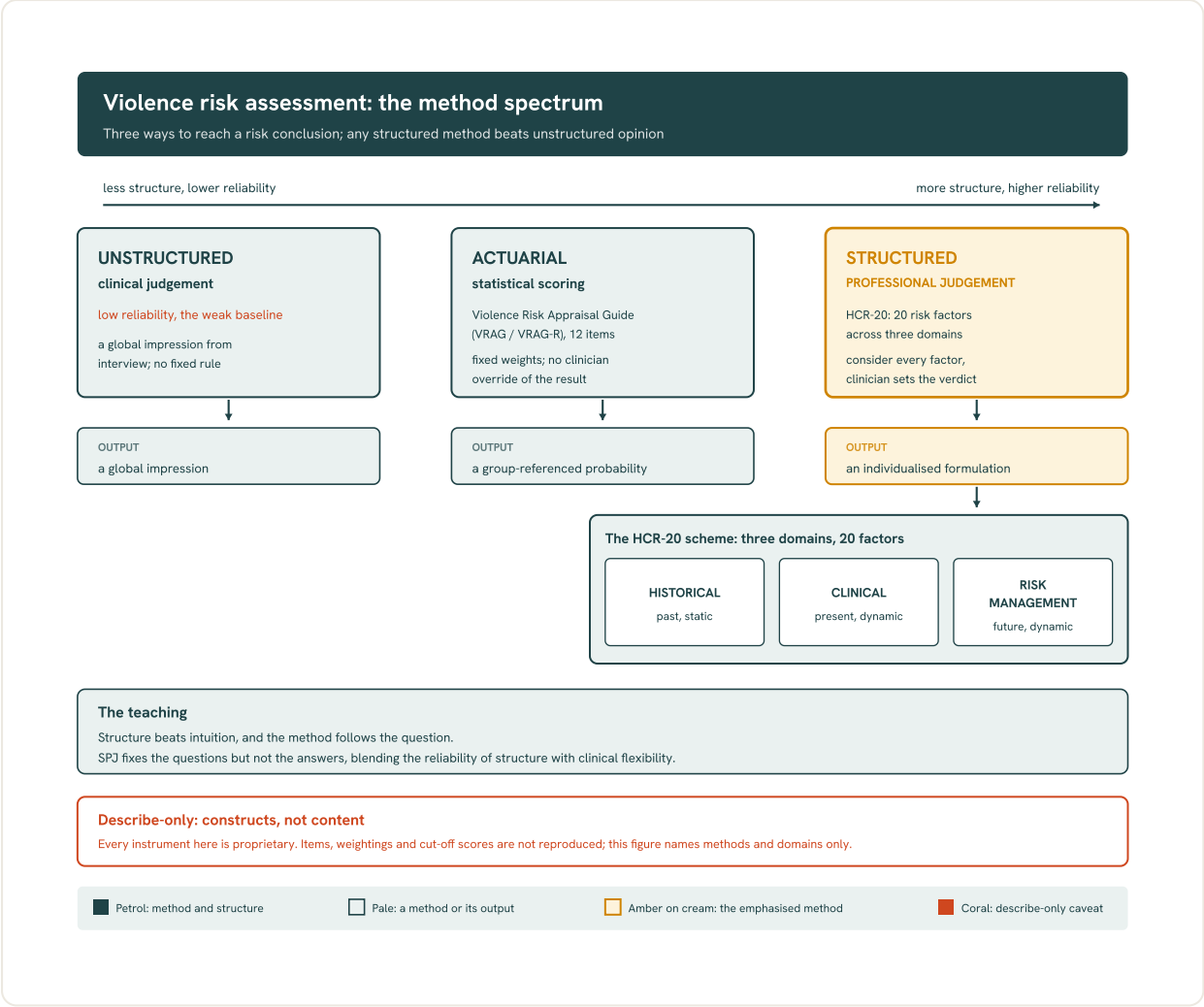


Fig 25.15. Violence risk assessment runs on a method spectrum. Unstructured clinical judgement is the discredited, low-reliability baseline; the actuarial Violence Risk Appraisal Guide (VRAG / VRAG-R) scores fixed weighted items to a group-referenced probability; and structured professional judgement, exemplified by the HCR-20 across its Historical, Clinical and Risk-management domains, fixes the factors that must be considered without pre-weighting them, so it blends the reliability of structure with the flexibility of clinical judgement. Instrument items and cut-off scores are proprietary and are not reproduced.

39.1 Structured professional judgement, and where this instrument sits

Structured professional judgement occupies the middle of a spectrum. At one pole is unstructured clinical opinion, which fixes neither the factors nor the method and predicts weakly; at the other is the actuarial method, which fixes both, combining predetermined and weighted items by a mechanical algorithm and leaving the clinician no licence to depart from the result. Structured professional judgement fixes the questions but not the answer. The instrument specifies the factors that must each be rated and considered, which is its central safeguard against the omission of a known predictor, but the integration of those factors into a risk statement, and the formulation that carries it, remain the clinician's own. The actuarial method itself and the long argument between the two approaches are developed with the account of the other risk tools in this chapter and are only placed here.

The HCR-20 is the exemplar of this method in violence risk work, now in its current third edition. It was developed by **Douglas, Hart, Webster and Belfrage**, and it is a set of professional guidelines rather than a test in the narrow psychometric sense: it directs the assessment without

dictating the verdict. Because it is a copyright-held, proprietary instrument, its manual must be purchased and its item content is not free to reproduce, so a teaching text describes its architecture and purpose and does not print its items. That constraint is returned to below, and it is itself examinable.

RULE **It structures the questions, not the answer.** The instrument ensures systematic consideration of its **20** specified factors, across the whole span of past, present and future, and prompts case-specific formulation; it does not exhaust every possible empirically supported predictor, and it does not convert them into a score. The safeguard is the fixed list; the judgement, the formulation and the final risk category remain the clinician's, which is exactly what makes the method structured and professional rather than actuarial or intuitive.

39.2 The shape of the instrument: the factors and the three domains

The instrument organises violence risk assessment around **20** key risk factors, and it groups them into **three** domains whose initials give the instrument its name: the **Historical** domain, the **Clinical** domain, and the **Risk management** domain. The grouping is not cosmetic. Each domain corresponds to a different tense of the patient's life - what has already happened, how the patient is now, and what is anticipated - so the three together oblige the assessor to look backward, at the present, and forward in one disciplined sweep. An assessment that attends only to a florid mental state, or only to a violent history, has examined one domain and mistaken it for the whole.

MNEMONIC

H, C, R - history, here-and-now, hereafter

The three domains are the three tenses of the assessment. The **H**istorical domain is the settled past, the **C**linical domain is the present state, and the **R**isk management domain is the anticipated future. The name of the instrument is its own contents list.

20	3	SPJ
KEY RISK FACTORS	TEMPORAL DOMAINS	STRUCTURED, NOT ACTUARIAL

Beyond the factors and their grouping, the item content, the coding criteria and the rating anchors are proprietary and are not set out here. The teaching point a candidate must carry away is the architecture - a fixed, comprehensive factor set, arranged by time - and the discipline it imposes, not a reproduction of the coding sheet.

39.3 The three domains and the logic of past, present and future

The value of the domain structure becomes clear when each domain is read for what it contributes to the final judgement. The historical domain gathers the relatively settled features of a life, the record of past behaviour and the long-standing characteristics that shape it, and its function is to anchor the baseline level of concern; being largely fixed, it moves little with treatment and changes slowly if at all. The clinical domain captures the here-and-now, the current state that can shift from week to week, and it is where an assessment registers that a person's risk has risen with a relapse or fallen with recovery. The risk management domain is

prospective: it asks what the future holds for this person, the plans, supports, stresses and supervision that lie ahead, and whether the arrangements around them will contain the risk or inflame it. Read together, a settled baseline, a current state and an anticipated trajectory give a far richer picture than any single snapshot.

This is also where the instrument operationalises the raw material of risk. The historical domain is built largely from static considerations, and the clinical and risk-management domains largely from changeable ones, which is how a fixed factor set nonetheless leaves room for risk to move over time. The full taxonomy of static and dynamic risk factors, and how they are grouped, is developed with the account of the risk factors for violence in mental illness in this chapter and is only named here; the instrument's job is to make sure they are all considered, not to define them.

DOMAIN	TENSE	WHAT IT GATHERS	ITS FUNCTION IN THE JUDGEMENT
Historical	The past	Settled features of the person and the record of past behaviour	Anchors the baseline; largely fixed, so it moves little with treatment
Clinical	The present	The current state and presentation, which can shift over short periods	Registers whether risk is rising or falling now
Risk management	The future	The anticipated situation - plans, supports, stresses and supervision ahead	Asks whether what lies ahead will contain the risk or inflame it

39.4 How an assessment is actually conducted

Structured professional judgement is a method as much as a list, and knowing the sequence is what separates a candidate who can name the instrument from one who could use it. The assessor does not fill in a form but works through a defined order of tasks, and two of those tasks are what give the method its character. One is the weighing of relevance: establishing that a factor is present is only the start, because a factor may be present yet peripheral in one case and decisive in another, and it is the judgement of what it means for this person that an actuarial tool has no equivalent for. The other is the building of a **risk formulation**, an account of what drives this person's risk and how, from which the assessor generates plausible **risk scenarios** - concrete stories of how, when and towards whom violence might occur - before arriving at a summary risk judgement and a plan. Set out in order, the sequence runs:

- establish the presence of each factor from interview, records and collateral information;
- weigh the relevance of each present factor to this individual, not merely its presence;
- integrate the relevant factors into a formulation of what drives the risk;
- generate specific scenarios of how, when and towards whom harm might occur;
- reach a categorical summary judgement and translate it into a management plan.

Why relevance and formulation carry the method. The steps that distinguish this approach from a checklist are the weighing of relevance and the building of a formulation. A checklist stops at presence and tallies it; structured professional judgement insists that presence is only the raw material and that the clinical work lies in deciding what each present factor means for this person and how the factors combine. The output is therefore an individualised, defensible account rather than a number, and the management plan that follows from it, the acting on the changeable drivers the formulation exposes, is taken up with the account of the management of the violent and high-risk patient in this chapter.

39.5 What the method buys, and what it does not

Set against both the unstructured opinion it replaces and the actuarial rule it sits beside, structured professional judgement has a characteristic profile of strengths. Its fixed factor set gives it comprehensiveness, making it hard to forget an established predictor. Because the basis of the opinion is explicit and open to review, it is transparent and defensible. It attends to the changeable and protective features of a case, not only to the fixed historical ones, so the assessment points at what can actually be done. And its output is built for management and communication, a formulation and its scenarios, rather than for prediction alone.

The costs are the other face of these strengths. The method leans on the competence of the assessor: because the judgement is retained, a poorly trained or careless rater can misuse a good instrument, and the reliability an actuarial algorithm delivers mechanically must here be earned by disciplined practice. It is more demanding of time and information than ticking a short actuarial list. And it deliberately declines to produce a probability, yielding a reasoned category and a formulation, not a percentage against a reference group. That structured methods in general outperform unstructured opinion is not in dispute; the finer comparison of accuracy between the actuarial and structured-judgement approaches, and the evidence for each, belongs to the account of the other risk tools in this chapter.

TRAP **Calling this an actuarial instrument, or expecting it to yield a probability.** Candidates group every risk tool together and describe the instrument as though it summed items into a predictive score. It does the opposite: it is a structured professional judgement scheme, and its output is a clinically reasoned category set in a formulation, not a group-referenced probability. An answer that reports a percentage risk, or an actuarial cut-off, from this instrument has misclassified the very method the question is testing.

39.6 A proprietary and restricted instrument

An unusual amount of what a candidate should know about this instrument concerns not its clinical content but its status as intellectual property, and the examiner does test it. The instrument is copyright-held and proprietary. Its manual, the user's guide, must be purchased; it is not a public-domain checklist, and its individual items are not available for licensing, so this resource follows a describe-only editorial policy and does not extract or print them. That the publisher declines to licence items does not by itself settle what Indian copyright law permits for every educational use; applicability turns on the specific use, audience, amount and context, and no categorical legal conclusion is drawn here. Access to the tool is pitched at a restricted

qualification level, on the assumption that a user has the professional training needed to code and interpret it responsibly. These facts explain why every responsible textbook, this one included, names the domains and describes the method but does not reproduce the items or their anchors.

The restriction is not mere legal housekeeping; it guards the instrument against exactly the misuse its structure invites. Because the factors are laid out as a list, an untrained reader is tempted to treat them as a questionnaire to be added up. But the coding of the factors is not a scoring system in the actuarial sense, and the discipline the manual and its training exist to instil is precisely that the number of factors present is not the risk level.

PITFALL

The characteristic misuse is to treat the factor list as a tally and to read a high count of present factors as automatically high risk. That is to smuggle an actuarial habit into a method built to resist it. In structured professional judgement the summary risk category is a clinical integration, what the present and relevant factors mean, taken together, for this person, and not the arithmetic of how many boxes are ticked. A patient with many present factors that are, on formulation, of little current relevance may warrant less concern than one with a few highly relevant ones. Counting the items is not assessing the risk.

39.7 Using the instrument in Indian forensic practice

Two practical realities frame the use of this instrument in India. The first is access: a proprietary, restricted, purchasable instrument is not uniformly available across public forensic services, and its use presupposes training that is not yet widespread, so a candidate should be honest that structured tools of this kind are used unevenly in Indian practice. The second is transfer: unlike an actuarial tool, whose probabilities are only as portable as the sample they were derived on, a structured professional judgement scheme travels comparatively well, because its product is a reasoned, individualised formulation rather than a number tied to a foreign reference group. The structure disciplines the assessment wherever it is used; what does not automatically transfer is any assumption that a given profile carries the same likelihood here as elsewhere.

IN INDIA

Indian courts and authorities tend to ask a categorical question, whether a person poses a risk and whether it can be managed, rather than to ask for a percentage, and that suits a method which yields a reasoned category and a formulation better than one which yields a normed probability. The workable position for the Indian forensic psychiatrist is to use a structured instrument as an aid that disciplines the assessment and makes the reasoning explicit and defensible, to keep its proprietary item content out of any document a lay reader will see, and to treat the categorical, formulated opinion, rather than a borrowed number, as the deliverable. The standards for the report itself and for giving evidence as an expert are set out in the Forensic ethics, consent and legal procedure notes.

GOOD TO REMEMBER

The completed structured assessment is, above everything else, your defensible record. When an opinion on violence risk is challenged, and in forensic work it will be, the worth of having worked through a fixed, recognised factor set is that you can show you systematically considered its **20** specified factors and can point to the formulation that led to your category. Present the domain your concern sits in and the scenario you fear, give a categorical judgement tied to a management plan, and let the structure carry the defence. The acute and longer-term management that plan sets in motion is taken up with the account of the management of the violent and high-risk patient in this chapter.

This is a structured professional judgement scheme, not an actuarial one: it fixes the factors you must weigh across a historical, a clinical and a risk-management domain - past, present and future - then leaves the conclusion, a reasoned risk category set in a formulation, to the clinician. The list is fixed; the judgement is yours.

40 · Other risk tools (VRAG, PCL-R, actuarial versus structured clinical judgment)

What the marks reward here. Structured violence risk assessment is a family of methods, not a single instrument, and the examiner almost never wants the internal scoring of any one tool. What earns the mark is understanding how a tool is built and how you would defend the one you chose. This section sits beside the best-known structured checklist and takes up the other instruments a candidate is expected to name and place: the **actuarial Violence Risk Appraisal Guide**, the clinician-rated psychopathy measure on which so many risk schemes lean, the **Psychopathy Checklist-Revised**, and a dynamic **Short-Term Assessment of Risk and Treatability**. The idea that binds them, and the one the marks are really testing, is the contrast between the actuarial method and structured clinical judgement.

Two questions sit under every risk instrument. The first is how the risk factors are combined into a conclusion: by a fixed arithmetic rule, or by a clinician's disciplined judgement. The second is what that conclusion is for: estimating the probability of a future event, or managing a particular person over time. The actuarial versus structured clinical judgement debate is an argument about the first question, and its modern resolution turns on the second.

40.1 Three ways to reach a risk conclusion

Historically, clinicians judged violence by unstructured opinion: a global impression formed from the interview, with no fixed set of factors and no rule for weighing them. This reads fluently in a report but performs poorly, with weak agreement between assessors and modest predictive validity, and it is the discredited baseline against which every structured method is measured. The actuarial method answered it with the opposite discipline. A fixed set of empirically derived items, each carrying a predetermined weight, is combined by a mechanical algorithm to yield an estimate of risk against a reference sample; the clinician who scores a pure actuarial tool has no licence to override the result. Between these poles sits **structured professional judgement**, which fixes the questions but not the answer: the instrument names the factors that must be

rated and considered, guarding against the omission of a known predictor, while the final risk statement and its formulation remain the clinician's.

The empirical backbone of the actuarial case is older than any of these instruments. Across many fields of prediction it has been found that the mechanical combination of a set of data points tends to equal or exceed the same clinician combining the same information in his head. The lesson carried into forensic work was not that clinicians are useless but that the unaided integration of many weighted cues is a task the human mind does unreliably, while a formula does it the same way every time. That is the argument an actuarial tool cashes out, and it is why a bare clinical impression is no longer a defensible method on its own.

The finding that organises the whole field is remarkably stable across decades of research: any structured method, actuarial or professional judgement, outperforms unstructured clinical opinion. The genuinely open question is therefore not whether to structure the assessment, but which structured method suits the task in front of you.

RULE **Structure beats intuition, and the method follows the question.** Unstructured clinical opinion is the weak comparator that both structured approaches defeat. The choice between actuarial scoring and structured professional judgement is not, then, a contest of accuracy; it is a choice of purpose - a group-referenced probability, or an individualised and manageable formulation.

40.2 The actuarial approach and the Violence Risk Appraisal Guide

An actuarial instrument works the way an insurer prices a policy. Predetermined items are scored from history and records, summed by a fixed formula, and read against tables that link the total to the observed rate of the outcome in the sample the tool was built on. The judgement has, in effect, already been done, by the researchers who derived and validated the weights, and frozen into the scoring. The exemplar in forensic psychiatry is the Violence Risk Appraisal Guide, built by **Quinsey, Harris, Rice and Cormier** from a forensic offender sample. Its current form is a **12**-item actuarial tool, revised in **2013** by **Rice, Harris and Lang** to be simpler to score. Its items and its score-to-probability bands are proprietary and are not reproduced here; what a candidate must carry away is the method, not the grid.

The strengths are the strengths of any mechanical rule: high reliability, transparency, and resistance to the impressionistic biases that sink unstructured judgement. The weaknesses are structural, and worth being able to list, because each is a discussion point:

- the group-to-individual problem, since the output is the rate observed in a reference group and no single person is a rate;
- a reliance on fixed, historical items that do not move with treatment, so the tool is nearly blind to change;
- sample specificity, since the probabilities hold only to the extent that the person resembles the population the tool was derived on;
- silence on protective factors, which are not part of the equation; and

- a design built for prediction, not for the management decisions a clinical team actually has to take.

The taxonomy of static and dynamic factors these tools weigh is developed with the account of violence risk factors in this chapter, and is only named here.

> **PITFALL**
> An actuarial probability is a property of a group, not a verdict on a person. Reporting a percentage risk as though the figure described the individual in the chair is the commonest misuse, and it compounds when a probability derived from a Western forensic sample is applied unmodified to a patient the tool was never normed on. State the estimate for what it is - the rate seen in similar cases, one input to a clinical opinion - and not as this person's settled destiny.

40.3 Structured professional judgement and the START

Structured professional judgement keeps the clinician in the loop by design. The instrument supplies an evidence-based list of factors that must each be rated and considered, which is its central safeguard: it stops an assessor forgetting a factor the literature says matters. It does not then dictate the conclusion. The clinician integrates the ratings, adds case-specific considerations, and produces a categorical judgement, usually low, moderate or high, embedded in a formulation and a set of plausible future scenarios. The best-known instrument of this type is the Historical Clinical Risk Management scheme, whose structure is taken up with the account of structured violence risk assessment in this chapter and is only named here.

A useful contrast within the same family is the Short-Term Assessment of Risk and Treatability, published by **Webster, Martin, Brink, Nicholls and Desmarais** in **2009**. It is explicitly dynamic: its **20** items are the changeable, treatment-relevant features of a case rather than settled history, which suits it to inpatient and rehabilitation work, where the live question is whether risk is rising or falling. Its signature feature is dual coding: every item is rated twice, once as a strength or protective factor and once as a vulnerability or risk factor, so the same domain can be read as an asset or a liability depending on the person. And it is deliberately broad in the outcomes it addresses, spanning not only violence towards others but suicide, self-harm and victimisation as well, so a single rating informs several risk questions at once.

As with the actuarial guide, the manual and its item content are proprietary; the teaching point is the design - dynamic, coded for both strengths and vulnerabilities, and treatability-focused - not the item list.

40.4 The Psychopathy Checklist-Revised and the place of psychopathy

The Psychopathy Checklist-Revised is routinely grouped with the risk instruments, but it is not, in itself, an actuarial predictor of violence. It is a clinician-rated measure of a personality construct, psychopathy, developed by **Robert D. Hare** and published by **Multi-Health Systems**. It is scored from a semi-structured interview together with a careful review of collateral and file information, which is why it cannot be completed from a single consultation and why thin records degrade it. Its items are organised into factors, but the item and factor content, and the

scores at which interpretive labels attach, are proprietary; it is a restricted-user tool that its publisher releases only to assessors holding an advanced degree with specific forensic training. That access restriction is itself an exam-relevant fact, and the reason these contents are named rather than printed in any teaching text.

Why the measure earns a place in a violence chapter is empirical: psychopathy is among the more robust individual correlates of violence and of reoffending, so a psychopathy rating frequently feeds a risk formulation, and several structured and actuarial schemes incorporate it as a component. The discipline to hold onto is that the score measures a construct. It is neither a psychiatric diagnosis nor, by itself, a risk score; it informs the risk judgement and does not constitute it. The three tools map onto the method spectrum as follows.

INSTRUMENT	METHOD CLASS	WHAT IT INDEXES	RATING SOURCE	OUTPUT
VRAG-R	Actuarial	Violence risk	Coded from history and records	Probability against a reference group
PCL-R	Clinician-rated construct measure	Psychopathy	Interview plus collateral and file review	Factor-structured score (proprietary)
START	Dynamic structured professional judgement	Short-term risk and treatability across outcomes	Clinician rating of strengths and vulnerabilities	Categorical risk plus formulation

40.5 Actuarial versus structured clinical judgement

Why the distinction earns marks. A candidate who can only recite instrument names has missed the question; the assessable skill is placing any tool on the actuarial-to-judgement spectrum and saying what that placement buys and what it costs. The contrast is cleanest laid out on shared axes.

AXIS	ACTUARIAL METHOD	STRUCTURED PROFESSIONAL JUDGEMENT
Item selection	Fixed, empirically derived and weighted	Fixed list that must be considered, not weighted
How factors combine	Mechanical algorithm	Clinical formulation
Clinical override	None in the pure form	Judgement is retained
Dominant factor type	Mainly fixed and historical	Historical, changeable and protective
What it yields	Probability against a norm group	Categorical risk plus a formulation
Primary purpose	Prediction and screening	Risk management and scenario planning
Worked example here	The VRAG	The START, and the Historical Clinical Risk Management scheme

The old "clinical versus actuarial" war, fought as though one side had to win outright, is largely settled, and in a way that dissolves the question. Structured methods beat unstructured judgement; that much is not in dispute. Between the two structured methods there is no single victor, because they answer different questions. An actuarial tool is efficient for screening and for anchoring a baseline against a known group rate. Structured professional judgement is built for what happens next: an individualised formulation, attention to changeable and protective factors, and the scenario planning a treating team needs in order to act. Mature practice uses them as complements, and the management of the high-risk patient, which works on the dynamic factors these tools expose, is taken up separately in this chapter.

In everyday forensic work the two methods are less often rivals than layers. A common pattern is to let an actuarial estimate set the baseline, the anchor against a known group rate, and then to adjust that anchor with structured judgement of the changeable and case-specific factors the formula cannot see; this is the so-called adjusted-actuarial approach. What structured professional judgement adds on top of an actuarial floor is incremental: the individualising detail, the modifiable drivers, the protective factors, and the account of the circumstances under which this person's risk rises or falls. Neither layer makes the other redundant, which is exactly why the modern answer to "actuarial or clinical" is "structured, and matched to the decision in front of you".

TRAP **Structured clinical judgement is not clinical intuition.** Candidates see the word clinical inside structured professional judgement, lump it with the discredited unstructured opinion, and then rank the actuarial method as automatically superior. The opposite is the case: structured professional judgement is a rigorous, evidence-guided method, and the weak comparator that both structured approaches beat is unstructured judgement, not each other.

Structure beats unstructured judgement; the actuarial method estimates a group-referenced probability while structured professional judgement builds an individualised, manageable formulation - so you choose between them by the question, prediction or management.

40.6 Using these instruments in Indian practice

Everything above was developed abroad, and that is the practical catch for an Indian forensic psychiatrist. An instrument's validity is not portable by default: it holds only to the extent that the person and the setting resemble the sample the tool was derived and validated on, and the base rates of violence, the completeness of recorded history, and the very questions the law asks all differ here from that context. The tools remain useful, but as structured aids to reasoning rather than as machines that hand down a verdict.

12	20	2009
VRAG-R ACTUARIAL ITEMS	START DYNAMIC ITEMS	START INTRODUCED

IN INDIA

These instruments were derived and normed on Western forensic populations, and none has an established Indian normative base, so their probabilities and interpretive bands cannot be assumed to transfer. Indian courts also tend to ask a categorical question, whether a person is dangerous or fit, rather than for a percentage, and the psychiatrist's reasoned opinion remains central. The workable position is to use these tools as structured aids that discipline the assessment and make the reasoning explicit, not as generators of a number, and to remember that no widely validated indigenous actuarial instrument is in routine use.

GOOD TO REMEMBER

In a forensic report, name the instrument and its method, state plainly that a structured tool informs but does not determine your opinion, and anchor the conclusion in an individualised formulation. Keep the proprietary contents of restricted instruments out of any document a lay reader will see. The standards for the report itself and for expert testimony are set out in the Forensic ethics, consent and legal procedure notes.

41 · Risk factors for violence in mental illness

Risk is read from factors, not from a diagnosis. When a court, a review board or a ward team asks how likely a patient is to be violent, the answer does not turn on the diagnostic label but on a set of identifiable features that raise or lower the probability of harm. Those features are the risk factors, and organising them is the substance of this topic. The reframing that made this the right question - the move from judging a person dangerous to estimating a risk that is probabilistic, contextual and changeable - is set out separately in these notes and is assumed here; the work now is to name the factors that a risk judgement weighs, to sort them in a way that guides action, and to be precise about which of them carry the excess risk seen in mental illness. Examiners return to this ground because it is where careless answers cluster. A candidate who reaches for "mental illness causes violence" has already lost the mark, while one who can separate the fixed markers from the modifiable ones, and can say where the real excess risk sits, has shown exactly the discipline the question is testing.

The factors themselves are the durable content of the field. The instruments that combine them into a structured assessment, the actuarial tools set beside those, and the plan that acts on them once risk is judged high are each taken up in their own right elsewhere in this chapter; here the task is to know the factors, to sort them in a way that leads to action, and to say precisely which of them carry the excess risk that attaches to mental illness. Get the factors right and the downstream machinery has something worth combining; get them wrong and no instrument will rescue the assessment.

41.1 The organising cut: static against dynamic

The single most useful way to hold the risk factors in mind is to ask, of each, whether it can change. On that test they fall into **two** classes. **Static** factors are historical and settled: they belong to what has already happened to a person, or to fixed features of who they are, and no

treatment will alter them. **Dynamic** factors are current and changeable: they are features of the present clinical state and social situation that can rise, fall, or be treated. The classes are grouped this way for a reason that is practical rather than tidy. The static factors tell you how much baseline concern a case warrants; the dynamic factors tell you what you can actually do about it.

Because this cut turns on modifiability, it maps straight onto the clinical task: it separates the part of the assessment that anchors a long-run estimate from the part that a management plan works on and then rechecks. A second, looser way of grouping the same factors is by domain - the person's history, their present mental state, and the circumstances around them. That domain lens is a descriptive convenience, and it is roughly how several structured instruments lay their items out, but it cuts across the static and dynamic division rather than replacing it, and it is the modifiability cut that carries the clinical and the examination weight.

Static	Dynamic	Combined
FIXED HISTORY; SETS THE BASELINE LEVEL OF CONCERN	CURRENT STATE; THE MODIFIABLE TREATMENT TARGETS	ACTIVE PSYCHOSIS WITH SUBSTANCE USE, WHERE RISK CONCENTRATES

41.2 Static (historical) risk factors

Static factors are the fixed history a risk assessment starts from. The most important of them, and the one every scheme places first, is **previous violence**: a documented history of violent behaviour is the strongest single anchor a clinician has for judging future violence. The others in this class share the quality of being settled facts about the person or their past. A young age at the first violent act marks an early-onset, more entrenched pattern rather than a late and situational one. Male sex carries a higher base rate of serious physical violence. And childhood maladjustment - conduct disturbance, abuse, instability and disrupted development in the early years - marks a developmental trajectory that raises the adult baseline. None of these can be shifted by treatment, which is precisely what makes them static: they set the floor of concern, and they do not move.

RULE **Past violence is the best single predictor of future violence.** Of all the factors weighed, a documented history of violent behaviour predicts future violence more strongly than any other, because past behaviour is the most reliable guide to behaviour under similar conditions and because it integrates, in one observable fact, the many influences that a list of separate predictors only approximates. This is why a careful, specific history of any previous violence - its context, its target, its severity and its pattern - is the core of every risk assessment, and why its omission is the most damaging single gap an assessment can carry.

The clinical value of the static factors is exactly their stability. They give a defensible baseline that does not swing with a good phase or a bad one, and they discipline an assessor against being falsely reassured by a calm interview in someone whose history says otherwise. Their limitation is the mirror image of that strength. Because they cannot change, they name no target and offer no lever; an assessment built on static factors alone can estimate risk but can do nothing to reduce it. That is the work the dynamic factors do.

41.3 Dynamic (changeable) risk factors

Dynamic factors are the current, modifiable features that raise or lower risk from week to week, and they are where the clinical yield of the whole assessment lies. The first group is the patient's active symptoms, and not all symptoms carry risk equally. The ones that matter are those that make violence feel, to the patient, necessary or externally driven. **Threat or control-override symptoms** - the belief that one is under threat from others, or that an outside force is overriding one's own control, as in delusions of passivity or of thought and behaviour being imposed - are the psychotic experiences most consistently linked to violence, because they recast an assault as self-defence or as something one is compelled to do. **Command hallucinations**, especially those instructing harm in a voice the patient feels unable to resist, work in the same way. It is the content and the felt compulsion of the symptom, not the diagnosis it sits within, that raises the risk.

Beyond the symptoms, several further dynamic factors recur. **Substance misuse** is among the most powerful of all, and its particular role in mental illness is considered further when the excess risk is discussed below; the clinical management of a substance use disorder itself belongs to the Substance use disorders notes. **Treatment non-adherence** - stopping medication, disengaging from services, missing the very contact through which deterioration would be caught - both reflects and drives rising risk. And social instability, meaning the loss of housing, occupation, supervision and supportive relationships, strips away the external structure that contains behaviour and amplifies the effect of everything else. Each of these can be targeted, which is why they, and not the settled history, are the material a management plan actually works on.

41.4 Setting the two classes side by side

The distinction is worth laying out on shared axes, because the examiner tests movement across the columns and because the two classes differ in almost everything except that both predict. Learn the pattern rather than any single row, and notice that the difference in modifiability is what drives every other difference below it.

AXIS	STATIC (HISTORICAL)	DYNAMIC (CHANGEABLE)
Nature	Settled facts of history and person	Current clinical state and circumstance
Modifiability	Fixed; unchanged by treatment	Modifiable; the targets of treatment
Typical members	Prior violence, early age at first violence, male sex, childhood maladjustment	Threat and control-override symptoms, command hallucinations, substance misuse, non-adherence, social instability
What they anchor	The long-run baseline level of concern	The current, near-term direction of risk
Clinical use	Screening and baseline estimation	Intervention, monitoring and reassessment
Limitation	Name no target to act on	Fluctuate, so demand repeated review

A closing word on the domain lens keeps it from becoming a third scheme to memorise. Grouping factors as historical, clinical and contextual describes where a factor comes from, not whether it can change, so a single domain holds both kinds: the historical domain is largely static, while the clinical and the contextual domains are where the dynamic, movable factors sit. Used together, the domain lens makes sure no source of information is overlooked, and the static and dynamic cut keeps sight of what can actually be done about what is found.

41.5 Where the excess risk sits in mental illness

The label is not the risk factor. The single most examined point in this topic is also the most misunderstood in public life: a psychiatric diagnosis, taken by itself, is a poor guide to violence. The excess risk that genuinely attaches to mental illness is not spread evenly across all patients or all conditions. It is concentrated in active psychosis complicated by co-occurring substance use, and it is carried by particular symptoms rather than by the diagnostic category. A person with a stable, treated illness and no substance use stands in a wholly different place from one in an untreated psychotic relapse who is also drinking or using, even under the same diagnostic heading.

The concentration comes from the active psychotic state and from substance use, acting together. Within the psychotic state the risk is carried by the specific symptoms already named: the sense of being threatened or of having one's control overridden, and commands that feel impossible to resist. These are features of a current relapse, not of the diagnosis in remission, which is why risk tracks the state and falls when the state is treated. Substance use raises risk by several routes at once - disinhibition and intoxication, the destabilising of an underlying illness, worsened adherence, and the social chaos that surrounds dependence - and its effect is more than additive when it sits on top of an active psychosis. It is the meeting of the two, far more than either alone and far more than the label, that accounts for most of the elevated risk clinicians actually meet.

TRAP **Naming the diagnosis as the risk factor.** Asked for the risk factors for violence in mental illness, candidates write "schizophrenia" or "psychosis" as though the diagnostic label were itself the factor. It is not. The risk is carried by an active symptomatic state - threat and control-override symptoms, commands that feel irresistible - and, above all, by co-occurring substance use, not by the diagnosis in the abstract. An answer that indicts the category rather than the state has lost the mark and repeated the very stigma the evidence corrects.

PITFALL

The mirror-image clinical error is to build the whole assessment on the static history - previous violence, sex, early onset - because it feels objective and countable, and to record the current state only in passing. Such an assessment can produce a plausible baseline and still be useless, because it names nothing that can be changed and so leads to no plan. The static factors tell you how worried to be; only the dynamic factors tell you what to do, and an assessment that neglects them predicts without managing.

In mental illness the excess risk of violence sits in active psychosis with co-occurring substance use, not in the diagnostic label; and across all cases previous violence remains the single strongest predictor.

41.6 From factors to formulation, and to practice

Risk factors are inputs, not conclusions. Counting them does not yield a risk level; they are weighed and combined, either by a fixed actuarial rule or through structured clinical judgement, into a formulation that ties the estimated harm to the circumstances that raise and lower it. The structured instruments that carry out that combining, such as the **HCR-20** and the **VRAG-R**, operationalise the very factors set out here, by structured clinical judgement and actuarial method respectively; their internal structure, and the actuarial-versus-judgement debate, are taken up in their own right elsewhere in this chapter and are only named here. The **PCL-R** measures psychopathy rather than combining this taxonomy into a violence-risk conclusion; it may inform a formulation or appear as a component within another instrument, but it is not itself a combining violence-risk tool. A full formulation also weighs protective factors - the supports, engagement and stability that lower risk - which a bare factor count leaves out; these too are named here and are developed with the instruments that code them.

Turning the taxonomy into an actual assessment means eliciting each class deliberately rather than hoping it surfaces. In practice that means covering, for every case:

- a detailed history of any past violence, including its context, target, severity and pattern, as the strongest single anchor;
- the current mental state for threat and control-override symptoms and for commands the patient feels unable to resist;
- current substance use, screened in every case and never assumed to be absent;
- engagement and adherence with treatment and services; and

- the stability of housing, occupation, supervision and close relationships.

The static items anchor the baseline; the dynamic items, being the modifiable ones, become the targets of the plan whose acute and longer-term forms are set out separately in this chapter. The point of sorting factors this way is never the sorting itself. It is that a formulation which ends with a set of dynamic targets can be acted on and revisited, while one that ends with a static score can only be filed.

IN INDIA

The factor taxonomy itself travels well - previous violence, active psychosis, substance use and social instability raise risk everywhere - but the instruments that weigh these factors were derived and normed on Western forensic populations and have no established Indian base, so their probabilities and cut-offs cannot be assumed to transfer. Indian practice therefore leans on the factors themselves, appraised through structured clinical judgement, more than on any actuarial score. Local realities shape the dynamic factors in particular. The family remains the main structure of supervision and the main route back into treatment, so involving it is often the most powerful modifiable protective factor available; and gaps in access and continuity of care make treatment non-adherence a live and common driver of relapse and of rising risk.

GOOD TO REMEMBER

A risk assessment that records the diagnosis and the past history but not the current dynamic state has captured the least changeable part of the picture and missed the part you can treat. Make it routine, in every case, to document the active symptoms that carry risk, to screen for co-occurring substance use rather than assume it, and to check adherence and social supports - and then, for each dynamic factor you find, to name what you intend to do about it. That is what turns a list of factors into a plan.

42 · Management of the violent and high-risk patient

Why the marks are here. The acutely violent or agitated patient is one of the few situations in psychiatry where a clinical decision and a legal act are the same act. Every step taken to make a ward safe, from a word to an offered tablet to an injection given without consent to a hand laid on a patient, runs from ordinary care toward the deprivation of another person's liberty, and the law watches the far end of that line closely. The examiner builds a whole question here because candidates who can recite risk factors and name instruments often come apart on what actually matters at the bedside: what to do, and in what order. This section teaches that answer, the graded response to acute disturbance and the longer-term work that follows once the emergency has passed.

Two ideas hold the topic together. The first is that management is *graded*: interventions are ranked by how far they override the patient's own choices, and you exhaust the less coercive before reaching for the more coercive, escalating only as far as safety requires and stepping back as soon as it allows. The second is that management runs across *two horizons* at once: the acute horizon of the next several minutes, where the task is to contain disturbance and prevent

immediate harm, and the longer horizon of weeks and months, where the task is to lower the risk that produced the episode. Answer only the first and you have described a scuffle; answer only the second and you have left a dangerous situation unmanaged.

RULE **Use the least coercive measure that will keep people safe, and no more.** Acute management climbs a ladder: environmental and verbal measures first, then medication offered and taken by choice, and only where safety demands it and the law permits, coercive sedation and physical control. Each rung is justified by the failure of the one below it, never by disruption or convenience, and you climb down the moment the danger falls.

MNEMONIC

Talk, offer, tranquillise, restrain

The four rungs of acute management, in order. **Talk** the situation down; **offer** medication the patient can accept by choice; **tranquillise** by injection only if talking and offering have failed and danger remains; **restrain** physically, only as a lawful last resort to prevent imminent harm. Seclusion and solitary confinement are prohibited outright in India and are never a rung on this ladder.

42.1 The graded ladder of acute intervention

The options are arranged as a ladder because coercion is a harm in itself: the burden of justifying each step rises as the step takes more of the patient's autonomy, so the least restrictive measure that will work is always the right place to start. The examiner tests movement between the rungs and the reasoning that carries you from one to the next, which the table lays out.

RUNG	WHEN YOU REACH FOR IT	WHAT IT AIMS AT	THE SAFEGUARD IT DEMANDS
Environmental and verbal de-escalation	First, in every case of acute disturbance, and continued throughout	Lowering arousal so the patient regains control and coercion becomes unnecessary	None beyond good practice, because it overrides no choice
Offered oral medication	When talking alone is not settling the patient	Relief of distress and agitation, taken by the patient's own consent	A genuine choice, since it is help offered and not force applied
Rapid tranquillisation	When de-escalation and offered medication have failed and danger persists	Calming enough to reduce risk and permit care, not sedation into unconsciousness	Given under necessity, with physical monitoring afterwards
Physical restraint	The last resort, when less restrictive measures cannot contain a risk of harm	The immediate physical safety of the patient and of others	Lawful only within the statutory limits set out elsewhere in this chapter, which permit physical restraint but ban seclusion outright

Reading down the last column shows the logic: each higher rung takes more of the patient's liberty and demands more justification.

42.2 De-escalation: the mandatory first line

De-escalation is the coordinated use of environmental and interpersonal measures to bring down a patient's arousal and help them recover their own control, so that no more coercive measure becomes necessary. It is not a soft preliminary to the real work; it is the first line of treatment for acute disturbance, attempted in every case and continued even while more coercive options are prepared in case it fails.

Its two arms are worth separating, because a candidate who names only the talking has described half of it. The **environmental** arm reshapes the situation the disturbance is happening in: reduce the stimulation and noise, remove the audience a frightened patient may be performing to, take away objects that could become weapons, and ensure there is space, a clear exit for patient and staff, and enough staff nearby that no one is trapped. A visible but unthreatening staff presence signals that the situation is contained without becoming a confrontation. The **interpersonal** arm is the manner of the person who engages: one clinician leads so the patient is not surrounded by competing voices, keeping a calm posture and tone, respecting personal space, and avoiding threats, ultimatums and any display that reads as a challenge. The aim is not to win an argument but to lower the temperature.

Much of what settles an agitated patient is the acknowledgement of a real grievance and the meeting of an unmet need. A patient may be agitated because they are in pain, frightened, thirsty, needing the toilet, or waiting without information, and a clinician who listens, names the distress and offers realistic choices restores a sense of agency. Practical verbal measures that repay learning include:

- letting the patient speak and signalling that their distress has been heard;
- speaking simply and slowly, in short sentences, without jargon or threats;
- offering realistic choices so the patient keeps some control of what happens.

42.3 Offered medication: the collaborative step

When talking alone is not settling the patient but the situation is not yet an emergency of imminent harm, the next rung is medication offered and taken by consent. The distinction between medication a patient accepts and medication imposed on them is not a technicality; it is the whole difference between collaboration and coercion. A patient who takes an oral medication offered as relief from distress has not been overridden at all, and their autonomy is left intact. Offering the choice, explaining that it is there to help rather than to control, and where possible giving some say in the form, keeps the encounter therapeutic rather than adversarial.

The specific agents and doses at this step are clinical-protocol matters this section does not fix; the reasoning the examiner wants is the principle. Where a patient will accept oral medication, that acceptance is preferable to any imposed alternative even when the imposed alternative would act faster.

42.4 Rapid tranquillisation: calming under necessity

When de-escalation and offered medication have failed and the patient remains an immediate danger to themselves or others, this does not by itself authorise treatment without consent:

where the Mental Healthcare Act's emergency-treatment provision is satisfied, necessary parenteral medication may be given under that provision to bring the disturbance under control, subject to its professional, consent, seriousness, purpose and duration limits, and otherwise the applicable treatment-consent provisions continue to govern. This is **rapid tranquillisation**, and its purpose is precise and easily misstated. The aim is to calm the patient enough to reduce the risk and allow assessment and treatment to proceed; it is not to sedate them into unconsciousness. An answer that describes the goal as knocking the patient out has misunderstood the intervention and the standard it is held to.

Because it is a treatment imposed without consent, rapid tranquillisation carries the same requirement of justification as any coercive act: it is used only where it is necessary for safety and the less restrictive rungs have not sufficed. It also carries genuine physical risk, and a sedated patient cannot simply be left, because over-sedation must be caught early. In broad terms the responsible clinician attends to:

- the level of consciousness and the depth of sedation against what was intended;
- the airway, breathing and circulation, which sedation can compromise;
- the patient's basic physical observations until they have recovered.

The exact agents, doses, observation intervals and escalation thresholds are protocol specifics this section does not assert. The frame it does assert is a calming aim not an obliterating one, a necessity justification not a convenience one, and mandatory physical monitoring of a chemically sedated patient.

TRAP **Jumping to rapid tranquillisation or restraint as the first move.** Under the pressure of a violence scenario candidates skip straight to the injection or the restraint team, and the examiner reads that as not knowing the graded approach. De-escalation is the first line in every case and is what a correct answer opens with; medication offered by consent precedes medication imposed; and coercive measures are justified only by the failure of the less coercive ones and by a genuine risk of harm. Naming the top of the ladder first, or omitting the rungs below it, loses the marks the question is built around.

42.5 Physical restraint, and the outright ban on seclusion

Physical restraint, the manual or mechanical holding of a patient, is the most restrictive measure the law still allows and therefore the last rung on the ladder. It is used only when the measures below it have failed or are inadequate and a risk of harm cannot otherwise be contained. **Seclusion**, the supervised confinement of a patient alone in a room they may not leave, is a different matter: in India it is not a bounded last resort at all but is prohibited outright, so it never appears on this ladder. Physical restraint, by contrast, is not merely a clinical decision; it is bounded by statute, where the clinical answer and the legal answer meet.

IN INDIA

The Mental Healthcare Act **2017** governs restraint and seclusion, and it draws a hard line between them. Its section **97**, set out in full with the prohibited and restricted procedures elsewhere in this chapter, prohibits seclusion and solitary confinement of a person with mental illness altogether. Physical restraint alone is conditionally permitted, and only where it is the sole means available to prevent imminent and immediate harm to the person or to others, only when authorised by the psychiatrist in charge, kept time-limited and recorded, and never used as a punishment or for the convenience of staff. The clinical decision to restrain therefore lives inside a statutory frame; to seclude a patient at all, however well meant, is unlawful, and restraint that steps outside those bounds is unlawful as well as poor practice.

Translated into practice, those bounds mean physical restraint is chosen only when nothing less will do, kept to the shortest duration the danger requires, held under continuous review, and ended the moment the risk has fallen. The patient is not abandoned to the measure: their physical safety is observed throughout, and the episode, its justification, duration and review, is documented contemporaneously. Its justification lasts exactly as long as the harm is imminent, and no longer.

PITFALL

The characteristic real-world failure is physical restraint used for the ward's convenience rather than the patient's safety: to manage staffing, to quieten a disruptive but not dangerous patient, or as an unspoken sanction for difficult behaviour, then left in place longer than any imminent risk warrants and poorly recorded. Each of these steps outside the statutory limits, which permit physical restraint only to prevent imminent harm, only as the sole means available, and only time-limited and recorded. Reaching for seclusion is a failure of a blunter kind, because seclusion is banned outright and is never a lawful option to begin with. Using restraint where there is no imminent risk, or continuing it past the point of danger, converts a lawful safety measure into an unlawful one.

One further boundary should be named and not taught here. When the assessment of a violent patient turns up a specific and credible threat to an identifiable other person, the duties that may then follow, the questions of confidentiality and of any duty to protect a third party, belong to the Forensic ethics, consent and legal procedure notes.

42.6 The longer horizon: targeting the modifiable drivers

Why the second horizon carries the marks. Containing an acute episode does nothing about the reasons it happened; a patient calmed today who returns to the same drivers will be back tomorrow. Longer-term management is therefore a change of task, from containing disturbance to lowering the probability of recurrence. The lever is the distinction between the drivers of risk that cannot be changed and those that can: the historical, static factors anchor a patient's baseline, while the modifiable, dynamic factors are what a treatment plan works on. The full taxonomy of these factors is developed in the separate treatment of the risk factors for violence

in mental illness in these notes rather than rebuilt here, and longer-term management is in essence the systematic pursuit of the **modifiable risk factors**.

Treat	Address	Support	Structure
THE UNDERLYING ILLNESS	SUBSTANCE USE	ADHERENCE	THE FOLLOW-UP

Each of these targets a driver that can actually move. **Treating the underlying illness** comes first, because active symptoms are themselves dynamic drivers of risk, and the effective treatment of a relapsing psychosis or a manic episode removes one of the strongest levers on the patient's dangerousness. **Addressing substance use** matters because intoxication and dependence are among the most powerful modifiable contributors to violence; the clinical treatment of substance use disorders and the pharmacology of de-addiction are covered in the Substance use disorders notes, and a violence-reduction plan which ignores a patient's substance use has left its most tractable driver untouched.

Supporting adherence follows directly, because the treatment that lowers risk only does so while the patient is actually receiving it, and disengagement or covert non-adherence is often the first step back toward relapse and the risk that comes with it. Attending to the therapeutic alliance, to side effects that drive patients away from their medication, and to the practical barriers to staying in treatment is part of managing risk, not separate from it. **Structured follow-up** ties the rest together: assertive engagement, a clear care plan, the monitoring of the dynamic factors, and a crisis plan for the situations known to raise this patient's risk. Because the modifiable drivers change with time, the plan is reviewed rather than written once, and the structured risk assessment covered separately in these notes is the instrument through which that review is kept honest.

42.7 The record and the review

Two practices run through the whole of management and are examined as competence, not paperwork. The first is **documentation**: a coercive decision that is not recorded cannot be shown to have been justified, proportionate, time-limited or reviewed, and where each step overrides a patient's liberty the record is the evidence that the law's conditions were met. The second is the **post-incident review**. After a serious episode, the event is reviewed for the patient, whose experience of being restrained or sedated needs understanding and whose care plan may need revising, and for the staff, whose safety and learning bear on the next episode. A ward that manages violence well de-escalates first, coerces only within the law when it must, and learns from each event.

GOOD TO REMEMBER

Two habits separate safe management from lucky management. In the acute phase, your manner and the environment are the first instrument, not the prescription pad, and if you do sedate, keep watching the patient's breathing rather than assuming the job is done. The work does not end when the patient settles: review the episode with patient and staff, then turn the care plan to the drivers that can be changed, because that is where the next incident is prevented.

Manage the violent patient by climbing the least-coercive ladder first, de-escalation, then medication offered by consent, then rapid tranquillisation only to calm and not to sedate into unconsciousness, and physical restraint only as a lawful last resort to prevent imminent harm, seclusion being prohibited outright in India; then lower future risk by treating the illness, addressing substance use, supporting adherence and structuring the follow-up.

Cross-cutting synthesis

43 · Cross-cutting synthesis

Why this synthesis earns its own place. Every other section in this chapter teaches one rule and then closes; this one shows how those rules interlock. Read alone, the Mental Healthcare Act, the disability legislation, the narcotics law, the tests of criminal responsibility, the civil and family capacities and the assessment of violence risk look like a list of unrelated statutes a candidate must memorise in parallel. They are not unrelated. The chapter has two spines - the legislation a psychiatrist practises inside, and the questions a court puts from the outside - and a single construct runs the length of both and holds them together. That construct is **capacity**, and learning to see it is what turns a dozen separate topics into one subject.

The reason it matters for the marks, and for the ward, is that capacity is almost never the global, once-settled attribute that everyday language implies. It is asked of a particular decision, and it is asked at a particular time. The same patient, on the same afternoon, can have the capacity the law requires for one decision and lack it for another; and a person who lacked it a month ago may have it today. Miss either property and the whole architecture collapses into the error the examiner is watching for - reading one capacity off another, or fixing a person's capacity as a permanent fact of who they are. This section re-teaches no single test. It names each in a clause, cross-refers it to the topic that owns it, and then does the one thing no other section can: it lays the tests side by side so the shared logic shows.

Which decision?	Which moment?	Which forum?
CAPACITY IS DECISION-SPECIFIC	CAPACITY IS TIME-SPECIFIC	COURT, BOARD OR WARD

43.1 One construct beneath two spines

Set the chapter out as its architects did and the shape becomes easy to hold. The first spine is the mental health legislation a psychiatrist works within: the Mental Healthcare Act with its definition of illness and its consent, admission and review machinery; the Rights of Persons with Disabilities Act with its certification and guardianship; and the narcotics law. The second spine is the run of forensic questions a court asks from the bench: was the accused responsible for the act, is a person competent to make a will, a contract or a marriage, is the accused fit to be tried, and does this patient pose a risk the law must weigh. The two spines are usually taught, and examined, apart. What binds them is that every question on either spine is, when you reach its base, a question about whether a specified person could make a specified decision. The legislation asks it

in order to protect and to empower; the court asks it in order to attribute or to withhold responsibility. The asking is the same act.

Because the seam is a single construct, the sections interlock rather than merely sit next to one another. A treatment refusal on the ward and a disputed will in a civil court are the same question - can this person make this decision - wearing different robes. Once that is seen, the statutes stop competing for memory and begin to reinforce it: recall the seam, and each provision hangs off it in its proper place. The rest of this section develops the two properties that make the seam behave the way it does, lays the capacities on a common grid, walks a single case across the handoffs it must cross, and shows how one judgement is read differently depending on who receives it.

43.2 The same patient, several decisions

The first property is that capacity is **decision-specific**. It is not a global competence a person carries about with them; it attaches to the decision in front of them, and it can be present for one and absent for another at the very same moment. The Mental Healthcare Act's treatment-decision capacity asks only whether the patient can make the mental-healthcare choice at hand; it says nothing about whether the same patient can make a will. **Testamentary capacity** asks whether the person grasps the nature of the act of making a will and the claims they ought to weigh, a standard taught in full in this chapter's topic on will-making capacity. **Contractual capacity** asks whether, at the point of contracting, the person was of sound enough mind to understand the bargain and judge its effect on their interests, which is a different topic again. **Criminal responsibility** asks whether unsoundness of mind at the time of an act should excuse it. Each is its own test, owned and set out in its own place in this chapter; none is a proxy for the others.

That they can diverge in the same person is not arbitrary but structural, because each decision makes a different demand. A will requires a person to hold in mind the extent of their property and the people with a claim on it; a consent to treatment requires them to weigh a foreseeable benefit against a foreseeable harm over a shorter horizon; a contract requires them to appraise an exchange and its consequences for their own interests. A delusion that fixes on the natural beneficiaries of an estate may destroy the capacity to make a valid will while leaving the capacity to consent to an injection wholly intact, and a fluctuating confusional state may remove the capacity to weigh a complex financial bargain while leaving a simple, well-rehearsed treatment choice within reach. So the answer for one decision genuinely does not settle another, and an opinion that a person "lacks capacity", full stop, is not an opinion at all until it names the decision it is about.

43.3 The same decision, a specified moment

The second property is that capacity is **time-specific**. It is judged as at a moment, not for a lifetime, and the moment the law fixes on differs for different questions - which is the single most consequential distinction in the whole chapter. Treatment-decision capacity is assessed when the decision must actually be made, and reassessed as the patient's state changes, because a person too disturbed to decide on admission this week may be well able to decide on discharge the next.

The capacity to make a valid will is judged as at the time the will is executed; the capacity to contract as at the time of contracting. And the forensic pair pulls furthest apart on precisely this axis: criminal responsibility is judged as at the time of the act, while **fitness to stand trial** is judged as at the time of the trial, which may fall months or years later and in a quite different mental state.

That gap is where careful candidates separate themselves from careless ones. A man may have been floridly psychotic when he killed and have recovered entirely by the time he is arraigned: responsible-or-not is answered by his mind at the act, fitness by his mind in the dock, and the two answers can point in opposite directions without any contradiction between them. The mirror case is just as real - a person sane at the time of an act may become unfit to be tried through an intervening illness. Because capacity moves in time, every forensic and civil opinion is anchored to a date and to a decision, and an assessment reported without its moment is incomplete in exactly the way an assessment reported without its decision is.

43.4 The capacities on one grid

Laying the capacities on shared axes is the payoff of treating them as one subject rather than five. The grid below restates no test - each is taught where it is owned - but sets each against the same three columns: the decision it governs, the moment at which it is judged, and who puts the question and answers it. Read down any column and the family resemblance is plain; read across any row and the test's own distinctness is preserved.

CAPACITY IN ISSUE	THE DECISION IT GOVERNS	WHEN IT IS JUDGED	WHO PUTS AND ANSWERS THE QUESTION
Treatment-decision capacity	Consent to, or refusal of, mental-healthcare and treatment	When the decision must be made, and again as the state changes	The treating clinician under the Mental Healthcare Act, open to the Review Board
Testamentary capacity	Making a valid will	As at the time the will is made	A civil court, on the will-making standard
Contractual capacity	Entering a binding contract	As at the time of contracting	A civil court, on the soundness-of-mind standard
Criminal responsibility	Whether unsoundness of mind excuses the act	As at the time of the act	The criminal court
Fitness to stand trial	Whether the accused can take part in the trial	As at the time of the trial	The criminal court

The grid makes one lesson unavoidable, and it is the rule to carry out of this section.

RULE **Capacity is decision-specific and time-specific - it is asked of one decision at one moment, never of the person in general.** A finding for one decision does not carry to another, and a finding at one time does not carry to another. So an assessment is complete only when it names both coordinates: which decision it is about, and as at which moment it speaks. Anything shorter - "the patient has capacity", or "the patient lacks capacity" - is not yet an opinion the law can use.

43.5 The handoffs a single case crosses

A real case does not stay in one box; it hands the same person from one capacity question to the next, and often from one forum to another. Watching a single patient move through the chapter is the surest way to feel how the sections interlock in practice rather than only on a grid.

- An admission decision turns first on treatment-decision capacity: whether the patient can make the admission and treatment choice themselves decides whether they are admitted on their own request or through the supported route, a determination the Mental Healthcare Act governs and the Review Board can later be asked to examine.
- A capacity question can become a **guardianship** question: where the inability to manage one's affairs is enduring rather than momentary, the issue shifts from a single bedside decision to the appointment of someone to decide across a domain of life, under the disability legislation's limited-guardianship route or the general property-management machinery, each taught in its own place here.
- A criminal act raises two capacity questions at once: responsibility, fixed as at the time of the act, and fitness, fixed as at the time of the trial - the same accused, two separate inquiries that must not be run together.
- A consent-to-treatment moment can recur inside the forensic pathway: a patient found unfit, or detained after a verdict, still has treatment decisions to be made, and a treatment such as electroconvulsive therapy re-poses the consent-and-capacity question the Act governs, while the clinical technique of that treatment belongs to the ECT and neurostimulation notes.

TRAP **Answering the responsibility question with evidence of the trial-time state, or the fitness question with evidence of the state at the act.** The two inquiries share an accused and a diagnosis, so a candidate under pressure fuses them and describes the mental state at the one moment they can most easily picture. But responsibility looks back to the act and fitness looks to the courtroom now, and the states at those two moments can be wholly different. Keep the clock, not the person, at the centre: name which moment the question fixes on before you describe any mental state.

Two boundaries are worth marking as the case crosses them. When the forensic frame touches a child - a custody dispute, or a juvenile whose case raises a preliminary assessment - the governing child-protection statutes are named here and taught in the Child psychiatry: assessment, treatment, services and protection notes, and are not reworked as though they were insanity assessments. And when the criminal inquiry reaches the substantive law, currency is everything: the insanity provision candidates first learned in the Indian Penal Code has been recodified into the Bharatiya Nyaya Sanhita, and the older provision is historical wording for an act committed after the recodification took effect. It is not automatically superseded for an act committed before

that date, because the recodifying statute's own transition clause keeps the older provision live as the operative law for offences from before commencement. The synthesis does not restate either provision - it is owned by this chapter's topic on criminal responsibility - but it insists that the offence date, not the date of writing, is what decides which version is named.

GOOD TO REMEMBER

When a patient is about to cross from one of these questions to the next, write the opinion to the decision and the moment actually in issue, and resist the pull to answer the broader question you can see coming. A capacity opinion for consent to admission is not a fitness opinion and not a testamentary opinion; date it, name its decision, and let the next question be assessed on its own facts when it arrives.

43.6 One judgement, three readers

The seam runs through risk as well as through capacity. A single clinical judgement that a patient carries some degree of **violence risk** does not hold one fixed meaning; it is read differently by each forum that receives it, because each brings a different question and does a different thing with the answer. The risk factors and the structured and actuarial instruments that generate the judgement are taught in this chapter's risk-assessment topics; what the synthesis adds is that the same judgement is not the same fact to a court, to a Review Board and to a ward.

WHO READS THE RISK JUDGEMENT	THE QUESTION THEY BRING TO IT	WHAT THEY DO WITH IT
The criminal or civil court	Is this person a risk the law must act on	Disposal, detention or conditions on liberty
The Mental Health Review Board	For a supported admission, should the admission or readmission be permitted, or should discharge be ordered; for a restraint episode, has the establishment persistently and wilfully ignored the restraint limits	Permit the admission or readmission, or order discharge, on the specific admission-review route; or, for restraint, issue the separate desist order the Act provides. There is no free-standing power to vary a detention or restriction outside these named routes
The ward team	How are this patient and others to be kept safe now	The clinical management plan, bounded by the statutory limits on restraint and seclusion

The practical corollary is that a risk opinion must be written for the reader who asked for it. A formulation built to guide a ward's management plan is answering "what do we do now", and it is not, without more, an answer to the court's question of whether detention is justified or to the Board's question of whether a restriction remains proportionate. The judgement can be the same and its use quite different.

IN INDIA

Every capacity and risk question in this chapter is answered under an Indian statute and before an Indian forum, and the examiner marks the Indian provision, not the Western test it descends from. Treatment-decision capacity and the review of detention sit with the Mental Healthcare Act and its Review Board; guardianship with the disability legislation and its committee route or the general civil machinery; criminal responsibility and fitness with the recodified criminal law before the trial court. A technically correct English or American answer to an Indian question still loses the mark here, because the question is written to test the Indian route, not the ancestor it grew from.

PITFALL

The recurring real-world error is to let a single opinion travel beyond the question it was written for. A capacity assessment recorded once, undated and unqualified, is read months later as though it still held and covered a different decision; a risk note written for the ward is quoted to a court as if it settled the court's question; a superseded section is copied forward as current law. Each is the same mistake - an opinion detached from the decision, the moment and the forum that gave it meaning - and each reaches a real report, not merely an exam script.

43.7 The map to carry into the hall

The map, when memory fails. If the chapter blanks you under pressure, the fastest way back in is not to grope for a section number but to place the question on the map. Ask which of the two spines it belongs to, and then find the capacity beneath it. Almost every question this paper can set is a statute you practise inside, a question a court asks, or a judgement of capacity underneath both, and naming which one narrows the search until the owned detail surfaces. Even when the exact section will not come, the map gives you a structured stem to write around instead of an empty page.

MNEMONIC

Law inside, court across, capacity beneath

Rebuild the whole chapter from three phrases. **Law inside** is the legislation you practise within - the Mental Healthcare Act, the Rights of Persons with Disabilities Act and the narcotics law. **Court across** is the run of questions a court puts to you - responsibility for an act, competence to will, contract or marry, fitness to stand trial, and risk to others. **Capacity beneath** is the one foundation carrying both, because each of those is finally a question about whether a particular person, for a particular decision, at a particular time, could do what the law asked. Recall the two spines, then the foundation under them, and the chapter reassembles itself from memory.

That is the whole of the synthesis. The tests differ in their words and their forums, but they rhyme, because each is asking one question in a slightly different accent. Hold the question and the accents sort themselves.

Capacity is one construct seen from many benches - always ask which decision, at which moment, before which forum, and the chapter's dozen tests collapse into one question with a dozen answers.

Apply and consolidate

44 · Applying the chapter

Why this closer works you, not the page. You have met every statute and every test in this chapter on its own terms. A worked vignette does the one thing the separate topics cannot: it hands you a presentation with no label on it and asks you to find the legal question inside it, fix the moment at which that question must be answered, and give an answer you could defend to a court. That is precisely what the long case and the viva examine, and it is where otherwise prepared candidates still come undone, because reciting a provision and deploying it against messy facts are different skills that fail independently. Every vignette below runs the same four beats - a short presentation, the decision point it forces, the reasoning a candidate must show, and the answer - and between them they span the four kinds of question the paper builds its scenarios from. The sections, durations, cases and instruments the reasoning deploys are taught, and cited to their source, in the topics that own them; what these pages rehearse is the judgement that puts them to work.

Beneath all four questions sits a single construct, **capacity** - whether a particular person, faced with a particular decision, at a particular time, could do the thing the law asked of them. The four families the paper draws its vignettes from are best held as one set, so that each scenario arrives as a member of a family you already recognise:

- a decision under the mental health legislation about how a person who may be unable to consent is to be admitted and treated;
- a civil assessment of whether a person is competent to a specific act, such as making a will or entering a contract;
- a criminal question of whether unsoundness of mind excuses an act, or unfits a person for trial;
- and a formulation of the risk that a patient will be violent, with the management plan that must follow it.

Read each vignette for the capacity beneath its surface and the answer begins to organise itself.

44.1 How to work a forensic vignette

Before the cases, a word on method, because the order in which you attack a vignette decides whether you answer the question asked or a neighbouring one. The first move is always to identify which of the four questions you are being given, because both the material you deploy and the moment you fix follow from that identification and from nothing else. The second move is to fix the time at which the question must be answered - the time of the act, the time of the

will, the time of the trial, the present moment on the ward - because the same person can hold a capacity at one instant and lack it at another. The third is to apply the specific standard for that decision, not a global impression of the person. The fourth is to answer in the register the forum expects: a ward decision is defended by the statute and the least-restrictive principle, a court opinion by the evidence and the correct current citation.

RULE **Name the question, then fix the moment, before you reach for a section.** A vignette punishes the candidate who recites a provision before deciding which question is being asked. Identify the family the scenario belongs to, anchor the assessment to the exact moment the law cares about, and only then retrieve the standard and its citation. Do it in the other order and you will produce an accurate answer to a question you were not asked, which earns nothing.

Present	Decide	Reason	Answer
READ THE SCENARIO	NAME THE LEGAL QUESTION	FIX THE MOMENT, APPLY THE STANDARD	IN THE FORUM'S REGISTER

44.2 Vignette: an admission that will not be consented to

Presentation. A family brings a man in mid-life to the emergency room. For some weeks he has barely slept, has stopped eating, and believes his neighbours are poisoning the household water; today he has threatened to leave and confront them. He does not accept that he is unwell, and he refuses to remain.

Decision point. On what lawful basis, if any, may he be admitted and treated when he will not consent, and what stops that basis from becoming simple detention at the family's request.

Reasoning to show. First place the question: this is an admission decision under the mental health legislation, not a forensic one, and its pivot is the capacity to make the treatment decision, assessed for this decision at this time and not read off his diagnosis. If, on assessment, he retains that capacity, he cannot be held against his will merely because he is unwell or because relatives wish it; the statute's default and its stated preference is the independent route, but that route runs only on the person's own free request, so a capacitous person who refuses admission cannot be admitted as an independent patient at all. If instead his mental state means he cannot understand the relevant information, appreciate the reasonably foreseeable consequences, or communicate the treatment decision, the **supported admission** route opens - but only where the statutory criteria are also met, namely mental illness of a severity that requires inpatient care together with a likelihood of harm or of an inability to meet basic self-care, and it proceeds through his **nominated representative** rather than on the ward's say-so. Even then the admission is not a blank cheque: it is time-bound, it runs under the statutory review timetable, it is open to scrutiny by the review board, and it must be the least restrictive option that meets the need. What is said to the family throughout is the plan and its purpose in plain terms; the condition itself is not labelled to them.

Answer. He is not detainable simply for being ill. Assess his capacity for the treatment decision now; if it is present, he can be admitted only as an independent patient on his own free request, so a capacitous man who refuses is not admitted at all; if it is absent and the severity-and-risk

criteria are satisfied, admit by the supported route through the nominated representative, least-restrictively and under board oversight, and keep the independent route in view for the moment his capacity returns.

IN INDIA

The Indian mental health legislation replaced a custodial reception model with a rights-and-capacity one, and the machinery in this vignette is the visible proof of that shift. The nominated representative and the review board are the Indian statute's safeguards against exactly the family-driven, open-ended detention the old law permitted, and supported admission is its carefully bounded substitute for the reception order, a route the nominated representative applies for when a person has high support needs and the severity-and-risk threshold is crossed. Answer the Indian route, not a generic Western involuntary-admission framework, because that route and its safeguards are what the paper is testing.

44.3 Vignette: is she fit to change her will

Presentation. An elderly widow, cared for by one of her several adult children, asks whether she is fit to change her will in a way that would favour that child. She has a fluctuating cognitive disorder with clearly better and worse periods within hours of each other.

Decision point. Does she have the capacity to make this will, and at what moment is that capacity to be judged.

Reasoning to show. Place the question: this is a civil capacity assessment, and capacity here is both decision-specific and time-specific. **Testamentary capacity** is not global competence and it is not the capacity to consent to treatment; it is the specific capacity to make a valid will, resting on a sound disposing mind - broadly, that she grasps the nature and effect of making a will, has a workable sense of the property she is disposing of and of those with a claim on her provision, and that no disorder of mind is perverting that judgement. The full limbs and the standard are set out where this chapter teaches testamentary capacity; a vignette applies them to the facts rather than reciting them. Because the capacity the law fixes on is ordinarily judged at execution, her fluctuating disorder settles nothing by itself: she may make a perfectly valid will in a lucid interval at execution, and a recognised exception also validates a will where full capacity was present when she gave the instructions, the will faithfully embodies them, and at execution she still understands enough to know she is executing that instructed will, even without the full disposing mind at that hour. The presence of a diagnosis does not decide it, and the presence of the specific understanding at the specific moment does. Note too the assessor's independence, because an opinion is worth less if the assessor is the instrument of the interested child.

Answer. Assess the specific limbs at execution, the moment the law ordinarily fixes on, not her global state or her worst hour, and hold the recognised exception in reserve for a will faithfully drawn from instructions given in an earlier, fully capacitated interval. A fluctuating disorder is entirely compatible with a valid will made in a lucid interval, so the task is to establish and document the disposing mind at that moment. Whether she carries a diagnosis is not the question; whether she holds the capacity for this decision, now, is.

44.4 Vignette: responsible then, fit now, or neither

Presentation. A man is charged with a serious assault on a stranger. At the time of the act he was acutely psychotic and believed the stranger was about to kill him. Some months later, awaiting trial and only partially treated, he remains disorganised, cannot follow the charges, and cannot give his lawyer coherent instructions. The court asks for a psychiatric opinion.

Decision point. This is two questions wearing one presentation - was he criminally responsible at the time of the act, and is he fit to stand trial now - and the commonest failure is to answer one with the other.

Reasoning to show. Criminal **responsibility** is judged at the time of the alleged act: the question is whether unsoundness of mind then deprived him of the capacity the substantive provision requires, broadly the capacity to know the nature of what he was doing or that it was wrong or contrary to law. Which provision governs turns on the date of the alleged act: the recodified penal code applies to an act on or after the recodification's commencement, while the superseded penal-code section remains the live law, not mere historical origin, for an act before that date, because the recodifying statute's own savings clause keeps it in force for those earlier acts. The burden of proving the exception rests on the defence, under the recodified law of evidence for a proceeding not already pending when that law commenced, and under the historical evidence provision, likewise kept live by its own savings clause, for a proceeding that already was pending; the wording in both eras descends from the same historical common-law rules. **Fitness to stand trial** is a wholly separate capacity, judged at a different moment - the time of the trial - and it asks only whether he can now understand the proceedings and the charges, appreciate their consequences, and instruct his defence; it says nothing about his mind at the time of the act. The two run on separate clocks: a man may have been responsible, being well when he acted, yet be unfit now; or be presently unfit but, once treated, become triable for an act whose excusability is still an open question. Whatever is communicated to him and his family is done without labelling the condition to them.

Answer. Separate the questions and anchor each to its own moment. On responsibility, opine on his mental state at the time of the act against the substantive standard that applied on that date, state the alleged-act date because it selects the recodified provision or the superseded provision that its own savings clause keeps live for an earlier act, and place the burden on the defence under whichever evidence provision the proceeding's pendency at commencement in turn selects. On fitness, assess his present ability to understand and participate; as presented he is unfit now, so the live issue is restorability on a timetable the court sets. The trial waits for fitness; it does not answer, or replace, the responsibility inquiry.

TRAP **Answering the responsibility question with the fitness answer, or the reverse.** Because both turn on mental state and both arise in the same case, candidates collapse them into one opinion - concluding that a man too unwell to stand trial must therefore have been insane at the time, or that a man now recovered must have been responsible. They are two capacities at two moments on two clocks. Fix the time first, and the two questions come apart cleanly; skip that step and you will confidently answer the one the court did not ask.

PITFALL

The recurring real-world error on this material is one of currency: writing an opinion or a court report that cites the superseded penal-code insanity section, or the old evidence-law burden provision, as though it were still the live law after the substantive criminal statutes were recodified. The doctrine usually survives the slip almost unchanged, so the reasoning still reads soundly - but the citation does not survive, and an opposing advocate who spots a report resting on a repealed section can weaken the witness before a word of substance is heard. Confirm the provision is the one in force, then cite it.

44.5 Vignette: the threat on the ward

Presentation. An inpatient recovering from a psychotic relapse has begun making specific threats against a named member of staff. He has one documented serious assault during a previous untreated episode, uses a substance intermittently while on leave, and is poorly adherent to medication. The team is asked for a risk formulation and a plan.

Decision point. How to formulate the risk and what to do about it, without either over-detaining him or under-protecting the person he has threatened.

Reasoning to show. Place the question: this is a **violence risk** formulation, not a verdict that the man is dangerous as a fixed trait. The modern task is to separate the factors that cannot move from the factors that can. His past assault and his historical pattern are static: they raise the baseline and must be weighed, but no intervention changes them. The current threats, the untreated psychotic symptoms, the substance use and the non-adherence are **dynamic risk factors**, and they are the entire point of the exercise, because they are where management acts. The estimate itself is best organised by a structured professional judgment approach, which weighs history, present clinical state and future context together, rather than by an actuarial score read in isolation or by unaided clinical intuition; the specific instruments are taught where this chapter owns them and are applied here as the frame. Management then targets the dynamic column - treat the psychosis, address the substance use, restore adherence, adjust leave, and contain the immediate situation - and any physical restraint used in an acute moment is bounded by the statute's limits on that measure, not left to clinical discretion alone, while seclusion and solitary confinement are prohibited outright and have no such bound to work within. The threat against a named person also raises a duty to weigh that person's safety alongside the patient's rights.

Answer. Formulate by separating static from dynamic factors; estimate by structured professional judgment rather than a bare score or a hunch; and build a plan that moves the dynamic factors - treatment, substance-use management, adherence, graded leave - while keeping any acute restraint within the statutory ceiling. Document the reasoning, because a risk opinion is judged on the quality of its method, not the confidence of its conclusion, and reassessment is part of the plan because dynamic risk, by definition, changes.

GOOD TO REMEMBER

A risk formulation that lists factors but never says which of them can be moved is a description, not a plan. On the ward the whole value sits in the dynamic column, because that is the only column you can act on, and a plan is simply the set of interventions aimed at those movable factors plus the date you will look again. If your risk note reads the same after treatment as before it, you have written a character sketch, not a management plan.

44.6 Vignette: the certificate that changes audience

Presentation. An employer asks you to certify whether a patient, recovered from an illness that had kept him off work, is now fit to resume his duties. Midway through, the request expands: the same patient is now a complainant in a criminal matter, and his lawyer asks you for a report the court can rely on.

Decision point. Are these the same task, and are they both yours to perform.

Reasoning to show. They are two different certifications, with two different audiences and two different duties, and the examiner sets exactly this drift to see whether you notice the boundary. The fitness-to-resume-work certificate is an occupational-fitness judgement made for the employer, asking whether the person can safely and effectively perform the role, and it belongs to this chapter's civil-certification material. The report and certificate written for a court are a different instrument altogether, governed by the expert's duty to the court and by its own frame of consent, confidentiality and the form of expert evidence - and that material is owned by the Forensic ethics, consent and legal procedure notes, named here and deliberately not taught. The same discipline governs the other borders a forensic scenario can wander into: were the matter to turn on a child, whether custody or a juvenile in conflict with the law, the governing statutes belong to the Child psychiatry: assessment, treatment, services and protection notes, and the clinical management of any substance use belongs to the Substance use disorders notes. Knowing where your own certificate stops is itself an examined skill.

Answer. Sign the occupational-fitness certificate on its own criteria as this chapter's task, and do not let it slide into a court report, which is a distinct duty owed to a distinct audience and is the business of the Forensic ethics, consent and legal procedure notes. Where a scenario reaches into child law or the clinical side of substance use, name the boundary and cross-refer rather than answering with a neighbour's material.

44.7 The four domains on one grid, the thread, and the map

Set side by side, the vignettes make the chapter's architecture visible in a single view. Each turns on a different family of question, yet each resolves to the same underlying move - name the decision, fix the moment, apply the standard for that decision - so the grid below is less a summary than a demonstration that one habit answers all four.

VIGNETTE	DOMAIN IT EXERCISES	THE DECISION POINT	THE CAPACITY OR QUESTION BENEATH
The unconsented admission	Admission under the mental health legislation	On what lawful basis may an unwilling person be admitted and treated	Capacity to make the treatment decision, now
The changed will	Civil capacity assessment	Is she competent to make this will, and when is that judged	Testamentary capacity, at the moment of the act
Responsible then, fit now	Criminal responsibility and fitness to plead	Was he excused at the act, and can he be tried now	Two capacities at two moments on two clocks
The threat on the ward	Violence risk formulation and management	How to formulate the risk and act on it proportionately	Static versus dynamic factors, and where management can move
The certificate that changes audience	Boundary and scope discipline	Whose task is this, and where does my certificate stop	The duty owed and the audience addressed

The thread, one last time. Every vignette in this closer is, underneath, a capacity question, and capacity has two properties worth committing to memory above any single test. It is **decision-specific**, so a person may hold it for one decision and lack it for another at the very same moment, and one capacity never settles another. And it is time-specific, so it is anchored to a fixed instant and can be present today and absent a month ago, or the reverse. The forensic and civil standards differ in their words, but each is asking whether this person, for this decision, at this moment, could do what the law required of them; and once you see that, the messy presentation in front of you stops being a puzzle and becomes a place on a map you already hold.

MNEMONIC

Law inside, court across, capacity beneath

Rebuild the chapter from three phrases when a vignette empties your head. **Law inside** is the legislation you practise within - the Mental Healthcare Act, the Rights of Persons with Disabilities Act and the narcotics law. **Court across** is the run of questions a court reaches in to ask - was the accused responsible, is a person competent to will, contract, marry or stand trial, and is a patient a risk to others. **Capacity beneath** is the single foundation carrying both, because each is finally a question about whether a particular person, for a particular decision, at a particular time, could do what the law demanded. Place the scenario on the two spines, find the capacity under it, and the answer you could not summon cold usually surfaces on its own.

Every vignette in this chapter is a capacity question - name the decision, name the moment, and name the forum, and the answer is most of the way found.

45 · Consolidation

Why this closer exists. You have read the chapter; the marks come from being able to produce it with the book shut. Everything below is built for **active recall**, so every line is a question and not one of them prints its answer alongside - the instant your eye lands on the answer, the effortful retrieval that actually fixes a fact in memory is spent for nothing. Read each prompt, answer it aloud or on paper from memory, and only then turn back to the relevant teaching section to mark what you produced. If a prompt asks for a section number, a threshold, a case or an instrument, say the number, the case or the name; the whole point is that these pages withhold it.

One idea runs the length of this chapter and is worth holding as you revise: **capacity**. Whether the question is a treatment refusal, a will, a contract, a criminal charge or a fitness-to-plead inquiry, the law is finally asking whether a particular person could make a particular decision at a particular time. Keep that thread in view and the statutes stop looking like unrelated laws and become one subject seen from several benches. The prompts are grouped into the six areas the paper draws from, and a short set of discriminations and a master map close the chapter.

45.1 Working the prompts

Before the content, a word on method, because how you use a prompt list decides whether it does anything. Retrieval is not a test you sit at the end of revision; it is the revision. The act of hauling an answer out of an empty head is what lays down the memory, and it feels harder and less productive than rereading precisely because it is doing the work rereading does not.

RULE **Retrieve first, read second.** Treat every prompt as a closed-book question, commit to the fullest answer you can generate cold, and open the notes only to correct what you generated. Rereading a section you have already read builds fluency with the page, not access to the fact; the effortful, slightly uncomfortable pull of recall is the only part of the loop that actually consolidates. The discomfort is the signal that it is working.

Read	Retrieve	Check
THE PROMPT ONLY	THE ANSWER FROM MEMORY	AGAINST THE SECTION

TRAP **Mistaking recognition for recall.** A model answer read the night before feels obvious on the page, and that fluency is quietly misread as knowledge; in the hall, asked to produce the same answer from nothing, the candidate stalls. Recognising an answer when you see it and generating it when you cannot are different skills, and only the second earns marks. If a prompt feels too easy to bother answering, that is the illusion talking - answer it anyway, out loud, and find out.

IN INDIA

This chapter is Indian statute end to end, and the examiner marks the Indian provision, not the Western test it descends from. When a prompt asks for a rule, retrieve the Indian Act, the Indian certifying instrument and the Indian case law by name and, where you can, the section. A technically correct English or American answer to an Indian question still loses the mark, and the questions are written to catch exactly that substitution.

45.2 The Mental Healthcare Act

The largest statute in the chapter and the one that most rewards precise recall of definition, section and procedure. Answer each strand from memory in a sentence or two before you check.

1. State the definition of mental illness the Act adopts and the test by which a person is judged able to make a mental-healthcare decision; then walk the advance directive - who may make one, how it is revoked, and on what grounds it can be overridden - and say who the nominated representative is, how that person is appointed, and what duties the role carries.
2. Distinguish independent from supported admission with the discharge route and safeguards for each; recall the composition and functions of the review board and how it differs from the central and state authorities; and name the ways this Act breaks from the mental health law that preceded it, with the shift in philosophy behind the change.
3. Which provision decriminalizes attempted suicide, what presumption does it raise and on what conditions does that presumption rest; separate the prohibited from the restricted procedures and give the consent position for modified treatment that induces a seizure, including where the patient is a minor; and recall the statutory ceiling on restraint and seclusion together with the offences the Act creates.

45.3 The Rights of Persons with Disabilities Act and the National Trust

A rights-based statute with a benefits-and-certification machinery attached. The trap in this area is borrowing one certificate's instrument for another purpose, so keep the aim of each in view.

1. Recall the salient features of the rights-based disability statute and where mental illness sits among the disabilities it recognizes; then name the instrument and the authority used to certify disability due to mental illness and the threshold at which it becomes a benchmark disability.
2. State the benefits, reservations and guardianship that follow, and how limited guardianship departs from the older plenary model; then recall the National Trust route to guardianship and the local committee that grants it.

45.4 The narcotics law

Here the recall is of the law only; the de-addiction pharmacology behind these provisions belongs to the Substance use disorders notes and is not what the forensic paper is asking for.

1. Recall how the statute classifies controlled substances and the logic that scales its penalties from lesser to graver quantities.
2. State the treatment and de-addiction provisions and the immunity available to an addict who volunteers for treatment - and, crucially, the conditions on which that immunity depends, since an immunity quoted without its conditions is worth little.

45.5 Criminal responsibility and forensic assessment

The busiest forensic band and the one where currency of the law matters most, because the substantive criminal statutes were recently recodified. Retrieve the transition rule before the

provision: fix the offence date and the proceeding's pendency at the recodification's commencement, then select the saved or the new provision accordingly.

1. Recall the common-law rules that supply India's insanity standard and the limbs a defence must establish; then name the current substantive provision and the code that now houses it, the burden of proof and who bears it, and the older sections these replaced; and contrast the alternative tests of responsibility with the retained standard, saying why India keeps the narrower frame.
2. Distinguish fitness to stand trial from criminal responsibility by the moment at which each is judged, and recall the criteria and assessment of fitness; then define diminished responsibility and automatism and where each operates; and separate mens rea from actus reus with the legal senses of intent.
3. Recall the deception-detection techniques, the case that governs their admissibility, and the constitutional protection and the consent it demands; then recall the indicators of malingering and the approach to a suspected feigned illness; and recall the psychiatric issues that recur in homicide and filicide.

PITFALL

The commonest real-world error on this material is one of **transition logic**: citing the new penal-code provision for an offence that predates the recodification, or the new evidence-code burden provision for a proceeding already pending when the recodification commenced, without first checking what the repeal-and-savings clauses preserve. Confirm the offence date and the proceeding's pendency at commencement before you commit either to a report or to an exam script; an old citation is not wrong merely for being old, and a candidate who forgets the savings clauses and calls it wrong on age alone is the one making the error.

45.6 Civil and family capacity

Several distinct capacities and several distinct certificates crowd this band, and the marks go to keeping them apart. Each is capacity for a specific decision, judged at a specific time.

1. Recall the limbs of testamentary capacity and the standard of a sound disposing mind; then state when a contract is void for want of competence due to unsoundness of mind, distinguish this from a voidable contract arising out of defective free consent, and give the moment at which soundness is judged; and distinguish a marriage that is void or voidable for mental illness from a valid marriage dissolved by divorce on that ground, with the different statutes and the different thresholds each needs.
2. Recall how a psychiatric evaluation informs a child-custody decision, and the routes for guardianship and for management of the property and affairs of a mentally ill person; then separate the certifications that are easily conflated - disability certification, fitness to resume work, and compensation or pension - by purpose and instrument; and recall the psychiatric fitness assessment of prospective adoptive parents.

45.7 Violence risk and dangerousness

Modern forensic practice has largely replaced the older language of **dangerousness** with the language of violence risk, and the prompts track that shift, because a candidate who answers with the trait model rather than the risk model loses the mark the question is testing.

1. Explain how and why the field moved from labelling a person dangerous to assessing violence risk; then recall the principal structured professional judgment instrument and the way it groups its items, and the actuarial tools and the psychopathy checklist beside it, with the trade-off between actuarial prediction and structured clinical judgment.
2. Separate static from dynamic risk factors and recall the factors specific to mental illness; then recall the acute and the longer-term management of the violent and high-risk patient, and the statutory limits that bound any restraint decision you take.

45.8 The discriminations, the thread and the map

A small number of pairings account for most of the avoidable errors on this chapter. For each, the retrieval to rehearse is the distinction itself, not either definition, because the examiner sets these pairs precisely to see whether you can hold them apart under pressure.

DO NOT MERGE	THE DISTINCTION TO RETRIEVE
Prohibited and restricted procedures	Which category bars a procedure outright and which only gates it behind consent or permission, and what falls in each
Marriage nullity and divorce	Which route treats a marriage as never validly formed and which dissolves one that was valid, and the grounds each demands
Criminal responsibility and fitness to plead	Which is judged at the time of the act and which at the time of the trial
Disability, fitness-to-work and compensation certificates	Distinct purposes and distinct instruments; name the aim of each and never lend one certificate's instrument to another
Static and dynamic risk factors	Which shift with treatment and which do not, and why management targets the one it can move
Actuarial and structured clinical judgment	Which yields a probability by rule and which yields a formulation by guided judgment, and the trade-off between them

The thread, one last time. Every prompt in this closer is, underneath, a capacity question, and capacity has two properties worth committing to memory above all else. It is **decision-specific**: a person may have the capacity to make a will and not to run a business, so the answer for one decision never settles another. And it is **time-specific**: capacity can be present today and absent a month ago, or the reverse, so an opinion is anchored to a moment and not to the person for all time. The forensic and civil tests differ in their words, but each is asking whether this person, for this decision, at this moment, could do what the law requires of them.

MNEMONIC

Law inside, court across, capacity beneath

Rebuild the chapter from three phrases. **Law inside** is the legislation you practise within - the Mental Healthcare Act, the Rights of Persons with Disabilities Act and the narcotics law. **Court across** is the run of questions a court puts to you - was the accused responsible, is a person competent to will, contract, marry or stand trial, and is a patient a risk to others. **Capacity beneath** is the single foundation carrying both, because each of those is finally a question about whether a particular person, for a particular decision, at a particular time, could do what the law demanded. Recall the two spines, then the foundation under them, and the chapter reassembles from memory.

GOOD TO REMEMBER

If a legislation-or-forensic question blanks you in the hall, run the map before you panic. Ask which of the three it is: a statute I practise inside, a question a court asks, or a judgment of capacity. Placing the question on the map narrows the search and usually surfaces the section, the test or the instrument you could not summon cold, and even when it does not, it gives you a structured stem to write around rather than an empty page.

Every question in this chapter is a capacity question - name the decision, name the moment, and name the statute, and the answer is most of the way found.

Previously asked

There is no indexed past-question bank for this chapter, so nothing in the table below is a catalogued past question and no board or year is claimed for any of them. Attributing a paper the index does not hold would be a fabrication, so in place of a board of origin each row is marked Representative, and the questions are written in the register an examiner uses. Legislation and forensic psychiatry are examined heavily and in every form the paper allows, as long answers, as short notes and in the viva, so the list maps the examined spine of this chapter rather than one board's recent record. Read it as a high-yield revision map, not as a set of questions on record.

QUESTION	MARKS	ASKED
Enumerate the rights of a person with mental illness under the Mental Healthcare Act 2017, and discuss the capacity to make treatment decisions and the advance directive, including how an advance directive may be reviewed or overridden.	10	Representative
Describe the provisions for admission of a person with mental illness under the Mental Healthcare Act 2017, contrasting independent admission, supported admission up to thirty days, and supported admission beyond it.	10	Representative
Prohibited and restricted procedures under the Mental Healthcare Act 2017.	*5*	Representative
Decriminalisation of attempted suicide under the Mental Healthcare Act 2017 (section 115).	*5*	Representative
Composition and functions of the Mental Health Review Board.	*5*	Representative
Describe the salient features of the Rights of Persons with Disabilities Act 2016 as they apply to mental illness, and outline the procedure for certification of psychiatric disability.	10	Representative
IDEAS (Indian Disability Evaluation and Assessment Scale).	*5*	Representative
Immunity from prosecution for an addict who volunteers for treatment under the NDPS Act 1985 (section 64A).	*5*	Representative

QUESTION	MARKS	ASKED
Discuss criminal responsibility in mental illness. Explain the McNaughton rules and the insanity defence under the current Indian law (Bharatiya Nyaya Sanhita section 22), and outline the assessment of fitness to stand trial.	10	Representative
Testamentary capacity and the assessment of a sound and disposing mind.	*5*	Representative
Mental illness as a ground for annulment of a Hindu marriage, and the distinction between a void and a voidable marriage.	*5*	Representative
Structured professional judgement in violence risk assessment.	*5*	Representative

The shape of these questions is worth reading before their content. A ten-mark question that opens with enumerate or describe wants a structured map rather than a definition, and the marks are won on the discriminations this chapter turns on: the disjunctive three-limb capacity test, the boundary between supported admission up to thirty days and supported admission beyond it, the split between a prohibited procedure and a merely restricted one, and the difference between a marriage that is void and one that is voidable. A short note carries fewer marks but the same demand for the exact section and the exact modal verb, because shall and may are not interchangeable and a note that gives the wrong section number reads as a note that has not opened the Act. Legislation is the one part of this paper whose answer is checkable against a single primary text, which is precisely why the examiner rewards the candidate who cites the section and marks down the one who paraphrases it.

TRAP **An unasked topic is not a low-yield topic, and a dated citation is a wrong one.** The absence of a catalogued bank for this chapter is a fact about the index, not about what the examiner may set, and legislation is tested every year in one form or another. Two currency traps decide the criminal-responsibility answer. The substantive insanity exception is now Bharatiya Nyaya Sanhita section 22 and the burden of proof rests on Bharatiya Sakshya Adhiniyam section 108, both in force from 1 July 2024; the Indian Penal Code section 84 that older textbooks name carries word for word the same cognitive test but is the historical provision, and citing it as the current law dates the answer. Inside the Mental Healthcare Act the advance-directive override is section 11, not section 13, which is the professional-liability provision; and the Act's definition of mental illness is a different provision from the Schedule definition in the Rights of Persons with Disabilities Act 2016. Prepare the sections and the discriminations, not the past paper.

The quick review

One table, read down the left column and cover the right. Every line is taught in full somewhere above and nothing here is new: each is that provision's single must-hold line, the section number and its operative rule lifted from the passage that teaches it, so a line you cannot recover is a section to reread rather than a fact to memorise here. Modal verbs are load-bearing: where the statute says shall it is kept as shall and where it says may it is kept as may, because that difference often decides the answer. Current criminal law is stated as current, the Bharatiya Nyaya Sanhita and the Bharatiya Sakshya Adhiniyam in force for offences on or after 1 July 2024; the older Indian Penal Code position is kept only where a candidate must still recognise it as the historical provision.

ASK	HOLD
MENTAL HEALTHCARE ACT 2017: DEFINITIONS AND CAPACITY	
DEFINITION OF MENTAL ILLNESS (S.2(1)(S))	A substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, reality-testing or the ordinary demands of life; it INCLUDES conditions of alcohol and drug use and EXPRESSLY EXCLUDES mental retardation.
DETERMINATION OF MENTAL ILLNESS (S.3)	Determined by nationally or internationally accepted standards including the latest ICD, never by political, economic or social status or moral non-conformity; and s.3(5), a determination of mental illness is not the same as unsound mind unless a competent court so declares.
CAPACITY, THE THREE-LIMB TEST (S.4)	Every person is DEEMED to have capacity if able to understand the relevant information, OR appreciate the reasonably foreseeable consequences, OR communicate the decision; the limbs are disjunctive in the bare text, and a choice others think wrong does not by itself negate capacity.
ADVANCE DIRECTIVE AND NOMINATED REPRESENTATIVE	
ADVANCE DIRECTIVE, THE RIGHT (S.5)	Any person who is not a minor may make a written directive stating how they wish, and wish not, to be treated and who is to be nominated representative; it takes effect only once capacity is lost, and a later capacitous decision over-rides it (s.5(4)).
HOW AN ADVANCE DIRECTIVE IS OVERRIDDEN	Three separate routes, do not conflate: the maker's own later capacitous decision (s.5(4)); the maker's revocation or amendment at any time (s.8); and the Board machinery (s.11), where a mental health professional, relative or care-giver applies and the Board, after hearing all parties, may uphold, modify, alter or cancel it. The override is s.11, not s.13; s.13 is professional liability.

ASK	HOLD
NOMINATED REPRESENTATIVE, DEFAULT ORDER (S.14, S.17)	Where none is appointed the order is the directive-named individual, then relative, then care-giver, then a suitable person appointed by the Board, then the Director of Social Welfare; the duty (s.17) is supported decision-making, not substituted judgment.
RIGHTS, ADMISSION AND REVIEW BOARDS	
CORE RIGHTS (S.18 TO S.23)	Access to mental healthcare (s.18), community living (s.19), protection from cruel or degrading treatment with no compulsory tonsuring or forced labour (s.20), equality with physical illness including insurance parity, every insurer shall cover mental illness on the same basis (s.21(4)), information (s.22) and confidentiality with enumerated exceptions (s.23).
INDEPENDENT ADMISSION (S.85, S.86, S.88)	Admission should be independent wherever possible (s.85); a non-minor may request admission and self-discharge, treated only with informed consent (s.86); but an MHP may hold an independent patient up to twenty-four hours to assess for supported admission (s.88(3)).
SUPPORTED ADMISSION UP TO THIRTY DAYS (S.89)	On the nominated representative's application, examination by one psychiatrist plus one MHP or medical practitioner; LIMITED to thirty days; report to the Board within three days for a woman or minor and seven days for others; Board review only on application, not automatic pre-authorisation.
SUPPORTED ADMISSION BEYOND THIRTY DAYS (S.90)	Two psychiatrists examine independently, harm shown consistently over time (stricter than s.89 recently); Board review is MANDATORY, the Board within twenty-one days permits the admission or orders discharge; up to ninety days first, then 120, then 180 days each time.
MENTAL HEALTH REVIEW BOARD (S.73, S.74, S.82)	Constituted by the State Authority (s.73); chaired by a District Judge with a Collector's representative, one psychiatrist and one medical practitioner, and two members who are persons with mental illness, caregivers or NGO representatives (s.74); it registers or cancels directives, appoints representatives, decides admission appeals, and may impose a penalty up to five lakh rupees (s.82).
AUTHORITIES AND REGISTRATION (S.33, S.43, S.45, S.55)	The Central Mental Health Authority (s.33) registers Central-Government establishments (s.43); every State sets up a State Authority (s.45) which registers all other establishments in the State (s.55); each within nine months of assent.
TREATMENTS, RESTRAINT AND ATTEMPTED SUICIDE	
EMERGENCY TREATMENT (S.94)	Any registered medical practitioner may treat to prevent death, serious self-harm, harm to others or serious property damage, subject to the representative's informed consent where available; it shall not use electro-convulsive therapy; limited to seventy-two hours, extendable to seven days in a declared disaster.

ASK	HOLD
PROHIBITED PROCEDURES (S.95)	Absolutely barred: unmodified ECT (without muscle relaxants and anaesthesia, no exception), ECT for minors, sterilisation as a treatment for mental illness, and chaining in any form; the narrow gate (s.95(2)) allows ECT for a minor only with the guardian's informed consent AND prior Board permission.
RESTRICTED PROCEDURE, PSYCHOSURGERY (S.96)	Psychosurgery is not banned but restricted, permitted only on BOTH the patient's informed consent AND the Board's approval; contrast s.95, an outright ban with the single minor-ECT exception.
RESTRAINT AND SECLUSION (S.97)	Seclusion and solitary confinement are absolutely prohibited; physical restraint only when it is the sole means to prevent imminent harm and is authorised by the psychiatrist in charge, kept time-limited, never as punishment or for staff shortage, the representative informed within twenty-four hours and every instance reported monthly to the Board.
ATTEMPTED SUICIDE (S.115)	Two limbs. Notwithstanding section 309 of the Penal Code, a person who attempts suicide is PRESUMED, unless proved otherwise, to have severe stress and shall not be tried or punished (a rebuttable presumption, not a repeal); and the appropriate Government has a DUTY to provide care, treatment and rehabilitation to reduce recurrence.
GENERAL PENALTY (S.108)	First contravention up to six months or up to ten thousand rupees or both; a subsequent contravention up to two years or a fine of fifty thousand to five lakh rupees or both.
THE SHIFT FROM THE 1987 ACT	The Act repealed the Mental Health Act 1987, moving from a custodial licensing-and-guardianship model to a rights-based, capacity-based framework aligned with the UNCRPD; new are the capacity presumption, the advance directive, the nominated representative, decriminalisation of a suicide attempt, prohibition of unmodified ECT and the Review Boards.
RIGHTS OF PERSONS WITH DISABILITIES ACT 2016 AND DISABILITY CERTIFICATION	
PERSON WITH DISABILITY VS BENCHMARK DISABILITY (S.2(S), S.2(R))	A person with disability has a long-term impairment which, in interaction with barriers, hinders full participation, with NO percentage threshold; a person with BENCHMARK disability has not less than FORTY per cent of a specified disability, the gateway to reservation and scheme entitlements. The forty per cent attaches to benchmark disability, not to person with disability.
LIMITED GUARDIANSHIP (RPWD S.14)	A district court or designated authority may appoint a LIMITED guardian for joint, supported decision-making, in consultation with and according to the will of the person, for a specific period and decision, total support only where required; contrast the National Trust Act 1999 plenary guardian appointed by the Local Level Committee for its four covered conditions.

ASK	HOLD
CERTIFICATION OF DISABILITY (S.56 TO S.58)	The Central Government notifies the assessment guidelines (s.56); designated certifying authorities issue the certificate (s.57), now valid across the country (s.58(3)); for mental illness the notified tool is IDEAS.
IDEAS COMPUTATION	Score four items (self-care, interpersonal activities, communication and understanding, work) each 0 to 4 and sum to a Total; ADD a duration-of-illness weightage from 1 to 4 to get the GLOBAL score (0 to 20); it is the global score, not the item total, that maps to the band, and forty per cent (global 7, the Moderate band) is the welfare cut-off.
NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES ACT 1985	
NARCOTIC DRUG VS PSYCHOTROPIC SUBSTANCE (S.2(XIV), S.2(XXIII))	A narcotic drug is enumerated in the Act itself (coca leaf, cannabis, opium, poppy straw and all manufactured drugs); a psychotropic substance is one INCLUDED in the Schedule; small versus commercial quantity is fixed by Central Government notification, not by the Act.
IMMUNITY FOR ADDICTS WHO VOLUNTEER FOR TREATMENT (S.64A)	CONDITIONAL, every condition matters: an addict charged under s.27 or with a SMALL-quantity offence who voluntarily undergoes de-addiction at a Government-run or recognised institution shall not be liable to prosecution; it does not reach commercial-quantity offences, and the immunity may be withdrawn if he does not complete treatment (the bar is mandatory, the withdrawal discretionary).
RELEASE FOR TREATMENT (S.39, S.71)	A court may, with the offender's consent, release an addict found guilty under s.27 or a small-quantity offence for de-addiction instead of immediate imprisonment (s.39); Government may establish or recognise de-addiction centres (s.71).
CRIMINAL RESPONSIBILITY AND FITNESS TO STAND TRIAL	
INSANITY EXCEPTION, CURRENT LAW (BNS S.22)	Nothing is an offence done by a person who, at the time, by reason of UNSOUNDNESS OF MIND is incapable of knowing the nature of the act, or that it is wrong, or that it is contrary to law; in force for offences on or after 1 July 2024. It is word-for-word identical to the old Penal Code s.84, which survives only as the historical provision for earlier offences.
BURDEN OF PROOF FOR THE EXCEPTION (BSA S.108)	The accused must prove the exception on the balance of probabilities and the court presumes its absence; the prosecution's proof beyond reasonable doubt is not displaced. Current law, reproducing the old Evidence Act s.105.
M'NAGHTEN RULES (1843)	Presumption of sanity; the defence needs clear proof that, from a defect of reason due to disease of the mind, the accused did not know the NATURE AND QUALITY of the act, or, if he did, did not know it was WRONG. This cognitive right-wrong test is what BNS s.22 tracks.

ASK	HOLD
BROADER TESTS (NOT INDIAN LAW)	The ALI Model Penal Code adds a volitional prong (substantial capacity to appreciate wrongfulness OR to conform conduct); Durham is the product test (the act as the product of mental disease); irresistible impulse is a volitional gloss; Indian courts generally do not accept irresistible impulse unless it defeats knowing the nature or wrongfulness of the act.
DIMINISHED RESPONSIBILITY AND AUTOMATISM (INDIAN POSITION)	India has no general diminished-responsibility defence; the nearest partial defence to murder is grave and sudden provocation, reducing murder to culpable homicide not amounting to murder; automatism arising from a disease of the mind falls within the unsound-mind exception.
ACTUS REUS AND MENS REA	An offence ordinarily needs both a prohibited act and a guilty mind, and the two must concur; the insanity exception works by negating mens rea; strict-liability offences are the exception.
FITNESS TO STAND TRIAL (BNSS S.367, S.368)	When an accused appears of unsound mind and incapable of making his defence, the court first tries that fact on medical and other evidence and postpones proceedings, at the inquiry stage (s.367) or at trial (s.368); current law, corresponding to the old CrPC s.328 and s.329.
NARCOANALYSIS, POLYGRAPH, BRAIN MAPPING (SELVI, 2010)	Compulsory administration violates Article 20(3) against self-incrimination and Article 21 and amounts to cruel, inhuman or degrading treatment; no such test without consent, and even voluntary results are governed by the National Human Rights Commission 2000 guidelines.
MALINGERING	Intentional production or gross exaggeration of symptoms for an EXTERNAL incentive, a condition warranting attention rather than a disorder; detected by inconsistency, atypical or over-endorsed patterns, poor validity-test effort and collateral; distinct from factitious disorder, whose incentive is internal, the sick role.
HOMICIDE AND FILICIDE	Homicide by a person with mental illness is uncommon but over-represented in active psychosis and intoxication; filicide is classified by motive (Resnick: altruistic, acutely psychotic, unwanted-child, accidental and spouse-revenge); neonaticide, killing within the first day, links to denied pregnancy; postpartum psychosis is a high-risk context.
CIVIL CAPACITY: WILLS, CONTRACTS AND MARRIAGE	
TESTAMENTARY CAPACITY (SUCCESSION ACT S.59)	Every person of sound mind who is not a minor may dispose of property by will; an ordinarily insane person may make a will in a lucid interval; none can make a will while, from intoxication, illness or any cause, he does not know what he is doing.

ASK	HOLD
BANKS V GOODFELLOW (1870)	The sound-and-disposing-mind test in four limbs: understand the act of making a will and its effects, the extent of the property, and the claims of those who might expect to benefit, with no insane delusion perverting the disposition; a delusion that does not influence the will does not remove capacity.
CONTRACTUAL CAPACITY (CONTRACT ACT S.11, S.12)	Competence needs majority AND sound mind AND not being disqualified (s.11); sound mind for a contract is the capacity, at that moment, to understand it and form a rational judgment as to its effect on one's interests (s.12), a different test from the wills test.
MARRIAGE, THE VOID OR VOIDABLE ASYMMETRY	Same mental-capacity condition, opposite consequence. Under the Hindu Marriage Act a breach of s.5(ii) makes the marriage VOIDABLE (s.12(1)(b)), valid until annulled; under the Special Marriage Act a breach of s.4(b) makes it VOID (s.24). Do not collapse them.
MARRIAGE, THE DISSOLUTION GROUND (HMA S.13(1)(III))	A different provision from the formation defect: either spouse may seek divorce where the other is incurably of unsound mind or has a mental disorder such that the petitioner cannot reasonably be expected to live with them; the Explanation includes schizophrenia.
VIOLENCE RISK ASSESSMENT	
FROM DANGEROUSNESS TO VIOLENCE RISK	Not a fixed personal trait but a probabilistic, contextual judgment described by its nature, magnitude, imminence and frequency; the clinical task is risk assessment and management, not prediction of an attribute.
RISK FACTORS	Static and historical (previous violence, young age at first violence, male sex, childhood maladjustment) and dynamic (active symptoms, especially threat or control-override and command hallucinations, substance misuse, non-adherence, social instability); previous violence is the single strongest predictor, and risk concentrates in active psychosis with co-occurring substance use.
ACTUARIAL VS STRUCTURED PROFESSIONAL JUDGMENT	Actuarial tools score mechanically (VRAG-R, a 12-item actuarial guide); SPJ tools guide the clinician through empirically supported factors (HCR-20 Version 3, twenty factors across Historical, Clinical and Risk-management domains; START, a dynamic strengths-and-vulnerabilities measure); PCL-R rates psychopathy. Know the family and purpose; the items are proprietary.
MANAGING THE VIOLENT PATIENT	Graded: de-escalation first, then offered oral medication, and only if necessary rapid tranquillisation and time-limited restraint within s.97 (seclusion banned, restraint conditional); longer term, treat the illness, address substance use, support adherence and keep structured follow-up.

References

Every specific in this chapter is bound to one of the sources below, and the count is the number of claim rows each carried. 65 of those rows are statutory and were read at the primary Act on India Code or an equivalent primary text rather than from any textbook summary, because a stale or paraphrased section changes what a clinician is legally obliged to do. The substantive criminal-responsibility law was read at its current form (Bharatiya Nyaya Sanhita section 22 and Bharatiya Sakshya Adhiniyam section 108, in force 1 July 2024), with the historical Indian Penal Code section 84 named as the superseded provision. 79 row(s) are recorded at verified confidence and 12 at partial, the latter authored from established forensic and clinical knowledge and checked by the adversarial content pass rather than bound to a single primary quote. The must-have-papers cross-check was NOT performed for this Paper III chapter, because the paper lists do not yet exist in the intel index; for Paper III the topic bank plus the syllabus scaffolding is the completeness authority. This table records provenance, not proof: it says where each specific came from, not that the chapter's prose uses it correctly, which the content pass and the ship review test.

SOURCE	CLAIMS CARRIED
India Code, Ministry of Law and Justice (primary Act text)	**52**
Primary source (URL on file)	**16**
Indian Kanoon (primary Act and case-law text)	**13**
Standard forensic and clinical psychiatry (general construct, no single primary source)	**10**

PART VII

VII

Forensic Ethics, Consent and Legal Procedure

Consent, capacity and confidentiality as legal acts, and how a psychiatrist gives evidence and writes for a court.

01 Orientation: forensic ethics and the legal interface

02 Professional ethics, consent and confidentiality

03 Disaster, prisoners and forensic special topics

04 Forensic Indian statutes and legal procedure

05 Cross-cutting synthesis

06 Apply and consolidate

PAPER III

Forensic ethics, consent and legal procedure

Five bands . one complete notes document

Orientation: forensic ethics and the legal interface

1 · Orientation: forensic ethics and the legal interface

Why this chapter earns its marks. Almost every question in forensic and ethical psychiatry is, underneath, a question about a single person standing in two places at once. The same clinician who sits with a patient in the consulting room may later sit in a witness box and be asked to give an opinion that helps convict that patient, or a different one. These two positions do not merely differ in setting; they impose opposing duties, answer to different masters, and are governed by different rules about what may be said and to whom. The candidate who holds that tension steadily can reason their way through unfamiliar vignettes; the candidate who has only memorised isolated rules cannot.

This opening section is the chapter's **advance organizer**: the map you should carry in your head while you read everything that follows. It asserts nothing new of its own and teaches no section numbers. Its whole job is to give the later material a shape, so that each rule you meet later has a place to sit rather than floating free. The accompanying figure sets out the same structure visually; read it alongside this text.

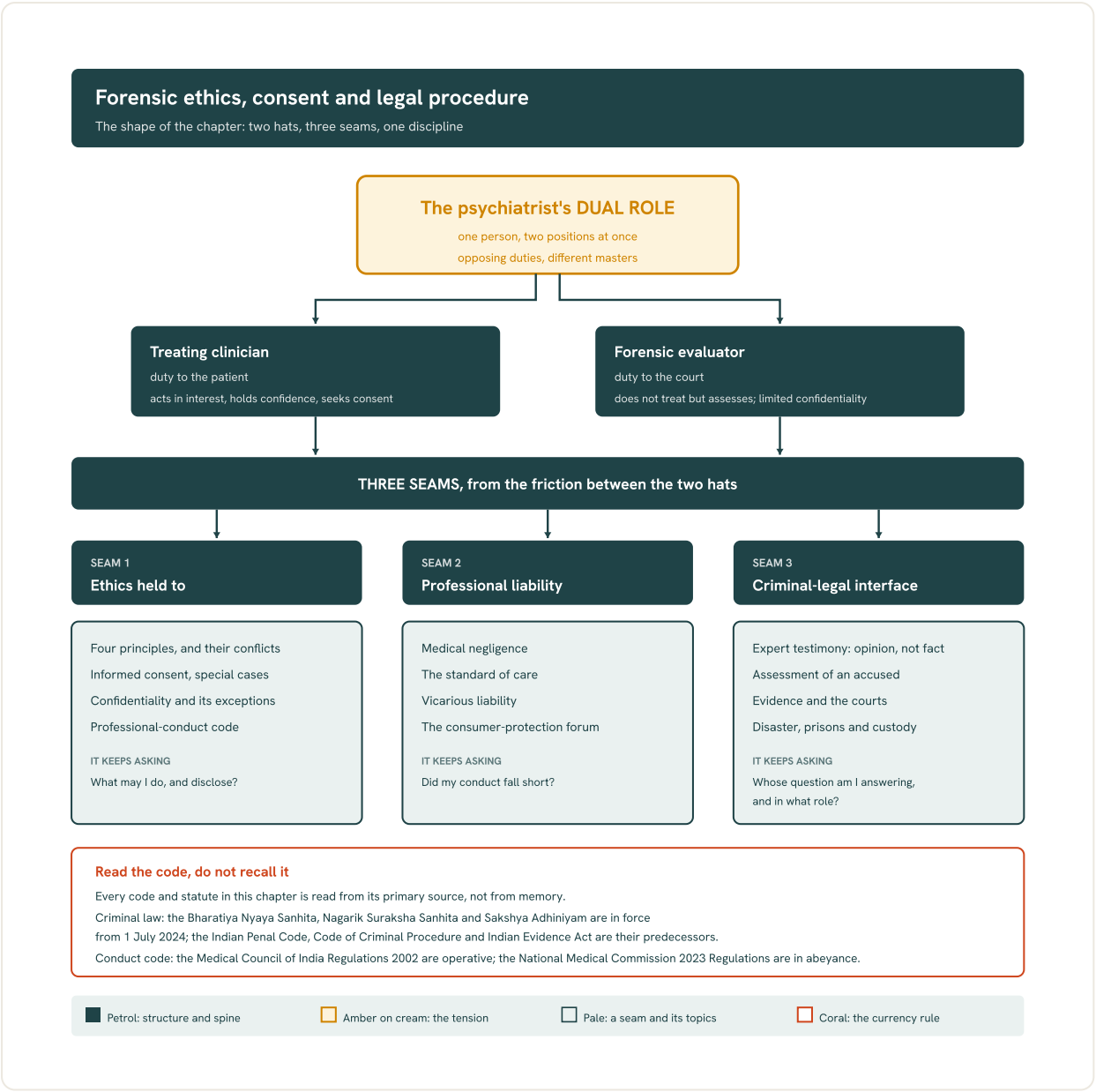


Fig 26.1. The chapter's architecture: one psychiatrist in a dual role, treating clinician on one side and forensic evaluator on the other, and from that friction three seams - the ethics held to, professional liability, and the criminal-legal interface - each read from its primary source with the law current as of 1 July 2024.

1.1 The two hats: the psychiatrist's dual role

The organising tension of this whole chapter is a **dual role**. In one role the psychiatrist is the **treating clinician**, who owes a set of duties to the patient in front of them: to act in that patient's interest, to hold their disclosures in confidence, to obtain their consent before acting. In the other role the psychiatrist is a **forensic evaluator**, who does not treat but assesses, and whose duty runs not to the person being examined but to the court that has asked the question. The forensic evaluator is not the person's doctor, owes them no therapeutic loyalty, and must say plainly, before beginning, that the ordinary clinical duty of confidentiality does not apply and that what is said may be set down in a report for whoever asked for the assessment.

Almost every controversy in the chapter is a friction between these two roles. The obligations that protect a patient in the first role become the very things a court needs the evaluator to set aside in the second. When a treating psychiatrist is dragged into a case about their own patient,

the two hats collide directly, and knowing which hat is being worn at a given moment is what tells you which duty controls.

MNEMONIC

Two Hats, Three Seams

The **two hats** are the treating clinician and the forensic evaluator. From that one tension follow the **three seams** the chapter is stitched along: the ethics a psychiatrist is held to, professional liability, and the criminal-legal interface. Hold the two hats and you can reconstruct the three seams; hold the three seams and you can place any rule the chapter teaches.

1.2 The first seam: the ethics a psychiatrist is held to

The first seam is the ordinary ethical scaffolding of practice, examined more strictly here because the forensic setting stresses it. It runs through the four principles of biomedical ethics and how they conflict; through informed consent and the special situations that complicate it; through confidentiality and, more importantly, the recognised grounds on which confidentiality may be broken; and through professional conduct under the statutory code and the profession's own code of ethics. The recurring exam move in this seam is to take a duty you think is absolute and show you its edge - the point at which a competing duty, or a statutory permission, lets it give way.

1.3 The second seam: professional liability

The second seam is what happens when practice is alleged to have fallen short. This is **professional liability**: the law of medical negligence, the standard of care against which a doctor is judged, the idea of vicarious liability for the acts of others, and the consumer-protection forum through which a patient can pursue a claim for a deficiency in medical service. The seam matters because it converts abstract ethical duty into concrete, enforceable consequence, and because candidates routinely underestimate how far the consumer-protection route reaches into medical practice.

1.4 The third seam: the criminal-legal interface

The third seam is where the psychiatrist meets the criminal justice system: as an expert witness whose opinion evidence must be kept distinct from fact evidence, in the assessment of an accused person, in the rules of evidence and the structure of the courts, and in the special settings of disaster, prisons and custody where a vulnerable population meets a coercive institution. This is the seam where the second hat is worn most consciously, and where the difference between treating and evaluating is not a nicety but the whole point.

SEAM	WHAT IT GOVERNS	THE QUESTION IT KEEPS ASKING
Ethics	Principles, consent, confidentiality, professional conduct	What am I permitted to do, and to disclose?
Professional liability	Negligence, standard of care, the consumer forum	Did my conduct fall below what was owed?
Criminal-legal interface	Expert testimony, assessment of the accused, evidence, custody	Whose question am I answering, and in what role?

1.5 One discipline throughout: the primary source and the currency problem

One habit binds the three seams together. Every code and statute in this chapter is read from its **primary source**, not from a summary or a remembered lecture, because this is precisely the ground that has been shifting under the profession's feet. Two live currency problems run across the whole chapter. The substantive criminal law has been recodified wholesale, so that the older penal, procedural and evidence statutes have given way to their successors, with a savings rule that decides which regime applies to a given case. And the professional-conduct code has its own complication: the long-standing Medical Council of India conduct regulations remain the operative code, while the successor National Medical Commission regulations, though formally notified, have been held in abeyance and are not operative pending a further notification. An answer written from memory of the old law, or from the assumption that the newest notified rule must be the live one, will be confidently wrong.

RULE **Read the code, do not recall it.** On this chapter the currency of the source is itself the examinable content. Name the statute you are relying on, confirm it is the version in force, and check the savings position before you apply it. The forensic seam punishes stale knowledge more than any other part of the syllabus.

TRAP **Citing the superseded criminal statutes as current law.** The Indian Penal Code, the Code of Criminal Procedure and the Indian Evidence Act read as the natural answers because they were the answers for a generation. After the recodification they are historical; the successor codes govern, subject to the savings rule. Candidates lose easy marks by naming the old statute by reflex.

PITFALL

The mirror-image real-world error is to treat the newest *notified* professional-conduct regulations as the live code. The newest notified regulations were themselves held in abeyance by a later amendment, which restored the earlier Medical Council of India code as the operative one, so that is the code a disciplinary body actually applies. Acting on the wrong code is a governance error, not merely an exam slip.

IN INDIA

This is an Indian statutory chapter, and its answers are Indian primary sources that differ from the Western textbook defaults: an Indian criminal law recently recodified, an Indian professional-conduct code with a live-versus-notified split, an Indian consumer-protection route into medical liability, and an Indian confidentiality regime that *permits* proportionate disclosure rather than importing a foreign duty to warn. Where a chapter topic has an Indian answer, that is the answer the examiner wants.

1.6 The edges of the map: what is named here and taught elsewhere

An advance organizer is as much about what lies outside the frame as inside it. Several bodies of law are touched by this chapter but owned by others, and are named here only so you know where they live:

- The Mental Healthcare Act machinery, the criminal-responsibility doctrine with its insanity-defence test and its burden of proof, the disability-rights and narcotics statutes, and the violence-risk instruments belong to the Mental health legislation and forensic psychiatry notes.
- The child-sexual-offences framework, the juvenile justice law and child custody belong to the Child psychiatry: assessment, treatment, services and protection notes.
- The clinical management of substance use in custodial and de-addiction settings belongs to the Substance use disorders notes.

Within this chapter, the material moves from the ethical foundations, through consent and confidentiality, into liability, and out to the criminal-legal interface and its special settings, before drawing the seams back together. Keep the two hats and the three seams in view and the sequence will read as one argument rather than a list.

Every duty in this chapter resolves to one question - what may be disclosed, to whom, and on whose authority - and the answer changes depending on which hat the psychiatrist is wearing.

Professional ethics, consent and confidentiality

2 · Principles of medical ethics (autonomy, beneficence, non-maleficence, justice)

The four principles are the grammar every ethical argument in medicine is written in. When a psychiatrist has to defend a decision - to admit a refusing patient, to withhold a diagnosis a family demands, to ration a scarce bed - the reasons that carry weight almost always reduce to four familiar considerations: the patient's right to decide for themselves, the duty to do them good, the duty not to harm them, and the duty to treat people fairly. These are not rules that dictate answers. They are the standing obligations a clinician must be able to name and weigh,

and an examiner who asks about medical ethics is asking whether the candidate can do that weighing out loud.

The marks here are for precision and for the hard part, which is conflict. Any candidate can list the four principles; the discriminating answer shows that they are separate obligations that routinely pull against one another, that none automatically defeats the others, and that resolving a real case is a matter of judged balance rather than a lookup. This account defines each principle at the depth the exam expects, then shows how they collide inside an ordinary psychiatric decision and how a defensible clinician reasons through the collision. The professional codes that translate these principles into enforceable conduct rules, and the specific law on consent, confidentiality and negligence, are each owned elsewhere in this chapter and are named here, not re-taught.

4

PRINCIPLES OF BIOMEDICAL ETHICS

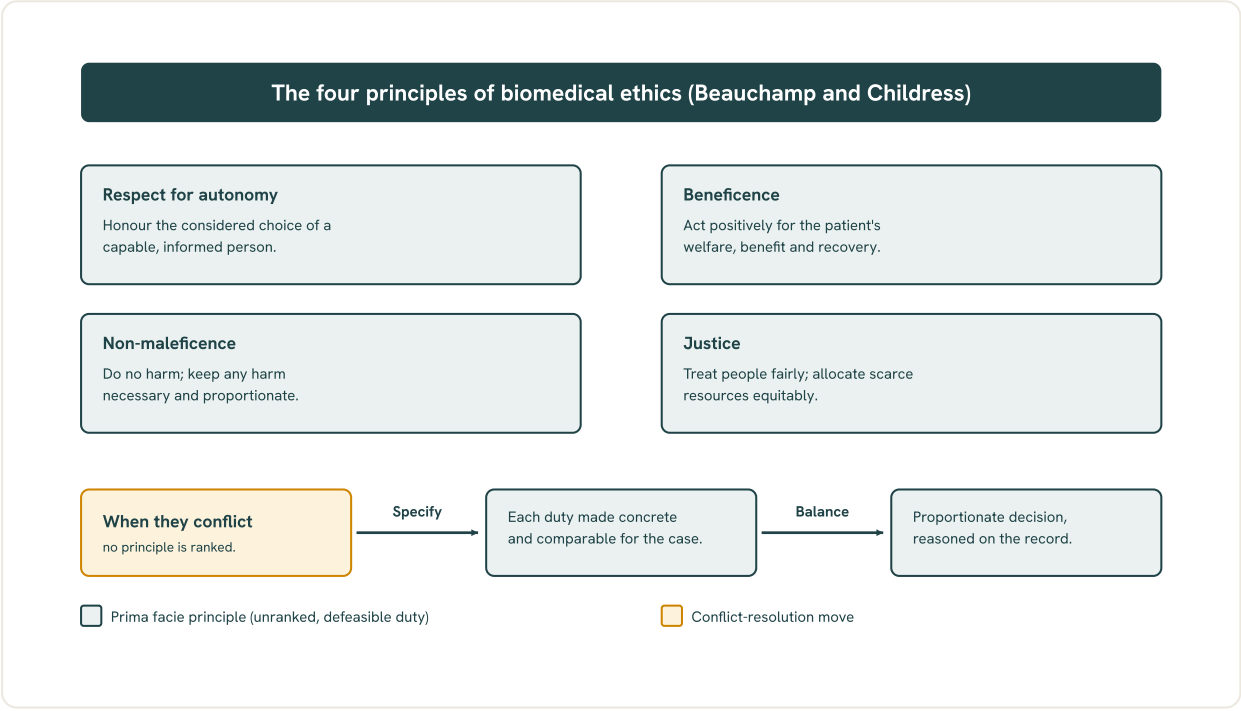


Fig 26.2. The four principles of biomedical ethics (Beauchamp and Childress) as unranked prima facie duties; at conflict, specify each then balance them into a proportionate, recorded decision.

2.1 The framework: four prima facie principles

The dominant framework in medical ethics is the four-principles approach set out by **Beauchamp and Childress**, who argued that a small set of general obligations, drawn from the morality that thoughtful people across traditions already share, can organise almost any clinical ethical problem. On this account there are **four** such obligations: respect for autonomy, beneficence, non-maleficence and justice. Their appeal is practical. They are neutral between the deeper moral theories a clinician may privately hold, so a consequentialist and a duty-based colleague can reason together in the same terms.

The single most important structural fact about the framework is that each principle is a **prima facie** obligation: it binds absolutely unless, in the particular case, it is outweighed by a competing obligation of equal or greater force. A prima facie duty is real and demanding, but it is defeasible. This is what separates the four principles from a code of commandments. There is no fixed ranking in which autonomy always beats beneficence, or non-maleficence always beats justice; the weight each carries is settled case by case. A candidate who writes that "autonomy is the highest principle" has misunderstood the model at its root, because a framework of prima facie obligations has no permanent highest.

MNEMONIC

A Bee Never Judges

The four principles of biomedical ethics: **A**utonomy (respect the capable patient's own choice), **Be**neficence (act for their good), **N**on-maleficence (do not harm), **J**ustice (treat people fairly and distribute resources justly). The phrase fixes the list; it deliberately encodes no ranking, because the framework sets none.

RULE **Each principle is a prima facie obligation with no fixed priority, so ethical reasoning is balancing, not ranking.** A principle can only be overridden by a competing principle that carries greater weight in the specific circumstances, and the clinician must be able to state which principle yielded to which, and why. An answer that resolves a dilemma by declaring one principle supreme has replaced the framework with a hierarchy the framework rejects.

2.2 Respect for autonomy

Respect for **autonomy** is the obligation to honour the considered choices of a person who is competent to make them. Its positive content is not merely leaving the patient alone; it is the duty to enable genuine self-determination - to tell the truth, to disclose what a reasonable patient needs in order to decide, to protect against coercion, and then to abide by the decision a capable person reaches, including a decision the clinician thinks unwise. Autonomy is the ethical engine behind the law of informed consent, whose elements, the assessment of decision-making capacity, and the special situations in which consent is complicated are set out in this chapter's account of informed consent and are not restated here.

Two clarifications earn marks. First, respect for autonomy presupposes capacity; it is a duty owed to a person who has the capacity to make the particular choice, so a decision made without that capacity is not an exercise of autonomy to be respected but an absence of it to be managed. The functional test for that capacity, and its statutory form under the Mental Healthcare Act, belong to this chapter's account of informed consent and to the Mental health legislation and forensic psychiatry notes, and are named here rather than stated. Where a patient lacks capacity, the clinician does not abandon autonomy but shifts to protecting the person's known will and preferences, a reframing the Mental Healthcare Act makes central and whose machinery belongs to the Mental health legislation and forensic psychiatry notes. Second, autonomy is not the same as getting whatever one asks for: a patient may refuse an offered treatment, but the right to

demand a treatment that is not indicated is not part of the principle, because the clinician's own duties of beneficence and non-maleficence remain in force.

2.3 Beneficence

Beneficence is the positive obligation to act for the patient's benefit - to prevent and remove harm, and to promote the patient's welfare and interests. It is the principle that makes medicine a helping profession rather than a merely technical one. In psychiatry beneficence is unusually demanding because the conditions treated can themselves impair the patient's ability to seek or accept help, so acting for the patient's good sometimes means acting before, or even against, what the patient currently says they want.

That is precisely where beneficence becomes dangerous, and the discrimination the exam wants is between beneficence and **paternalism**. Beneficence exercised over a capable patient's contrary wishes is paternalism, and paternalism is defensible only in narrow circumstances - broadly, where the patient's capacity for the decision is genuinely absent or compromised, and the benefit at stake is significant. When a clinician overrides a capable refusal in the name of the patient's own good, they have not applied beneficence cleanly; they have set beneficence against autonomy and must justify the trade. The habit of reaching for "it was in the patient's best interests" as though beneficence settled the matter is the commonest way this principle is abused.

> **PITFALL**
>
> Invoking beneficence to override a capable patient's refusal without ever naming the conflict. In real wards, "it is for their own good" is used to close a decision that the four-principles framework says is still open: acting for the patient's good against their competent choice is not beneficence operating alone, it is beneficence defeating autonomy, and it needs the higher justification that overriding a capable choice always demands. Clinicians who never notice they have made that trade drift into routine paternalism and cannot defend the individual decision when it is later questioned.

2.4 Non-maleficence

Non-maleficence is the obligation not to inflict harm, the principle behind the old maxim primum non nocere, first do no harm. It is often paired with beneficence, and in Beauchamp and Childress's own account the two are distinct obligations rather than two faces of one: beneficence requires positive acts to help, while non-maleficence sets a floor by forbidding acts that harm. The distinction matters because the two carry different stringency. The duty not to harm is generally the more stringent - a clinician is expected to refrain from harming everyone, always, whereas the duty to actively benefit is owed within the specific therapeutic relationship and is bounded by what is feasible and proportionate.

Non-maleficence has sharp teeth in psychiatry, where the treatments themselves carry real burdens: the metabolic and neurological costs of medication, the harms of seclusion and restraint, the stigma that a careless disclosure can cause. Because almost every effective intervention carries some risk of harm, the principle is not a prohibition on all risk but a demand that harm be necessary, proportionate to the expected benefit, and reduced to the least that

achieves the aim - the ethical root of the least-restrictive-option requirement that runs through mental health law. The professional liability that follows when a clinician causes harm by falling below the standard of care - the law of negligence - is the subject of this chapter's account of professional negligence and is named, not developed, here.

The framework also supplies the tool for the case where doing good and doing harm are inseparable: the doctrine of **double effect**, by which an action with both a good intended effect and a harmful foreseen one may be permissible only when strict conditions hold together:

- the act itself is good, or at least morally neutral, and not wrong in its own right;
- the harmful effect is genuinely not the aim but a tolerated side effect;
- the good effect is not achieved by means of the harm; and
- the good is proportionate to the harm risked.

It is the reasoning that lets a clinician offer a treatment whose necessary benefit comes with a foreseen burden, without thereby intending the burden.

2.5 Justice

Justice is the obligation to treat people fairly - to give each their due, to treat like cases alike, and to distribute the benefits and burdens of care equitably. It is the principle that looks beyond the individual consultation to the patient's standing relative to others, and it is the one clinicians are least trained to reason about, which is exactly why it is examined. In its distributive form, **distributive justice** governs how a genuinely scarce resource - an inpatient bed, a slot in a specialist clinic, staff time, a costly medication in a public system - is allocated when not everyone who could benefit can be served.

Justice in psychiatry carries an added weight because of the population served. People with mental illness are among the most likely to face discrimination, to be denied parity with physical health in funding and access, and to have their preferences discounted; a serious commitment to justice therefore includes non-discrimination and the protection of a vulnerable group's fair claim on care, not merely the arithmetic of dividing a resource. Fairness also has a procedural dimension: an allocation decision is more defensible when the criteria are explicit, consistent and applied without regard to a patient's social worth.

PRINCIPLE	CORE OBLIGATION	WHAT IT PROTECTS	SIGNATURE TENSION	PSYCHIATRIC APPLICATION
RESPECT FOR AUTONOMY	Honour the considered choice of a capable person	Self-determination, truth, freedom from coercion	Against beneficence when a capable patient refuses help	Consent to and refusal of treatment; enabling choice where capacity is intact
BENEFICENCE	Act positively for the patient's welfare	The patient's interests and recovery	Against autonomy; slides into paternalism if it overrides a capable choice	Treating a disorder that impairs the will to be treated
NON-MALEFICENCE	Do not inflict harm; keep harm necessary and proportionate	The patient's safety from iatrogenic harm	Against beneficence when the helpful act also burdens	Medication burden, seclusion and restraint, least restriction
JUSTICE	Treat people fairly and allocate resources equitably	Equity, non-discrimination, parity of the vulnerable	Against beneficence to the individual when the resource is shared	Bed and clinic rationing; parity for mental illness

2.6 How the principles conflict, and how a clinician resolves it

The framework earns its keep at the point of conflict, not in the list. Because each principle is prima facie and none is ranked above the rest, a real case can present two or more principles that cannot all be satisfied, and the framework does not resolve this by producing a winner from a formula. It resolves it by two disciplined moves. The first is **specification**: taking an abstract principle and making it concrete for the situation, so that "respect autonomy" becomes "abide by this patient's refusal of this medication given their intact capacity to make it", narrowing a vague obligation into one that can actually be acted on and compared. The second is **balancing**: weighing the specified obligations against each other in the particular circumstances to decide which should prevail here.

Balancing is not licence to prefer whichever principle the clinician favours. A defensible override of one principle by another should meet recognisable conditions: the overriding principle must have a realistic prospect of achieving its aim, no less restrictive action would achieve it, the harm to the overridden principle is the least necessary, and the balance of benefit over harm is proportionate. Set out this way, "I decided on balance" becomes an argument that can be examined and defended.

- **Specify each principle** for the actual patient and decision, so the obligations are concrete enough to compare rather than slogans.
- **Identify the genuine conflict** - which specified obligations cannot both be honoured - rather than pretending one principle simply does not apply.
- **Weigh them** against the conditions above: prospect of success, necessity, least infringement, proportionality.

- **Record the reasoning**, naming which principle yielded to which and why, because a balancing judgement is only as defensible as the account that can be given of it.

TRAP **Treating the four principles as a fixed hierarchy, usually with autonomy on top.** Candidates resolve a dilemma by asserting that autonomy always prevails, or that beneficence does, and stop. The framework is explicit that the principles are prima facie and unranked; the whole task is to show the specification and the balance, not to crown a winner. An answer that names a permanent top principle scores below one that shows two principles in genuine tension and reasons to a proportionate resolution.

2.7 The conflicts in a psychiatric decision

Psychiatry concentrates the classic conflict of medical ethics into its sharpest form, because the disorders it treats can impair the very capacity on which respect for autonomy depends. The signature tension is autonomy against the paired duties of beneficence and non-maleficence: a patient whose illness drives a refusal that threatens their health or safety. The clinician who simply defers to the stated wish may abandon a patient who cannot, in this moment, choose freely; the one who simply overrides it may trample a capable person's right to decide. The framework insists that the decision turns first on capacity - the hinge that determines whether there is an autonomous choice to respect at all - and that assessment, together with the legal thresholds for acting without consent, belongs to this chapter's account of informed consent and to the Mental health legislation and forensic psychiatry notes, and is applied here rather than re-derived.

The conflict rarely stays a clean two-way contest. Non-maleficence enters through the harms of the very interventions that beneficence recommends, so that admitting or medicating a refusing patient to do them good also imposes the burdens of coercion and side effect that the duty not to harm requires be minimised - which is the ethical source of the demand that the least restrictive effective option be used. Justice enters whenever the resource is shared: the bed given to one acutely unwell patient is a bed denied another, so beneficence to the individual is checked by fairness to the population. A mature answer to a psychiatric ethics question therefore does not pick a principle; it maps which principles are engaged, shows where they conflict, and reasons to a proportionate resolution that respects capacity, uses the least restriction, minimises harm and remains fair.

IN INDIA

Indian mental health law has taken a deliberately autonomy-forward turn, and the four principles have to be read in that light. The Mental Healthcare Act reframes the autonomy of a person with mental illness around their will and preferences and supported decision-making rather than around substitute judgement made over their head, and it embeds least restriction and non-discrimination as legal duties, not merely ethical aspirations - the statutory machinery for all of which belongs to the Mental health legislation and forensic psychiatry notes. Justice also bites harder in the Indian setting, where a public system serves large numbers with scarce inpatient and specialist resources and where parity for mental illness against physical illness is still being won, so distributive fairness is a live daily judgement and not a seminar abstraction. The principles are universal; their weighting in Indian practice is shaped by a statute that puts the patient's own will near the centre and by a resource reality that keeps justice in the room.

GOOD TO REMEMBER

When a case feels like an ethical knot, name the four principles for that specific patient before reaching for a conclusion: what does respecting this person's choice require, what would do them good, what would harm them, and what does fairness to others demand. The knot almost always turns out to be two of the four in genuine tension, most often autonomy against beneficence, with capacity as the hinge. Decide which principle should yield, choose the least restrictive way to honour the one that prevails, and write down the reasoning. A decision reasoned that way is far easier to defend than one reached by instinct and dressed up afterwards.

The four principles - respect for autonomy, beneficence, non-maleficence and justice - are prima facie obligations with no fixed ranking, so medical ethics is the balancing of principles that conflict, not the application of one that wins; in psychiatry the signature conflict is autonomy against beneficence and non-maleficence, turning on the patient's capacity, and the defensible decision is the one that respects a capable choice, does good, minimises harm, stays fair, and is reasoned on the record.

3 · Informed consent in psychiatry (elements, capacity, special situations)

Consent is where the patient's autonomy stops being an abstraction and starts governing what a doctor may lawfully do. Nothing a psychiatrist proposes, from a first prescription to admission to electroconvulsive therapy, is lawful merely because it is clinically indicated; it is lawful because the person it is done to has agreed, or because a specific legal exception has displaced the need for agreement. Informed consent is how that agreement is made real, and the examinable weight of the topic sits in its structure: what makes a consent valid rather than a formality, how the capacity to give it is judged, how much the patient must be told, and what happens where the ordinary rule cannot apply.

Marks are lost when a candidate treats consent as a signature on a form. The signed form is evidence that a conversation happened; it is not the consent, and a form signed by a patient who did not understand, was not free, or was not told what mattered is worth nothing in law. This

account sets out the three elements of a valid consent as the Indian courts define them, the standard of disclosure, the scope to which a consent is confined, the documentation the conduct code requires, and the special situations where consent is modified or displaced. Where the Mental Healthcare Act's own machinery governs, this account names the provision and points to the Mental health legislation and forensic psychiatry notes for its full working.

2008	3	19	4
SAMIRA KOHLI, THE INDIAN AUTHORITY ON REAL AND VALID CONSENT	ELEMENTS OF A VALID CONSENT: CAPACITY, VOLUNTARINESS, ADEQUATE INFORMATION	INFORMED-CONSENT REGULATION IN THE MOST RECENTLY NOTIFIED CONDUCT CODE	MENTAL HEALTHCARE ACT SECTION STATING THE STATUTORY CAPACITY TEST

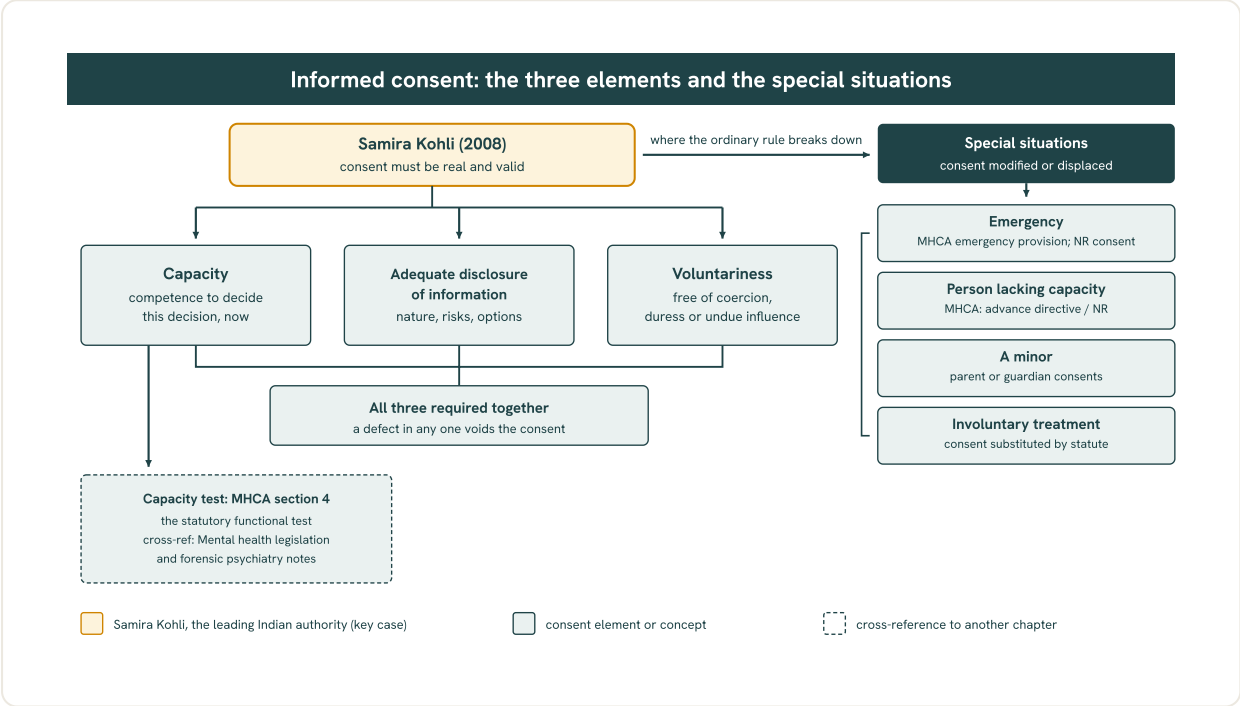


Fig 26.3. Informed consent has three cumulative elements - capacity, adequate disclosure of information and voluntariness - all required together for a valid consent (Samira Kohli, 2008), with a defined alternative for each special situation where consent is modified or displaced.

3.1 What informed consent is, and why the form is not the consent

Informed consent is a patient's voluntary, competent and informed agreement to a proposed procedure, given before it is begun. It rests on two footings that reinforce each other. Ethically it is the operational expression of respect for autonomy, the principle whose full treatment belongs to this chapter's account of the principles of medical ethics: a person has the right to decide what is done to their own body, and consent is how that right is exercised. Legally, treating a competent adult without valid consent is not merely poor practice but a wrong: it can found a claim in negligence where the failure lies in inadequate disclosure, and can amount to assault and battery where there was no agreement to the touching at all.

The conceptual correction to make early is that consent is a process, not a document. The conversation in which the clinician explains and the patient asks, weighs and decides is the consent; the signature merely records that it took place. A form can be exhaustive and the consent still invalid where the patient lacked capacity, was pressured, or was told nothing that

mattered, and a consent can be valid though its record is thin. The document protects the clinician evidentially but neither creates nor cures the underlying agreement, which is why the elements below attach to the patient's actual state of mind and freedom, not to the paperwork.

RULE **A consent is lawful only if it is real and valid, which means the patient had the capacity to decide, decided voluntarily, and decided on adequate information.** All three must be present together; a defect in any one voids the consent however well the other two are satisfied. The signature is evidence that consent was sought, not proof that it was valid.

3.2 The three elements: Samira Kohli

The Indian leading authority on what makes a treatment consent valid is **Samira Kohli**, decided in **2008**. The court held that a doctor must seek and secure the patient's consent before commencing treatment, and that the consent obtained must be real and valid. It then unpacked that phrase into **three** requirements that every candidate should be able to state and defend: the patient must have the capacity and competence to consent; the consent must be voluntary; and it must rest on adequate information about the nature of the treatment, so that the patient knows what they are agreeing to.

The value of the case is that it converts a vague ideal into a checklist that can be tested against the facts, with each element answering a different question. **Capacity** asks whether this patient, at this moment, can make this decision at all. **Voluntariness** asks whether the decision was the patient's own or the product of pressure. **Adequate disclosure** asks whether the patient was given enough to decide on. The three are cumulative and independent, and the following subtopics take each in turn.

MNEMONIC

Capable, Free, Informed, and Specific

A consent is valid only if the patient is **Capable** of deciding, decides **Free** of coercion, decides **Informed** by adequate disclosure, and the agreement is **Specific** to the procedure actually done. The first three are the elements of validity; the fourth is the limit on its scope, taken up below.

3.3 The first element: capacity to decide

Capacity is the ability to make a particular decision at the time it must be made, and three properties of it are examinable. It is **functional**: judged by the patient's actual reasoning about the decision in front of them, not by their diagnosis, their age, or how others rate the wisdom of the outcome. It is **decision-specific and time-specific**: a person may have capacity for a simple choice and lack it for a complex one, and may lack it in the morning and regain it by evening, so capacity is assessed for this decision now, never certified once for all purposes. And it is **presumed**: every adult is taken to have capacity unless the contrary is shown, so the burden lies on whoever asserts incapacity, and mental illness never by itself removes it.

The Mental Healthcare Act gives this a statutory form. At section **4** it provides that every person, including a person with mental illness, shall be deemed to have the capacity to make treatment decisions if they can understand the information relevant to the decision, appreciate the

reasonably foreseeable consequences of deciding or of not deciding, or communicate the decision, which is the Act's own disjunctive formulation. Two features of the statutory test are the ones candidates get wrong, and both matter directly to consent. The full working of the section, and how capacity interacts with advance directives, nominated representatives, admission and the review boards, belongs to the Mental health legislation and forensic psychiatry notes; what the consent doctrine needs from it is the functional standard and the discriminations below.

TRAP **A decision that looks wrong does not prove incapacity, and the statutory abilities are read disjunctively, not as a set all of which must be present.** Candidates infer incapacity from an unwise refusal, but a competent patient is entitled to make a decision others consider mistaken, and a choice perceived as inappropriate does not by itself negate capacity. The second error is to treat the statutory abilities as a conjunctive checklist; in the bare text of the Act they are joined by "or", and capacity is a rebuttable deeming rather than a hurdle the patient must clear.

3.4 The second element: voluntariness

Voluntariness means the decision was the patient's own, made free of coercion, duress and undue influence. It is the element most easily overlooked because it leaves no trace on a form, yet it is the one most often compromised in psychiatric settings, where the pressures are structural rather than crude. The test is whether the patient's choice was improperly controlled, not whether a consequence was mentioned: a patient pressured by a threat that refusal will be punished, or by a controlling inducement, may not be deciding freely even where no crude threat is spoken, whereas explaining a genuine clinical consequence of refusal, or offering a proportionate incentive, does not by itself negate voluntariness. Family pressure is a particular hazard in Indian practice, where treatment decisions are frequently made collectively and the identified patient may have the least voice in the room.

The clinician's task is not only to avoid applying pressure but to notice and, where possible, neutralise it: separating the consent conversation from any implied consequence, giving the patient a genuine and unpenalised option to decline, and staying alert to the difference between a family reaching a shared decision and a family overriding the patient's own. The distinction between a voluntary agreement and a merely compliant one is the distinction the law draws between a valid consent and an invalid one.

3.5 The third element: adequate disclosure and its standard

The third element asks how much the clinician must tell the patient, and here the Indian courts made a deliberate choice between two rival standards. One is the professional or **Bolam** standard, which measures disclosure against what a responsible body of skilled practitioners in the field would regard as normal and proper. The other is the patient-centred **Canterbury** standard, which measures it against what a reasonably prudent patient would want to know. In Samira Kohli the court adopted the former: the information a doctor must furnish to secure consent need not reach the more stringent degree required by the patient-centred approach, but should be of the extent accepted as normal and proper by a responsible body of skilled and experienced practitioners in that field, adjusted to the patient's condition and the treatment's risks.

The practical content of adequate disclosure follows from this: the nature and purpose of the proposed treatment, its risks and likely consequences, the reasonable alternatives including doing nothing, and enough about the illness for the choice to make sense. Two points sharpen it. The standard is not a licence to tell the patient as little as the profession can get away with; it sets a floor of what a responsible practitioner would disclose, and defensive minimalism does not meet it. And the measure is relevance to the decision, not exhaustiveness; a patient buried in every conceivable rare risk is no better placed to decide than one told too little.

AXIS	PROFESSIONAL STANDARD (BOLAM, REAL CONSENT)	PATIENT-CENTRED STANDARD (CANTERBURY)
THE QUESTION ASKED	What would a responsible body of practitioners disclose?	What would a reasonably prudent patient want to know?
WHOSE VIEWPOINT SETS THE MEASURE	The profession's accepted practice	The reasonable patient's information needs
RELATIVE DEMAND ON THE DOCTOR	Lower; the accepted and proper extent for the field	Higher; a more stringent degree of disclosure
POSITION ADOPTED IN INDIAN LAW	Adopted in Samira Kohli as the governing standard	Expressly not required to the stringent degree it sets

3.6 The scope of consent: specific, not general

A valid consent authorises only what it was given for. This is **specific consent**, and Samira Kohli states it with unusual clarity: consent given for a diagnostic procedure cannot be treated as consent for therapeutic treatment, and consent given for one specified treatment procedure will not be valid for conducting some other procedure. A patient who agreed to an assessment has not agreed to whatever the assessment reveals may be needed.

The court closed the obvious escape route as well. The fact that an unauthorised additional procedure turned out to benefit the patient, saved time or expense, or spared future suffering is no defence to an action in negligence or in assault and battery. Benefit does not backfill absent consent. For psychiatry the point bites wherever one intervention opens onto another; each step requires its own agreement, and the reasoning that "it was for the patient's good" is precisely the reasoning the court rejected.

> **GOOD TO REMEMBER**
>
> Treat consent as reopened whenever the plan moves beyond what the patient actually agreed to. If the working diagnosis, the drug class, the route, or the setting of care changes materially, consent afresh for the new proposal rather than reading the old agreement forward: a short documented second conversation is cheaper than defending an intervention the patient never agreed to.

3.7 Documentation and the conduct code

The professional-conduct code turns the doctrine into a documentation duty. The most recently notified conduct regulations set out informed consent at regulation **19**: before any diagnostic or therapeutic procedure or operation the registered medical practitioner should obtain the patient's

signed documented informed consent; where the patient is unable to consent, the consent of the legal guardian or a family member must be taken; an operation that may result in sterility requires the consent of both spouses; and assisted-reproduction procedures require the written consent of the female patient, the spouse and the donor. The modal verbs are not interchangeable and carry the marks: the practitioner should obtain the patient's consent, the guardian's consent must be taken where the patient cannot, and both spouses' consent is required for a sterilising operation.

A currency caution attaches to this. Whether the most recently notified regulations are the edition currently in force is a separate question, settled in this chapter's account of the professional-conduct codes; the operative professional-conduct code remains the earlier one, and the most recent regulations, though notified, were held in abeyance and are not yet in force. Both editions impose a documented consent duty, but the precise scope and wording of each edition's consent provision belong to this chapter's account of the professional-conduct codes; what matters here is that an answer presenting the most recent regulations as the live code states a currency that does not hold.

PITFALL

Citing the most recently notified professional-conduct regulations as the operative code. They were notified and then held in abeyance, and the earlier professional-conduct code remains the one in force; naming the newer set as live misstates the governing law even though the substance of the consent duty is largely unchanged. Name the provision actually in force, and defer any contested currency to this chapter's account of the professional-conduct codes rather than asserting it in passing.

3.8 The special situations

The elements describe the ordinary case; the marks cluster in the situations where the ordinary case breaks down. Four recur, and each modifies or displaces one element of consent rather than abolishing the requirement.

- **Emergency.** Where a patient needs immediate treatment to avert death or serious harm and cannot give consent, the practitioner should still try to obtain it, and if that is not possible must act in the patient's best interest and record the basis for doing so. Where the Mental Healthcare Act governs an emergency in a person with mental illness, the Act's own emergency-treatment provision supplies the rule rather than the general one: it requires the informed consent of the nominated representative where one is available, and attaches its own indications, time limit and excluded treatments; the full working of that provision belongs to the Mental health legislation and forensic psychiatry notes. The exception is necessity and is bounded by it: it authorises only what the emergency requires, not a general power to treat without agreement.
- **The person who lacks capacity.** Where an adult cannot give a valid consent, the most recently notified conduct regulations direct that the consent of the legal guardian or a family member be taken, subject to the currency caution above, and the decision must serve the

patient's interests rather than the convenience of others. Where the Mental Healthcare Act governs, a family member is not a generic substitute decision-maker: the advance directive carries the person's own earlier choice forward, and the nominated representative supports the person's decision-making and gives consent in their place only where a provision of the Act expressly says so; the full working of both belongs to the Mental health legislation and forensic psychiatry notes. Capacity being decision-specific and often fluctuating, the clinician should reassess it and return the decision to the patient once it is regained.

- **Minors.** A child below the age at which the law recognises a valid consent cannot give one, and consent is taken from the parent or legal guardian on the child's behalf, again in the child's interest. The statutory age thresholds and the child-protection framework, including the law on child sexual offences and juvenile justice, belong to the Child psychiatry: assessment, treatment, services and protection notes.
- **Consent under involuntary treatment.** Involuntary admission and treatment are precisely the situation in which ordinary consent has been lawfully displaced by a statutory framework, which substitutes its own safeguards, the nominated representative and independent review, for the patient's contemporaneous agreement, while the advance directive preserves the person's own earlier choice rather than replacing it. The mechanics of that framework belong to the Mental health legislation and forensic psychiatry notes, and its ethical frame to this chapter's account of the ethics of involuntary treatment and restraint; the consent point is that involuntary treatment is not consent-free but consent-substituted, and the safeguards are what police the substitution.

Consent to research, and the distinct criminal-law meaning of consent in sexual-offences law, are separate constructs treated in this chapter's accounts of the ethics of research and of sexual-offences law; each invokes the clinical elements set out here but adds rules of its own.

IN INDIA

The Indian consent doctrine is anchored in a single case and a statute a candidate should be able to pair. Samira Kohli supplies the three elements and the choice of the professional standard of disclosure over the more demanding patient-centred one, so an Indian answer asserting a Canterbury-level duty overstates the law. The Mental Healthcare Act supplies the statutory, functional capacity test and the framework under which consent is displaced in involuntary care, and the conduct code supplies the documentation duty. Together they make consent in Indian psychiatry a valid agreement properly recorded, with the statute governing the situations where agreement cannot be obtained.

TRAP **Reciting the three elements while omitting the special situations, or treating a signed form as conclusive proof of a valid consent.** The question on consent almost always turns on the hard case, the emergency, the incapacitated adult, the minor, the involuntary patient, so an answer that stops at capacity, voluntariness and disclosure has answered half the question. The paired error is evidential: producing a signed form as if it settled validity, when a form signed without capacity, freedom or adequate information is no consent at all.

A consent is lawful only if it is real and valid, meaning the patient had the capacity to make this decision, decided voluntarily, and decided on adequate information, and it authorises only the specific procedure agreed to; where the patient cannot give it, the emergency, the incapacitated adult, the minor and the patient under involuntary treatment each substitute a defined alternative rather than dispensing with the requirement.

4 · Confidentiality and its limits (duty to warn, Tarasoff)

Confidentiality is the promise that makes psychiatry possible. A patient tells a psychiatrist things they may never have said aloud, and does so only because they trust that what is spoken in the consulting room stays there. That trust is the working condition of honest disclosure, which is the raw material of every assessment and treatment decision, so the law and the professional codes treat confidentiality as a default duty the clinician owes, not a favour the clinician grants. The duty is not absolute, however, and the examinable heart of this topic is the exact shape of its limits: when the clinician may lift the veil, on whose authority, and how far.

Marks are lost in two opposite directions: one candidate treats confidentiality as sacrosanct and freezes when a patient names a person they mean to harm, another treats any hint of risk as a licence to broadcast the record. Both misread a rule that is conditional and whose conditions are specific. This account sets out the default duty, the principal grounds on which a disclosure is permitted, the American case that gave the world the language of a duty to warn, and the very different Indian position, in which a protective disclosure to an endangered other is permitted rather than commanded, alongside the separate mandatory-reporting duties that particular statutes impose in their own defined situations. Where the Mental Healthcare Act's own internal machinery is concerned, this account names the provision and points to the Mental health legislation and forensic psychiatry notes for its full working.

1976 TARASOFF, THE UNITED STATES ORIGIN OF THE DUTY TO PROTECT	**1998** MR X V HOSPITAL Z, THE INDIAN AUTHORITY ON PROTECTIVE DISCLOSURE	**23** MENTAL HEALTHCARE ACT SECTION, THE STATUTORY RIGHT TO CONFIDENTIALITY	**24** PROFESSIONAL-CONDUCT REGULATION ON CONFIDENTIALITY

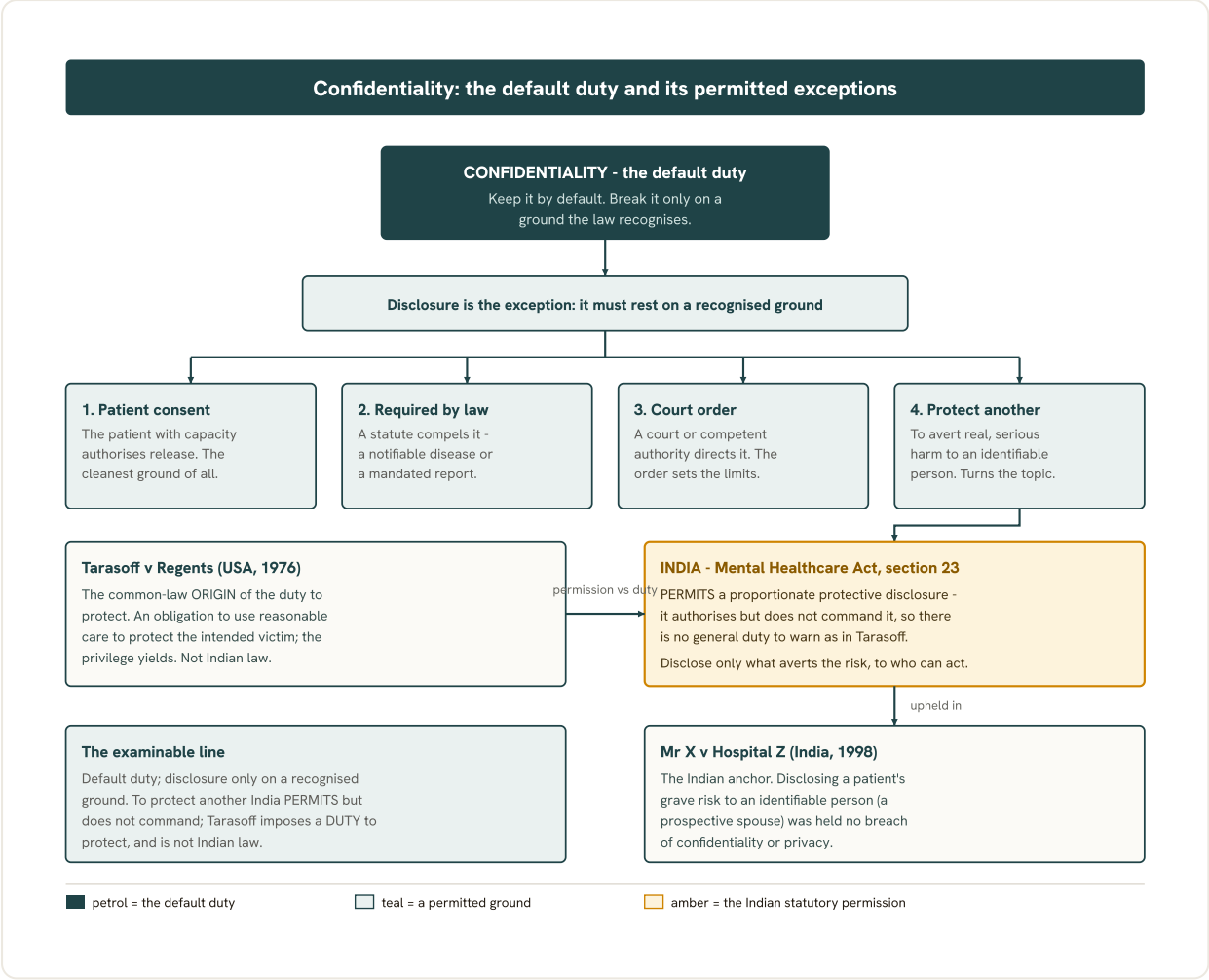


Fig 26.4. Confidentiality is a default duty that yields only on a recognised ground, principally consent, a requirement of law, a court order, or protecting an identifiable other, and for that last ground India permits but does not command disclosure, unlike the United States Tarasoff duty to protect the intended victim, with Mr X v Hospital Z holding a protective disclosure to a person at real risk no breach.

4.1 The default duty and where it comes from

At its core, **confidentiality** is the obligation not to disclose information a patient shares in the course of care to anyone outside that care without a justification the law recognises. It rests on more than one footing. Ethically it protects the patient's autonomy and privacy and secures the trust without which candour collapses; legally it is a duty imposed by both statute and the conduct code, and a serious breach can expose the clinician to complaint and to a civil claim.

Two sources give the duty its force in Indian practice. The statutory source is the Mental Healthcare Act, whose section **23** gives a person with mental illness a right to confidentiality over their mental health, mental healthcare and treatment, and places a corresponding duty on every health professional to keep that information confidential, subject to defined exceptions. The professional source is the medical conduct code. The most recently notified conduct regulations state the duty at regulation **24**: every communication between a practitioner and a patient shall be kept confidential and shall not be revealed except in stated circumstances. Whether that most recent edition is the one currently in force is a separate currency question, settled in this chapter's account of the codes of professional conduct; the duty is stated in the same mandatory terms across the editions and in the statute, so the doctrine does not turn on which edition governs.

One distinction should be fixed at the outset. Confidentiality is the clinician's ethical and statutory duty not to disclose. **Testimonial privilege** is a separate, courtroom creature: whether a clinician can be compelled to testify to what a patient said, and the rules that govern it. Both concern keeping a patient's words private, but they answer to different masters, confidentiality to the codes and the Act, privilege to the law of evidence. What the rules of evidence permit in the witness box is taken up in this chapter's treatment of the expert witness and the rules of evidence; the duty examined here is the clinical one.

RULE **Confidentiality is the default, and disclosure is the exception that must find a specific footing.** The clinician does not need a reason to keep a confidence; they need a reason the law recognises to break one. Every lawful disclosure must rest on a recognised ground, and a disclosure that cannot name its ground is a breach, however well meant.

4.2 When the veil may be lifted: the principal grounds

Because disclosure must justify itself, the circumstances that justify it form a defined set of recognised grounds, each carrying its own conditions. The conditions are where the marks sit, because collapsing a conditional rule to its headline is how a candidate loses the point. The principal grounds are these, and the Mental Healthcare Act's own statutory list of exceptions is fuller than this teaching set and is set out in the Mental health legislation and forensic psychiatry notes.

- **The patient's own consent.** A patient with capacity may authorise the release of their information, the first and cleanest ground of all. What consent requires, how capacity is judged and how special situations are handled are set out in this chapter's account of informed consent; here it is simply the ground needing no further justification once validly given.
- **Disclosure required by law.** Certain statutes compel a practitioner to disclose defined information, and where a law of the state requires the disclosure the duty of confidentiality gives way to it. The conduct code's own exception preserves exactly this, permitting a communication to be revealed where it is required by the laws of the state.
- **An order of a court or a competent authority.** A court or other authority empowered by law may direct the production of records or the giving of testimony, and confidentiality yields to a lawful order. The order defines and limits what must be produced; it is not a general waiver.
- **Protection of an identifiable other from serious harm.** Where withholding information would expose another person to a real risk to health or life, a proportionate disclosure to avert that risk is permitted. This is the ground the rest of the topic turns on.

MNEMONIC

Consent, Compulsion, Court, Caution

The principal grounds on which a confidence may lawfully be broken. **Consent** of the patient; **Compulsion** by a law of the state; a **Court** order or the direction of a competent authority; and **Caution** for an identifiable other in serious danger. A disclosure that fits no recognised ground has no footing and is a breach.

The last ground generates the hard cases and the examination questions, because it turns on judgement rather than on a document. It is available only when the danger is to an **identifiable other** and is serious, and even then it authorises only the disclosure necessary to avert the harm, made to the person who can act on it. It is a permission tightly bounded by proportionality, not a general waiver.

4.3 Tarasoff and the origin of the duty to warn

The vocabulary of a **duty to warn** entered clinical practice from a single American case. **Tarasoff**, decided by the California Supreme Court in **1976**, held that when a therapist determines, or under the standards of their profession should determine, that a patient presents a serious danger of violence to another, the therapist incurs an obligation to use reasonable care to protect the intended victim. The discharge of that obligation may require warning the intended victim, warning others likely to alert the victim, notifying the police, or taking whatever other steps are reasonably necessary in the circumstances. The confidentiality privilege yields to this duty: the protective purpose of the profession does not extend to guarding a patient's confidences at the cost of the intended victim's life.

The popular name understates the holding, and the discrimination is worth marking. The case did not create a narrow duty to send a warning; it created a broader **duty to protect**, of which warning is only one possible discharge. A therapist might protect the victim by warning them, by alerting someone able to warn them, by informing the police, or by intensifying treatment or arranging admission. Reducing the whole of it to a mechanical duty to warn shrinks a flexible standard of reasonable care into a single required act.

Two features of the case must travel with it into any Indian answer. First, it is United States common law, the decision of a state court, and it binds no Indian clinician; it is the origin of a concept, not a rule of practice here. Second, it frames a positive obligation, a duty the therapist incurs, which is a stronger thing than a permission to disclose, and it is on this second point that the Indian rule departs from it.

TRAP **Tarasoff is the United States origin of the duty to warn, not Indian law, and India permits protective disclosure without compelling it.** Candidates import Tarasoff wholesale and write that an Indian psychiatrist is under a legal duty to warn a third party. There is no such positive statutory duty in India. The Mental Healthcare Act's confidentiality section permits a proportionate disclosure to protect another; a permission is "may" and a duty is "shall", and the two are different laws. Answering with a duty where the statute gives only a permission loses the mark.

4.4 The Indian position: permission, not command

India has no case and no statute that imposes a Tarasoff-style positive duty to warn an endangered victim; what the law provides instead is a permission. That is a distinct question from the specific mandatory-reporting duties that particular statutes impose in defined situations, such as the reporting of child sexual abuse set out in the Child psychiatry: assessment, treatment, services and protection notes; those duties, where they apply, must be complied with on their own terms and are not displaced by anything said here. The Mental Healthcare Act's

confidentiality provision keeps confidentiality as the patient's right and the professional's duty, then lists the exceptions to it; among them is disclosure to protect any other person from harm or violence, releasing only the information necessary for that protection. The provision is permissive in character: it authorises the professional to make the protective disclosure and shields them when they do, but does not oblige them to make it. The full working of that section, its complete list of exceptions and the machinery around them, belongs to the Mental health legislation and forensic psychiatry notes and is named here rather than reworked; the point is the character of the provision, that it authorises and does not oblige.

The professional conduct code points the same way. Its confidentiality regulation allows a communication to be revealed where non-disclosure may itself be detrimental to the health of the patient or of another human being, again a permission to protect and not a duty to warn. Statute and code therefore converge on a single Indian rule: confidentiality yields to the protection of an identifiable other, but the yielding is discretionary and proportionate, exercised by a clinician who has judged the risk, not triggered automatically by the fact of a threat. A clinician who never discloses to protect an endangered third party may be criticised for poor judgement, but breaches no general duty to warn the victim, because Indian law imposes none; any separate mandatory-reporting duty a specific statute may create in a defined situation is a different matter and continues to apply on its own terms.

AXIS	TARASOFF (UNITED STATES)	MENTAL HEALTHCARE ACT CONFIDENTIALITY SECTION (INDIA)	MR X V HOSPITAL Z (INDIA)
SOURCE OF THE RULE	State supreme court, common law	Statute	Supreme Court judgment
LEGAL CHARACTER	A positive duty to protect	A permission to disclose	A holding that a protective disclosure was lawful
WHAT TRIGGERS IT	A serious danger of violence to another that the therapist determines or should determine	A need to protect any other person from harm or violence	A real risk to an identifiable person, a prospective spouse, from a life-threatening condition
EFFECT ON THE CLINICIAN	Must take reasonable steps to protect; the privilege yields	May disclose the information necessary to protect; the duty yields but is not compelled	The disclosure made was held not to breach confidentiality or privacy
WHAT IT DOES NOT DO	Does not fix one required act; warning is one option among several	Does not impose a duty to warn	Does not make privacy absolute, nor command disclosure in every case

4.5 Mr X v Hospital Z: the Indian judicial anchor

The Indian courts have addressed the limits of medical confidentiality directly, and the case every candidate should be able to name is **Mr X v Hospital Z**, decided in **1998**. A hospital disclosed a

patient's HIV-positive status to the woman he was about to marry. The court held that the disclosure violated neither the rule of confidentiality nor the patient's right to privacy, because the prospective spouse, an identifiable other, was thereby saved in time from a real risk to her health and life. The reasoning is the load-bearing part and repays exact memory: the right to privacy is not absolute and may be restricted to protect the rights, the health and the freedom of others.

Read carefully, the case supports the Indian permission and no more. It justified a disclosure that protected a specific person from a grave and avoidable harm; it did not announce a general duty on doctors to warn, nor make every disclosure lawful. Its principle is a limit on privacy, not an engine of disclosure: where a specific other faces a specific serious risk, protecting them is a legitimate reason to reveal what would otherwise be confidential. That is the same shape as the statutory permission and the protective ground in the general list.

IN INDIA

The Indian picture is coherent once its pieces are named: a statutory right to confidentiality with a protective exception in the Mental Healthcare Act, a professional conduct code that permits disclosure where silence would endanger the patient or another, and a Supreme Court holding that a protective disclosure to an identifiable person at real risk breaches neither confidentiality nor privacy. Nowhere in that picture is a positive duty to warn. The working rule for an Indian psychiatrist is therefore a permission exercised with judgement, not an American duty transplanted whole, and the difference between "may" and "shall" is what an answer must make explicit.

4.6 Making a protective disclosure well

Knowing that you may disclose is only the start; disclosing well is the harder part. Because the protective ground turns on judgement, the quality of the decision is what protects both the endangered third party and the clinician who acts. The organising idea is **proportionality**: the disclosure must be matched to the risk in its target, its content and its recipient, and no wider. The practical discipline runs as follows.

- Establish that the risk is to an identifiable person and is serious and real, not a vague unease that names no one.
- Prefer the least intrusive step that will actually avert the harm, whether intensifying treatment, arranging admission, or warning where a warning is what protects; escalation should track the danger.
- Disclose only the minimum necessary to the person able to act on it, not the whole clinical record and not to an audience wider than protection requires.
- Record the reasoning as it is made: the risk assessed, the options weighed, the ground relied on, and what was disclosed to whom. The contemporaneous note is what distinguishes a considered protective disclosure from a careless one.

GOOD TO REMEMBER

When a patient names a person they intend to harm, the move is neither silence nor a broadcast. Confirm that the threat is serious and the target identifiable, choose the least intrusive step that will actually protect them, disclose only what that step needs to whoever can act on it, and write down why. The defensible position is the proportionate one, and the record is what makes it defensible.

PITFALL

Treating a justified risk as a licence to empty the file. Once a clinician has decided that a protective disclosure is warranted, the temptation is to hand over the entire history to be safe, or to tell more people than need to know. The permission is to reveal what is necessary to avert the specific harm, to whoever can act on it, and no further; a disclosure wider than the risk requires is itself a breach, even where a narrower one would have been entirely lawful. Over-disclosure and non-disclosure are opposite failures of the same judgement.

4.7 The other direction of flow: the right to information

Confidentiality governs what leaves the consulting room about the patient, and it has a mirror-image companion governing what must reach the patient. The Mental Healthcare Act's section **22** gives a person with mental illness, together with their nominated representative, a right to information: about the provision under which they are admitted and its criteria, their right to seek review of that admission, and the nature of the illness and the proposed treatment plan with its known side effects, all in a language and form the person can understand. The complete machinery of this right, like that of the confidentiality right, belongs to the Mental health legislation and forensic psychiatry notes; it is named here to complete the picture.

The two rights are complementary rather than opposed. The patient is entitled to be told the truth about their own condition and care, and entitled to have what they disclose held in confidence. Confidentiality is not secrecy from the patient; it is the protection of the patient's information from the world outside the care they have entered, coupled with candour toward them within it.

Confidentiality is the default duty and disclosure the exception: it is lawful on a recognised ground, principally the patient's consent, a requirement of law, an order of a court or competent authority, or the protection of an identifiable other from serious harm, and even then only so far as the risk requires. Tarasoff is the United States origin of the duty to warn and does not bind Indian practice; in India the Mental Healthcare Act's confidentiality section permits, but does not command, a proportionate protective disclosure, and Mr X v Hospital Z holds that such a disclosure to an identifiable person at real risk is no breach.

5 · IPS code of ethics (Cuttack 1989)

A psychiatrist in India answers to two written standards of conduct at once, and they are not the same kind of thing. One is the profession's own **code of ethics**, drawn up by psychiatrists for

psychiatrists, which states the ideals the discipline holds itself to. The other is the statutory **professional-conduct code** made under the law that governs the medical register, which carries the disciplinary machinery and can end a career. The examiner who sets a question on the Indian Psychiatric Society code is really testing two things: whether the candidate knows the profession's own code and its history, and whether the candidate knows which statutory code is actually in force, because that second fact reversed itself recently and a great many textbooks now print the wrong answer.

This topic therefore has an unusually high yield relative to its size. The substance a candidate must carry is small and quotable, but it sits on a moving legal floor. The professional code is an ethical and professional standard; the statutory code is the enforceable one, and it has changed on paper without yet changing in force. Getting the currency right is the single discriminator between a safe answer and one that confidently states a regulation that does not operate. The underlying principles this code applies, the four principles of biomedical ethics, are set out in this chapter's account of the principles of medical ethics and are named here rather than relisted.

1989	2 Aug 2023	23 Aug 2023	2002
THE IPS CODE OF ETHICS APPROVED AT CUTTACK	THE 2023 REGULATIONS NOTIFIED	HELD IN ABEYANCE, DAYS LATER	THE MCI CODE THAT IS CURRENTLY OPERATIVE

5.1 Two codes, two kinds of force

The first discrimination to hold is between a professional code and a statutory code, because candidates blur them and the blur costs marks. A professional code of ethics is issued by a professional body to its own members; it articulates the standards the profession aspires to and expects, and it educates and guides more than it punishes. A statutory professional-conduct code is subordinate legislation made under the statute that regulates the medical profession; it defines misconduct and attaches consequences to it, and a breach can lead to erasure from the register. The two are not rivals. The professional code supplies the moral content and the statutory code supplies the enforceable floor, and in practice a serious breach of the profession's own ethics will usually also be a breach of the statutory conduct rules the regulator can act on.

For psychiatry the distinction has extra bite, because psychiatric practice raises ethical problems the general codes handle only thinly: consent where capacity is in question, confidentiality where a third party may be at risk, treatment that may be given against a patient's stated wishes. A discipline-specific code exists precisely to speak to these, which is why the Indian Psychiatric Society drew up its own rather than resting on the general medical code alone.

5.2 The Indian Psychiatric Society code and Cuttack, 1989

The Indian Psychiatric Society appointed a committee to prepare a code of ethics specifically for psychiatrists practising in India, and that code was approved at the Society's annual conference held in **Cuttack** in **1989**. This is the foundational Indian psychiatry-specific code of ethics, and its significance is as much symbolic as textual: it marked the point at which Indian psychiatry set down a written ethical standard of its own. For the examination the year and the place are the memorable pair, and they are the part most reliably asked.

The code is not a static document. What began at Cuttack has been revised and republished by the Society since, so the version a clinician reads today is the descendant of that original text rather than the original itself. The examinable spine is the lineage: a psychiatry-specific ethical code, originated by an IPS committee and adopted at Cuttack, which the profession has kept current. The content that follows is drawn from the Society's current published statement of that code.

IN INDIA

The IPS code sits alongside, not instead of, the statutory conduct rules that bind every registered medical practitioner. A psychiatrist is a doctor first, so the general professional-conduct code applies in full; the IPS code adds the discipline-specific ethical detail the general code cannot supply. Where the IPS code speaks of confidentiality, it is careful to tie the duty to the law of the land, which in Indian mental-health practice means the framework taught in the Mental health legislation and forensic psychiatry notes. The code guides the psychiatrist's conduct; the statute and the regulator supply the consequences.

5.3 What the code asks of the psychiatrist: the Fourteen Codes

The current published form of the code sets out the psychiatrist's duties as **fourteen** numbered codes. They do not need to be memorised verbatim, but a candidate should be able to reproduce their shape, because they map neatly onto the principles this chapter teaches elsewhere and onto the consent and confidentiality duties taught in their own fragments here. The core duties the code lays down are these:

- **The patient comes first.** The patient's care, well-being and best interests are the paramount consideration for the psychiatrist, which is the code's governing clause and the one everything else serves.
- **Competent, dignified care.** The psychiatrist provides competent care while respecting the humanity, dignity and autonomy of the person, so that skill and respect are held together rather than traded off.
- **Valid informed consent.** The psychiatrist acts to establish valid, informed consent with people living with mental illness; the elements of that consent and its special situations are taught in this chapter's account of informed consent in psychiatry and are not reworked here.
- **Professionalism and conflicts of interest.** The psychiatrist maintains professional standards, which includes recognising and managing conflicts of interest rather than pretending they do not arise.
- **Confidentiality within the law.** The psychiatrist upholds the patient's right to confidentiality, but expressly within the provisions the law of the land prescribes; the default duty and its permitted exceptions belong to this chapter's account of confidentiality and its limits.
- **Ethical research.** Research is conducted ethically and under the oversight of ethics committees or institutional review boards, a duty this chapter's account of the ethics of research develops in full.

- **No exploitation of the relationship.** The psychiatrist upholds the sanctity of the doctor-patient relationship and does not exploit it for personal, social, business or sexual gain, which is the code's firmest prohibition and the seam it shares with the topic of boundary violations.

Read together, the codes are less a checklist than a description of a trustworthy psychiatrist: one whose skill is placed at the patient's service, who seeks genuine agreement, who guards what is told in confidence, and who never turns the relationship to private advantage. That last duty, against **exploitation** of the relationship, is the one the code states most absolutely, and it is worth carrying as the code's moral centre.

5.4 The statutory code and the currency trap: 2002 operative, 2023 in abeyance

Here is the fact that decides the mark. The professional-conduct code currently operative for Indian doctors is the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, commonly abbreviated the MCI 2002 code after the Council that made it. It is tempting to assume the newer instrument has replaced it, and the newer instrument does exist: the National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations, 2023 were notified by the Commission on 2 August 2023 and were to come into force from the date of their publication in the Official Gazette. On the face of the notification, the 2023 Regulations looked like the new code.

They did not survive the month. On 23 August 2023 the Commission held the 2023 Regulations in **abeyance** with immediate effect, clarifying that they would not be operative or effective until a further Gazette notification, and in the same instrument it re-adopted and made effective the Indian Medical Council 2002 Regulations. The net position is precise and counter-intuitive: the 2023 code is notified but suspended, and the 2002 code is the one that governs conduct today. A candidate who writes that the NMC 2023 Regulations are the current professional-conduct code is stating a regulation that does not operate.

RULE **The operative statutory professional-conduct code is the MCI 2002 Regulations; the NMC RMP 2023 Regulations are notified but held in abeyance and are not in force.** The 2023 Regulations were notified and were to commence on Gazette publication, but the Commission suspended them within weeks and re-adopted the 2002 Regulations with immediate effect. Until a further Gazette notification revives the 2023 code, conduct is judged against the 2002 code. State the 2002 code as live and the 2023 code as notified-but-in-abeyance; do not present the 2023 Regulations as the current law.

TRAP **Naming the NMC 2023 Regulations as the code in force.** Because the 2023 Regulations were formally notified and are widely reported as the new ethics code, candidates and even recent textbooks cite them as operative. They are not: they were held in abeyance days after notification and remain suspended pending a further Gazette notification, while the 2002 MCI Regulations were re-adopted and are the code actually applied. The examinable point is not the content of either code but the currency: the newer, notified instrument is dormant and the older one governs.

5.5 Professional misconduct and graded discipline

Even though it does not currently operate, the suspended 2023 code repays study as a proposed framework, though its future operative form is uncertain: a further Gazette notification could revive, amend or replace it. Its treatment of misconduct is exam-friendly. In that code, professional misconduct is defined broadly at Regulation **37**: any violation of the Regulations, or of other applicable Acts relating to medical practice in force, shall constitute professional misconduct. The definition is deliberately open-ended, so that conduct need not be separately itemised to be actionable; a breach of the conduct rules is itself the misconduct.

The consequences are graded rather than binary. The 2023 code arranges disciplinary action across **five** levels, running from exoneration through a reformative warning and fixed periods of suspension of increasing length up to permanent debarment from practice. This graduated structure matters clinically: the regulator's response is meant to be proportionate to the gravity of the breach, so a first, minor lapse and a serious, repeated one do not attract the same sanction. A separate provision addresses criminal conviction: where a practitioner is convicted of a cognizable offence involving **moral turpitude**, that conviction may result in suspension of the licence to practise.

> **PITFALL**
>
> Reading conviction as automatic erasure. The provision on a cognizable offence involving moral turpitude says such a conviction may result in suspension, not that it must; the sanction is discretionary and sits within the graded scheme, not outside it. Telling a colleague that any conviction ends the registration overstates the rule and misreads the modal verb. A conviction opens the disciplinary process and permits suspension; it does not, of itself, strike the name off.

5.6 How the two codes bind together

The profession's code and the statute's code are two faces of one duty. The IPS code tells the psychiatrist what good practice looks like; the statutory conduct code is the instrument through which failures of that practice are called to account. A psychiatrist who exploits the therapeutic relationship, for instance, breaches the IPS code's firmest prohibition and, at the same time, commits professional misconduct the regulator can act on. The moral standard and the enforceable standard converge on the same conduct from different directions, which is why a candidate should be able to move between them: cite the IPS code for the ethical content and the statutory code for the consequence.

AXIS	IPS CODE OF ETHICS (CUTTACK LINEAGE)	STATUTORY PROFESSIONAL-CONDUCT CODE
WHO ISSUES IT	The Indian Psychiatric Society, for psychiatrists	The statutory medical regulator, for all registered practitioners
NATURE	Professional and aspirational; discipline-specific	Subordinate legislation; enforceable
PRIMARY FUNCTION	Guides and educates on ethical practice	Defines misconduct and attaches sanctions
CURRENCY	Originated at Cuttack, kept current by the Society	MCI 2002 Regulations operative; NMC 2023 Regulations in abeyance
CONSEQUENCE OF BREACH	Professional and reputational; feeds the statutory process	Graded action up to erasure from the register

GOOD TO REMEMBER

When a conduct question arises in real practice, ask two questions in order. First, what does good psychiatric ethics require here, for which the IPS code and the four principles are the guide. Second, which enforceable rule is engaged, and against which code, for which the answer today is the MCI 2002 Regulations and not the suspended 2023 code. Keeping the aspirational and the enforceable separate stops a clinician from either dismissing the profession's own code as toothless or mistaking the dormant statute for the live one.

The Indian Psychiatric Society's psychiatry-specific code of ethics was approved at Cuttack in 1989 and, in its current published form, states the psychiatrist's duties as fourteen codes centred on the patient's paramount interest, valid consent, confidentiality within the law and no exploitation of the relationship; the operative statutory conduct code is the MCI 2002 Regulations, while the NMC RMP 2023 Regulations, though notified, are held in abeyance and are not in force.

6 · Professional negligence and medical malpractice (four Ds, vicarious liability)

Every clinical act carries the standing risk that a bad outcome will be read as a wrong done. A patient who is harmed in the course of care may frame that harm as the doctor's fault, and the law of negligence is the machinery that decides whether the framing is right. For the psychiatrist the stakes are peculiar, because so much of the work is judgement exercised under uncertainty, with outcomes that are probabilistic and diagnoses that are contested; the discipline of this topic is learning exactly what turns an adverse outcome into an actionable wrong, and what does not. The examiner is testing whether a candidate can separate the two.

The account here is built around four questions that a negligence claim must answer in turn: was a duty owed, was it breached, did the breach cause harm, and was there harm to be caused. Those four questions are the "four Ds" that every candidate can recite, but the more precise formulation is what the Supreme Court of India actually said, and the discrimination between the mnemonic

and the holding is where marks are made and lost. On the standard against which a breach is judged, on the higher bar the criminal law sets, and on the liability an employer carries for its staff, the rules are settled and quotable. The forum in which a patient brings such a claim, chiefly the consumer forum, belongs to this chapter's account of the Consumer Protection Act and medical practice, and is named here rather than reworked.

1957	1997	1996	2005
BOLAM, THE ORIGIN OF THE PROFESSIONAL STANDARD OF CARE	BOLITHO, THE LOGICAL-BASIS GLOSS ON BOLAM	ACHUTRAO, THE INDIAN AUTHORITY ON HOSPITAL LIABILITY	JACOB MATHEW, THE INDIAN SETTLEMENT OF MEDICAL NEGLIGENCE

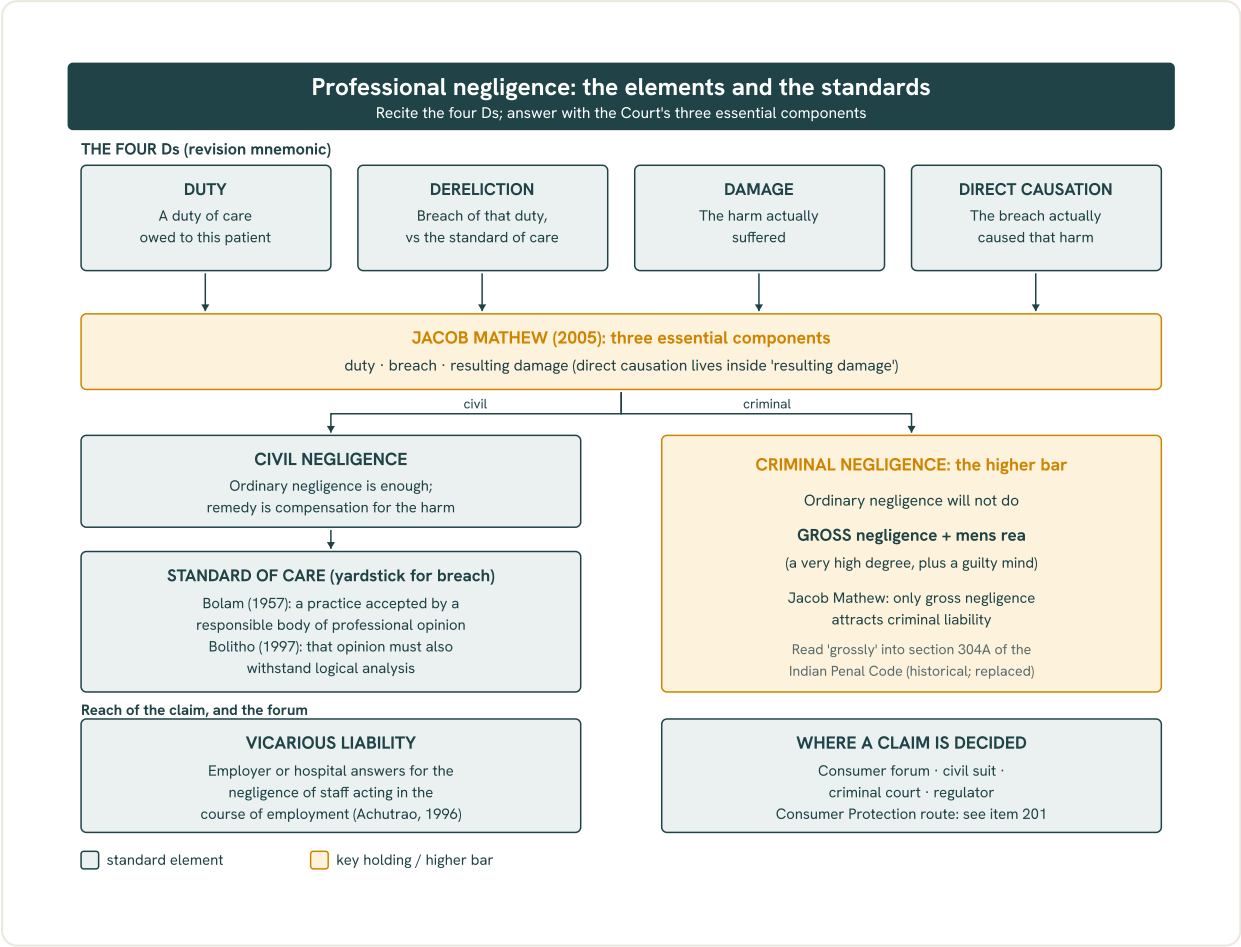


Fig 26.5. Professional negligence: the four Ds unpack the three essential components of Jacob Mathew (2005), breach is judged by Bolam as qualified by Bolitho, and criminal liability needs gross negligence plus mens rea.

6.1 What actionable negligence is: the four Ds and the three components

In ordinary language **negligence** is carelessness, but as a cause of action it is a structured thing with parts that must all be present. It is the breach of a duty caused by an omission to do what a reasonable person, guided by the considerations that ordinarily regulate human affairs, would do, or the doing of what a prudent and reasonable person would not do. A patient who alleges it must establish each of its elements; the absence of any one defeats the claim entirely, however grievous the outcome.

The revision mnemonic gathers those elements as the four Ds: a **Duty** of care owed to the patient, a **Dereliction** or breach of that duty, resulting **Damage**, and **Direct causation** linking the breach to the damage. The mnemonic is a useful scaffold and worth keeping, but it must be

married to what the Court actually held. In **Jacob Mathew** the Supreme Court of India stated that the essential components of negligence are **three**: duty, breach and resulting damage. Causation is not dropped; it lives inside "resulting damage", because damage that does not result from the breach is not the defendant's damage at all. The four Ds and the three components describe the same law: the mnemonic simply unfolds the causation that the holding keeps folded into its third element.

MNEMONIC

Duty, Dereliction, Damage, Direct causation

The four Ds of the negligence action: a **Duty** of care owed to this patient; a **Dereliction**, the breach of that duty measured against the standard of care; the **Damage** actually suffered; and the **Direct causation** that ties the breach to the harm. Recite the four for structure, but answer with the Court's three components, causation embedded in resulting damage, when asked for the authority.

TRAP **The Supreme Court states three essential components, not four Ds.** Candidates write that the Court laid down "four Ds" and lose the mark for putting a teaching mnemonic in the Court's mouth. The holding in Jacob Mathew names three components, duty, breach and resulting damage, with causation carried inside the third. State the three as the law, then offer the four Ds as the device that unpacks the causation requirement. Getting the direction of that relationship right, mnemonic derived from holding and not the reverse, is what a careful answer shows.

6.2 The standard of care: the Bolam test

The second element, breach, cannot be judged without a yardstick, and the yardstick is the heart of medical negligence law. A doctor is not measured against the ordinary reasonable person, because the ordinary person does not possess the special skill in question. This is the insight of the **standard of care** for skilled work, given its classical statement in **Bolam**. Where an act involves a special skill or competence, negligence is judged by the standard of the ordinary skilled person exercising and professing to have that skill, not by the standard of the ordinary person on the street. The practitioner need not possess the highest expert skill; it is enough that they exercise the ordinary skill of an ordinarily competent practitioner of that art.

The operative principle follows: a practitioner is not negligent if they have acted in accordance with a practice accepted as proper by a responsible body of professional opinion, even if other practitioners would have taken a different view. Medicine tolerates genuine differences of approach, and the law protects the doctor who has followed one recognised school of thought against the charge that a different school would have done otherwise. This is why a mere error of judgement, or the existence of a better alternative in hindsight, is not by itself negligence.

IN INDIA

The Bolam standard is not merely borrowed here; the Supreme Court in Jacob Mathew adopted it expressly, holding that the test for determining medical negligence laid down in Bolam holds good in its applicability in India. The practical consequence for civil liability is precise: so long as a doctor follows a practice acceptable to the medical profession of the day, they are not negligent merely because a better alternative existed, or because a more skilled doctor might have chosen differently. The Indian civil standard is therefore the accepted-practice standard, applied to Indian conditions and the resources actually available, not a counsel of perfection.

6.3 Bolam qualified: the Bolitho gloss

Bolam left an obvious gap. If any body of professional opinion could shelter a defendant, then a defendant needed only to find one supportive expert, and the profession, rather than the court, would decide what counted as reasonable care. The correction came in **Bolitho**, which glosses rather than overturns Bolam. A body of professional opinion protects a defendant only if that opinion can be shown to rest on a logical basis. The adjectives the law uses, that the body of opinion be responsible, reasonable and respectable, require the court to be satisfied that its exponents have actually weighed the comparative risks and benefits and reached a defensible conclusion. In the rare case where the opinion relied on is not capable of withstanding logical analysis, the judge is entitled to hold that it is not reasonable or responsible, and the shelter falls away.

The combined rule, Bolam as qualified by Bolitho, is the single most examinable proposition in this topic. The standard of care is set by a responsible body of professional opinion, but the court retains a residual power to reject that opinion when it cannot survive logical scrutiny. This keeps the final judgement of reasonableness with the court while giving proper weight to genuine professional practice, and it forecloses the defence built on an opinion that is merely asserted rather than reasoned.

RULE **The standard of care is Bolam as qualified by Bolitho: a responsible body of professional opinion sets the standard, but only where that opinion withstands logical analysis.** A doctor who acts in line with an accepted professional practice is not negligent, and this protects legitimate differences of clinical approach. Bolitho adds the safety catch: the practice relied on must have a logical basis, weighing risks against benefits, or the court may find it neither reasonable nor responsible. Both halves must appear in a full answer, because Bolam alone overstates the doctor's protection and misses where Indian and English law now stand.

GOOD TO REMEMBER

What protects the clinician is not a good outcome, which cannot be guaranteed, but a defensible process. Choose a management that a responsible body of your profession would accept, be able to say why the comparative risks and benefits pointed that way, and write that reasoning in the notes as it is made. A documented choice within accepted practice is answerable to Bolam and Bolitho even when the result is poor; an undocumented departure from it is exposed even when the result is good.

6.4 Causation: the fourth D and where the burden lies

Even a proven breach of duty does not by itself make a case, and this is the element candidates most often skate over. **Causation** is the requirement that the breach actually produced the injury complained of, and it is a distinct hurdle the claimant must clear. Bolitho is authority for the point as well as for the standard of care: where a breach of the duty of care is proved or even admitted, the burden still lies on the plaintiff to prove that the breach caused the injury suffered. A patient who was negligently managed but who would have come to the same harm regardless has suffered a breach without a remedy, because the breach caused nothing.

This is the "direct causation" the fourth D names, and it is why the mnemonic is a fair unpacking of the three components rather than an inflation of them. The link between breach and damage must be shown, not assumed from the coincidence of a lapse and a bad result. For the psychiatrist, where outcomes are multiply determined and the natural course of an illness may itself account for the harm, the causation question is frequently the strongest ground of defence: the illness, not the treatment, may be the operative cause.

6.5 Civil and criminal negligence: the higher bar

The same careless act can be met with a civil claim for compensation or, in a serious case, a criminal prosecution, and the two run on entirely different standards. The distinction is grounded and load-bearing. For civil liability the accepted-practice standard of Bolam and Bolitho governs, and ordinary negligence suffices. For criminal liability the bar is far higher: **mens rea** must be shown, and the degree of negligence must be **gross negligence**, or negligence of a very high degree. Negligence that is neither gross nor of a high degree may found a civil action but cannot form the basis of a prosecution. In Jacob Mathew the Court read the words "rash or negligent act" in the historical penal provision, Section **304A** of the Indian Penal Code, as qualified by "grossly", so that only gross negligence would attract criminal liability.

The rationale is protective. A doctor who acts in good faith and within accepted practice should not face the criminal law every time treatment fails, because that would make defensive medicine the rule and deter the very risk-taking that patients need. The criminal law is reserved for negligence so gross that it approaches recklessness, coupled with the guilty mind the offence requires. The insanity-defence doctrine and the burden of proof that attend criminal responsibility more generally belong to the Mental health legislation and forensic psychiatry notes and are not reworked here; the point retained is the standard specific to negligence.

AXIS	CIVIL MEDICAL NEGLIGENCE	CRIMINAL MEDICAL NEGLIGENCE
STANDARD APPLIED	Bolam, as qualified by Bolitho: departure from accepted responsible practice	Gross negligence, or negligence of a very high degree
MENTAL ELEMENT	None required; the act and its consequences are judged objectively	Mens rea must be shown to exist
DEGREE OF FAULT	Ordinary negligence is enough	Ordinary negligence will not do; the lapse must be gross
WHAT THE CLAIMANT SEEKS	Compensation for the damage caused	Punishment of the practitioner by the State
PURPOSE OF THE STANDARD	To make good the harm to the patient	To protect the good-faith doctor from prosecution for every failure

PITFALL

Citing the Indian Penal Code as the current source of the criminal-negligence provision. Jacob Mathew construed Section 304A of the Indian Penal Code, which was the operative penal code when the case was decided, but the substantive criminal law has since been replaced and the old codes are now historical. Quoting the Court on the qualifying word "grossly" is correct; presenting the Indian Penal Code as the code in force today is not. The current penal framework and the savings rule that decides which code applies to a given prosecution are set out in this chapter's account of the penal-code framework and its transition; name the new provision as current and the old as historical.

6.6 Vicarious liability: the employer answers for the servant

A negligence claim does not stop at the individual who erred. **Vicarious liability** is the principle that an employer, though personally without fault, is answerable for the harm done by the fault or negligence of a servant acting in the course of employment. The doctrine matters intensely in practice, because the individual clinician may be uninsured or of modest means while the hospital that employs them is not, and because the harm done by any of the doctors or other employees through whom a hospital delivers care is answered for by the hospital itself. The rule is stated authoritatively in **Achutrao**: an employer, though guilty of no fault himself, is liable for the damage done by the fault or negligence of his servant acting in the course of his employment.

The liability is not unlimited, and its boundaries are where the marks sit. Applied to the hospital, the Court held that running a hospital is a welfare activity and not a sovereign function, so the State or the hospital cannot claim sovereign immunity and is vicariously liable for the negligence of its doctors and other employees. The claimant may sue the individual, the institution, or both. The requirements that must hold, and the defence that fails, are these:

- **An employer-servant relationship.** The person who erred must be an employee, not an independent contractor beyond the employer's control; the closer the control over how the work is done, the firmer the liability.

- **Acting in the course of employment.** The negligent act must be part of, or reasonably incidental to, the work the servant is engaged to perform, not a personal venture unconnected with it.
- **A welfare, not a sovereign, function.** Because running a hospital is a welfare activity, the defence of sovereign immunity does not shield a public hospital from vicarious liability for its staff.

6.7 Where a negligence claim is decided

A patient harmed by alleged negligence is not confined to a single door, and the available tracks run on different standards and to different ends:

- **The consumer forum.** A dedicated statutory route treats a deficiency in a medical service as consumer redress; that forum, its remedy and the settled position that paid medical services fall within it belong to this chapter's account of the Consumer Protection Act and medical practice, and are named here without being reworked.
- **An ordinary civil suit.** A patient may sue for damages in the courts, where ordinary negligence against the accepted-practice standard suffices.
- **A criminal prosecution.** Available only where the negligence is gross and accompanied by the guilty mind the offence requires.
- **A complaint to the regulator.** Engaging the professional-conduct code, this track is concerned with fitness to practise rather than with compensation.

The tracks are independent and may run in parallel: a single episode of negligent care can generate a consumer complaint, a civil suit, a criminal case and a disciplinary inquiry at once, each on its own standard and to its own end. What travels across the civil and consumer forums is the substance taught in this fragment, the elements of the action and the standard of care: each asks whether a duty was breached against the Bolam-Bolitho yardstick and whether the breach caused the harm. The criminal court demands more, gross negligence and mens rea, and the regulator asks about fitness to practise rather than compensation, so the yardstick is not identical everywhere. The forum changes the procedure, the degree of fault required and the remedy; the underlying account of what negligent care is remains the reference point each forum starts from.

Actionable negligence has three essential components in Jacob Mathew, duty, breach and resulting damage, with causation embedded in the third and unpacked by the four-D mnemonic; the standard for breach is Bolam as qualified by Bolitho, an accepted responsible practice that must also withstand logical analysis; civil liability needs ordinary negligence while criminal liability needs gross negligence plus mens rea; and by vicarious liability the hospital, running a welfare and not a sovereign function, answers for the negligence of its servants acting in the course of employment.

7 · Consumer Protection Act and medical practice

A doctor who charges for care has, in the eye of the law, supplied a service, and a patient who feels short-changed by that service can come after the doctor not only as an injured plaintiff but as a dissatisfied consumer. That single move, treating the clinical encounter as a transaction in services, is what brought medical practice within consumer law and gave the aggrieved patient a forum that is faster and cheaper than an ordinary civil suit. The marks are for knowing which statute is actually in force, what the Act means by "service" and by "deficiency", and how the landmark judgment settled that a doctor's work is a service the Act can reach: each a discrete, quotable point, and each a place a hurried candidate goes wrong.

This fragment owns the consumer forum and its definitions, not the law of negligence itself. Whether a doctor was negligent, the elements of the action and the standard of care against which a breach is measured, belongs to this chapter's account of professional negligence and medical malpractice and is named here, not reworked. The Consumer Protection Act does not invent a new standard of care; it opens a door to a particular tribunal and calls the wrong a "deficiency in service". Keeping that boundary clear, forum here, standard there, is the discipline the examiner is testing.

2019	1986	1995
THE CONSUMER PROTECTION ACT NOW IN FORCE	THE EARLIER ACT, SINCE REPEALED	IMA V V.P. SHANTHA BROUGHT MEDICINE WITHIN THE ACT

7.1 The current statute and what it replaced

The first thing to fix is currency, because the obvious answer is now the wrong one. The operative law is the Consumer Protection Act, 2019, enacted as Act 35 of 2019, which received assent on 9 August 2019. By Section **107(1)** it repealed the earlier Consumer Protection Act, 1986. The older Act is historical, and a candidate who cites it as governing law is quoting a repealed statute.

The Act's commencement is itself a conditional worth stating precisely, because it is not a single switch. It comes into force on such date or dates as the Central Government appoints by notification, and different dates may be appointed for different provisions of the Act and for different States. That staggered commencement means the practical answer to "when did it apply" is a matter of notification rather than of the date of assent. What matters for medical practice is that the core concepts, service, deficiency and consumer, are carried forward from the old Act with their sense intact.

7.2 What the Act means by "service"

Everything turns first on whether the doctor supplies a **service** the Act recognises, because only then can the patient be a consumer of it. Section **2(42)** defines service expansively as service of any description made available to potential users, with an illustrative sweep from banking and insurance through transport and housing construction. The breadth is deliberate: the definition is inclusive, not a closed list, so a service is not excluded merely because it is unnamed.

Against that breadth the section sets two express exclusions, and stating the definition without them is how a candidate loses the mark:

- **Service rendered free of charge.** A service rendered free of charge is outside the definition, a carve-out decisive for camps, charitable care and government facilities; but as the discussion of free versus paid care below shows, whether care is "free" is read by how the facility is funded, not by what a given patient paid.
- **Service under a contract of personal service.** A master-and-servant employment relationship is excluded, so that the ordinary grievance of an employee against an employer does not become a consumer complaint.

The free-of-charge limb generates almost all the medical litigation, because it forces the question of exactly when treatment counts as free.

7.3 What the Act means by "deficiency"

If the encounter is a service, the actionable wrong is a **deficiency** in it. Section **2(11)** defines deficiency as any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance that is required to be maintained by law or has been undertaken by contract in relation to a service. Critically for medicine, the definition expressly includes any act of negligence, or omission or commission, by the provider that causes loss or injury to the consumer. This is the bridge that lets a negligence complaint be pursued as a consumer matter at all.

What the Act does not do is tell you when negligence exists. The **deficiency in service** is defined by reference to the performance "required to be maintained by law", and the content of that requirement, the four-part structure of the negligence action and the standard of care by which a breach is judged, is drawn from the general law set out in this chapter's account of professional negligence and medical malpractice. The consumer forum applies that standard; it does not lower it. A poor outcome is not a deficiency unless the care fell below the standard the law already demands, which is why the same fact may be a deficiency in one case and a non-negligent misadventure in another.

7.4 The landmark: medicine is a "service"

For years it was argued that a learned profession stood apart from consumer law, and that a doctor answerable to the medical regulator could not also be hauled before a consumer tribunal. That argument was settled by **IMA v V.P. Shantha**, which remains the governing precedent. The Court held that service rendered to a patient by a medical practitioner, by way of consultation, diagnosis and treatment, both medicinal and surgical, falls within the expression "service" as then defined in Section **2(1)(o)** of the 1986 Act, the historical predecessor of the current definition. Two exceptions were carried over from the statute itself: service rendered free of charge to every patient, and service under a contract of personal service.

The judgment also disposed of the profession's favourite escape route. The fact that a doctor is subject to the disciplinary control of the Medical Council does not take the doctor's service outside the Act. Regulatory oversight and consumer liability are parallel, not alternative; a clinician can face both a disciplinary inquiry into fitness to practise and a consumer complaint for compensation arising from the same episode. That the Court read a professional's work as a

marketed service, rather than as a calling immune from commercial law, is the conceptual core of the whole topic.

RULE **A doctor's diagnostic and therapeutic service is "service" under the Act, and a deficiency in it is actionable in the consumer forum, unless the service is rendered free of charge to everybody or under a contract of personal service.** The default is coverage; the exclusion is narrow and must be stated with its condition. Where a practitioner or facility charges no fee from any patient, the service is outside the Act, and the payment of a token amount for registration only does not change that position. The rule is not "free treatment is never covered" but "treatment free to everyone is not covered", and the difference between those two sentences is where the marks live.

7.5 The free-versus-paid distinction

The single most examined product of Shantha is the way it worked the free-of-charge exclusion out across the mixed economy of Indian hospitals, where paying and non-paying patients are treated side by side. Rather than a crude "did this patient pay" test, it asks how the facility is funded, so that a patient treated free at a hospital that charges others is still a **consumer**. The accompanying grid sets out the four situations the Court distinguished.

SITUATION	IS IT "SERVICE" UNDER THE ACT?	IS THE RECIPIENT A "CONSUMER"?
CHARGES ARE PAYABLE AND THE PATIENT PAYS	Yes; paid medical service falls squarely within the Act	Yes; may complain of a deficiency
CROSS-SUBSIDISED: THOSE WHO CAN PAY ARE CHARGED, THOSE WHO CANNOT ARE TREATED FREE	Yes; even the free treatment is "service"	Yes; the non-paying patient is also a consumer
FREE TO EVERYBODY, NO CHARGE TAKEN FROM ANY PATIENT	No; wholly free service is outside the Act	No
ONLY A TOKEN REGISTRATION FEE IS TAKEN, ALL ARE TREATED FREE	No; the token fee does not alter the free character	No

The organising idea is that the paying patients underwrite the free ones, so the institution supplies a service for consideration and the benefit of that service reaches the non-paying patient too. Coverage follows the economic character of the facility, not the receipt in a given patient's hand, and only where the service is free to all comers does the exclusion truly bite.

TRAP **Reading the free-of-charge exclusion too widely, so that any free treatment is treated as outside the Act.** Candidates state the exclusion correctly, then apply it as though a patient who paid nothing can never complain. Shantha holds the opposite for the cross-subsidised case: where a hospital charges paying patients and treats others free, the free treatment is still "service" and its recipient a consumer. The exclusion is confined to the facility that charges no one at all. Answer with the four situations, not with the headline, because the headline states a rule the judgment expressly rejected.

7.6 The forum, the remedy and the boundary with negligence

What the Act really gives the patient is a place to go. Beyond defining service and deficiency, it establishes a dedicated tier of consumer commissions, sitting at the district, State and national

levels, before which a consumer may bring a complaint of deficiency and seek redress, most commonly an award of compensation. The attraction over an ordinary civil suit is procedural: the consumer route offers a dedicated statutory forum and a compensation remedy, and it became a common route for medical grievances once Shantha confirmed doctors were within reach of it. The exact pecuniary jurisdiction of each tier, the limitation period for a complaint, and the statutory definitions of "consumer" and "complaint" are matters of the Act's machinery not reproduced here.

The boundary with the law of negligence is the point to carry away. The commission decides the forum question, is this a service, is the complainant a consumer, has there been a deficiency, but the deficiency question still turns on the ordinary negligence standard, the accepted-practice test qualified by the requirement of a logical basis, taught in this chapter's account of professional negligence and medical malpractice. The Consumer Protection Act is thus best understood as a remedy and a forum bolted onto the substantive law of negligence, not as a separate or stricter code of medical liability. A clinician who satisfies the standard of care has committed no clinical negligence, though the statutory definition reaches wider than negligence alone: a fault, imperfection, shortcoming or inadequacy in a performance the law requires or a contract undertook can still be a deficiency.

IN INDIA

Since IMA v V.P. Shantha the consumer commission has been the workhorse of medical-liability litigation in India, because it spares the patient the cost and delay of a regular civil action. For the practising psychiatrist the Act bites at the ordinary paid consultation: consultation, diagnosis and treatment given for a fee is service within the Act, so a dissatisfied patient may bring a complaint alleging a deficiency in it. The fee-paying private consultation is the paradigm covered service, so the everyday out-patient encounter falls squarely within the Act's reach.

GOOD TO REMEMBER

Do not treat a fee waiver as a shield. If your clinic charges other patients, the concession you extend to one does not put that patient's care outside the Act; a camp or charitable service is exempt only when nobody is charged at all. Because coverage follows how the service is funded rather than what this patient paid, hold every episode of care, subsidised, discounted or free within a paying practice, to the same documented standard, so that the deficiency question is answered by your notes whichever forum asks it.

PITFALL

Citing the Consumer Protection Act, 1986 as the statute in force. It was repealed by the 2019 Act, and quoting the old Act, or its old section for the definition of service, in a report, an opinion or an examination answer marks the writer as working from a superseded source. The case law decided under the 1986 Act, IMA v V.P. Shantha among it, remains good authority on the concepts, but the section it construed is historical. Name the 2019 Act as current and treat the 1986 provisions as the predecessor they now are.

The operative statute is the Consumer Protection Act, 2019, which repealed the 1986 Act; a doctor's paid diagnostic and therapeutic work is "service" and its negligent shortcoming a "deficiency", so IMA v V.P. Shantha lets a patient sue as a consumer, with only service that is free to everybody, unaltered by a token registration fee, falling outside the Act, while the standard of negligence itself is drawn from the account of professional negligence.

8 · Expert testimony and the psychiatrist as expert witness

Why the marks are here. Forensic work asks the psychiatrist to do something the rest of medicine never demands: to serve a master other than the patient. The clinician who, in the consulting room, owes undivided loyalty to the person in front of them may later be asked by a court to examine a litigant, an accused or a claimant and to report - not for that person's benefit, but for the administration of justice. The two examinations can look almost identical across the desk, yet they pull the clinician in different directions: to whom the duty is owed, and what confidentiality and stance the encounter carries, invert between them, even though duties of honesty, respect and competence hold in both. Evaluators who miss this produce reports that are partisan, poorly received, or quietly damaging to the very patient they meant to help; candidates who miss it lose an easy viva question that examiners return to year after year.

This section teaches the psychiatrist as an **expert witness**: how the treating role is held apart from the expert role, and how the law separates the opinion the expert is uniquely permitted to give from the facts to which an ordinary witness is confined. The rules of admissibility, the court hierarchy and the mechanics of how an opinion is received in evidence are set out elsewhere in this chapter and are only named here; the criteria of criminal responsibility and of fitness to stand trial belong to the Mental health legislation and forensic psychiatry notes.

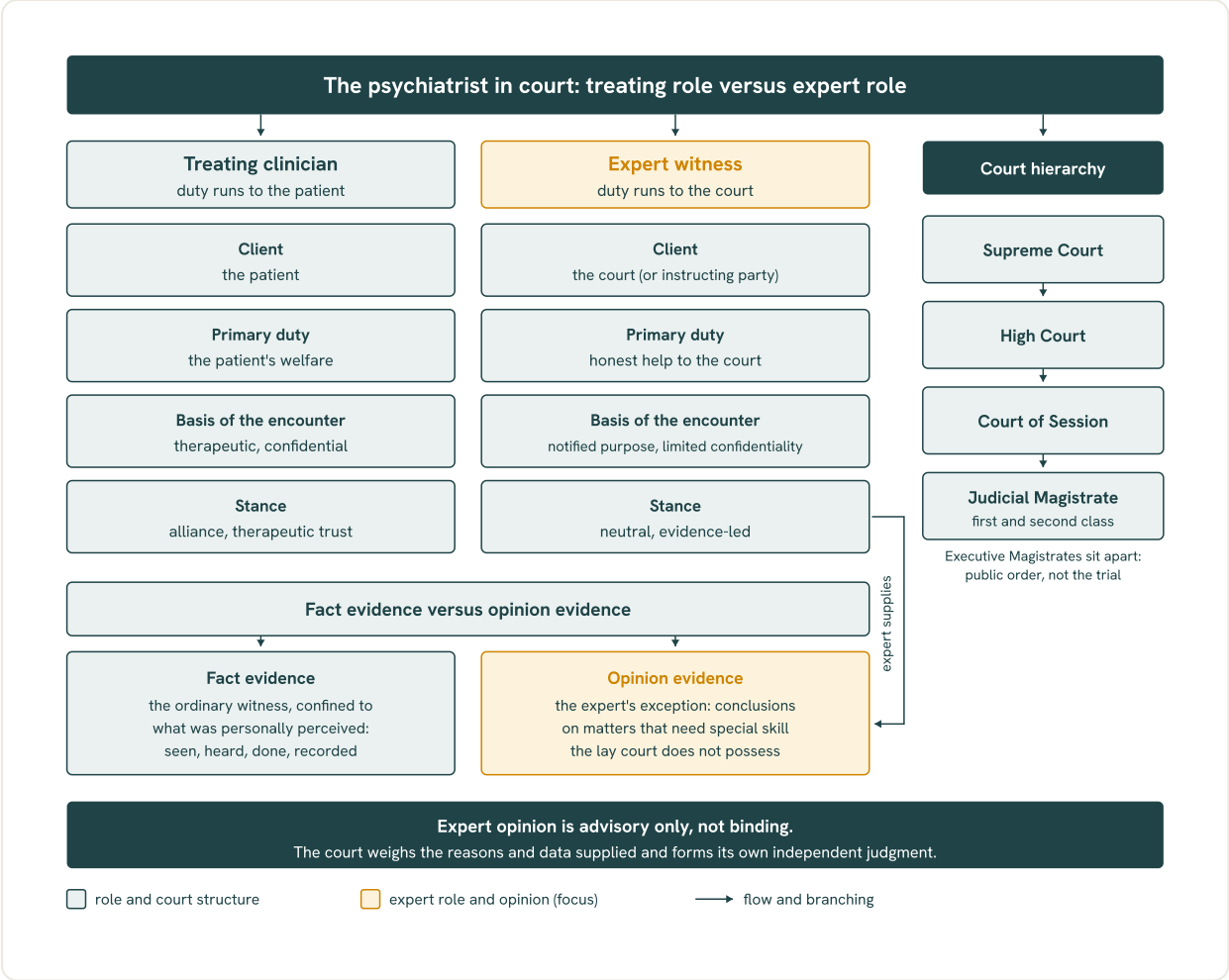


Fig 26.6. The treating role serves the patient and the expert role serves the court; the ordinary witness gives fact while the expert alone gives opinion on matters needing special skill, and that opinion is advisory only, the court never bound by it (Ramesh Chandra Agrawal, 2009).

8.1 Two roles, one clinician: treatment and evaluation

The confusion at the heart of forensic psychiatry is that one professional, with one set of skills, is asked to occupy two structurally different positions. In the **treating role** the client is the patient. The primary obligation is to that patient's welfare, resting on the principles of beneficence and non-maleficence (the four principles of biomedical ethics are set out elsewhere in this chapter and named here only). Consent is therapeutic consent to be helped; confidentiality is the default posture, breached only within the narrow permitted circumstances taught elsewhere in this chapter. The stance is one of alliance and therapeutic trust, because trust is itself part of the treatment, while clinical assessment stays objective.

In the **forensic evaluator** role almost every one of those settings inverts. The functional client is the court, or a retaining party whose instructions the evaluator accepts but whose interests do not command the opinion. There is no therapeutic purpose, and confidentiality is correspondingly limited rather than absent: before anything is said, the person examined must be told that the encounter is not treatment, that what they disclose is not held in the usual clinical confidence and may be set out in a report, and who will receive that report. The goal is not the person's welfare but an accurate answer to a legal question, and the stance is neutral and, where the data demand it, sceptical. When these two roles are forced into one person at one time - the treating

psychiatrist asked to be the court's expert on their own patient - a dual relationship forms that corrodes both the objectivity the court needs and the alliance the patient needs.

AXIS	TREATING ROLE	EXPERT ROLE
Who is the client	The patient	The court (or an instructing party)
Primary duty	The patient's welfare	Honest assistance to the court
Basis of the encounter	Therapeutic consent	Notified purpose, limited confidentiality
Confidentiality	Default, narrowly limited	Limited by the forensic purpose
Goal of the contact	To help the person	To answer a legal question accurately
Stance toward the person	Alliance, therapeutic trust	Neutral, evidence-led

8.2 Opinion and fact: why the expert is the courtroom's exception

A court is a machine for finding facts and drawing inferences from them, and it reserves the drawing of inferences to itself. The ordinary witness is therefore confined to **fact evidence**: what they personally perceived - saw, heard, did, recorded. They are not permitted to offer their conclusions, because inference is the court's own work. The expert is the deliberate exception to this rule. Where a question turns on specialised knowledge the lay judge does not possess, the law admits **opinion evidence** from a person qualified in that field, precisely so the court can reason about matters it could not otherwise understand.

The distinction has a direct and frequently examined consequence for the psychiatrist. A treating psychiatrist summoned to testify about a patient they have managed is, in that capacity, usually a witness of fact: they speak to their own observations, their records, the treatment given. That is fact evidence, even though the witness happens to be an expert by training. Giving an opinion on a legal question about someone the witness has not evaluated for that purpose is a different act, requiring the expert footing. The same psychiatrist may therefore be a witness of fact in one proceeding and an expert in another; the discipline is to know, at every moment, which capacity is being exercised, because the permissions and the duties differ.

8.3 The advisory character of the opinion

Because opinion is admitted only by way of exception, the law is careful to fix its weight. The governing Indian authority is **Ramesh Chandra Agrawal v. Regency Hospital Ltd.** (Supreme Court, **2009**), which states the principle plainly: an expert is not a witness of fact, and the evidence is really of an advisory character. The expert's duty is to furnish the judge with the necessary scientific criteria for testing the accuracy of the conclusions, so as to enable the judge to form an independent judgment by applying those criteria to the facts proved in the case. It is not the province of the expert to act as judge or jury; the court is not bound by the opinion, and weighs it against the reasons and the data the expert has actually supplied.

2009

RAMESH CHANDRA AGRAWAL: THE SUPREME COURT ON THE EXPERT'S ROLE

Two things follow, and both are examinable. First, the opinion is only ever an aid to the court's own reasoning, never a substitute for it, so a decision-maker who simply adopts an expert's conclusion has abdicated the very function the law reserves to it. Second, and more useful at the bedside of report-writing, an opinion carries weight in large part according to how far it exposes the criteria and data on which it rests. A bare conclusion, however eminent its author, gives the court nothing to test and therefore earns little. The reasoning is the evidence; the conclusion is merely its endpoint.

> An expert witness is not a witness of fact: the opinion is advisory only, and the court, never bound by it, forms its own independent judgment on the reasons and data supplied.

RULE **The expert advises; the court decides.** Expert evidence is of an advisory character. Its job is to hand the court the scientific criteria for testing a conclusion, not to deliver the conclusion the court is bound to accept. Weight tracks the transparency of the criteria and data offered.

8.4 Objectivity, and the partisan-expert trap

If the opinion is advice to the court, then the expert's overriding duty runs to the court and to the truth, not to whoever pays the fee. This is the ethical spine of the role and the point at which it most often fails in practice. The **partisan expert** - the hired opinion that shades every ambiguity in the instructing party's favour - is not merely distasteful; it is worthless in exactly the terms the governing authority sets out, because an opinion shaped to a conclusion cannot honestly furnish the criteria by which that conclusion could be falsified. Independence is not a courtesy the expert extends to the other side; it is the condition on which the evidence has any value at all.

Signs that an opinion has slipped from expert to advocate include:

- a conclusion stated with a confidence the underlying data cannot support;
- selective use of the record, with inconvenient findings omitted rather than addressed;
- straying beyond the witness's actual field of competence;
- answering the ultimate legal question directly instead of supplying the material the court needs to answer it.

TRAP **Deciding the ultimate legal issue.** The expert may give the clinical opinion, including whether the person was, by reason of unsoundness of mind, in a particular mental state, which the evidence code names as a paradigm expert question. What the expert must not do is announce the verdict: whether the statutory defence is made out, or whether the doctor is legally liable. That legal conclusion is the court's province. The expert furnishes the clinical criteria and findings; the judge, not bound by the opinion, applies the law.

IN INDIA

Indian courts treat expert medical and psychiatric opinion as advisory rather than conclusive, and the Supreme Court's statement of that position is the authority discussed above. A well-reasoned report that lays out its criteria and data will be given weight; an assertion offered on authority alone will not. The practical lesson for the Indian evaluator is to write for a reader who is entitled to disagree.

8.5 From consulting room to witness box

The expert's product is the written report, and it is prepared on the assumption that it will be read by an adversary and tested under cross-examination. A defensible report therefore does the opposite of what a clinical note does for a colleague: it spells out its own workings so that a hostile reader can retrace them. The psychiatrist states the instructions received and the question asked, records who was examined and on what material, distinguishes what was observed from what was inferred, and confines every opinion to matters within genuine competence. Where the data are thin or the literature divided, the honest report says so, because a candid limitation strengthens the parts that remain and a concealed one collapses the whole under cross-examination.

A defensible expert report characteristically:

- identifies the instructing party, the question, and the material relied on;
- separates facts observed from opinions drawn;
- gives the reasoning and criteria behind each opinion, not the conclusion alone;
- stays within the author's field and flags the limits of the data.

GOOD TO REMEMBER

Keep the two roles physically separate whenever you can: if you are the treating psychiatrist, resist accepting an expert brief on your own patient, and if you must give evidence about them, give it as a witness of fact - what you saw, recorded and did. Because those treating records can themselves be summoned as fact evidence, contemporaneous, legible and complete documentation is a medico-legal protection long before any court is involved.

PITFALL

A common and damaging real-world error is not a courtroom blunder but an acceptance made months earlier: agreeing to serve as the court's expert on a patient one is actively treating. The clinician believes they are best placed because they know the patient, but they arrive with a therapeutic loyalty and a prior belief that no amount of good faith can neutralise, and the resulting opinion is both ethically compromised and easily discredited. Decline the dual role at the outset, and refer the evaluation to an independent colleague.

8.6 Where the expert role meets the rest of forensic practice

The advisory posture set out above is not confined to one kind of case; it is the common footing on which the psychiatrist enters every legal forum. The psychiatric assessment of an accused,

whose procedural pathway of court referral and reporting is dealt with elsewhere in this chapter, is an application of exactly this role: the psychiatrist furnishes the court with clinical findings and criteria, while the substantive question of criminal responsibility, and the tests and burden of proof that govern it, belong to the Mental health legislation and forensic psychiatry notes. In a professional-negligence action the standard of care, taught elsewhere in this chapter, is itself proved through expert testimony about accepted practice, so the credibility of the whole claim can turn on how transparently that expert reasons. And the rules of evidence and the court structure that decide how an opinion is admitted and received, also treated elsewhere in this chapter, are the procedural frame within which the advisory character of the opinion actually operates.

The unifying idea. Across all of these settings the psychiatrist is doing one thing: translating clinical observation into criteria a court can test, while leaving the decision to the court. Hold the treating role and the expert role apart, remember that opinion is admitted only as an aid and never as a verdict, and the harder forensic tasks in this chapter become variations on a single, well-understood discipline.

9 · Boundary violations and ethics of the therapeutic relationship

The therapeutic relationship is the instrument of psychiatric treatment, and boundaries are what keep that instrument safe to use. Psychiatry works through a relationship in which a distressed person discloses the most private material of a life to a clinician trusted to hold it and to act only in that person's interest. That trust rests on an asymmetry of power, knowledge and dependence that does not reverse itself, and it is that asymmetry which makes the relationship both healing and dangerous. The ethics of the therapeutic relationship is the discipline of managing that danger, and its central examinable idea is the distinction between a departure from the frame that remains safe and one that has become harmful. A candidate who can define a boundary crossing and a boundary violation, hold the two apart on stated grounds, and trace the progression that carries one into the other has this topic; one who treats every deviation as misconduct, or reserves the word violation for sexual contact alone, has misunderstood it.



Fig 26.7 A boundary crossing is a departure from the usual therapeutic frame that may remain clinically justified; a boundary violation exploits the asymmetry of the relationship and harms the patient. Context, purpose, cumulative drift and patient welfare determine the distinction.

What is owned here is the doctrine of the relationship itself. The four principles of biomedical ethics, informed consent, confidentiality and its limits, and the professional-conduct codes each have their own treatment in this chapter and are named here, not re-derived; so too the disciplinary, civil and consumer-forum consequences of a breach.

Fiduciary	Clinician	Absolute
THE NATURE OF THE DUTY THE RELATIONSHIP IMPOSES	WHO OWNS THE BOUNDARY, IN EVERY CASE	THE PROHIBITION ON SEXUAL CONTACT WITH A CURRENT PATIENT

9.1 The therapeutic frame and the fiduciary duty

Every treatment proceeds inside a set of expectations about how the clinician and patient will relate: the length, time and place of appointments, what is discussed, the handling of money, touch and personal information, and the understanding that the encounter exists for the patient's benefit alone. This set of expectations is the **therapeutic frame**, and boundaries are its edges.

They are not coldness or rigidity but the conditions under which a patient can safely regress, disclose and depend, knowing the clinician will not exploit the openness that treatment requires.

The frame is necessary because the relationship is a **fiduciary** one: the patient entrusts their welfare to a clinician who holds greater power and knowledge and is bound, in return, to place the patient's interests first, subject to the law and to the narrowly defined duties owed to others, and never to convert the relationship to their own advantage. Two features of psychiatric treatment sharpen this duty beyond that of most specialties. The first is **transference**, in which the patient unconsciously experiences the clinician through the template of earlier significant relationships, investing them with an authority, intimacy or idealisation carried from those earlier relationships rather than earned by the real person; realistic reactions to what the clinician actually says and does run alongside it, and the two are not always easy to separate. The second is **countertransference**, the clinician's own emotional responses to the patient, ordinary and useful in the work but which, unexamined, can pull the clinician toward gratifying their own needs under the guise of helping. Because transference makes the patient especially susceptible and countertransference makes the clinician especially fallible, responsibility for the boundary can never be shared with the patient; it rests wholly and permanently with the clinician.

RULE **The relationship is fiduciary, and the duty to maintain its boundaries rests entirely with the clinician, never with the patient.** Because transference and the power asymmetry leave the patient unable to protect themselves within the relationship, the patient's apparent willingness, invitation or even initiation never transfers responsibility: whatever the patient does, the clinician is answerable for the boundary, at every stage.

9.2 Boundary crossing versus boundary violation

The pivotal distinction of this topic is between two kinds of departure from the frame. A **boundary crossing** is a deviation from usual practice that is minor, non-exploitative and potentially benign or even helpful, and that can be openly acknowledged and discussed. Offering a distressed patient a tissue, briefly extending a session at a moment of crisis, or a small self-disclosure that normalises a fear may all be crossings: they step outside the frame, but they serve the patient, are reversible, and survive being talked about in supervision or written in the notes.

A **boundary violation** is a departure that is exploitative and harmful, that serves the clinician's needs rather than the patient's, and that damages the treatment. The difference is not the size of the step but its direction and effect: whose need it meets, whether it can be reversed, whether it can be discussed honestly, and whether it stands alone or forms part of a drift away from the patient's interest. A crossing that recurs, escalates, is concealed and begins to gratify the clinician has stopped being a crossing. The two therefore describe points on a single continuum, not unrelated categories, which is why the same act can be either depending on context and motive.

AXIS	BOUNDARY CROSSING	BOUNDARY VIOLATION
WHOSE NEED IS SERVED	The patient's; consistent with the treatment	The clinician's; the treatment is subordinated to it
EFFECT ON THE PATIENT	Neutral or beneficial	Harmful; exploits the patient's vulnerability
EXPLOITATION	Absent	Present, by definition
DISCUSSABILITY	Openly acknowledged and documented	Concealed, rationalised or kept secret
REVERSIBILITY	Reversible; the frame is easily restored	Damages the frame, often irreparably
PATTERN	Isolated and self-limiting	Recurrent, escalating, part of a drift

MNEMONIC

Whose need? Reversible? Discussable? A pattern?

The four questions that sort a crossing from a violation. **Whose need** is served, the patient's or the clinician's (beneficence against self-interest). **Reversible**, can the frame be restored or is the harm done (non-maleficence). **Discussable**, could it be said aloud in supervision and the notes, or must it be hidden. **A pattern**, does it stand alone or is it one step in an escalating drift. Answer patient, yes, yes, no and it is a crossing; the reverse and it is a violation.

9.3 The domains in which boundaries operate

Boundaries are not confined to physical contact; they run through every dimension of the clinical encounter, and a violation can occur in any of them. Naming the domains matters because clinicians tend to watch only the most obvious one and miss a breach in another. The recurring domains are:

- **Role.** Keeping the clinical role distinct from social, business or personal roles; a **dual relationship** arises when a second relationship is superimposed on the treating one.
- **Time and place.** The scheduling, duration and location of contact; appointments drifting to the end of the working day, lengthening without clinical reason, or moving outside the clinical setting.
- **Money and gifts.** Fees, business dealings, borrowing or lending, and the giving or receiving of gifts and services beyond token courtesy.
- **Self-disclosure and language.** How much of the clinician's own life enters the room, and a shift toward an intimate or personal register.
- **Physical contact.** Touch of any kind, at the far end of which lies sexual contact, the gravest breach of all.

The value of the list is that it makes the drift visible. Serious violations rarely begin with the act that finally destroys the treatment; they begin with small, defensible-looking changes across

several domains at once, each innocuous in isolation. Watching all the domains, not only the physical one, is how a clinician catches a problem while it remains a crossing.

9.4 The slippery slope

The **slippery slope** is the observation that boundary violations characteristically develop by gradual progression rather than a single decisive act. A clinician rarely moves directly from correct practice to gross exploitation; instead a series of minor crossings accumulates, each normalising the next, until the relationship has slid far from its therapeutic purpose. A common progression begins with a subtle shift toward the personal and a growing sense that one patient is special, moves through appointments lengthened or rescheduled to the end of the working day, extra-clinical contact, the exchange of confidences and gifts, and meetings outside the clinical setting, and ends in sexual involvement. The precise sequence varies, but the shape is consistent: incremental, mutually reinforcing steps, each small enough to be rationalised.

The mechanism is what makes the concept clinically useful rather than merely descriptive. Because each step is small, it evades the clinician's own alarm; because transference makes the patient receptive and countertransference makes the clinician gratified, both are drawn along the slope rather than pulled back; and because the steps are concealed, the ordinary corrective of open discussion never operates. The practical implication is decisive: a violation is reliably prevented early, at the first crossings and the first stirrings of specialness, not at the edge of the sexual act, where the clinician's judgement has usually already been captured. This is why the doctrine treats trivial-looking early crossings with a seriousness that seems disproportionate until the trajectory is understood.

TRAP **Equating any boundary crossing with a boundary violation, or reserving the word violation for sexual contact alone.** Both errors lose marks. A crossing is not automatically wrong; a rigidly withholding clinician who never adapts the frame may serve the patient badly, and a crossing is distinguished from a violation by exploitation, harm and concealment, not by the mere fact of deviation. Equally, violations occur across every domain, and financial, social or dual-relationship exploitation is a genuine violation even where no sexual contact occurs. The candidate who defines the distinction correctly, and locates sexual misconduct as the gravest point on a continuum rather than the whole of it, answers the question actually asked.

9.5 Sexual misconduct: the paradigm violation

Of all boundary violations, sexual contact with a patient is treated as categorically the most serious. **Sexual misconduct** covers any sexual contact, relationship or exploitation of a patient by the treating clinician, and both professional consensus and the conduct codes treat it as absolutely prohibited for the duration of the clinical relationship. The prohibition is not softened by the patient's apparent willingness, and apparent consent is never a defence: even where the patient appears willing and has full decision-making capacity, the power asymmetry and the transference that treatment generates mean that agreement cannot make the clinician's sexual conduct permissible, and responsibility for avoiding exploitation remains entirely with the clinician. This clinical meaning of consent is distinct from the criminal-law meaning of consent in sexual-offences law, which has its own treatment in this chapter.

The harm is severe: exploited patients suffer damage resembling other betrayals of trust by a person in authority, including lasting difficulty ever trusting a clinician again. The former-patient question is the harder discrimination and a favourite of examiners. Because the transference and the imbalance of power do not end cleanly at the final appointment, the strictest professional position, often summarised as once a patient, always a patient, holds that a sexual relationship with a former patient remains unethical for as long as the residue of the therapeutic power imbalance persists. A candidate should state the in-treatment prohibition as absolute and treat the post-termination question as governed by the persistence of that imbalance, not by the mere ending of treatment. Where the patient is a minor, the conduct additionally engages the child-protection statutes, which belong to the Child psychiatry: assessment, treatment, services and protection notes and are named here rather than worked through.

GOOD TO REMEMBER

Treat the feeling of specialness as a clinical sign, not a private matter. When a clinician notices that one patient has become an exception, wanting to give them extra time, thinking of them between sessions, quietly bending the frame in their favour, the right response is to take it to supervision, not to act on it. Boundaries are protected far more reliably by routine self-monitoring, consultation and honest documentation than by willpower at the edge of the slope. The safe working test is that anything you would be unwilling to record in the notes or describe to a supervisor is already the problem.

9.6 Risk, prevention and the Indian setting

Boundary violations are not confined to a few predatory clinicians; ordinary practitioners are vulnerable under particular conditions. Recognised risk situations include the clinician passing through personal crisis, loss or loneliness, professional isolation without supervision, idealising or being idealised by a patient, and the seductive belief that this relationship is a unique exception to the rules. The protective measures follow from the mechanism of the slippery slope: regular supervision and consultation that make countertransference discussable, transparent documentation, attention to all the boundary domains rather than only the physical, judicious use of a chaperone, and a low threshold for referral where a conflict of interest cannot be contained.

The professional-conduct codes give this discipline its formal force. The duty not to exploit the therapeutic relationship for personal, social, business or sexual gain is stated in those four terms by the Indian Psychiatric Society's code of ethics; the operative statutory conduct code supplies the disciplinary consequence in its own terms, which are set out in this chapter's account of the professional codes of ethics and applied here rather than restated.

IN INDIA

The unavoidability of dual relationships in Indian practice makes the boundary discipline more demanding, not less. In a small town or close community the psychiatrist often cannot be a stranger to the patient outside the clinic, and shared social circles and family referrals are the norm. The frame then has to be defended deliberately: naming the clinical role where social and clinical worlds overlap, declining business or financial entanglement with patients, guarding confidentiality where relationships are interconnected, and referring on where a conflict of interest cannot be managed. The overlap of worlds is a fact of the setting; the exploitation of it is still a violation.

9.7 Accountability and the currency of the code

A proven boundary violation engages several distinct forms of accountability at once, and a complete answer names each. It is professional misconduct under the conduct code and can lead to disciplinary action up to erasure from the medical register. It can support a civil claim in professional negligence, whose elements must still be proved, and a deficiency in service can be pursued in the consumer forum; both have their own accounts in this chapter and are named here, not reworked. Where the conduct is itself criminal, the ordinary criminal law applies. A single violation can be actionable at once before a disciplinary body, a civil court and a consumer forum, and none forgives the others.

One currency point must be got right, because examiners use it to separate candidates. The provisions a clinician is held to are those of the operative Medical Council professional-conduct code; a more recent set of registered-medical-practitioner conduct regulations was notified by the National Medical Commission, came into force on publication, but was then held in abeyance and is not operative until a further Gazette notification. The earlier Council code therefore remains operative, including for a boundary violation. The exact editions, citations and dates belong to this chapter's account of the professional codes of ethics and are not asserted here.

PITFALL

Anchoring a misconduct analysis to the most recently notified conduct regulations as though they were the live code. It is natural to assume the newest professional-conduct regulations must be in force, and a clinician who does so will apply the wrong standard to a boundary breach. The recently notified registered-medical-practitioner conduct regulations came into force on publication but were then placed in abeyance and are not currently operative, so the earlier Medical Council code remains operative. Judging a disciplinary matter against a code not yet in force is a live-practice error with real consequences.

A boundary crossing is a minor, non-exploitative, discussable departure from the therapeutic frame that may even help the patient; a boundary violation is an exploitative, harmful departure that serves the clinician and betrays the fiduciary duty, and the slippery slope is the progression of unmonitored crossings that carries one into the other; sexual contact with a current patient is the paradigm violation, absolutely prohibited and never excused by apparent consent, because the patient's willingness cannot make the clinician's conduct permissible, and responsibility for every boundary rests always with the clinician.

10 · Ethics of research, publication and conflicts of interest

Why the marks sit here. Research is where a psychiatrist's two loyalties collide most sharply. Ordinary clinical work exists to help the person in the room; research exists to answer a question that may benefit no current patient at all. When the same doctor holds both roles over the same person, the informal safeguards of the consulting room are no longer enough, and a candidate is expected to show exactly how the ethical frame changes once a patient becomes a participant. Publication and conflict of interest share this subtopic because they are the downstream expressions of the same problem: whose interest is being served when data are gathered, written up and rewarded.

What this topic genuinely owns is the ethics specific to doing and reporting research: the way the general duties are re-shaped in the research setting, the Indian regulatory frame for clinical research, the management of competing interests, and the integrity of the published record. The principles of biomedical ethics and the elements of valid consent are taught elsewhere in these notes and are only invoked here, never relisted.

19(C)	2018
THE CONDUCT REGULATION TYING RESEARCH TO ICMR GUIDELINES	THE YEAR THE SUSPENDED 2023 CODE CITES FOR THE DRUG-TRIAL RULES

10.1 The dual role: treatment versus research

Clinical care is governed by a primary loyalty to the person in the room, so that, subject to the law and the narrow duties owed to others, everything the psychiatrist does is meant to help the patient being treated. Research answers to a different master. Its purpose is to produce generalisable knowledge, and the participant may gain nothing personally from taking part. This is not a flaw of research; it is its definition, and it is precisely why research needs a stricter apparatus than treatment. The error the examiner is probing is the **therapeutic misconception**: the participant, and sometimes the doctor, believing that study procedures are individualised treatment chosen for this person's benefit, when in fact they are dictated by a protocol and by the needs of the question.

Because the two roles pull in different directions, they must be held analytically apart even when one person carries both. The accompanying comparison sets out the axes on which they diverge, and the pattern to carry is that at every axis the research column demands an external check that clinical care can leave implicit.

AXIS	CLINICAL CARE	RESEARCH
Primary purpose	Benefit this patient	Generate generalisable knowledge
Duty runs to	The individual before you	The participant, whose welfare stays primary over science and society
What consent is to	An offered treatment	Voluntary participation, freely withdrawable
Independent oversight	Clinical governance	A prior, formal ethics-committee review
How risk is justified	Expected benefit to the patient	A favourable balance of risk against knowledge, with added protections

10.2 Informed consent for research

The same requirements, at a higher bar. The requirements of valid consent are taught in full under informed consent in psychiatry in these notes and are not reworked here. What changes in the research setting is their weight and their content. Voluntariness carries far more strain, because the person is often the doctor's own patient and may agree out of gratitude, dependence or fear that refusal will sour their care. The disclosure must be fuller and more honest than a treatment discussion, and it must be explicit about the things a therapeutic conversation can take for granted. A research consent conversation should establish:

- that the activity is research rather than individualised treatment, and what it is trying to find out;
- that participation is voluntary and that refusal will not compromise their ongoing care in any way;
- the right to withdraw at any time, without penalty and without giving a reason;
- the foreseeable risks and burdens, and the honest possibility of no personal benefit;
- the alternatives, including the standard treatment they would receive outside the study;
- how the confidentiality of their data will be protected, the duty and its permitted exceptions being set out under confidentiality and its limits in these notes.

Where a prospective participant's capacity to consent is impaired, as it may be in acute psychosis, severe mood disorder or cognitive impairment, the additional protections of the mental-health law apply, and these are addressed in the Mental health legislation and forensic psychiatry notes. Research involving children carries its own protective framework, addressed in the Child psychiatry: assessment, treatment, services and protection notes. The candidate's task is to name these safeguards and route to them, not to reconstruct them.

TRAP **Treating research consent as ordinary treatment consent.** Candidates assume that a patient who has agreed to be in a trial has consented the way they consent to a prescription. Research consent is a distinct, heavier act: it must name the research nature explicitly, promise that refusal will not affect care, and preserve an unconditional right to withdraw. A consent that a treating clinician obtains from their own patient without these features is the classic setting for the therapeutic misconception, and it is exactly what the examiner wants flagged.

10.3 The Indian regulatory frame

Research on patients or volunteers in India is governed by dedicated national instruments rather than by clinical convention. Under the newer National Medical Commission professional-conduct Regulations, at regulation **19**(C), clinical drug trials and other research involving patients or volunteers must comply with **ICMR guidelines** and the **New Drugs and Clinical Trials Rules, 2018** - the year as the suspended 2023 regulation itself records it. Consent that is not taken in accordance with those guidelines shall be construed as professional misconduct. The force of that phrasing repays attention: in that code's own terms a defect in the research consent process is not a documentary technicality but misconduct. Because that code is in abeyance, what makes such a defect actionable today has to be found in the operative conduct code, in the national research guidelines and the drug-trial Rules, and in the conditions of the ethics committee's own approval.

Two layers therefore sit over the same activity. The research-conduct layer routes the study through independent ethics-committee review and the national research guidelines; the professional-conduct layer makes a breach of those requirements a matter for the regulator. A candidate should be able to say that Indian research is anchored to primary national instruments, and should be careful about which conduct code is actually in force, because that is where the confident answer most often goes wrong.

IN INDIA

The practical machinery a clinician meets is the registered ethics committee and the national ethical guidelines for biomedical and health research. Regulated drug trials sit additionally under the New Drugs and Clinical Trials Rules and their consent and oversight requirements. The suspended 2023 professional-conduct code expressly requires the practitioner to disclose the dual role of treating doctor and investigator; independently of that suspended text, such disclosure remains sound ethical practice under the conflict-of-interest and consent principles, so that the participant understands the two hats being worn at once.

PITFALL

Do not cite the newer National Medical Commission Regulations as the professional-conduct code currently in force. They were notified and then held in abeyance, so the earlier Medical Council of India professional-conduct code remains the operative one. The codes themselves are set out under the Indian Psychiatric Society code of ethics in these notes; here the point is only that the research and conflict-of-interest duties are read from the code that actually governs, not from a notified-but-suspended one.

10.4 Conflict of interest

A **conflict of interest** arises whenever a secondary interest threatens to distort the primary duty owed to the patient or participant. The secondary interest need not be sinister: industry sponsorship, a gift or honorarium, academic advancement, the desire to publish, or simply the pressure to meet a recruitment target can all bend judgement without any conscious intent to do harm. That is why the profession treats the situation, and not merely the bad act, as the thing to manage.

The code does not pretend such situations can always be abolished. It requires the practitioner to recognise them, and to avoid or minimise them; where a conflict cannot be removed, the patient's interest should take precedence over any other consideration, and the honest course is to disclose the competing role rather than conceal it. In the research setting this bites hardest when the investigator is the patient's own psychiatrist, which is why separating the consent conversation from the treating relationship is the single most protective step available.

RULE **Disclosure does not resolve a conflict; it only makes it visible.** Naming a competing interest is the beginning of managing it, not a substitute for putting the patient first. Where the two genuinely cannot be reconciled, it is the research that yields, not the patient's welfare.

GOOD TO REMEMBER

Whenever you recruit your own patient into a study, say so out loud. Name your dual role, make explicit that declining will not change their care, and record that you did both. Routing the consent through an independent colleague, rather than obtaining it yourself at the bedside, protects the patient from the therapeutic misconception and protects you from the charge of exploiting the relationship. The ethics committee's part in this is the prior review that approves the consent process; it does not take the consent for you.

10.5 Publication and research integrity

The published record is the currency of science, and guarding its integrity is an ethical obligation continuous with the duties owed to participants. If consent protects the person, publication ethics protect everyone who will later rely on the result. Authorship is the first pressure point: it should reflect a genuine substantial contribution together with accountability for the work, and the recognised authorship criteria exist to keep credit and responsibility joined. Where they come apart, the familiar abuses appear:

- **gift authorship**, awarding or accepting authorship without a real contribution, often to a senior figure;
- **ghost authorship**, omitting a genuine contributor, classically an industry-employed writer;
- **redundant publication**, presenting the same data as though new, including slicing one study into several thin papers;
- **plagiarism**, presenting another's work, words or ideas as one's own;
- undisclosed conflicts of interest, and the selective or non-reporting of unwelcome results.

Beneath these lie the cardinal breaches of integrity, the ones that corrupt the data themselves rather than the credit around them. Prospective registration of trials, transparent reporting of methods and outcomes, and a willingness to share data are the countermeasures the field has adopted, and they matter clinically because the psychiatrist at the other end of the literature prescribes on the basis of what was published.

MNEMONIC

Fabricate, Falsify, Plagiarise

The three cardinal breaches of research integrity: inventing data that were never collected, altering data that were, and passing off another's work as one's own. Everything else, from gift authorship to redundant publication to a hidden conflict of interest, erodes the record more quietly, but these three are the ones that make a result simply false.

Research does not suspend the psychiatrist's duty to the patient; it adds a second, competing duty, and when the two collide the patient's welfare comes first. In India the research and conflict-of-interest duties are read from the professional-conduct code that is actually operative, research on patients or volunteers must comply with the national research guidelines and the drug-trial Rules, and a consent taken outside them is a substantive breach and not a paperwork slip, though which code makes it actionable depends on the code in force.

11 · Medical records, documentation and certification standards

Every duty in this chapter leaves a paper trail, and the paper is where the duty is proved or lost. Consent, the mental state examination, the risk assessment, the disclosure made to a third party, the opinion handed to a court - each of these is invisible after the encounter unless it was written down, so the record is the physical substrate on which the whole of forensic ethics rests. The marks in this topic are for knowing what a defensible record contains, how long it must be kept and who may see it, and the standard a psychiatrist is held to when signing a certificate. These are discrete, quotable points, and each is a place a hurried clinician, and a hurried candidate, comes to grief.

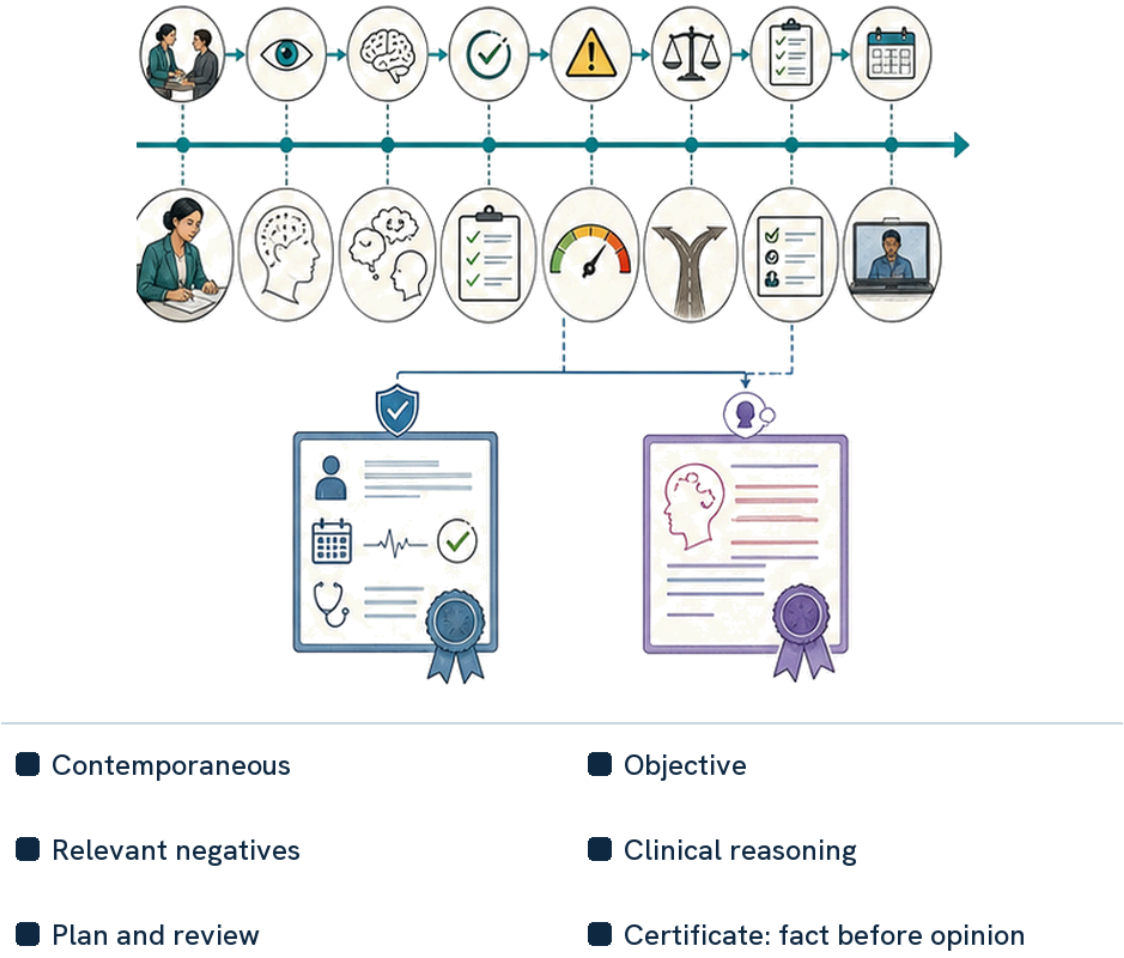


Fig 26.8 A defensible psychiatric record is contemporaneous, objective and sufficient to show assessment, relevant negative findings, clinical reasoning, decisions and review. A certificate separates verified fact from professional opinion and states its purpose.

This fragment owns the record itself: its making, its keeping and the certificates drawn from it. It does not own the confidentiality rule that governs when the contents may be released, which belongs to the separate account of confidentiality and its limits in this chapter; nor the professional-conduct code whose provisions it applies, which belongs to this chapter's account of the professional-conduct codes. Keeping those boundaries clear - the document here, the disclosure rule there, the code elsewhere - is the discipline the examiner is testing.

11.1 Why the record carries the marks

The **medical record** is at once a clinical instrument and a legal document, and the two functions pull in the same direction. Clinically it is the memory of the treating team, the substrate of continuity when care passes between hands, and the audit trail that lets a later reviewer reconstruct what was known and decided at each point. Legally it is the doctor's first and best evidence: in any dispute over what was done, the contemporaneous note carries a weight that

recollection years later cannot, because it was made before anyone had a reason to shade the account. The medicolegal maxim - that what is not recorded is, in the eye of the court, treated as not done - is less a rule of evidence than a warning about the burden a silent chart throws back on the doctor.

Psychiatry sharpens this. The findings a psychiatrist relies on - the form and content of thought, the assessment of capacity, the judgement that a patient did or did not pose a risk - are matters of clinical opinion that leave no radiograph and no laboratory value behind them. If the reasoning is not on the page there is nothing to show it was ever done, and a note that records only a conclusion is far weaker in defence than one that shows the work.

> In law a clinical entry that was never recorded is hard to prove was ever done, and a silent chart throws the burden back on the doctor, so the record is the psychiatrist's primary evidence of what was known and decided.

11.2 The anatomy of a defensible entry

A record earns its evidentiary weight through the manner of its making. The qualities a court looks for, and that distinguish a defensible chart from a liability, are few and can be stated plainly:

- **Contemporaneous.** Made at the time of the encounter or as soon as practicable after it, so that the entry precedes any dispute and cannot be said to have been composed for the occasion.
- **Legible and attributable.** Readable, dated and timed, and signed with an identifiable name and designation, so that every entry can be traced to an author.
- **Accurate and factual.** Recording observation and reasoning, not speculation or gratuitous remarks about the patient, which serve no clinical purpose and read badly when the file is opened in public.
- **Complete for its purpose.** Carrying the findings, the assessment and the plan, and, for the decisions that matter medicolegally, the reasoning - the consent taken, the capacity judged, the risk weighed.
- **Unaltered.** Corrected only in the open: an error struck through with a single line that leaves the original readable, initialled and dated, never erased, overwritten or made to disappear.

The last of these is the one that turns a weak case into an indefensible one. An honest error in a note is forgivable and often irrelevant; a note that has been quietly changed after the event destroys the credibility of the whole record and, with it, the doctor's. This is why **tampering** - backdating, insertion, obliteration - is treated so gravely, and why the correct way to amend is always additive and transparent rather than concealing.

RULE **A record's value is a function of its being contemporaneous and unaltered; a correction is made by open amendment, never by erasure.** The point is not perfection at the moment of writing but honesty over time. An entry made late should be dated to the true date of writing and marked as retrospective, not slipped in under an earlier date, and an error should be struck through so the original stays legible, with the correction, initials and date beside it. A chart that can be shown never to have been secretly changed will defend a clinician who erred in good faith; a chart that has been doctored will sink one who did not.

GOOD TO REMEMBER

Write the note as though it will be read aloud in a courtroom with the patient present, because one day it may be. Record the reasoning behind decisions that carry legal weight - why capacity was accepted, why a risk was judged manageable - not just the conclusion. If you must add to a note after the event, say so openly and date the addition to the day you wrote it; the habit costs seconds and is the best protection you have.

11.3 Retention, ownership and the patient's right of access

Two questions follow the making of a record: how long it must be kept, and who may have it. On ownership the settled position is that the custodian - the institution or the self-employed practitioner - holds and preserves the physical record, while the patient has an enforceable right of access to the information within it and to a copy of it. The patient is entitled to a copy, not to carry off the original, and the duty to supply it runs to the patient, an authorised attendant, or a legal authority making a proper request.

3 years	5 working days
INPATIENT RECORD RETENTION UNDER THE 2023 REGULATIONS (IN ABEYANCE)	SUPPLY OF RECORDS ON A PROPER REQUEST

Currency is where this topic is won or lost. The clearest recent statement of a retention standard is the National Medical Commission's Registered Medical Practitioner (Professional Conduct) Regulations 2023; but those Regulations, though notified, were held in abeyance shortly afterwards and are therefore not the operative code. The live professional-conduct code remains the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002, whose provisions are set out in this chapter's account of the professional-conduct codes. Read with that caveat, the 2023 Regulations provide at Regulation **13** that a self-employed practitioner shall maintain inpatient medical records for **3 years** from the date of last contact with the patient, in a standard **proforma** laid down by the Commission, and that records requested by the patient, an authorised attendant or a legal authority shall be supplied within **5 working days**. The same regulation would also require records to be fully digitised in due course, in compliance with information-technology and data-protection law. All of this describes the suspended 2023 text, not a prediction of the eventual operative code, which a further Gazette notification could revive, amend or replace; the requirement that binds a practitioner today is the one the operative 2002 code lays down.

TRAP **Quoting a retention period without the event it runs from, or across the wrong code.** Under the suspended 2023 Regulations the inpatient clock runs from the date of last treatment contact, not from admission and not from discharge, so a return for follow-up would reset it; the operative 2002 code's own starting point is owned by this chapter's account of the professional-conduct codes and must not be assumed identical to the suspended one. Candidates who quote a bare number of years without its starting point answer half the rule, and the starting point is exactly the half an examiner tests. State the period, the event it runs from, and which code you are quoting, or the figure means nothing.

IN INDIA

Access to records in India runs on parallel tracks. The professional-conduct code obliges the treating practitioner to furnish records on request; for a public hospital the same information is reachable through the right-to-information machinery; and the Mental Healthcare Act carries its own provisions on records and on a patient's access to information, which belong to the Mental health legislation and forensic psychiatry notes and are named, not restated, here. What may actually be released, and when confidentiality is set aside, is governed not by the retention rule but by the duty of confidentiality set out in this chapter's account of confidentiality and its limits.

PITFALL

Quoting the National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations 2023 as the code in force. They were notified and then held in abeyance, and the operative professional-conduct code remains the Indian Medical Council Regulations 2002. Citing them as live - in a report, an opinion or an examination answer - states as currently binding a code that commenced on publication but was then held in abeyance, and is the commonest currency error here. Name the 2002 code as operative and the 2023 Regulations as notified but in abeyance.

11.4 Certification and the duty of truthful attestation

A **medical certificate** is a formal attestation, over the doctor's signature, of a clinical fact - fitness or unfitness, the presence or absence of illness, a capacity or its lack. Its authority rests entirely on two things: that the signing doctor personally examined the patient and formed the opinion, and that the record behind it supports what the certificate asserts. A certificate is thus only as good as the notes from which it is drawn. The governing duty is truthfulness: the practitioner attests only what has been personally verified and does not issue a false, misleading or loosely worded certificate, a failing the professional-conduct code treats as misconduct, as set out in this chapter's account of the professional-conduct codes.

Psychiatric certification spans a distinctive range, and each type carries its own evidential demand:

CERTIFICATE	WHAT IT ATTESTS	WHAT THE RECORD MUST SHOW
SICKNESS AND FITNESS	Unfitness for, or fitness to resume, work or duty over a stated period	Dated examination findings and the functional basis for the opinion
MENTAL ILLNESS OR SOUNDNESS	The presence or absence of a mental disorder for a defined legal purpose	A recorded mental state examination and the clinical reasoning behind the finding
TESTAMENTARY AND OTHER CAPACITY	That the person could, at the material time, understand and weigh a specific decision	A contemporaneous, decision-specific capacity assessment, ideally at the time of the act
DISABILITY CERTIFICATION	The degree of disability arising from a mental condition, for statutory benefit	Assessment against the applicable schedule, with the instrument and findings on file

Two need a word of care. The **testamentary capacity** certificate is decision-specific and time-specific: it speaks to the person's ability to make a particular disposition at the particular moment, so a general statement of soundness recorded weeks before or after is of little value, and the strongest evidence is a capacity assessment documented at the time of the act itself. And a certificate touching a person's fitness to face criminal proceedings engages criteria that are not this fragment's to teach - the fitness-to-stand-trial criteria belong to the Mental health legislation and forensic psychiatry notes and are named, not restated, here; what this topic owns is the standard for the certificate and the record beneath it, not the legal test it serves.

11.5 When the record becomes evidence

The record's final role is one the clinician does not control. A chart can be summoned to court, produced under a legal authority's request, or made the foundation of an expert opinion, and at that point every quality discussed above is examined by an adversary. The treating record and the forensic report are different documents made for different masters - the first for the patient's care, the second for the court - and the discipline of keeping the treating role separate from the expert role belongs to this chapter's discussion of the psychiatrist as expert witness, named here rather than reworked. What the records topic contributes is the raw material: an opinion offered to a court is only as sound as the contemporaneous notes it is built on, and a report that cannot point back to a dated, unaltered record is opinion floating free of evidence. This is why documentation is not clerical housekeeping but the load-bearing wall of forensic practice, the place where good clinical care and defensible legal standing turn out to be the same thing.

12 · Ethical issues in involuntary treatment, restraint and end-of-life care

Every coercive act in psychiatry has to be justifiable to the person it is done to. Involuntary treatment, physical restraint and decisions about life-prolonging care are the three moments at which what a person wants is most openly at stake: the first two override an expressed wish, while withholding or withdrawing life-prolonging treatment is often instead the way a capacitous refusal or a recorded wish is honoured. They are examined together because one ethical spine runs through all three: coercion is defensible only as the narrowest, most proportionate response

to a genuine necessity, and it must stay answerable to the person's own will and preferences. The statutory machinery that gives that spine force - the emergency-treatment power, the prohibited and restricted procedures, the seclusion-and-restraint provision and the advance directive - is set out in the Mental health legislation and forensic psychiatry notes and is named here, not re-worked.

The four principles of biomedical ethics are invoked by name rather than re-defined, as laid out in this chapter's account of the principles of medical ethics; valid consent belongs to its account of informed consent in psychiatry, and the legal safeguards around seclusion and restraint to its account of the legal aspects of seclusion, restraint and involuntary treatment. What this topic owns is narrower: how those principles are weighed when a patient refuses the treatment thought to be in their interest, and how the weighing shifts from acute crisis, through restraint, to the end of life.

12.1 The ethical spine: least restriction, proportionality and will

Three ideas together decide whether an override of a patient's choice can be defended. The first is the **least restrictive alternative**: of the options that meet the clinical need, the one chosen must intrude least on liberty, bodily integrity and dignity, so restraint is used only when nothing milder will do and is stepped down the moment a gentler option becomes safe. The second is **proportionality**: the degree and duration of coercion must match the seriousness and imminence of the harm it prevents, so open-ended control is never the answer to a transient risk. The third, which most separates the current Indian frame from older paternalism, is that care must be anchored to the person's **will and preferences** - what this patient, knowing themselves, would want - not what a clinician judges good for a generic patient in that position.

These five conditions - necessary, proportionate, least restrictive, time-limited and reviewable - turn a vague sense that coercion is regrettable into a standard testable at the bedside and in the witness box. A measure that fails any one is not merely suboptimal; it is unethical, and increasingly unlawful.

RULE **Coercion is justified only as the least restrictive measure proportionate to a genuine and present necessity, and only for as long as that necessity lasts.** This one sentence is the whole topic in miniature. The question is never simply "is this good for the patient" but "is this the mildest thing that will meet a real and immediate danger, and can I stop it the moment the danger passes". Every rule that follows is an application of it.

MNEMONIC

Necessary, Proportionate, Least-restrictive, Time-limited, Reviewable

The five tests any coercive measure must pass. **N**ecessary (no non-coercive route will do); **P**roportionate (matched to the danger); **L**east-restrictive (the mildest effective form); **T**ime-limited (no longer than the necessity); **R**eviewable (open to reassessment and challenge). A measure you can defend on all five, you can defend anywhere.

12.2 Involuntary treatment and the narrow window of emergency

Treatment given against a refusal is the sharpest form of coercion, and the ethical burden is correspondingly heavy. It rests not on the fact of illness or the clinician's confidence that treatment would help, but on necessity, the absence of a less intrusive route, and wherever possible a substitute decision made through the person's chosen representative. Indian law keeps the power to treat outside ordinary consent exceptional and tightly bounded. The Act's emergency-treatment provision allows treatment only where it is immediately necessary to prevent death or irreversible harm, serious harm by the person to self or others, or serious damage to property flowing from the illness; where the nominated representative is available, emergency treatment is subject to their informed consent; and, most tellingly for proportionality, the power is capped in time. Emergency treatment is limited to **seventy-two hours**, or until the person is assessed at a mental health establishment, whichever comes first, and may extend to **seven days** only during a disaster or emergency declared by the appropriate Government.

Two features are ethically load-bearing. It is a bridge, not a treatment plan: it holds a person safely until proper assessment and consent can happen, which is why it expires. And it is no licence for any intervention the clinician thinks necessary; the emergency power shall not extend to electroconvulsive therapy, which cannot be given under cover of emergency at all. The detailed conditions are set out in the Mental health legislation and forensic psychiatry notes; what matters here is the shape - a power that is necessary, proportionate and self-terminating.

> **GOOD TO REMEMBER**
>
> Your defence for an emergency intervention is a contemporaneous note of the specific danger, the less restrictive options you weighed and why they failed, and the point at which you sought the nominated representative. "The patient was unwell" is not a justification; "the patient was about to act on a command to jump and refused oral medication" is. Record it while it is in front of you: the power is short-lived and the note is what proportionality is later judged against.

12.3 Restraint and seclusion: the least-restrictive ladder

Physical containment is where least restriction does its hardest work, because the measures form a ladder and the demand is to stay as low on it as safety allows and climb down fast. Restraint manages an immediate risk; it is never a treatment or a convenience, uses minimum force for the shortest duration that will contain the danger, and is released the moment that danger recedes.

- **Verbal de-escalation and environmental measures:** the first resort whenever it is safe and feasible, and often enough on their own; the least intrusive rung. Immediate physical restraint may still be required where it is the only means available to prevent imminent and immediate harm.
- **Seclusion and solitary confinement:** not a rung on the ladder at all; a person with mental illness shall not be subjected to seclusion or solitary confinement, which are barred outright and cannot be made lawful by monitoring or a time limit.
- **Physical restraint:** the highest rung short of the floor, minimum force for the shortest time; its exact authorisation and monitoring safeguards are set out in the Mental health legislation

and forensic psychiatry notes.

How physical restraint may lawfully be used, and its safeguards, belongs to the Mental health legislation and forensic psychiatry notes and to this chapter's account of the legal aspects of seclusion, restraint and involuntary treatment; seclusion and solitary confinement of a person with mental illness are prohibited outright. What the ethics fixes as an absolute is the floor beneath the ladder: no person with mental illness **shall be chained** in any manner or form whatsoever, and the bar holds because chaining is degrading regardless of the danger it might contain. Below a certain point, restraint stops being a graded response and becomes an assault on dignity, and the law draws that line without exception.

12.4 The absolute bars and the one conditional gate

The clearest ethical teaching here is the small set of procedures the law places out of bounds, each a point where consent and best interests are judged insufficient protection. Three are absolute. **Unmodified electroconvulsive therapy**, meaning electroconvulsive therapy given without muscle relaxants and anaesthesia, is prohibited outright and cannot be rescued by consent, because the harm it risks is not one a patient can validly agree to run. Sterilisation intended as a treatment for mental illness is prohibited, closing off a historic abuse in which reproductive capacity was removed under a therapeutic pretext. And chaining is barred in any form. The single conditional gate is electroconvulsive therapy for a minor: prohibited by default, but where the psychiatrist in charge of the minor's treatment is of the opinion that it is required, it shall be given only with the informed consent of the guardian and the prior permission of the concerned Board. The structure to carry is an absolute prohibition softened by a narrow, externally checked exception, not by clinician discretion alone.

MEASURE	ETHICAL AND LEGAL STATUS	WHAT THE FLOOR TURNS ON
CHAINING, IN ANY FORM	Barred absolutely	Degrading regardless of the danger contained
UNMODIFIED ELECTROCONVULSIVE THERAPY	Barred absolutely; consent cannot cure it	A harm a patient cannot validly agree to run
STERILISATION AS A TREATMENT FOR MENTAL ILLNESS	Barred	Closes a historic reproductive abuse
ELECTROCONVULSIVE THERAPY FOR A MINOR	Barred by default; a narrow gate	Guardian's informed consent plus prior Board permission
EMERGENCY INVOLUNTARY TREATMENT	Permitted but tightly bounded	Time-limited, and excludes electroconvulsive therapy

TRAP **Believing that consent can license an absolutely prohibited procedure, or that a grave enough emergency justifies electroconvulsive therapy.** Candidates reason that guardian or patient consent makes unmodified electroconvulsive therapy or a "therapeutic" sterilisation permissible, and that a serious enough emergency lets a clinician reach for electroconvulsive therapy. Both are wrong: the absolute bars operate above the level of consent, and the emergency power is defined so as to exclude electroconvulsive therapy. Consent is a gateway for permitted treatment, not a key to prohibited treatment.

12.5 End-of-life care: autonomy at the close of life

The same spine bends at the end of life, but it does not break. End-of-life care tests the will-and-preferences principle at its limit, because the patient may be dying, may have fluctuating or absent capacity, and may have recorded wishes long before the crisis. The psychiatrist's role is often not to decide but to assess: whether this patient can accept or refuse a life-prolonging intervention, and whether a treatable mental illness, depression above all, is so distorting the decision that an apparent wish to die is a symptom to treat rather than a settled preference to honour. Making that discrimination well, and documenting it, is the examinable core of the psychiatrist's end-of-life contribution.

Three distinctions carry the ethical weight. A refusal by a person with capacity, or through a valid advance instruction, is not the same as a request that the clinician actively bring about death; respecting the first is autonomy, the second a separate legal and moral question. Withholding or withdrawing an intervention of no proportionate benefit is not abandonment, because comfort, symptom relief and dignity are owed whatever else is stopped. And the **doctrine of double effect** is the frame invoked for proportionate sedation or analgesia given to relieve suffering where shortening of life is a foreseen risk rather than the aim; a relief-directed intention is necessary to it, but the doctrine's conditions are not reducible to intention alone, so it cannot be cited as a single-condition licence. Wishes recorded in advance should guide care as an expression of will and preferences; the statutory form and force of the advance directive belong to the Mental health legislation and forensic psychiatry notes.

12.6 Will and preferences over best interests

The deepest change the current Indian frame makes is a shift of default. The older posture was best-interests: the clinician decided what was good for the patient and acted on it. The newer posture is **supported decision-making**, in which the patient's own will and preferences govern and the clinician helps the person exercise their capacity rather than substitute a judgment for it. Coercion does not vanish but retreats to the margins, permitted only where a real necessity cannot be met any other way. The broader disability-rights statute underpinning this posture is set out in the Mental health legislation and forensic psychiatry notes.

> **PITFALL**
>
> The commonest real-world error is not cruelty but well-meant paternalism: a clinician sure they know best treats "best interests" as the deciding standard and reads the patient's stated wishes as an obstacle to manage rather than the thing that governs. Under a will-and-preferences frame that inversion is itself the fault. Start from what the person wants, treat capacity as something to be supported rather than presumed absent, and reserve override for genuine, documented necessity.

IN INDIA

The current mental health law is explicitly rights-based: it abolishes chaining outright, channels the most invasive procedures through consent and independent review, keeps the emergency power short and ring-fenced from electroconvulsive therapy, and subordinates treatment to the person's will and preferences rather than an unaided best-interests judgment. The working question shifts from "what is best for this patient" answered alone to "what does this patient want, and what is the least I must do to keep them safe".

94
EMERGENCY TREATMENT: TIME-LIMITED, AND NO ELECTROCONVULSIVE THERAPY

95
PROHIBITED PROCEDURES: CHAINING, UNMODIFIED ELECTROCONVULSIVE THERAPY, STERILISATION

One test governs involuntary treatment, restraint and end-of-life care: coercion is permissible only as the least restrictive, proportionate response to a genuine and present necessity, no longer than that necessity lasts, and always anchored to the person's will and preferences rather than the clinician's unaided view of their best interests; chaining and unmodified electroconvulsive therapy are barred absolutely, sterilisation as treatment is barred, and electroconvulsive therapy for a minor is permitted only through guardian consent and prior Board permission.

13 · Telepsychiatry ethics and social media professionalism

Why the marks are here. Telepsychiatry moved from a fringe convenience to routine practice almost overnight, and the ethics did not keep pace with the technology. The examiner's interest is precise: does the candidate understand that a consultation delivered down a video link owes the patient exactly the same duties as one delivered across a desk, and does the candidate know which code actually governs it in India today. Both halves of the topic - the clinical encounter conducted remotely, and the doctor's separate life on social and public media - test the same instinct, which is that the medium never dilutes the obligation. The currency of the governing rules has also shifted recently, and that shift is a favourite trap.



- Identity and location
- Consent
- Privacy
- Clinical standard unchanged
- Emergency plan
- Professional digital conduct

Fig 26.9 Telepsychiatry changes the medium, not the clinical standard. Identity and location, consent, privacy, documentation and an emergency contingency are established for remote care, while public and social-media conduct remains professionally bounded.

What this section owns is the ethics of remote consultation and of a psychiatrist's conduct in the public digital sphere. The four principles that frame every ethical judgement are set out with the principles of medical ethics in these notes; the anatomy of valid consent is taught with informed consent in these notes; the default duty of confidentiality and the closed list of when a disclosure is permitted are taught with confidentiality and its limits in these notes; and the professional-conduct code itself is treated with the professional-conduct codes in these notes. Those are invoked here, not restated.

13.1 What telepsychiatry is, and why the medium raises the stakes

Telepsychiatry is the delivery of psychiatric assessment, treatment and consultation through information and communication technology when patient and clinician are not in the same room. It spans real-time video and telephone contact and the store-and-forward exchange of clinical information, and it reaches rural and underserved populations that would otherwise

never see a psychiatrist. That reach is its ethical justification and also its hazard: a discipline whose primary instrument is the interview loses part of that instrument at a distance. Subtle motor signs, the smell of alcohol, the atmosphere of a household, the collateral in the waiting room - a proportion of the mental-state examination simply does not travel down a video link. The ethical task is to decide, case by case, whether what remains is enough to discharge the standard of care, and to recognise when it is not.

The peculiar risk of psychiatry is that the high-risk presentations a remote service must be ready for - acute distress, suicidality, psychosis with impaired insight - are exactly those in which a remote encounter is least able to contain risk. Convenience and access must therefore be weighed against the clinical adequacy of the channel, not assumed to settle the matter.

13.2 The regulatory basis, and the currency question

Telepsychiatry in India is not a legal vacuum, but candidates routinely cite the wrong instrument as its source. The recently notified National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations address it directly: at Regulation **29**, consultation by telemedicine *is permissible*, but only on the condition that it follows the **Telemedicine Practice Guidelines**. That conditionality is the point: the permission and its precondition are a single rule, and telemedicine detached from the Guidelines is not authorised practice. The Guidelines themselves supply the operational scaffold - the modes of consultation, the identification of both parties, the framework for prescribing at a distance - which is applied, not reproduced, here.

The currency trap sits one layer up. Those Regulations came into force on publication but were then held in abeyance and are **not** currently operative; the code that actually governs a psychiatrist's conduct remains the earlier Medical Council of India professional-conduct code, treated with the professional-conduct codes in these notes. The safe posture in the exam and in practice is to take the substance of remote-consultation practice from the Telemedicine Practice Guidelines themselves, and to treat that regulation as notified-but-suspended text rather than transplanting it into the live code. A written answer that names the newer Regulations as the operative code is stating a code that came into force on publication but was then held in abeyance and is not currently operative.

IN INDIA

Remote consultation received its first clear national footing through the Telemedicine Practice Guidelines, later carried into the newer National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations at Regulation **29**. Those Regulations stand notified but in abeyance; the operative statutory code is still the Medical Council of India professional-conduct code, taught with the professional-conduct codes in these notes. Ground your answer in the live code and read the newer provision for its content.

13.3 Consent, confidentiality and the standard of care at a distance

Every ethical obligation of an in-person consultation survives the move to a screen; what changes is the effort needed to satisfy it. Valid consent, whose three elements are taught with informed consent in these notes, must additionally cover the modality itself: the patient should understand

that this is a remote consultation, its limits, what happens if the connection fails, and how an emergency will be handled. Confidentiality is governed by the same default duty and the same closed list of permitted disclosures taught with confidentiality and its limits in these notes; the remote setting does not create a fresh licence to disclose, but it multiplies the ways confidentiality can leak - an unsecured platform, a household member off-camera, a session recorded without consent, records held on a personal device. The **standard of care** is the anchoring construct: it is set by what a reasonable psychiatrist would do, and it does not fall because the encounter is remote.

OBLIGATION	IN-PERSON CONSULTATION	TELEPSYCHIATRY CONSULTATION
Consent	To assessment and treatment	Also to the remote modality and its limits
Standard of care	Reasonable clinical practice	The same standard, or refer to in-person care
Confidentiality	The room and the record	The platform, the setting at both ends, the stored data
Identity	Established directly; verified where required	Actively verified for patient and clinician
Emergency and risk	Managed in the room	Needs a pre-agreed local escalation plan

RULE **The medium changes the method, never the duty.** A remote consultation is held to the same standard of care, the same consent and the same confidentiality as a face-to-face one. Where the channel cannot support that standard for a given patient, the ethical answer is to convert to in-person care, not to lower the bar to fit the link.

TRAP **Believing the duties relax because the encounter is remote.** Candidates treat telepsychiatry as a lighter form of practice with softer obligations. The reverse is true: the same duties apply, and several - identity, confidentiality, emergency planning - actually demand more work to discharge at a distance.

13.4 When a remote encounter is not enough

Recognising the limits of the channel is itself an ethical duty, because persisting with an inadequate medium is a breach of the standard of care. Remote consultation is poorly suited, and often should give way to in-person assessment, in situations such as:

- acute suicidality or a patient who cannot be kept safe remotely;
- a first presentation of possible psychosis where insight and reality-testing must be examined directly;
- the need for a physical examination, an injectable, or supervised administration;
- a patient who cannot consent to or operate the technology, or lacks a private space;
- any encounter where identity, or the presence of a coercive third party off-camera, cannot be assured.

None of these forbids telepsychiatry outright; each demands a judgement that the remote channel can still deliver safe care, and a readiness to escalate to a physical review when it cannot.

13.5 Social media and public professionalism

A psychiatrist's conduct online is a professional matter and not merely a private one: the duties of confidentiality, restraint in advertising and general professional conduct that the operative code imposes follow the doctor onto the screen. The newer Regulations go further and address the medium directly: at Regulation **20**, a practitioner's conduct on social, electronic and print media *shall follow* the prescribed **Social Media Guidelines**, a dedicated framework that stands notified but in abeyance with the rest of that code. That provision is the codified form of what is better called **digital professionalism**: the recognition that a doctor carries the profession's standards into every public post. The recurring failures are specific to psychiatry. Confidentiality is breached by a case detail vivid enough to identify a patient even when the name is withheld. Boundaries erode when a treating psychiatrist accepts a patient's friend request or drifts into personal messaging, blurring the therapeutic frame that the work depends on. And the reach of a post multiplies both harms: an indiscretion that a corridor would swallow can travel to thousands. The corrective is to treat every public communication as though a patient, a colleague and a regulator will all read it, because any of them may.

GOOD TO REMEMBER

Keep one clear line between a professional presence and a personal account, and never take a treating relationship into either. Do not accept patients into your private social networks, do not discuss identifiable cases even in disguised form, and assume any post is permanent and public. If you use messaging for clinical contact, agree its scope with the patient and keep it inside the record, not on a personal phone.

13.6 Advertising, self-promotion and the boundary of legitimate announcement

The same conduct code that governs the consulting room governs how a psychiatrist may present a practice to the public, and here too the digital age has widened the temptation. The newer Regulations draw the line tightly: at Regulation **11** a practitioner may make only limited formal announcements - the starting, change or resumption of practice, a change of address, and a declaration of charges - and an institutional advertisement may not carry more than the name, the type of patients treated, the staff, the facilities and the fees. Everything beyond that factual minimum, particularly the soliciting of patients or the claiming of superiority, falls outside what an announcement may contain. The principle is old and survives the change of medium: a doctor informs the public of a service, and does not tout for custom. A polished website, a sponsored post or a testimonial reel is subject to the same restraint as a newspaper notice once was.

PITFALL

The commonest real-world error on this topic is citing the newer National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations as the operative code. They came into force on publication and were then held in abeyance, so a clinician who governs their advertising, telemedicine or social-media conduct by them alone is following rules that are not currently in force. The live code remains the Medical Council of India professional-conduct code, taught with the professional-conduct codes in these notes; read the newer provisions for substance but comply with the code that is actually operative.

Whatever the channel - a video link, a public post or an advertisement - the psychiatrist owes the same duty of care, confidentiality and honesty, and the currently operative code is the Medical Council of India professional-conduct code, not the newer Regulations still held in abeyance.

Disaster, prisoners and forensic special topics

14 · Disaster Management Act 2005 (psychiatric relevance)

A disaster statute earns its place on a forensic syllabus because it is administrative law the psychiatrist has to work inside, not around. Mass-casualty events - floods, earthquakes, industrial and transport accidents, epidemics - produce a predictable surge of acute stress reactions, grief, sleep disturbance, exacerbation of pre-existing illness and, in a minority, persistent post-traumatic and depressive morbidity. The clinician who wants to deliver care in that setting does not command the response; a statutory authority does. The examinable content is deliberately narrow: the architecture the Act builds, who heads each level of it, what the Act says disaster management is, and - the point most candidates miss - what it conspicuously does not say. Get those, and you can locate the psychiatric role precisely; miss them, and you will keep looking for a legal mandate the statute never wrote down.

Teach this as what it is: a piece of administrative machinery. The Act does not create clinical duties, define capacity, or authorise treatment; those belong to the mental-health statute and are developed in the Mental health legislation and forensic psychiatry notes. What it does is build a chain of authority from the national government down to the individual district, and then define the process those authorities are to run. The psychiatric role has to be read into that structure, because the structure will not hand it over.

14.1 A tiered command structure, not a clinical statute

The Act builds authorities at successive levels of government. It constructs a vertical chain: a national authority at the apex, a mirror authority in every State, and an operational authority in every district. Each is headed **ex officio** by the executive of its level, which is the deliberate design point - disaster response is treated as a whole-of-government function commanded from the top of government rather than by a technical body advising from the sidelines. At the

national and State tiers that head is the elected political executive; at the district tier it is the administrative executive - the Collector, District Magistrate or Deputy Commissioner - sitting alongside an elected local-authority co-chairperson. The comparison below fixes the section, the head and the establishing duty for each level; commit the section numbers, because a report or an answer that misplaces them signals unfamiliarity with the primary Act.

LEVEL	STATUTORY SECTION	CHAIRPERSON, EX OFFICIO	THE ESTABLISHING DUTY
National (apex)	section **3**	the Prime Minister	an authority shall be established for the purposes of the Act
State	section **14**	the Chief Minister of the State	every State Government shall establish an authority for the State
District	section **25**	the Collector, District Magistrate or Deputy Commissioner (co-chaired by the elected local-authority representative)	every State Government shall establish an authority for every district

The chain of authority the Act creates. Note that the head of each level is fixed by office, not appointed for expertise, and that the duty to establish the State and district authorities is mandatory and lies with the State Government.

Read the establishing duties for the modal verb, because it is examinable. At every level the statute is mandatory: the national authority *shall be established*, and every State Government *shall establish* both its State authority and a district authority for every district. There is no discretion in whether the machinery exists. What the Act leaves open is operational - how each authority discharges its functions - not whether it comes into being.

14.2 The apex and the State tiers

The national authority sets the policy floor. At the top the Act establishes the **National Disaster Management Authority**, under the establishment section set out above, chaired ex officio by the Prime Minister with not more than **nine** other nominated members. As the apex body its work is national in scope: it is the source of country-wide policy, plans and guidance, which is exactly why any national statement on how mental-health and psychosocial needs are to be met in disasters is issued from this level rather than written into the parent Act. Hold that distinction, because it explains where the mental-health content actually lives - in guidance under the machinery, not in the sections that build it.

The State authority mirrors the apex. One level down, the Act requires each State to constitute a **State Disaster Management Authority**, under its State-tier section, chaired ex officio by the Chief Minister. Its role is to translate national policy into a State plan and to coordinate the State's departments - health among them - so that a directive from the apex becomes a deliverable service on the ground. For the psychiatrist this is the tier at which mental-health

services are meant to be built into the State's disaster health response, alongside the rest of the health system.

14.3 The district tier, and why it is the one you will meet

This is where response actually happens. The **District Disaster Management Authority**, established under the Act's district-tier section, is the operational cutting edge of the whole structure - the level closest to survivors and the one that runs relief, rescue and coordination on the affected ground. Its chairperson is fixed by office: the Collector, District Magistrate or Deputy Commissioner heads it ex officio, and, distinctively at this level, the elected local-authority representative sits as ex officio co-chairperson, pairing the administrative head with local political representation. A clinician deployed into a disaster response is, in practice, working within this district authority's plan and under the district administration's coordination, not answering directly to the State or national bodies.

MNEMONIC

Prime Minister for the nation, Chief Minister for the State, Collector for the district

The head of each authority is the political or administrative executive of its own level, sitting by virtue of office rather than expertise. Only the district level adds a co-chairperson - the elected local-authority representative - which flags it as the tier where administration and local representation meet the survivor.

RULE **The Disaster Management Act is a chain of administrative authority, not a mental-health statute.** It mandates authorities at national, State and district level, each headed ex officio by the executive of that level, and defines the process they must run. It creates no clinical duty and names no psychiatric service, so the mental-health role must be located within its general functions, not read off an express provision.

14.4 What the Act means by disaster management - and its silence on mental health

The definition is broad, cyclical and process-oriented. The Act defines **disaster management**, at section **2(e)**, as a continuous and integrated process rather than a one-off emergency reaction. That process runs across the whole disaster cycle: preventing danger, mitigating risk and severity, building capacity, preparing to respond, mounting a prompt response, assessing the magnitude of effects, carrying out evacuation, rescue and relief, and finally rehabilitation and reconstruction. The pedagogical point is the shape: the statute conceives of management as spanning the time before, during and long after the event, which is precisely the time-course over which psychiatric morbidity emerges and recovers.

Now the omission that carries the marks. Read that definition again for what is absent. Nowhere in it does the Act name psychosocial or mental-health support as an express limb of disaster management. The functions it enumerates are physical and administrative - risk, rescue, relief, reconstruction - and the psychological dimension is simply not written in as a category of its own. This is not a drafting accident to be corrected in an answer; it is the settled position of

the primary text, and the honest teaching is to state it plainly and then show where the mental-health role has to be fitted instead: inside **capacity-building**, preparedness, response and rehabilitation, each of which can carry a psychosocial component even though none is labelled as such.

> **PITFALL**
> Assuming the Act itself contains an express psychosocial or mental-health provision, and then waiting for a statutory mandate that does not exist. Because national guidance on psychosocial support and mental-health services in disasters does exist, it is easy to project that content back onto the parent Act. It is not there. The clinician who understands this does not wait to be named in a section; they embed mental-health care within capacity-building, preparedness and rehabilitation, which is where the general functions leave room for it.

14.5 Locating the psychiatric role within the machinery

The role is real even though the statute is silent. The absence of a named limb does not make mental health optional; it makes it the clinician's job to insert it into the general process the Act defines. Disaster mental-health work maps onto that same cycle. Across it, the psychiatrist's contributions cluster into a few recognisable tasks:

- before the event - training first responders and building local capacity, so that psychological needs are anticipated rather than discovered;
- in the acute phase - **psychological first aid** and the triage of acute distress, distinguishing normal acute reactions from those needing active intervention;
- in relief and rehabilitation - continuity of treatment for people with severe mental illness whose medication and follow-up have been interrupted, and detection of the delayed post-traumatic and depressive morbidity that surfaces weeks to months later.

Continuity of care is the quiet emergency. The most avoidable harm in a disaster is not the new-onset disorder but the interruption of existing treatment: a person already stabilised on psychotropic medication who loses their supply, their prescriber and their records when services collapse. Restoring that continuity, and where necessary arranging care under the ordinary mental-health law, is squarely within the response and relief functions of the district authority, and the legal framework for such care sits in the Mental health legislation and forensic psychiatry notes, not in this Act. The disaster statute tells you which authority coordinates the response; the mental-health statute tells you how care may lawfully be given.

Equity is the ethical hinge. Disaster settings force allocation decisions - whose distress is attended to first when the need vastly exceeds the resource - and the principle of justice in the fair distribution of scarce care is the frame the psychiatrist brings to that. The principles of biomedical ethics are developed elsewhere in this chapter and are invoked, not re-listed, here; what matters for this topic is that the machinery gives you the coordinating authority, and the ethics gives you the priority rule for working within it.

IN INDIA

Because the definition of disaster management names no psychosocial limb, mental-health and psychosocial support in Indian disasters is delivered through guidance issued under the national authority and operationalised down the chain to the district level, rather than through an express section of the Act. In practice the clinician interfaces with the district authority under the Collector or District Magistrate, whose plan coordinates the response on the ground. Read the governing plan and the current national guidance from primary sources rather than from memory, because the Act itself will not point you to the mental-health role.

GOOD TO REMEMBER

If you are deployed, the authority you actually work within is the district one, headed by the Collector or District Magistrate, with the elected local representative as co-chair. That is where you register your service, plug into the coordinated response, and locate mental-health care inside the relief, response and rehabilitation functions. Do not wait for a statutory instruction naming psychiatry; the Act does not give one, and the role is yours to insert.

TRAP **Misassigning the heads of the three authorities.** The apex authority is chaired by the Prime Minister, the State authority by the Chief Minister, and the district authority by the Collector, District Magistrate or Deputy Commissioner, with the elected local-authority representative as co-chairperson. Candidates lose the mark by handing the State authority to the Governor or the district authority to the Superintendent of Police; each head is fixed by office at its own level, and only the district tier carries a co-chair.

3	14	25	2(e)
SECTION ESTABLISHING THE NATIONAL AUTHORITY, CHAIRED BY THE PRIME MINISTER	SECTION REQUIRING A STATE AUTHORITY, CHAIRED BY THE CHIEF MINISTER	SECTION REQUIRING A DISTRICT AUTHORITY, CHAIRED BY THE COLLECTOR	THE DEFINITION OF DISASTER MANAGEMENT

The Disaster Management Act builds authorities at national, State and district level, each headed ex officio - by the Prime Minister, the Chief Minister and the Collector or District Magistrate respectively, the district tier alone carrying an elected co-chairperson. Its definition of disaster management spans the whole cycle from prevention to reconstruction but names no psychosocial or mental-health limb, so the psychiatric role must be located within the general functions of capacity-building, preparedness, response and rehabilitation.

15 · Mental health of prisoners and forensic psychiatry services

Where this topic sits. A prison gathers, into one closed population, almost every risk factor a psychiatrist studies separately: poverty, substance use, head injury, trauma, social exclusion and untreated illness. It then strips away most of what protects mental health. The predictable result is that psychiatric morbidity in custody runs far above the community rate, while the services meant to answer it are thinnest exactly where the need is greatest. This topic asks two linked

questions: what is the mental health of prisoners, and what services, inside the prison and across the wider **forensic psychiatry** system, meet it.

What earns the marks here is not a table of prevalence figures but a service architecture and the single principle that organises it. You are expected to describe how psychiatric care actually reaches a prisoner, to place the Indian statutory backdrop correctly, and to keep a forensic psychiatry service distinct from the medico-legal assessments taught in neighbouring topics. The route by which a mentally ill prisoner is transferred into hospital care is developed in the companion account of the transfer and treatment of mentally ill prisoners, and the dignity and rights framing in the account of human rights and ethical issues in custodial psychiatry; the focus here is the burden and the service response to it.

15.1 The burden: psychiatric morbidity is concentrated in custody

Prisoners carry a marked excess of mental disorder across the whole diagnostic range. Relative to an age-matched community sample, custodial populations show more psychotic illness, more mood and anxiety disorders, far more substance use disorder, a high load of personality disorder, and an over-representation of intellectual disability and acquired cognitive impairment. This is a compounded burden, not a single condition, which is why a prison mental health service cannot be built around one diagnosis. The excess is real, large and consistent across settings; the precise magnitudes vary by jurisdiction and instrument.

Two mechanisms produce the concentration, and a good answer names both. The first is selection: people with mental illness are over-represented among those who enter custody in the first place, through offending linked to untreated illness, homelessness, substance use and the criminalisation of the mentally ill when community care is absent. The second is the effect of custody itself. Juvenile detainees sit under an entirely separate statutory framework and are dealt with in the Child psychiatry: assessment, treatment, services and protection notes; the clinical management of substance withdrawal and dependence in custodial settings belongs to the Substance use disorders notes. Both are named here, not taught.

15.2 Importation and deprivation: why prison generates and worsens disorder

The environment is part of the formulation. The excess morbidity is usually understood through two complementary models. The **importation** model holds that prisoners bring pre-existing vulnerability in with them: prior illness, developmental adversity, substance use and low social capital. The **deprivation** model holds that the custodial environment itself is pathogenic, independent of what a person arrives with. Neither model alone is sufficient; they operate together, and the clinical implication is that a prisoner's disorder cannot be treated as if it were context-free.

The deprivations of custody are specific and psychologically active. Loss of liberty and autonomy, overcrowding, enforced idleness, the threat of violence and bullying, separation from family and children, uncertainty about the future, and the collapse of privacy together constitute a chronic stressor field. Solitary confinement is the most concentrated form and is associated with acute deterioration, self-harm and psychotic phenomena. Because these are environmental

drivers, part of the treatment is sometimes environmental: relocation, occupation, family contact and the removal from isolation, alongside conventional psychiatric care.

15.3 The Indian statutory backdrop: the Prisons Act and its silence

Prison administration in India is still substantially governed by a colonial-era statute, and its treatment of mentally ill prisoners is notable for an absence. The Prisons Act of **1894** contains no substantive stand-alone section devoted to the care of mentally ill prisoners. The only hook is the State Government's rule-making power at section **59**, which at clause **(23)** authorises rules for the treatment, transfer and disposal of criminal lunatics or recovered criminal lunatics confined in prisons. Read the provision precisely: it is a discretionary power under which the State Government *may* make rules, not a substantive duty of care, and it uses the archaic term **criminal lunatic** that both modern law and clinical practice have long abandoned.

The lesson is structural: the primary prison statute does not itself build a mental health service or confer a right to treatment; it merely enables subordinate rules. The substantive machinery for actually moving a mentally ill prisoner into psychiatric care sits elsewhere, combining the older warrant power for removal with the mental-health statute's prisoner-specific provision, and is developed in the companion account of the transfer and treatment of mentally ill prisoners; the general mental-health law machinery belongs to the Mental health legislation and forensic psychiatry notes. That historical silence is why India's prison mental health provision has depended on the later statute, on prison manuals and on the courts rather than on the parent Act.

IN INDIA

The governing prison statute is over a century old and, on mental health, gives only a rule-making power rather than a service. The practical consequence is that a mentally ill prisoner's care depends on the mental-health law, on State prison manuals, and on directions issued by the constitutional courts, rather than on any express care provision in the Prisons Act. When answering, place the substantive rights and transfer route in the mental-health statute and treat the Prisons Act as the historical backdrop, citing the primary Act and clause rather than a remembered figure.

PITFALL

Reading the Prisons Act rule-making power as if it were a substantive care regime, and then treating a mentally ill prisoner's admission or transfer as a matter of prison rules. The enabling clause lets the State make rules; it does not itself authorise clinical care or lawful transfer. The care standard and the transfer route are set by the mental-health law, not by that rule-making power, and a clinician who looks only to the prison statute will not find the authority they need.

15.4 The architecture of forensic psychiatry services

A forensic service is a pathway, not a place. Forensic psychiatry is the subspecialty concerned with the assessment, treatment and risk management of the **mentally disordered offender** and with the interface between psychiatry and the courts. A mature forensic service is not a single

ward but a tiered system that meets the offender at each point of the criminal-justice pathway, from first contact with the police through to eventual return to the community.

SERVICE COMPONENT	WHERE IT OPERATES	PRIMARY FUNCTION
Court liaison and diversion	police station and courts	identify mentally disordered defendants at the earliest point and divert them to health care rather than custody where that is appropriate
Prison in-reach	within the prison	bring specialist mental health assessment and treatment to prisoners in situ, functioning as the prison's equivalent of a community mental health team
Secure forensic inpatient unit	dedicated secure hospital (graded levels of security)	treat offenders who need hospital-level care under conditions of physical, procedural and relational security
Forensic rehabilitation and community forensic team	step-down and community	rehabilitate, supervise and manage risk as the offender transitions out of secure care

The tiers of a forensic psychiatry service, arranged along the offender's pathway. Each tier answers a different need; a system missing any one tier tends to silt up at the level below it, most visibly when the absence of secure beds strands seriously ill offenders in the prison.

The tiers depend on one another. Diversion works only if there is somewhere to divert to; in-reach can identify a prisoner who needs hospital care but cannot deliver it without secure beds; and secure units block if no rehabilitation tier receives their recovered patients. This is why forensic planning is done as a whole system, and why the commonest failure is a bottleneck rather than an absent service.

RULE **Prisoners are entitled to the same standard of health care as the general community.** This is the principle of **equivalence of care**, and it is the organising rule for every prison and forensic mental health service: the fact of imprisonment removes liberty, not the right to health care. It sets the benchmark against which a custodial service is judged, and it is the reason care that would be routine in the community cannot be rationed away simply because the patient is a prisoner. The broader dignity and rights framing is developed in the account of human rights and ethical issues in custodial psychiatry.

15.5 Mental health services within the prison: screening, in-reach and continuity

The service inside the wall begins at the gate. The single most important service element is **reception screening**: a structured assessment at the point of entry, because the early days of custody are the highest-risk window for both crisis and undetected illness. It is not a formality; it is how a service finds the people it must treat before they deteriorate. Its aims are:

- to detect existing serious mental illness and any current treatment that must be continued without interruption;

- to identify acute suicide and self-harm risk in the first, most dangerous nights of custody;
- to flag substance intoxication or impending withdrawal for management under the appropriate protocol;
- to recognise intellectual disability and cognitive impairment that will shape how the prisoner copes and is managed.

From screening, a referral pathway feeds the prison's tiered response: primary mental health care delivered on the wing, specialist in-reach assessment for those who need it, and onward referral for the minority who require hospital-level care, the transfer route covered in the companion account. The quiet failure of prison mental health is discontinuity: care interrupted at the point of entry, or dropped at the point of release, when a person leaves custody without a prescription, a follow-up appointment or a receiving service. Release is a period of markedly elevated relapse and mortality risk.

GOOD TO REMEMBER

Screen at reception and act on it, rather than waiting for breakdown. The prisoners who die or deteriorate are disproportionately those missed in the first days, and the two decisions that change outcomes are continuing established treatment without a gap on the way in, and arranging a warm handover to a community service on the way out. Build the pathway around those two transitions.

15.6 Suicide, self-harm and the crisis end of custodial care

This is where the service is tested hardest. Suicide and self-harm are the sentinel outcomes of a custodial mental health system, and a disproportionate share occurs early in custody, in remand and in the first period after reception, when uncertainty, withdrawal and the shock of imprisonment converge. A credible service therefore runs a suicide-prevention system rather than relying on individual vigilance: identification at reception and at points of change, safer environments, graded observation for those at acute risk, peer support, staff training to recognise and escalate concern, and structured review after every serious incident so the system learns. This is where equivalence of care stops being abstract: the community standard for a person in suicidal crisis is active, urgent intervention, and custody must meet it.

TRAP **Confusing a forensic psychiatry service with the assessment of criminal responsibility.** The service exists to assess, treat and rehabilitate mentally disordered offenders and to run mental health care in prisons; it operates whether or not any insanity defence is ever raised. The criminal-responsibility doctrine, the insanity-defence test and the fitness-to-stand-trial criteria are a separate matter, taught in the Mental health legislation and forensic psychiatry notes. Candidates lose marks by collapsing the whole of forensic psychiatry into the courtroom question of responsibility, when the great majority of forensic clinical work is service delivery to offenders who are simply unwell.

1894	59	(23)
THE PRISONS ACT STILL FORMING THE BACKDROP TO PRISON ADMINISTRATION	ITS SOLE MENTAL-HEALTH HOOK, THE STATE RULE-MAKING POWER	THE CLAUSE ON TREATMENT, TRANSFER AND DISPOSAL OF CRIMINAL LUNATICS

Prisoners carry a large excess of mental disorder, driven together by importation of pre-existing vulnerability and by the deprivations of custody, and are entitled by the principle of equivalence of care to the same standard of mental health care as the community. In India the Prisons Act of 1894 creates no substantive care provision, only a State rule-making power over criminal lunatics, so the substantive care and transfer machinery lives in the mental-health law and the older warrant power it rests on, not in the Prisons Act; the forensic response is a tiered service running from court diversion through prison in-reach and secure inpatient care to community rehabilitation, anchored at reception screening and at the crisis prevention of suicide and self-harm.

16 · Transfer and treatment of mentally ill prisoners

A term of imprisonment does not suspend a person's mental illness, and the law has to answer a plainly administrative question - on whose authority, and to which bed, is a prisoner who is or becomes mentally ill moved for treatment. The examinable content here is narrow but exact, and the marks reward a candidate who can name the operative provision, state the order of preference it lays down, and keep its mandatory language distinct from the older discretionary power it rests upon. Get the sequence wrong, or soften a "shall" into a "may", and you have described a different rule from the one the statute actually enacts.

This account owns the transfer-and-treatment route only. The wider structure of mental health services inside prisons and the forensic psychiatry service belongs to this chapter's account of the mental health of prisoners and forensic psychiatry services and is named here, not rebuilt; the rights lens - dignity, least restriction, non-discrimination in custody - belongs to this chapter's account of human rights and ethical issues in custodial psychiatry. The general machinery of the Act, its definitions, the review board's constitution and powers, capacity and admission, is taught in the Mental health legislation and forensic psychiatry notes; the prisoner-specific transfer provision is what is grounded and taught in full below.

103	2017	30	1900
MENTAL HEALTHCARE ACT SECTION FOR PRISONERS WITH MENTAL ILLNESS	THE MENTAL HEALTHCARE ACT NOW IN FORCE	PRISONERS ACT SECTION IT CROSS-REFERS TO	THE OLDER ACT THAT PROVISION SITS IN

16.1 The provision that supplies the authority

The governing provision is the Mental Healthcare Act, 2017, at section **103**, and its first job is to solve a purely legal problem: what document is enough to lawfully admit a **prisoner with mental illness** into an establishment for care. The answer the section gives is that an order directing such admission, made under any of a specified set of Acts, is by itself enough. Among those specified sources is section **30** of the Prisoners Act, 1900, alongside orders made under the armed-forces Acts and under the criminal procedure law.

The operative words are that such an order "shall be sufficient authority" for admitting the person to the establishment to which they may lawfully be transferred for care and treatment. That

modal verb is the whole point. The section does not create a fresh discretion to be exercised at the prison gate; it declares that a validly made order already carries the legal weight needed, so the receiving establishment need not look behind it for some further sanction. This is **sufficient authority** in the technical sense - a completed legal warrant, not an invitation to reassess.

16.2 The first door: the prison's own psychiatric ward

Having settled authority, the section settles destination, and it does so with an order of preference that is the single most tested feature of the whole topic. The first proviso states that transfer of a prisoner with mental illness to the **psychiatric ward in the medical wing of the prison** shall be sufficient to meet the requirements of the section. In other words, the default and preferred response is to treat the prisoner inside the prison, in a dedicated psychiatric ward, rather than to move them out of custody into an external hospital.

The reasoning behind this preference matters for the answer, not only for practice. Keeping treatment within the prison medical wing avoids the security and continuity problems of moving a prisoner to and from an outside facility, keeps the person within a single accountable custodial system, and reflects the Act's commitment to the least disruptive appropriate setting. The examiner is testing whether you know that the in-prison ward is the statutory first line, because the intuitive answer - send the mentally ill prisoner to a mental hospital - is the second line, not the first.

16.3 The second door, the Board's permission, and the continuing safeguards

The second proviso supplies the fallback and hedges it with a condition. Where there is no provision for a psychiatric ward in the medical wing, the prisoner may be transferred to a **mental health establishment** with the prior permission of **the Board**. Two elements have to be stated together for the mark. First, the external transfer is contingent - it becomes available only when the in-prison ward does not exist, not as a free alternative. Second, it is gated: it requires the Board's permission in advance, not a post-hoc ratification. The review board itself, how it is constituted and what else it does, is a matter for the Mental health legislation and forensic psychiatry notes; here it functions as the authorising gate on the out-of-prison route.

The section does not stop at the moment of transfer. It builds in continuing oversight so that a prisoner moved for mental illness is not simply lost inside the system, and these duties are worth listing because a "state the safeguards" question turns on them:

- a quarterly reporting duty on the prison medical officer;
- powers of visitation exercisable by the Board;
- special reports at six-monthly intervals, giving a fixed rhythm of scrutiny beyond the routine quarterly report;
- a duty on the appropriate Government to establish a mental health establishment in the medical wing of at least **one** prison in each State and Union Territory, so that the preferred in-prison route is actually available and does not collapse into the external transfer for want of a ward.

That last duty is the structural safeguard behind the whole preference: the first-line option only means something if a psychiatric ward physically exists to receive the prisoner, so the statute obliges the Government to build the capacity its own order of preference assumes.

RULE **An order directing admission of a prisoner with mental illness is itself sufficient authority; the first option is the psychiatric ward in the prison's medical wing, and only where no such ward exists may the prisoner be transferred to a mental health establishment, and then only with the Board's prior permission.** The sequence is fixed and conditional, not a menu. Sufficiency of authority is declared in mandatory terms; the in-prison ward "shall be sufficient" to meet the section; the external transfer is the exception, unlocked by the absence of a ward and licensed by the Board in advance. Collapsing this to "a mentally ill prisoner is sent to a mental health establishment" states the fallback as if it were the rule.

16.4 The older statute the section rests on: the Prisoners Act warrant

Section **30** of the Prisoners Act, 1900, is the provision the current section expressly cross-refers to, and it is the historical engine that produces the very "order directing admission" the modern Act then treats as sufficient. Its language is of its era and should be read as such, but its structure is still live. Where it appears to the State Government that a person detained or imprisoned under any order or sentence of a court is of unsound mind, the State Government may, by a **warrant** setting out the grounds of that belief, order the person's removal to a lunatic asylum or other **place of safe custody** within the State, there to be kept and treated as the Government directs for the remainder of the term of detention or sentence.

Two features carry the marks. The power is discretionary - "may, by a warrant" - and it is exercised by the State Government on a stated belief of unsound mind, with the grounds recorded in the warrant itself, which is the accountability check built into an otherwise wide power. And it contains a continuation clause that reaches beyond the sentence: if, on the expiry of the term, a medical officer certifies that further detention under medical care or treatment is necessary for the safety of the prisoner or of others, the person may be kept until discharged according to law. That is how a person can lawfully remain in medical custody after the original sentence has run - not on the executive's say-so alone, but on a medical certification of necessity tied to safety.

16.5 Reading the two provisions together

The clean way to hold this is as one modern authority-and-destination rule sitting on top of an older warrant power. The Prisoners Act warrant produces the order; the Mental Healthcare Act declares that order sufficient and then dictates where the prisoner should go, ward first, external establishment only by exception. Keeping the two verbs straight - the discretionary "may" of the warrant, the declaratory "shall be sufficient" of the modern authority - is what separates a precise answer from an approximate one. The grid sets the contrast out.

AXIS	PRISONERS ACT WARRANT	MENTAL HEALTHCARE ACT PROVISION
FUNCTION	Creates the power to remove a prisoner of unsound mind	Declares an admission order sufficient authority and fixes the destination
WHO ACTS	The State Government, by warrant recording its grounds	The prison system, under the order, subject to the Board for external transfer
MODAL CHARACTER	Discretionary: "may, by a warrant" order removal	Mandatory/declaratory: the order "shall be sufficient authority"
DESTINATION	A lunatic asylum or other place of safe custody within the State	First the prison's psychiatric ward; an external establishment only if no ward exists, with the Board's prior permission
DURATION	Remainder of the term, and beyond it if a medical officer certifies continued detention necessary for safety	Governed by the originating order and applicable law, with quarterly and six-monthly reporting and Board oversight

TRAP **Stating external transfer to a mental health establishment as the standard response for a mentally ill prisoner.** Candidates recall that the prisoner is "sent for treatment" and name the outside hospital, missing that the section makes the psychiatric ward in the prison's own medical wing the first option and treats the external establishment as the exception - available only where no such ward exists, and only with the Board's prior permission. Answer with the order of preference, not with the fallback, because the fallback is the very thing the section is drafted to make secondary.

IN INDIA

This is an entirely Indian statutory scheme with no Western template to borrow. The current authority is the Mental Healthcare Act, 2017, which folded the prisoner provision into the same rights-based Act that governs civil admission, while expressly preserving the older removal power in the Prisoners Act, 1900. The practical gap the Act tries to close is the historical shortage of in-prison psychiatric wards, which is precisely why it lays a duty on the appropriate Government to build a mental health establishment in the medical wing of at least one prison per State and Union Territory.

GOOD TO REMEMBER

When advising on a prisoner who has become mentally ill, look first to the prison's own psychiatric ward, because that is the statutory first line, and reserve transfer to an outside establishment for where no such ward exists - flagging that the external move needs the Board's prior permission before it happens, not after. If care will be needed beyond the end of the sentence, the lawful route to continuation is a medical officer's certification that further detention is necessary for the safety of the person or of others, which is what turns the end of a sentence into grounded continued care rather than unlawful detention.

PITFALL

The section cross-refers to orders made under the criminal procedure law, and those references are to the provisions of the 1973 Code as they stood when the Act was passed. Since the criminal statutes changed on the first of July 2024, an author who cites the old procedural sections as current is quoting a superseded code; the savings position and the current successor provisions are treated in this chapter's account of the current penal-code framework and its transition to the new criminal codes, and should be cross-referred rather than restated here. Name the transfer authority from the Mental Healthcare Act and the Prisoners Act, which are grounded, and do not attach a procedural section number from memory.

An order directing admission of a prisoner with mental illness is sufficient authority under the Mental Healthcare Act, 2017; the first option is the psychiatric ward in the prison's medical wing, and only where no such ward exists may the prisoner be transferred to a mental health establishment, and then only with the Board's prior permission - the power to remove being drawn from the discretionary warrant of the Prisoners Act, 1900.

17 · Human rights and ethical issues in custodial psychiatry

A person does not surrender the right to health, to dignity or to protection from cruelty at the prison gate. Custodial psychiatry is where the ordinary ethics of the profession meet the extraordinary fact that the patient cannot walk away and often cannot freely refuse. The setting concentrates every rights problem the discipline has: liberty is already removed, the environment is coercive, the clinician answers to an institution as well as to the patient, and the people most affected are among the least able to assert a claim for themselves. The marks here are for the rights-and-ethics lens itself, not for the plumbing of prison mental health, and an examiner rewards the candidate who can name the rights at stake, the Indian authority that protects them and the ethical trap the custodial role sets.



- Dignity
- Equivalent care
- Confidentiality
- Protection from cruelty
- Clinical independence
- Dual loyalty

Fig 26.10 A person in custody retains the rights to dignity, health care and protection from cruel or degrading treatment. The psychiatrist must preserve clinical independence and confidentiality while recognising the dual-loyalty pressures created by the institution.

What this topic owns is that lens. The structure of mental health services for prisoners belongs to this chapter's account of the mental health of prisoners and forensic psychiatry services, and the pathway for moving and treating a mentally ill prisoner belongs to this chapter's account of the transfer and treatment of mentally ill prisoners; both are named here and cross-referred, not reworked. The ethical frame for coercion and restraint in general is developed in this chapter's account of the ethical issues in involuntary treatment, restraint and end-of-life care, and its legal frame in the account of the legal aspects of seclusion, restraint and involuntary treatment. The clinical management of drug and alcohol problems in custody sits in the Substance use disorders notes.

17 Aug 1993	3 Oct 1994	19 Jun 2023
SUPREME COURT BARRED JAILING THE NON-CRIMINAL MENTALLY ILL	THE FOLLOW-UP ORDER ENFORCING THAT BAR	NHRC ADVISORY ON CUSTODIAL SELF-HARM AND SUICIDE

17.1 The rights lens: dual loyalty and the equivalence of care

Two ideas organise the whole topic. The first is the psychiatrist's problem of **dual loyalty**: a clinician working inside a custodial system owes the ordinary fiduciary duty to the patient in front of them, but the institution that pays and permits them wants order, security and compliance, and those two pulls do not always point the same way. A request to certify a prisoner fit for punishment, to medicate a difficult inmate for the convenience of the wing, or to disclose clinical information to custodial staff for reasons that are not the patient's, are all moments where loyalty to the patient and loyalty to the institution collide. The rights lens resolves the collision in one direction: the clinical relationship, and the patient's rights within it, come first, and the doctor's role is never to be an instrument of punishment or control dressed as treatment.

The second idea is the principle of **equivalence of care**: a person deprived of liberty is entitled to a standard of health care equivalent to what is available in the community, without discrimination on the ground of their legal status. Detention removes freedom of movement; it is not a sentence to worse medicine. Because the detained person cannot seek a second opinion, cannot easily complain and cannot leave, equivalence is a corrective for a captive population's structural disadvantage. Taken together, dual loyalty tells the clinician whom they serve, and equivalence tells them to what standard.

RULE **Loss of liberty is not loss of the right to health, to dignity or to consent; care in custody must be equivalent to care in the community and must never become an instrument of the institution against the patient.** Every specific rule that follows, the bar on jailing the non-criminal ill, the duty to screen, the limits on coercion, is an application of this one sentence. When a custodial question puzzles you, return to it: what would this person be owed outside, and what is the least the institution may do to them inside.

17.2 Sheela Barse: the non-criminal mentally ill do not belong in jail

The single most examinable Indian authority in this area is the **Sheela Barse** litigation, in which the Supreme Court confronted the practice of holding mentally ill persons who had committed no offence in ordinary jails, frequently under the label of "safe" or protective custody, for want of anywhere else to put them. By its judgment dated **17 August 1993** the Court strictly prohibited the confinement of non-criminal mentally ill persons in jails. The prohibition was not advisory and not conditional: a person whose only "offence" is their illness may not be warehoused in a penal institution, because a jail is a place of punishment and this person is not being punished.

The force of the ruling lies in how the Court framed the wrong. Confining the non-criminal mentally ill in jail was treated as a violation of their constitutional rights, and therefore as a matter attracting the Court's compensatory jurisdiction: not merely bad administration but an actionable breach for which the State could be held answerable. That the point had to be restated is itself the lesson: by the follow-up order dated **3 October 1994** the Court recorded its dismay that the earlier prohibition was still not understood, and reiterated it. For the exam, the case stands for a clean proposition: illness is not criminality, and the response to a person found wandering and unwell is care in a health facility, never a cell.

TRAP **Treating "protective" or "safe" custody of the non-criminal mentally ill as a benign holding measure.** Candidates soften the Sheela Barse bar into a matter of resources, reasoning that a jail is acceptable when no hospital bed is free. It is not: the prohibition on confining the non-criminal mentally ill in jail is a rights bar, not a preference, and the absence of an alternative is the State's problem to solve, not a defence to the wrong. The correct answer is always diversion to a health facility, and the pathway for a prisoner who does need psychiatric care sits in this chapter's account of the transfer and treatment of mentally ill prisoners.

17.3 Custodial self-harm and suicide: the duty to look

Suicide and deliberate self-harm are the sharpest rights problem inside the wall, because the State that has taken a person into its exclusive control has assumed a corresponding duty to keep them alive, and a custodial death raises at once the questions of what was known and what was done. The population is high-risk by construction: the shock of first reception, withdrawal from substances, isolation from family, the loss of autonomy and the concentration of untreated mental illness make the early days of custody especially dangerous. A rights-respecting system therefore treats detection as an active duty rather than waiting for a prisoner to declare distress they may be least able to voice.

The Indian regulatory answer is captured in the National Human Rights Commission advisory dated **19 June 2023** on mitigating deliberate self-harm and suicide attempts by prisoners, which recommends, among other measures, that mental health screening be included in the initial health screening report of every prisoner and that prison staff be trained in **Psychological First Aid** and mental health literacy. Note the two moves. Screening at reception catches the risk when it is highest and before the system has lost sight of the person; training the frontline staff, who see prisoners far more than any clinician does, turns wing officers into the first line of recognition rather than bystanders. These are recommendations of a rights body, not a statutory command, but they set the standard of humane practice against which a custodial system's failures are now measured.

GOOD TO REMEMBER

When you assess anyone entering custody, screen for suicide risk as a routine part of the reception health check, not only when a threat is voiced. Document what you asked and what you found, and flag those at risk to the staff who will actually be watching them overnight. In a custodial death the contemporaneous reception note is the first thing scrutinised, and "no concerns raised" is not the same as "screened and none found".

17.4 Consent, confidentiality and coercion behind the wall

The everyday ethics of the encounter are distorted by the setting. Consent given in custody is suspect on its voluntariness: a person who believes that refusing treatment will affect their parole, their classification or their handling by staff is not consenting freely, so the clinician must work harder to separate a genuine choice from a coerced one. Confidentiality is under constant pressure, because custodial staff routinely want clinical information, yet the duty follows the patient into custody and is not waived by their status; disclosure to the institution is justified only on the same narrow grounds that would justify it outside. The elements of valid consent and the

permitted grounds for breaching confidence are taught in this chapter's own accounts of those topics and are applied here, not restated.

Coercive control is the third pressure, and custody offers instruments a hospital does not. The ways the setting erodes rights are worth holding as a list, because each is a distinct place a clinician can be co-opted:

- segregation imposed for order being passed off as therapeutic seclusion;
- medication used for the convenience of the regime rather than the patient's illness, so-called chemical restraint;
- solitary confinement of a mentally ill prisoner, which can itself cause or worsen psychiatric harm;
- clinical information fed to custodial or disciplinary processes without the patient's interest in view.

The general ethics of restraint and seclusion, and their legal safeguards, belong to this chapter's accounts of the ethics and of the legal aspects of seclusion, restraint and involuntary treatment; the statutory restraint machinery itself sits in the Mental health legislation and forensic psychiatry notes. What the rights lens adds is the reminder that in custody every one of these instruments is more available and less visible, so the clinician's refusal to lend clinical authority to punishment is the safeguard that matters most.

PITFALL

The commonest real-world error is accepting a prisoner's consent, or their apparent calm, at face value. A man who agrees to depot medication because he fears the consequences of refusal has not truly consented, and a prisoner segregated "for his own safety" may be deteriorating in isolation rather than being protected by it. Read voluntariness in the light of the coercive environment, and do not treat isolation of a mentally ill person as a neutral administrative fact: a person with mental illness shall not be subjected to seclusion or solitary confinement, so safety must be met through lawful alternatives rather than isolation.

17.5 Non-discrimination and the standard-setting frame

Underlying all of the above is the principle of **non-discrimination**: legal status is not a permissible ground for delivering worse care, and the detained mentally ill are entitled to the same rights and quality of treatment as any other patient. This is why equivalence of care is stated as a right and not an aspiration, and why the Sheela Barse bar and the NHRC's reception-screening recommendation are best read together, one keeping the wrong person out of the penal system entirely, the other protecting the right person once lawfully within it.

The topic also sits within a wider architecture of standards. International minimum standards for the treatment of prisoners and for the protection of persons with mental illness, and India's own disability-rights and mental-health statutes, all articulate versions of dignity, equivalence and non-discrimination in custody; the domestic statutory machinery is set out in the Mental health legislation and forensic psychiatry notes and is applied here rather than restated. For the

practising psychiatrist the message survives the detail: the rights of the person in custody are the rights of any patient, made more fragile by captivity and therefore owed more vigilance, not less.

RIGHT AT STAKE IN CUSTODY	HOW THE SETTING THREATENS IT	THE RIGHTS ANSWER
LIBERTY OF THE NON-CRIMINAL ILL	Held in jail as "protective" custody for want of a bed	Absolute bar on jailing them; divert to a health facility
LIFE (PROTECTION FROM SELF-HARM)	High-risk population, distress unvoiced, watch diffuse	Mental health screening at reception; trained frontline staff
VOLUNTARY CONSENT	Refusal feared to affect parole, classification or handling	Test voluntariness against the coercive environment
CONFIDENTIALITY	Staff demand clinical information; no private space	Duty follows the patient; disclose only on the usual narrow grounds
EQUAL STANDARD OF CARE	Legal status used to justify inferior treatment	Equivalence of care and non-discrimination

A person in custody keeps every health-related right they had outside, made more fragile by captivity and so owed more vigilance: care must be equivalent to the community standard and free of discrimination, the non-criminal mentally ill may not be confined in jail at all, self-harm and suicide risk should be actively screened at reception as the NHRC advises, and the psychiatrist's clinical authority must never become an instrument of the institution against the patient.

Forensic Indian statutes and legal procedure

18 · Sexual offences law and Criminal Law Amendment (rape, consent, psychiatric assessment of survivors)

The law changed its numbers, not the reader's duty to get them right. This topic is the criminal law of sexual offences as it now stands: the definition of rape and its punishment in the current penal code, the exact legal meaning of consent on which the offence turns, and the part a psychiatrist plays when a survivor is examined or when a court needs to know whether a complainant could consent. The marks cluster in three places, and each is one where confident memory of the old law is a liability. The first is currency: the provisions were re-enacted when the colonial-era penal code was replaced, so the section a report cites must be the live one. The second is a conceptual trap: the criminal law's "consent" is a different construct from the consent a clinician takes before treatment, and the two are examined together precisely so that candidates conflate them. The third is the narrow but genuinely psychiatric interface, the short list of conditions - unsoundness of mind, intoxication, an inability to communicate - in which whether there was consent at all becomes a question a psychiatrist is competent to address.

A psychiatrist who assesses a survivor, or who is asked to opine on capacity to consent, works entirely inside this statutory frame. The full account of how the penal code changed, and the savings rule that decides which code governs a given matter, belongs to this chapter's account of the current penal code and its predecessor, and is named here rather than re-derived; the task here is the sexual-offences provisions themselves and the clinician who stands beside them.

18.1 The reform lineage: from a committee's report to the current code

Why the modern definition looks the way it does. The shape of the present offence is the direct product of a single wave of reform. After the Delhi gang-rape case that provoked national reform, the **Justice Verma Committee** was convened, and its recommendations were substantially enacted as the **Criminal Law (Amendment) Act 2013**. That amendment did two things that still dominate the topic. It broadened the offence of rape well beyond the older, narrow idea of peno-vaginal intercourse, replacing it with a defined set of sexual acts, penetrative and oral; and it recast consent as something that must be affirmatively communicated rather than merely not refused. When the penal code was later rewritten, these post-2013 amendments were not reopened: the broadened definition and the affirmative-communication consent standard were carried forward substantively unchanged into the current code. For the examinee this continuity is a gift and a trap at once: the settled understanding of the amended offence survives intact, but the section numbers moved, so an answer written in the old citations describes the right law under the wrong name.

18.2 The offence defined: rape under the current penal code

An act, done in a defined circumstance. The offence of **rape** is defined in the current penal code, the **Bharatiya Nyaya Sanhita**, at section **63**, the successor to the repealed penal code's rape provision. Its architecture is two-part, and the discipline is to hold both parts together: a defined physical act, performed under one of a defined set of circumstances. The amendment carried into this section widened the physical act into **four** categories of sexual conduct: penile penetration of the vagina, mouth, urethra or anus; insertion of an object or a body part other than the penis; manipulation of a part of the body so as to cause penetration; and application of the mouth to the vagina, anus or urethra. The first three turn on penetration or insertion; the fourth is complete on the application of the mouth, without proof of penetration, and a candidate who calls all four penetrative has narrowed the section. None of these is an offence in the abstract; each becomes rape only when done in one of the listed circumstances.

The circumstances, and where the psychiatry lives. The circumstances that make an act rape are a closed statutory list, and they repay grouping rather than rote recall. They run:

- against the woman's will, or without her consent at all;
- with a consent extracted by putting her, or someone she cares about, in fear of death or of hurt;
- with her consent, where the man knows he is not her husband and she consents because she believes he is another man to whom she is, or believes herself to be, lawfully married;

- with a consent given when, by reason of unsoundness of mind, intoxication, or a stupefying or unwholesome substance, she is unable to understand the nature and consequences of that to which she consents;
- where she is below the age the section fixes, in which case her consent is immaterial; and
- where she is unable to communicate consent.

The fourth and the last of these are the psychiatric heartland of the whole topic. Whether a person could, at the material time, understand the nature and consequences of a sexual act, or could communicate a choice about it, is not a lay judgement; it is a capacity assessment, and it is the point at which a court is most likely to want a psychiatrist. The section itself, by writing unsoundness of mind and intoxication into the definition, makes the clinician's assessment part of the legal question rather than a bystander to it.

MNEMONIC

Mind, Substance, Speech

The three circumstances in the rape definition that turn on the complainant's capacity rather than on the surrounding facts: **M**ind (unsoundness of mind), **S**ubstance (intoxication or an administered stupefying or unwholesome substance), and **S**peech (an inability to communicate consent). Each may call for clinical expert evidence rather than lay judgement, and the cause decides which expert: intoxication may turn on toxicological evidence and an inability to communicate on neurological or physical evidence, while the psychiatrist speaks only to the psychiatric question. Where the cause is psychiatric, whether there was consent has become, in part, a question about capacity, and that is the clinician's territory.

18.3 The legal meaning of consent, and why it is not clinical consent

Consent defined by the section, not by the clinic. The definition the offence turns on is the criminal-law meaning of **consent**, set out in Explanation **2** to the rape section, and it is the single most examined line in the topic. Consent means an **unequivocal voluntary agreement**, in which the woman, by words, gestures, or any form of verbal or non-verbal communication, communicates willingness to participate in the specific sexual act. The definition then closes a door that the older law had left ajar: a woman who does not physically resist the act shall not, by reason only of that fact, be regarded as consenting. Two features are load-bearing. Consent is affirmative and communicated, not inferred from the absence of a "no"; and it is act-specific, so agreement to one thing is not agreement to another.

A different construct that shares a word. This is where candidates lose marks, because the clinical doctrine of informed consent, its elements of capacity, adequate disclosure and voluntariness, is taught in this chapter's account of informed consent in psychiatry, and the two doctrines overlap far less than the shared noun suggests. Both ask for voluntariness, and both attach to a specific act rather than to a general willingness, and there the resemblance stops. Clinical consent is a prospective authorisation a competent patient gives a clinician for an intervention, built on capacity and on disclosure of risks and alternatives; the criminal law's consent is a retrospective factual question about whether an unequivocal, communicated

willingness to a specific act existed at a particular moment. The comparison below fixes the contrast so it cannot be blurred under pressure.

AXIS	CLINICAL (INFORMED) CONSENT	CONSENT IN THE LAW OF SEXUAL OFFENCES
The question it answers	May this clinician proceed with this intervention?	Did an unequivocal, communicated willingness to this specific act exist?
Where it is defined	The general doctrine of informed consent (its own topic in this chapter)	The Explanation to the rape section of the current penal code
Its core standard	Capacity, adequate disclosure of information, and voluntariness	An unequivocal voluntary agreement, communicated by word, gesture or other means, to the specific act
Orientation in time	Prospective: an authorisation given before the act	Retrospective: a finding of fact about a past moment
Effect of silence or non-resistance	Silence is not authorisation; a positive agreement is required	Failure to physically resist is not, by that fact alone, consent
Whose interest it protects	The patient's autonomy over their own treatment	The complainant's sexual autonomy against a criminal wrong

Two constructs that share the word "consent" and, beyond voluntariness and an act-specific agreement, little else. A report that answers the clinical-capacity question when the court asked the criminal-law-consent question, or the reverse, has misread the brief before it has misread the facts.

RULE **Criminal-law consent is an unequivocal, communicated, act-specific willingness, and the absence of physical resistance is not consent.** The definition is affirmative and positive: it asks what the woman communicated, not what she failed to do. It is tied to the specific sexual act, so agreement to one act does not extend to another. And it stands apart from the clinical doctrine of informed consent, which is a prospective authorisation for treatment built on capacity and disclosure. The two are examined side by side so that they will be confused; the mark is in keeping them separate.

TRAP **Answering the criminal-law consent question with the clinical capacity-and-disclosure test.** Asked whether a complainant consented, the unwary candidate reaches for the informed-consent checklist - was there capacity, was there disclosure, was it voluntary - and imports a treatment doctrine into a criminal statute. The section does not ask whether a valid clinical authorisation was obtained; it asks whether an unequivocal, communicated willingness to the specific act existed, and it treats the absence of resistance as no answer at all. Capacity enters the criminal analysis only through the circumstances the section names, unsoundness of mind, intoxication and inability to communicate, not as a free-standing test.

18.4 The exceptions and the punishment

Two exceptions, each with its condition. The offence carries two carve-outs, and each must be stated with its condition or not at all. A medical procedure or intervention shall not constitute rape, which shields the clinician performing a lawful examination or treatment. Separately, intercourse or sexual acts by a man with his own wife are not rape, provided the wife is not below

the age the section fixes: the exception operates only at or above that age threshold, and where the wife is below it the exception does not apply. Naming the **marital-rape exception** without its age condition is how a candidate turns a precise carve-out into a wrong general statement.

Punishment. The punishment for rape is prescribed at the section that follows the definition, section **64**, the successor to the repealed penal code's punishment provision. An offender shall be punished with rigorous imprisonment for a term which shall not be less than **ten** years, which may extend to imprisonment for life, and shall also be liable to fine. The modal verbs are the law: the minimum term is mandatory ("shall not be less than"), the extension to life is discretionary ("may extend"), and the fine is a mandatory addition ("shall also be liable"). A separate sub-section lists aggravated categories - among them a police officer, a public servant, a person in a custodial or fiduciary position of trust - for which a heavier term is prescribed, reflecting the abuse of power the section singles out.

PITFALL

Citing the repealed Indian Penal Code's rape and punishment sections as the governing law for a current offence, or without first establishing when the offence was committed. The wording of the offence was carried across largely intact, which is exactly why the error is so easy: the substance feels current even though the citation is dead. A medico-legal report that names a repealed code as the live one reads as out of date and invites the court to discount the opinion. Read the governing section from the current code, and let this chapter's account of the transition settle which code applies to an older matter.

18.5 The psychiatrist and the survivor

The clinician's role is real but bounded. The psychiatrist's involvement with a survivor of a sexual offence runs along several tracks, and the examinable skill is knowing which one is in play: assessing and documenting the survivor's mental state and the psychological sequelae, as treating clinician; assessing **capacity to consent** where the section's own circumstances of unsoundness of mind, intoxication or an inability to communicate are in issue; supporting a vulnerable survivor through the process of giving evidence; and providing continuing treatment for the psychiatric consequences.

The dual role, and the line not to cross. These tracks map onto the two roles that organise all forensic work, the treating clinician who owes duties to a patient and the forensic evaluator who serves the court, and the distinction between them is developed in this chapter's account of the psychiatrist as expert witness. The critical discipline is that a psychiatrist assesses mental state and capacity but does not pronounce on the ultimate legal question of whether there was consent, which is for the court alone to decide on all the evidence. An opinion that a survivor "did not consent", or that an account is true, usurps the court's function and is worth less, not more, for its overreach. The proper contribution is narrower: whether, at the material time, this person had the capacity to understand the nature and consequences of the act, or to communicate a choice about it.

How the assessment is conducted matters as much as what it finds. A survivor examination is itself a potential source of further harm, so the assessment is trauma-informed and unhurried, with the survivor's own authorisation sought for each step and the findings recorded contemporaneously and precisely. Where the survivor is a child, the dedicated child-protection statute applies alongside the applicable general provisions, and both the substantive framework and the special procedures for a child are the province of the Child psychiatry: assessment, treatment, services and protection notes, which are named here and cross-referred, not re-taught.

IN INDIA

The sexual-offences law is one of the most heavily reformed corners of the Indian criminal code, and the psychiatrist sits inside a defined medico-legal pathway. A survivor presenting after an assault is examined under a standardised medico-legal protocol, and a psychiatric opinion on capacity to consent is sought specifically where the statute's own circumstances - unsoundness of mind, intoxication or an inability to communicate - are raised. The practical safeguard is to write every such opinion against the current code read from the primary source, and to keep the clinical capacity finding distinct from the legal conclusion the court will draw from it.

GOOD TO REMEMBER

Before you commit any opinion in a sexual-offences matter, settle two things. First, which question the court is actually asking: a clinical-capacity question about whether this person could understand or communicate, or something the law reserves to itself. Second, that your report answers the first and never trespasses on the second. State the mental state and the capacity, document how you assessed both, and stop short of the ultimate issue of consent, which is the court's to decide.

63	64	10
CURRENT PENAL-CODE SECTION THAT DEFINES RAPE	THE SECTION THAT PRESCRIBES THE PUNISHMENT	YEARS, THE MANDATORY MINIMUM RIGOROUS IMPRISONMENT

Rape is defined and punished under those two sections of the current penal code by a mandatory minimum of rigorous imprisonment extendable to life; the definition, broadened after the post-2013 reforms and carried forward unchanged, turns on the criminal-law meaning of consent in Explanation 2, an unequivocal, communicated, act-specific willingness in which non-resistance is not consent. That construct is not the clinical doctrine of informed consent. The psychiatrist assesses a survivor's mental state and capacity to consent where unsoundness of mind, intoxication or an inability to communicate is in issue, and never pronounces on the ultimate legal question of consent, which is the court's.

19 · Section 105 BSA (formerly Section 84 IPC under BNS) and updated penal code provisions

Get the citation right, or the opinion is worthless. The examinable core of this topic is small, exact and unforgiving. The insanity defence and the rule about who must prove it are two

different provisions, sitting in two different codes, and the penal and evidence codes carrying these two provisions changed on **1 July 2024**. A psychiatrist who cites the wrong section, or a repealed code, in a report to a criminal court has undermined the one thing an expert is there to supply: a precise, current and defensible statement of the law the opinion is built on. The marks here reward accuracy, not breadth, and the commonest way to lose them is to answer confidently in the language of a code that no longer governs.

The heading a candidate is most likely to meet, pairing an evidence-code section number with the old insanity section, is itself wrong, and correcting it is half the answer. This topic fixes the mapping, states what each current section actually provides, and then teaches the transition rule that decides which code governs a given case. The cognitive test that the defence turns on, and the doctrine of the burden of proof, are developed in the Mental health legislation and forensic psychiatry notes and are named here, not re-taught; the courtroom procedure for referring and assessing an accused is carried in the accompanying forensic-procedure material.

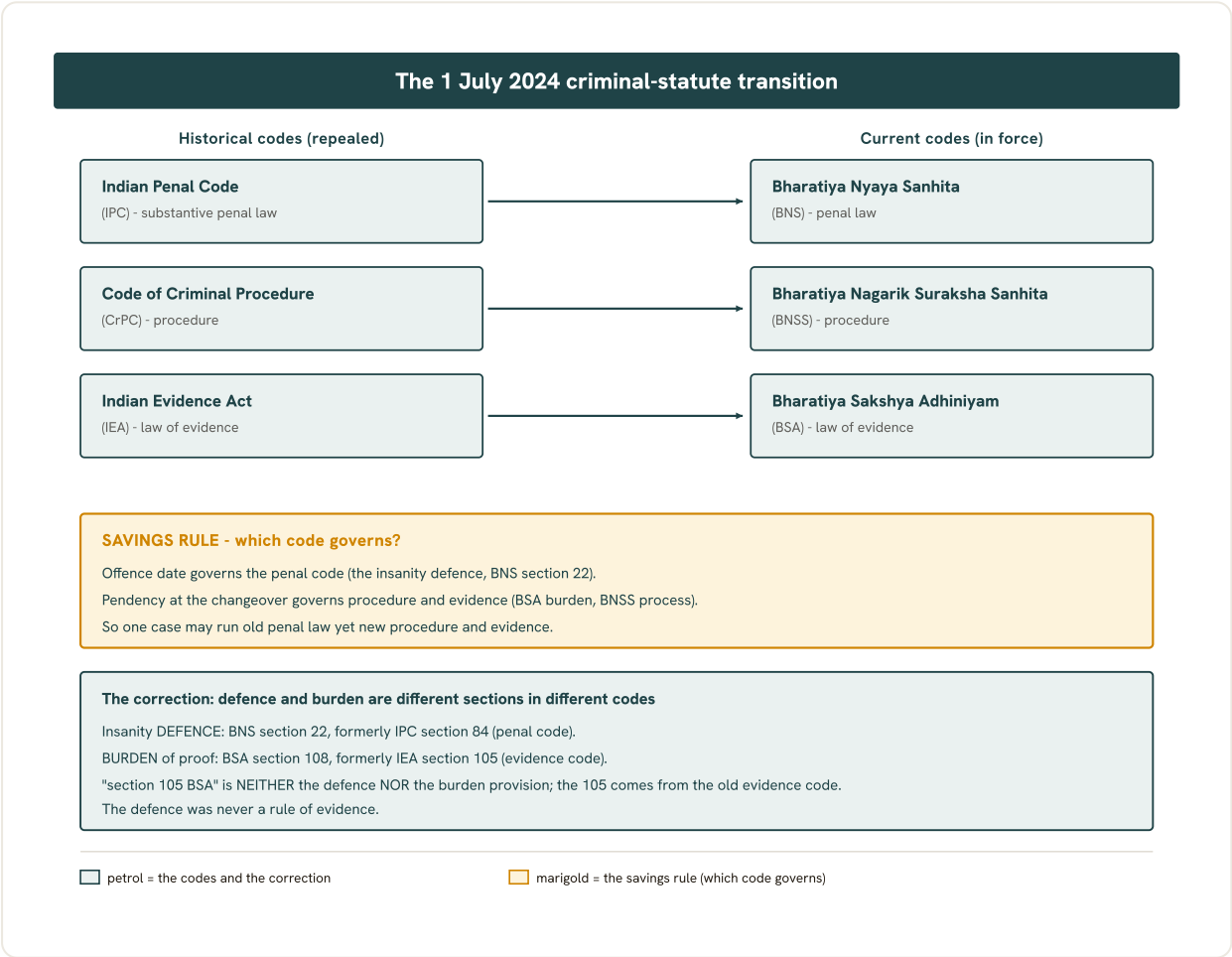


Fig 26.11. On 1 July 2024 the three colonial codes were replaced together, the Indian Penal Code by the Bharatiya Nyaya Sanhita, the Code of Criminal Procedure by the Bharatiya Nagarik Suraksha Sanhita and the Indian Evidence Act by the Bharatiya Sakshya Adhiniyam, with the offence date governing the penal code and pendency at the changeover governing procedure and evidence, so the insanity defence is BNS section 22 (formerly IPC section 84) and the burden of proof BSA section 108 (formerly IEA section 105), not section 105 BSA.

19.1 The correction: a defence and a burden, in two separate codes

Two functions, two statutes, two section numbers. The loose shorthand that files the insanity defence under an evidence-code section number collapses two entirely separate provisions into

one. The **general exceptions** to criminal liability, among them the exemption for the **act of a person of unsound mind**, live in the penal code; the rule about who must prove that an accused falls within such an exception lives in the law of evidence. These are not two names for one thing. One asks whether the act is an offence at all; the other asks who carries the risk of not proving the answer. The comparison below fixes both the function and the location.

AXIS	THE INSANITY DEFENCE	THE BURDEN OF PROVING IT
Question it answers	Given the accused's state of mind at the time, is the act an offence at all?	Once the defence is raised, who must establish that the accused was of unsound mind?
Where it lives	The penal code, among the general exceptions (the Bharatiya Nyaya Sanhita, formerly the Indian Penal Code)	The law of evidence (the Bharatiya Sakshya Adhiniyam, formerly the Indian Evidence Act)
Section, current and former	section **22**, formerly section **84**	section **108**, formerly section **105**
Nature of the rule	A general exception that exempts the act from criminal liability	A rule of evidence that places proof on the accused and directs the court to presume the exception absent

The two provisions the garbled heading conflates. Because the defence and the burden are separately located, no single section of the Bharatiya Sakshya Adhiniyam can carry the insanity defence: the popular phrasing borrows the repealed evidence-Act number and pins it to the new code, pointing at neither the defence nor its correct home.

Why the shorthand is not merely sloppy but wrong. The number in the heading was never the defence at all. In the old scheme, the exempting provision was the penal code's insanity section, and its successor is the general-exceptions insanity provision of the Bharatiya Nyaya Sanhita. The number the heading borrows belonged instead to the evidence Act's burden-of-proof provision, whose successor is the current burden section of the Bharatiya Sakshya Adhiniyam. So the correction is not a matter of updating a digit: it is recognising that the defence and the proof of it are different laws, and that the shorthand mixes an old evidence-section number with a new code's name to describe a provision that does not exist.

MNEMONIC

Defence in the Nyaya Sanhita, burden in the Sakshya Adhiniyam

The exemption for the act of a person of unsound mind sits in the penal Sanhita; the rule that the accused must prove it sits in the evidence Adhiniyam. Two functions, two codes: a single evidence-code section can never be the home of the defence, because the defence was never a rule of evidence.

RULE **The defence and the burden are different sections in different codes, and both codes changed at the transition.** The insanity exemption is a penal-code general exception (now the Bharatiya Nyaya Sanhita, formerly the Indian Penal Code); the rule that the accused must prove it is a provision of the evidence code (now the Bharatiya Sakshya Adhiniyam, formerly the Indian Evidence Act). No single provision holds both, so the popular pairing of the defence with an evidence-code number is a category error before it is a numbering error.

19.2 The insanity defence now: the penal code's act of a person of unsound mind

What the current section actually provides. The Bharatiya Nyaya Sanhita's general-exceptions insanity provision exempts from criminal liability an act done by a person who, at the time of doing it, by reason of **unsoundness of mind**, was incapable of knowing the nature of the act, or that it was wrong or contrary to law. Read the clause slowly, because each element does work: the incapacity must arise from unsoundness of mind, it must exist at the time of the act, and it is an incapacity of knowing, that is, a defect of cognition rather than of control or of motive. The exemption is framed as an absolute one, nothing done in that condition is an offence, which is why the defence, when it succeeds, negates criminal responsibility rather than merely mitigating it.

The test has a name, and it is deliberately not re-taught here. The cognitive standard the section encodes is the **M'Naghten standard**. Its limbs, the meaning of knowing the nature of the act, the distinction between legal and moral wrong, and the way the standard is applied and assessed in a real accused, are the doctrine of criminal responsibility and are developed in the Mental health legislation and forensic psychiatry notes; naming the test is the task here, unpacking it is not. One point of continuity is worth holding, however. The statutory wording of the current section is carried across word for word from the repealed penal-code provision, so the substantial body of case-law decided under the old section remains directly instructive, and nothing about the substantive test changed at the transition. What changed is the citation, not the content.

19.3 The burden of proving the defence: the evidence code's exceptions provision

The accused who raises the exception must prove it. The general rule of criminal proof, that the prosecution establishes guilt, does not extend to the general exceptions. When an accused claims to fall within an exception such as unsoundness of mind, the evidence code places the **burden of proof** on the accused: the burden of proving the existence of the circumstances that bring the case within the exception rests on the person asserting it, and the court shall presume the absence of those circumstances until they are established. The section's own first illustration is, tellingly, the insanity case itself, an accused charged with an offence who alleges that by reason of unsoundness of mind he did not know the nature of the act, on whom the burden of proof then lies. The provision does not decide guilt; it allocates who bears the risk on the question of the exception.

Where the statute stops and the doctrine begins. Note the exact structure, because candidates lose the mark by softening it. The burden is placed on the accused, and the court is directed to presume the exception absent, not merely permitted to. How heavy that burden is, and how it

interacts with the presumption of sanity and with the prosecution's own standard, is the doctrine of the burden of proof, which is developed in the Mental health legislation and forensic psychiatry notes and is named, not restated, here. What this topic owns is the location: the burden that used to sit in the repealed evidence Act now sits in the current exceptions provision of the Bharatiya Sakshya Adhiniyam, and that is the provision the garbled heading was reaching for and missing.

TRAP **Naming the evidence code's burden section as the home of the insanity defence.** The number in the garbled heading is borrowed from the repealed evidence Act's burden-of-proof provision, not from the penal code at all, and the defence never lived in the law of evidence. Candidates conflate the two because the exempting section and its burden are examined together, but the provision that exempts the act and the provision that allocates its proof are separate laws in separate codes, and an answer that fuses them has misunderstood the topic, not merely mistyped a digit.

19.4 The transition and the savings rule

The date is not a light switch. On the transition the three colonial-era codes were repealed and replaced together: the penal code, the evidence Act and the code of criminal procedure gave way to the Bharatiya Nyaya Sanhita, the Bharatiya Sakshya Adhiniyam and the **Bharatiya Nagarik Suraksha Sanhita**. Each replacing Act carries its own **repeal and savings** clause, and those clauses are the reason a clinician cannot simply assume that the newest code is the one in force for the matter in front of them. Repeal removes a statute going forward; the savings clause decides what happens to everything already under way.

The penal code follows the date of the offence. The savings clause of the penal Sanhita repeals the Indian Penal Code but preserves its previous operation for what has already happened under it. In particular it keeps the old code alive for offences committed before the change, so that the substantive law, including the insanity defence, is judged by the penal code in force on the **offence date**. Concretely, the savings clause preserves:

- the previous operation of the repealed code, and anything duly done under it;
- any right, obligation or liability already acquired, accrued or incurred;
- any penalty or punishment incurred for an offence already committed against the repealed code;
- any investigation, proceeding or remedy in respect of such a matter, which may be instituted, continued or enforced as if the code had not been repealed.

Procedure and evidence follow pendency, not the offence date. The savings rule for the other two codes turns on a different pivot. Where a trial, inquiry, application, appeal or investigation was already **pendency** pending immediately before the transition, that matter is dealt with under the old evidence Act and the old procedure code, as in force before the change, as if the new codes had not come into force. So the currency of procedure and evidence follows whether the proceeding was pending at the transition, while the currency of the penal code follows when the offence was committed. This asymmetry is the examinable subtlety: a single case can be governed

by the old penal code for its offence and defence, yet by the new procedure and evidence codes for its trial, if the offence predated the change but proceedings began after it.

19.5 Which code governs the matter in front of you

The first question in any criminal referral. The practical payoff of the savings rule is a discipline that must run before any opinion on criminal responsibility is committed to paper. The psychiatrist is not the arbiter of which code applies, that is for the court, but the report must be framed in the law that actually governs, and getting it wrong signals to the court that the expert is working from stale knowledge. Two questions settle the framing:

- When was the offence committed? That fixes the penal code, and therefore the section under which the insanity defence is judged.
- Was the proceeding pending at the transition? That fixes the procedure and evidence law, and therefore the provision under which the burden of proof is allocated.

Name the current provision by its current name. Once the two questions are answered, the report should cite the governing code and section correctly and consistently, and should not drift between old and new names within the same document. Where the current codes govern, the defence is the general-exceptions insanity provision of the Bharatiya Nyaya Sanhita and the burden rule is the exceptions provision of the Bharatiya Sakshya Adhiniyam. Where the savings rule keeps an older matter alive, the report should say so explicitly, rather than silently using whichever names the clinician happens to remember.

IN INDIA

For years to come, Indian forensic practice will run old-code and new-code cases side by side, because the offence date and pendency, not the calendar, decide which law applies. A psychiatrist writing reports today will still meet matters governed by the repealed penal, evidence and procedure codes, alongside matters under the new Sanhita, Adhiniyam and the successor procedure code, sometimes within a single case. The safe habit is to read the governing provision from the primary code rather than from memory or an old handout, and to state, in the report, the code and section the opinion is written against.

GOOD TO REMEMBER

Before you frame any opinion touching criminal responsibility, establish two facts and record them at the top of the report: the date the alleged offence was committed, and whether proceedings were already pending at the transition. Those two facts, not the current year, tell you which penal code carries the defence and which evidence and procedure code carries the burden and the process. Everything else in the medico-legal opinion is built on that footing.

PITFALL

Citing the Indian Penal Code, the Indian Evidence Act or the Code of Criminal Procedure as the current law in a report written after the transition. It is an easy error, because the wording of the insanity defence did not change and the old citations are deeply familiar, but a report that names a repealed code as the governing law reads as out of date and invites the court to discount the opinion. The wording continuing unchanged is exactly why the citation, not the content, is where the mistake hides.

22	84	108	105
BHARATIYA NYAYA SANHITA SECTION CARRYING THE INSANITY DEFENCE	THE REPEALED INDIAN PENAL CODE SECTION IT REPLACED	BHARATIYA SAKSHYA ADHINIYAM SECTION PLACING THE BURDEN ON THE ACCUSED	THE REPEALED INDIAN EVIDENCE ACT SECTION IT REPLACED

The insanity defence is the penal code's general exception for the act of a person of unsound mind (the Bharatiya Nyaya Sanhita, formerly the Indian Penal Code); the burden of proving it rests on the accused under the evidence code, which also directs the court to presume the exception absent (the Bharatiya Sakshya Adhiniyam, formerly the Indian Evidence Act). They are separate sections in separate codes, so an evidence-code number can never be the insanity defence. The penal code follows the date of the offence; procedure and evidence follow whether the matter was pending at the transition.

20 · Procedure for psychiatric assessment of an accused (Sections under CrPC/BNSS, court referral)

A criminal court cannot try a defendant it cannot reach. When an accused's mental state puts their ability to follow and answer the case in doubt, the criminal procedure code does not leave the matter to the clinician's goodwill: it lays down a defined pathway by which the court itself obtains, records and acts on a psychiatric assessment of an accused. This topic is procedure, not doctrine. It governs three linked steps - how the court refers, how the person is examined, and what the court does with the report - and the disposal that follows once a finding of incapacity is recorded. The marks reward the sequence and the exact duties, not the headline that an unfit accused is referred for assessment.

Two features frame everything below. First, the question can surface at two different points in a prosecution, and each has its own section: while a Magistrate is holding an **inquiry** before trial, and once the **trial** itself is under way. Second, the assessment is anchored to a present-tense question - whether the person is **incapable of making his defence** - which is the construct of fitness to stand trial. The criteria that decide fitness are developed in the Mental health legislation and forensic psychiatry notes and are named here, not restated; likewise the separation of the treating from the forensic role belongs to the accompanying material on the psychiatrist as expert witness, and the rules that govern how the resulting opinion is received in court belong to the accompanying material on court structure and the rules of evidence. What this topic owns is the procedural spine that connects them.

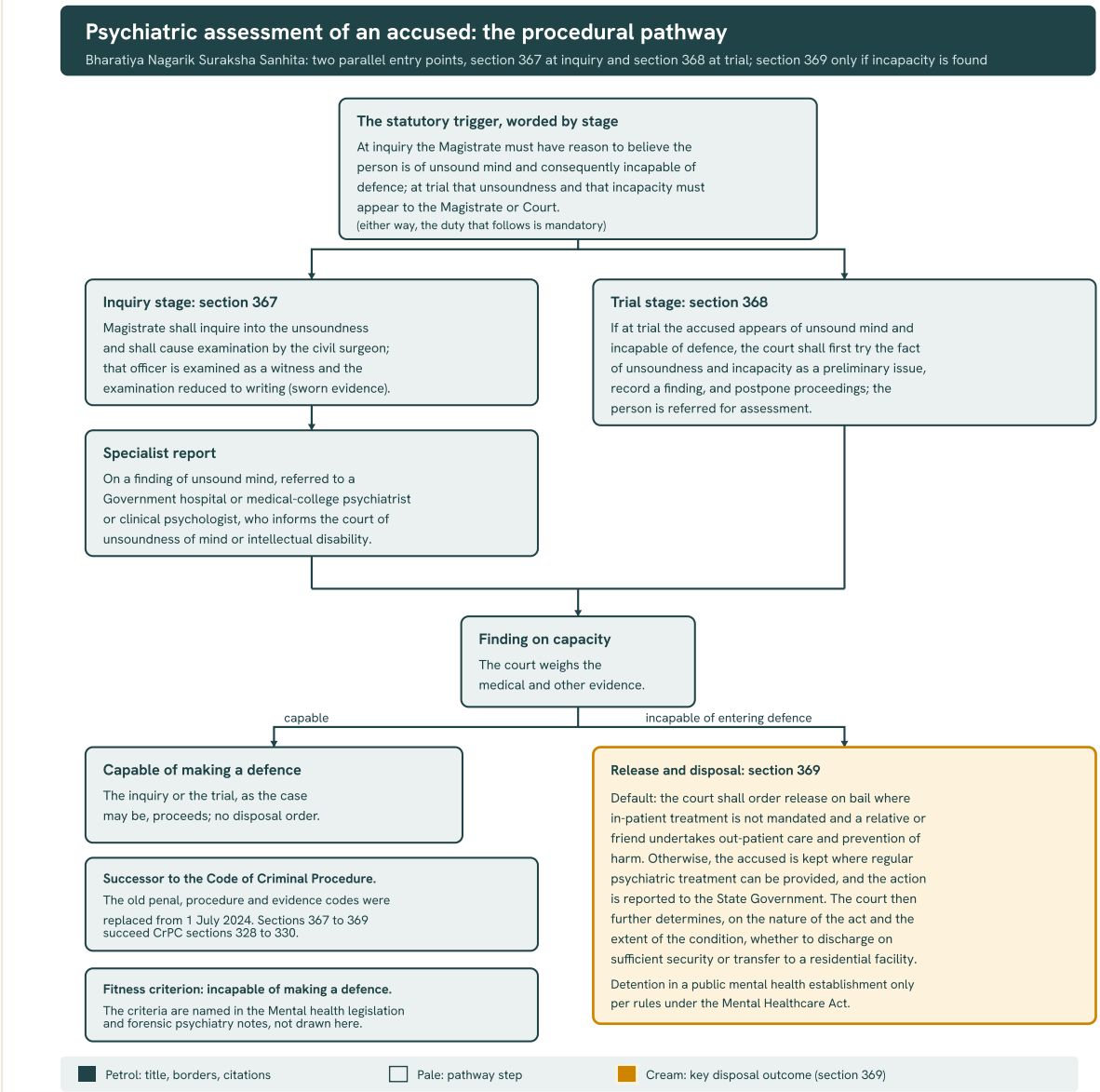


Fig 26.12. The psychiatric assessment of an accused under the Bharatiya Nagarik Suraksha Sanhita has two parallel entry points, worded differently. Under section 367, where a Magistrate holding an inquiry has reason to believe the person is of unsound mind and consequently incapable of defence, the Magistrate shall inquire into that unsoundness and shall cause the prescribed medical examination. Under section 368, where unsoundness and incapacity appear to the Magistrate or Court at trial, the court shall first try the fact of unsoundness and incapacity. A finding of capacity lets the inquiry or the trial proceed; a finding that the accused cannot enter a defence leads to disposal under section 369: release on bail where in-patient treatment is not mandated and an undertaking is given, otherwise safe custody with regular psychiatric treatment reported to the State Government, and a further determination whether to discharge on sufficient security or transfer to a residential facility. These provisions succeed Code of Criminal Procedure sections 328 to 330.

20.1 The pathway and the code it lives in

One question, two entry points, three provisions. The current procedure code is the Bharatiya Nagarik Suraksha Sanhita, the successor to the Code of Criminal Procedure. It carries the unsound-mind machinery in three consecutive sections that read as a single scheme: a referral-and-report provision for the inquiry stage, a parallel provision for the trial stage, and a disposal provision for a person found under either to be unable to enter a defence. The reason the law splits the referral across two sections is that the disability can become apparent before the case is

fully framed or only after evidence has begun, and the safeguard that no one is tried while unable to participate must be available at both moments. The disposal provision sits downstream of both, because a finding of incapacity raises the same practical question however it is reached.

The trigger is worth stating precisely, because it is where the court's duty attaches, and the two entry points word it differently. It is not enough that the accused is unwell or behaving oddly. At the inquiry stage the provision bites when the Magistrate has reason to believe the person is of **unsoundness of mind** and consequently incapable of making a defence; at the trial stage it bites when that unsoundness and that incapacity appear to the Magistrate or Court. The wording differs, the conjunction does not: a mental state together with its consequence for participation opens the pathway, and neither alone will do.

RULE **Once the Magistrate holding an inquiry has reason to believe the accused is of unsound mind and consequently incapable of making a defence, the duty to inquire and to obtain a medical examination is mandatory, not discretionary.** The statute says the Magistrate shall inquire into the fact of unsoundness and shall cause the person to be examined; it is not a power the court may exercise if it chooses. A candidate who writes "the court may refer" has changed the law, because a discretionary power and a mandatory duty are different provisions.

20.2 Referral, examination and report at the inquiry stage

The core provision, step by step. The referral-and-report section of the current code is the one to know in full, because the trial-stage provision and the disposal provision both take their shape from it. When a Magistrate holding an inquiry has reason to believe the person is of unsound mind and consequently incapable of making a defence, four mandatory steps follow in order:

1. inquire into the fact of the unsoundness of mind;
2. cause the person to be examined by the **civil surgeon** of the district, or such other medical officer as the State Government directs;
3. examine that surgeon or officer as a witness; and
4. reduce that examination to writing.

Each step is deliberate: the examination is sworn evidence taken on the record, so the court's later finding rests on testimony that can be tested, not on an informal impression.

From the first-line examiner to the specialist. The section then builds in an escalation. If the civil surgeon finds the accused to be of unsound mind, the surgeon shall refer the person to a psychiatrist or **clinical psychologist** of a Government hospital or Government medical college for **care, treatment and prognosis** of the condition. The specialist, in turn, shall inform the Magistrate whether the accused is suffering from unsoundness of mind or from **intellectual disability**. Two points repay attention. The specialist referral is triggered by the first examiner's finding, so the civil surgeon is the gatekeeper of the pathway rather than its endpoint; and the specialist's report is framed as the binary the court needs, unsoundness of mind or intellectual disability, because the two carry different implications for whether the person can be tried and

treated. An appeal against the specialist's opinion lies to a Medical Board, whose exact composition is recorded in this topic's gaps rather than asserted from memory.

MNEMONIC

Believe, Inquire, Examine, Report, Dispose

The five beats of the pathway in order: the court must have reason to **believe** the accused is of unsound mind and unable to defend; it must **inquire** into the fact; it must have the person **examine**d, first by the civil surgeon and then, on a finding, by a Government-facility specialist; the specialist must **report** unsoundness of mind or intellectual disability; and the court must then **dispose** of the person under the release provision.

20.3 The parallel provision at the trial stage

The same safeguard, one step later in the process. The trial-stage section is the mirror of the inquiry-stage provision for the point at which the case has reached trial. If, at the trial of a person before a Magistrate or a Court of Session, it appears to the court that the person is of unsound mind and consequently incapable of making a defence, the court shall, in the first instance, try the fact of that unsoundness and incapacity. It is a preliminary issue that must be resolved before the substantive trial can go further: the court considers such medical and other evidence as is produced, and if it is satisfied of the fact, it shall record a finding to that effect and shall postpone further proceedings in the case. The structure matters: the court does not simply accept the medical report but tries the fact on evidence, which is why the psychiatric assessment enters as evidence to be weighed rather than as a verdict to be rubber-stamped.

Fitness is the criterion, and it is not decided here. Both this provision and the inquiry-stage one turn on whether the accused is capable of entering a defence, which is the fitness-to-stand-trial question. What that capacity consists of - what the person must be able to understand and do to be tried fairly - is the fitness construct owned by the Mental health legislation and forensic psychiatry notes, and it is named here and cross-referred, not enumerated. This topic owns the machinery that surrounds the criterion: who refers, on what trigger, with what evidence, to what recorded finding. Keeping the fitness question apart from the responsibility question is the discipline the exam is testing.

TRAP **Reading this assessment as an opinion on the insanity defence.** The question this pathway asks is present-tense: can the accused understand and participate in the proceedings now. That is fitness to stand trial, decided by the court after medical evidence. It is a different question from criminal responsibility, which asks about the accused's mind at the time of the offence and is governed by the insanity defence and its burden - the criminal-responsibility doctrine developed in the Mental health legislation and forensic psychiatry notes. A report that answers the responsibility question when the court asked the fitness question has answered the wrong provision, and candidates lose the mark by fusing the two.

20.4 Release and disposal after a finding of incapacity

What happens to the person while the case stands still. The final section of the scheme governs the disposal of a person found, under either of the two referral provisions, to be

incapable of entering a defence by reason of unsoundness of mind or intellectual disability. Its default is liberty with treatment, and the modal force matters: whether or not the case is one in which bail may ordinarily be taken, the court shall order **release on bail** where the person's condition does not mandate in-patient treatment and a relative or friend gives an undertaking that the person will receive out-patient psychiatric treatment and be prevented from harm. Only where, in the court's opinion, bail cannot be granted, or where no appropriate undertaking is given, does the fallback apply: the court shall then order the accused to be kept in a place where **regular psychiatric treatment** can be provided, and shall report the action taken to the State Government. Drop the conditions and the answer is wrong: safe custody is not the norm but what remains when supervised community release is unavailable. The section does not stop there: keeping in view the nature of the act committed and the extent of the unsoundness of mind or intellectual disability, the court further determines whether release can be ordered, and may either discharge the accused on sufficient security or, where discharge cannot be ordered, transfer the accused to a residential facility for persons with unsoundness of mind or intellectual disability.

The one hard limit on where the person may be held. The section closes with a proviso that a candidate should be able to reproduce in substance: no order for the detention of the accused in a public mental health establishment shall be made otherwise than in accordance with the rules made by the State Government under the Mental Healthcare Act, **2017**. This is the seam where criminal procedure hands off to mental health law. The procedure code decides that the person is to be kept and treated; it does not itself authorise admission to a mental health establishment. The definitions, the admission machinery and the review boards under that Act belong to the Mental health legislation and forensic psychiatry notes and are named here, not taught.

GOOD TO REMEMBER

Write the report to the question the court actually asked. The referring provision wants to know two things: whether the person is of unsound mind or has an intellectual disability, and whether that condition makes them unable to follow and answer the case. Address prognosis and treatability, because the disposal provision turns on them, and say plainly whether supervised out-patient care under a relative's undertaking is feasible, the court's preferred route before custody for treatment. An opinion pitched at the wrong question, however clinically sound, does not help the court apply the section.

20.5 The psychiatrist's place in the pathway, and getting the code right

The expert serves the court, not the accused. Within this procedure the psychiatrist or clinical psychologist enters as an examiner and reporter to the court, a role distinct from that of a treating clinician who owes duties to a patient. Where the person is not already under one's care, the assessment is a forensic evaluation whose client is effectively the court, and the report must be framed accordingly: neutral, addressed to the statutory question, and defensible on cross-examination. The full separation of the treating role from the expert role, and the way opinion evidence is distinguished from fact evidence and received by the court, are developed in the

accompanying material on the psychiatrist as expert witness and the accompanying material on court structure and the rules of evidence.

Which code governs the case in front of you. Because the procedure code changed at the recent transition, the psychiatrist must be careful to frame the report in the law that actually governs. For matters already under way before the change, the corresponding provisions of the repealed Code of Criminal Procedure may still govern the proceeding, while current matters run under the successor sections described above. The savings rule that decides which code applies to a given case, and the wider transition from the old penal, procedure and evidence codes, is owned by the accompanying material on the current penal-code framework and the transition. What this topic asks of the clinician: read the governing section from the primary code, cite it correctly, and do not drift between the old and new names within a single report.

IN INDIA

The pathway is built around the public system. The first examiner is the district civil surgeon or a medical officer the State Government directs, and the specialist referral runs specifically to a psychiatrist or clinical psychologist of a Government hospital or Government medical college, not to any qualified practitioner the accused might prefer. Detention for treatment, when it comes to that, is permitted only in a place where regular psychiatric treatment can be provided, and admission to a public mental health establishment is tied to the rules made under the Mental Healthcare Act. In practice this concentrates forensic assessment in a small number of Government facilities, which is where delay and waiting-list pressure tend to accumulate.

AXIS	AT THE INQUIRY STAGE	AT THE TRIAL STAGE	ON A FINDING OF INCAPACITY
Governing section (current code)	section **367**	section **368**	section **369**
When it operates	During a Magistrate's inquiry, before trial	During trial before a Magistrate or Court of Session	After a finding under either provision that the person cannot enter a defence
What the court shall do	Inquire into the unsoundness and cause the person to be examined	Try the fact of unsoundness and incapacity as a preliminary issue	Order release on bail with an undertaking, or safe custody with treatment
Who examines or treats	Civil surgeon or directed medical officer, then a Government-facility psychiatrist or clinical psychologist	Court weighs medical and other evidence; specialist assessment on reference	A place where regular psychiatric treatment can be provided
The recorded output	Examination taken as sworn evidence and reduced to writing; report of unsoundness or intellectual disability	A recorded finding of unsoundness and incapacity; proceedings postponed	Action taken reported to the State Government

The three-provision scheme read across its two entry points and its single disposal route. The inquiry-stage and trial-stage provisions are parallel referral routes to the same fitness question; the disposal provision sits downstream of both.

PITFALL

Citing the Code of Criminal Procedure sections as the current law in a report or answer written after the transition. The old numbers are deeply familiar and the scheme has carried across largely intact, which is exactly why the error hides in the citation rather than the content. A report that names a repealed procedure code as the governing law reads as out of date, and a candidate who cannot say whether the old or the new code applies to a given matter has missed the savings rule that decides it.

328	329	330
THE REPEALED PROCEDURE-CODE SECTION FOR THE INQUIRY-STAGE REFERRAL AND REPORT	THE REPEALED TRIAL-STAGE PROVISION IT REPLACED	THE REPEALED DISPOSAL AND REPORTING PROVISION IT REPLACED

The psychiatric assessment of an accused runs on a three-section scheme in the current procedure code: a referral, examination and report at the inquiry stage; a parallel provision at the trial stage where the court shall first try the fact of unsoundness and incapacity; and a disposal provision under which the court shall order release on bail where in-patient treatment is not mandated and an undertaking is given, or safe custody with regular psychiatric treatment reported to the State Government, and shall further determine whether to discharge the accused on sufficient security or transfer them to a residential facility. The trigger is unsound mind that makes the accused incapable of defence, the duty to refer is mandatory, and the criterion is fitness to stand trial, which is named here and taught in the Mental health legislation and forensic psychiatry notes.

21 · Dying declaration and psychiatric assessment of competence

Why this earns marks. The **dying declaration** is one of the few rules of evidence in which the psychiatrist is not a bystander but a participant. The treating team is often the only body present when a fatally injured person names how the injury came about, and a court will later ask whether that person was in a fit enough mental state for the statement to be believed. Two competencies are being tested at once: a point of substantive evidence law, and a bedside psychiatric judgement about capacity. Candidates who can hold the two apart, and then join them, score cleanly. The evidence rule tells you what such a statement is worth in principle; the psychiatric assessment tells you what this particular statement, from this particular declarant, is worth in fact.

The provision must be read from the current code. The substantive criminal law of India was recently recast, and the older evidence statute is now historical; the transitional savings rule that decides which code governs a case already pending at the changeover is set out where this chapter treats the penal-code framework, and is not re-derived here.

21.1 The provision: what the statute makes relevant

The dying declaration is governed by section **26(a)** of the Bharatiya Sakshya Adhiniyam, the successor to what was section **32(1)** of the Indian Evidence Act. Ordinarily a statement made out of court by a person who is not before the court to be cross-examined is hearsay and cannot be received. The dying declaration is a recognised exception: a statement by a person as to the cause of his death, or as to any of the circumstances of the transaction that resulted in his death, is a relevant fact whenever the cause of that person's death comes into question. The rationale traditionally offered is twofold - necessity, because the best witness to the killing is now dead and cannot be produced, and a presumption of trustworthiness, the old intuition that a person who feels death approaching is unlikely to leave the world with a lie on the lips. The second limb of that rationale is exactly where Indian law then parts company with the tradition that produced it.

21.2 The Indian departure: no expectation of death, and any proceeding

This is the discrimination examiners most want to see. In the English common-law tradition the exception is narrow: the maker must have been under a settled, hopeless **expectation of death** at the moment of speaking, and the statement is admissible essentially only on a charge concerning the declarant's own homicide. The Indian statute is deliberately wider. The statement is relevant whether or not the maker was, at the time it was made, under any expectation of death, and whatever the nature of the proceeding in which the cause of death comes into question. A declarant who fully expected to recover, and who only later died, may still have made a relevant dying declaration; and the statement may be used in a civil suit as much as in a criminal trial. The maker's belief about survival has not been abolished from the analysis - it survives as a factor going to how much the statement is trusted - but it has been removed as a precondition of receiving it at all.

RULE **Under Indian law the maker need not have expected to die, and the statement is not confined to a homicide trial.** The statute makes the statement a relevant fact whenever the cause of death is in question, whatever the proceeding; the settled, hopeless expectation of death is the English precondition, not ours. The declarant's belief about survival goes to weight, never to admissibility.

Not required
EXPECTATION OF DEATH

Any proceeding
WHERE CAUSE OF DEATH IS IN ISSUE

Fit mind
WHAT THE STATEMENT'S WEIGHT TURNS ON

AXIS OF COMPARISON	ENGLISH COMMON-LAW TRADITION	INDIAN STATUTORY POSITION
Expectation of death	Required: a settled, hopeless expectation when speaking	Not required; relevant to weight only
Proceedings covered	Essentially the declarant's own homicide	Any proceeding where the cause of death is in question
Use in a civil dispute	Not available	Available
Effect if the maker expected to live	Statement excluded	Statement still relevant

TRAP **Importing the English precondition into Indian law.** Candidates who learned the topic from older or foreign texts write that the declarant must have abandoned all hope of life. In India that is wrong: the expectation of death was deliberately dropped from the statutory test, and stating it as a condition of admissibility loses the mark even when the rest of the answer is sound.

21.3 Admissibility is not reliability: the requirement of a fit mind

Where the psychiatrist enters. That the statement is a relevant fact settles only that the court may receive it. What the court then does with it - how far it relies on it, whether it convicts on it alone - is a separate question of weight, and here the declarant's mental state becomes decisive. A dying declaration carries no oath and cannot be tested by cross-examination, the two ordinary safeguards of testimony, so the court leans heavily on being satisfied that the maker was **compos mentis**. Fitness in this sense has two layers, and it helps to name them separately:

- A **physical capacity to communicate** - the declarant can produce a statement at all, by speech, gesture or sign.
- A **mental capacity** to understand what is asked and to give a rational, self-consistent account of it.

It is the second that is the psychiatric question. Note precisely what it is not: it is not whether the declarant told the truth, which is for the court to decide, but whether the declarant had the **capacity** to give a reliable statement in the first place. The psychiatrist assesses the instrument, not the tune played on it.

IN INDIA

A dying declaration is most safely recorded by a judicial magistrate, but the fatally injured are usually in casualty, and in practice the recording frequently falls to the attending medical officer or the investigating police. The settled expectation is that the treating doctor certifies, ideally both before and after the statement is taken, that the patient was conscious and in a fit state of mind to make it. Where a psychiatrist is available, that certification of mental fitness is exactly the contribution asked of them. The certificate should record the examination actually done, not merely assert a conclusion, because a bare line that the patient "was conscious" is worth little when it is later challenged.

21.4 The competence assessment at the bedside

The assessment is a focused mental-state examination directed at a single question: could this person, at this moment, take in a question, understand it, retrieve the relevant memory, and express a rational answer? The domains to examine are the familiar ones, sharpened to that purpose:

- **Consciousness and the sensorium** - alert, drowsy, fluctuating or obtunded; a clouded sensorium is a leading reason a declaration's weight is later doubted.
- **Attention and comprehension** - can the patient hold attention long enough to follow a question to its end and grasp what is being asked.

- **Coherence and memory** - a connected, internally consistent narrative of the event, drawn from recall rather than confabulated across a gap.
- **Freedom from tutoring** - whether the account was prompted, led or coached by relatives or police crowding the bedside. This goes to the reliability of the recording rather than to the declarant's mental capacity, so the clinician documents what was observed at the bedside and leaves the effect of any tutoring for the court to weigh.

MNEMONIC

Is the mind CLEAR?

Consciousness unclouded; **L**evel of attention sustained; **E**xpression coherent and comprehension intact; **A**nswers rational and internally consistent; **R**ecall of the event in the patient's own words. CLEAR is a bedside prompt, not a formula: fitness remains a case-specific conclusion supported by the recorded examination.

GOOD TO REMEMBER

Document the examination contemporaneously and in the patient's own words: the exact questions put, the exact answers given, the time, and the state of the sensorium at that time. A record showing the questions posed and the rational replies received is far stronger in court than a later assertion that the patient was "conscious and oriented". If the sensorium is fluctuating, assess and certify fitness immediately before the statement is taken, because capacity present an hour earlier does not establish capacity at the moment of the declaration.

21.5 Conditions that cloud the declarant's mind

Where competence actually fails. Almost every dying declaration is taken from a patient who is, by definition, gravely injured or ill, and the same processes that threaten life threaten the sensorium. The psychiatrist should look actively for the states below rather than presume fitness from the fact that the patient is talking; fluent speech and a clear mind are not the same thing. **Delirium** in particular can coexist with apparently purposeful conversation.

THREAT TO COMPETENCE	MECHANISM	WHAT THE ASSESSMENT FOCUSES ON
Extensive burns	Shock, toxaemia and hypoxia cloud the sensorium; pain and dehydration compound it	Alertness and coherence now, not the proportion of surface burnt, which does not by itself decide fitness
Head injury	Raised intracranial pressure, contusion and post-traumatic amnesia	Consciousness, orientation, and whether the event itself can be recalled
Haemorrhage and hypoxia	Cerebral hypoperfusion and hypoxaemia impair attention and thought	Sustained attention and fluctuation over minutes
Acute intoxication	Alcohol or other substances disinhibit and disorganise; withdrawal may bring delirium	Slurring, disinhibition, and the ability to give a consistent account
Sedation and analgesia	Opioids and sedatives blunt the sensorium precisely as pain relief is given	Timing relative to the last dose and the depth of sedation
Delirium	Fluctuating attention, disorganised thinking and altered awareness	Attention, fluctuation, disorganisation and perceptual disturbance
Psychotic or demented state	Delusional content or established cognitive impairment may distort the account	Whether the narrative is reality-based and internally consistent

A recurring bedside error concerns burns. The extent of a burn is frequently taken as a proxy for mental fitness, so that a very large burn is assumed to render the patient incompetent and a smaller one is assumed to leave competence intact. Neither inference is safe. The burnt surface tells you about prognosis and physiology, not directly about the sensorium, and a coherent contemporaneous assessment of mental state is what the question actually requires.

PITFALL

Do not anchor a report or certificate to the repealed evidence statute. The dying-declaration provision now sits in the Bharatiya Sakshya Adhiniyam; the corresponding section of the Indian Evidence Act is historical and reaches a case only through the transitional savings rule. A certificate that cites the old provision as the live law reads as out of date and quietly undermines the very reliability the psychiatrist is there to support.

21.6 Weight, corroboration and the limits of the opinion

Because it is untested by cross-examination, a dying declaration is scrutinised closely for reliability before a court acts on it, and a mentally fit declarant is central to that scrutiny; the general rules of evidence, and how a court treats and corroborates such a statement, are set out where this chapter treats the psychiatrist in court and the rules of evidence. The psychiatrist's contribution stays within its lane. We opine on capacity - whether the declarant was able to perceive, remember and communicate - and not on veracity, which is the court's exclusive

province. The separation of the treating clinician's role from that of the forensic evaluator, and of opinion evidence from fact evidence, is discussed where this chapter treats the psychiatrist as expert witness; the same discipline applies here, because the doctor who both resuscitates the patient and certifies fitness is wearing two hats at once and should say clearly which one each part of the record belongs to.

> A dying declaration is relevant under the Bharatiya Sakshya Adhiniyam whether or not the maker expected to die and in any proceeding where the cause of death is in issue; its weight, however, turns on the declarant having been of fit mind, and that fitness is the psychiatric question.

22 · Court structure, the psychiatrist in court and rules of evidence

Why the marks are here. A psychiatric opinion is only as good as the forum that receives it and the rule that lets it in. A report may be clinically impeccable, but if the psychiatrist does not know which court has summoned them, or cites the provision that admits their opinion in the language of a repealed code, the credibility of the whole exercise is undercut before a word of the clinical reasoning is read. Examiners test this because it is where a well-trained clinician is most easily caught out: the medicine is sound, the legal frame is out of date. Two things must be exact - the structure of the courts a psychiatrist may testify before, and the evidentiary rule under which their opinion is admitted.

This section teaches the statutory hierarchy of the criminal courts and the **rules of evidence** that govern how an expert opinion is received, both read from the current codes. The separation of the treating role from the expert role, and the advisory weight an opinion carries once admitted, are set out elsewhere in this chapter and are named here only; the substantive test of criminal responsibility, and the burden of proving it, belong to the Mental health legislation and forensic psychiatry notes and are not re-taught here.

22.1 The statutory ladder of the criminal courts

The current code of criminal procedure sets out, at section **6**, the classes of criminal court that exist in every State, and it is before these classes that a psychiatrist may be called to testify; the powers to summon a witness or to order a psychiatric assessment come from other provisions, not from this section. The provision is framed as a mandatory one: besides the High Courts and any courts constituted under other laws, every State shall have the classes of criminal court it enumerates. The enumerated classes are the **Courts of Session**; the **Judicial Magistrates of the first class**; the Judicial Magistrates of the second class; and the **Executive Magistrates** - the first three exercising judicial trial power in descending order, while the Executive Magistrate exercises executive and public-order functions rather than the trial of offences. The word "besides" does real work: it places the High Courts outside and above this list of State classes. The Supreme Court of India, higher still, is the constitutional apex, but its position is established by the Constitution and not by this section, which does not mention it.

The distinction the section draws between the two kinds of magistrate is the one most often missed. The Judicial Magistrate exercises judicial functions - trying offences, taking evidence, convicting and sentencing within the limits of the class - and it is before a Judicial Magistrate or a Court of Session that a psychiatrist's evidence on a contested criminal question is usually led. The Executive Magistrate performs executive and public-order functions rather than the trial of offences, and a psychiatrist encounters this office in the machinery that surrounds custody and order rather than in the trial.

COURT	PLACE IN THE LADDER	WHERE THE PSYCHIATRIST MEETS IT
Supreme Court of India	Constitutional apex, above the High Courts	Rarely in person; its judgments set the law the report must follow
High Court	Sits besides and above the State classes	Appeals and references turning on a psychiatric question
Court of Session	Highest of the State trial classes	Trial of the graver offences where responsibility is in issue
Judicial Magistrate (first and second class)	The magistracy exercising judicial trial functions	Trial of lesser offences; taking of evidence and committal
Executive Magistrate	Executive and public-order functions, not trial	Order-maintenance and custodial machinery, not the trial itself

The statutory classes under the current procedure code, with the High Courts and the Supreme Court above the State list. The section fixes the classes; which class hears a given matter turns on the offence and the stage of proceedings.

MNEMONIC

Sessions sit highest, Judicial magistrates try, Executive magistrates keep order

Read the State ladder top to bottom: Court of Session, then Judicial Magistrate of the first and then second class, then the Executive Magistrate. The first three are judicial and try offences; the last is executive and keeps public order. The High Courts sit besides and above the whole list, and the Supreme Court above them.

22.2 Why the forum matters to the report

The court decides the shape of the answer. Knowing the ladder is not academic. The court issuing the summons frames the question being asked and identifies the person to whom the duty of the evidence is owed, which is the court and not the party who arranged the attendance; the standard of proof, by contrast, is fixed by the nature of the proceeding and the law that governs it, not by the court that issues the summons. The scope of the opinion is set by the question the court has framed and not by the rank of the court that framed it: a magistrate's inquiry may call for a comprehensive assessment while a Court of Session may want one narrow issue answered, and accuracy, transparency and defensibility are owed in equal measure to every court. A psychiatrist who does not register what was actually asked either over-answers a small question or under-serves a large one. The pathway by which an accused is referred for assessment is a

separate topic set out elsewhere in this chapter; what matters here is that it ordinarily proceeds before one of the courts named above, subject to any special court constituted under another law.

GOOD TO REMEMBER

Before writing a line, establish which court has called you and in what capacity. Match the report to the forum: state the court, the question as the court framed it, and the material examined. Because a treating psychiatrist's own records can be summoned as evidence of fact in any of these courts, contemporaneous and legible documentation is a medico-legal protection long before a summons ever arrives.

22.3 The rule that admits an expert opinion

The ordinary rule of evidence is that a witness may speak only to facts they personally perceived, because drawing inferences from facts is the court's own work. The expert is the deliberate exception, and the current evidence code fixes that exception at section **39**, the successor to the corresponding provision of the repealed Indian Evidence Act. The rule is precise about when it operates: it is only when the court has to form an opinion upon a point of science, art, foreign law, any other field, or the identity of handwriting or finger impressions that the opinions of persons specially skilled in that field are, in the language of the code, **relevant facts**, and the persons who give them are called **experts**. The trigger is the court's own need for specialised knowledge it does not itself possess; where no such need arises, the exception does not open and an opinion is not received.

Two features of the current section repay attention:

- its illustrations expressly include the psychiatric question, one being precisely whether a person was, by reason of unsoundness of mind, in a particular mental state, the evidentiary hook on which psychiatric testimony hangs;
- it has been modernised for the digital age, a sub-section making the **Examiner of Electronic Evidence** an expert so that opinions on electronic records are admitted on the same footing.

For the psychiatrist the first of these is load-bearing: the code does not merely tolerate psychiatric opinion, it names unsoundness of mind as a paradigm of the specialised question an expert exists to address.

RULE **Expert opinion is admitted only where the court needs specialised knowledge to form its own opinion.** When the court has to form an opinion on a point of science, art, foreign law, any other field, or the identity of handwriting or finger impressions, the opinions of persons specially skilled in that field are relevant facts, and those persons are experts. The psychiatric question of unsoundness of mind falls squarely within the field the section describes.

22.4 A relevant fact, not a verdict

Calling the opinion a relevant fact is exact, and it marks the boundary of what the evidence rule delivers. Admissibility is one question and weight is another. The expert-opinion section makes the opinion admissible, that is, something the court is entitled to consider; it does not make it binding, and it does not transfer the decision to the expert. The distinction between fact evidence

and opinion evidence, and the advisory character an admitted opinion carries, is the treating-versus-expert material developed elsewhere in this chapter and is only named here. What the evidence rule itself contributes is narrower: it opens the door through which a specialised opinion may pass, on a defined class of question, given by a person specially skilled. What the court then does with the opinion is a matter of weight, not of the rule that let it in.

TRAP **Citing the repealed evidence and procedure codes as current.** Candidates and clinicians reach for the section numbers of the old Indian Evidence Act and the old Code of Criminal Procedure, the codes they trained on, when stating the rule that admits their opinion or the court that will hear it. Those codes are historical; the expert-opinion rule and the classes of criminal court are now provisions of the current evidence code and the current procedure code. An opinion built on a repealed citation is easy to discredit, however sound the psychiatry beneath it.

22.5 The psychiatric question inside the rules of evidence

Several distinct evidentiary questions bring the psychiatrist into this framework, and it is worth separating them so that each is answered under the right rule and the right owner. They are:

- the admissibility of psychiatric opinion itself, which is the expert-opinion rule owned here, with unsoundness of mind named in the section's own illustration;
- the substantive test of criminal responsibility and the burden of proving it, which the illustration points toward but does not decide, and which belong to the Mental health legislation and forensic psychiatry notes;
- the assessment of a declarant's competence when a dying declaration is offered in evidence, a distinct evidence rule set out elsewhere in this chapter;
- the procedure for referring and assessing an accused, whose pathway is likewise carried elsewhere in this chapter.

Keeping these apart is the discipline the topic rewards. The evidence rule tells you that a psychiatric opinion on unsoundness of mind is receivable; it does not tell you what the test of unsoundness is, nor who must prove it, nor how heavy that burden sits. Those belong to the doctrine of criminal responsibility, and answering them here would blur the very line the evidence rule draws. The section admits the opinion; the doctrine, taught in the Mental health legislation and forensic psychiatry notes, decides what the opinion must establish.

IN INDIA

Both provisions a psychiatrist relies on in a criminal court are now Indian statutes of recent vintage: the classes of criminal court are fixed by the current procedure code, which replaced a post-independence Code of Criminal Procedure, and the admissibility of expert opinion by the current evidence code, which replaced the colonial-era Indian Evidence Act. The Indian evaluator testifies within this specific statutory ladder and under this specific evidentiary rule, not a generic or textbook-Western frame, and the report should name whichever code actually governs the proceeding rather than reaching by habit for the Act it replaced.

22.6 Currency: testifying after the codes changed

The evidence code and the procedure code that carry these two rules are themselves the products of the recent replacement of the three colonial criminal codes, when the old penal, procedure and evidence Acts gave way to their current successors. The rule that decides which code governs a particular matter - the savings rule that turns, for procedure and evidence, on whether the proceeding was already pending at the changeover - is set out elsewhere in this chapter and is not re-derived here. What the psychiatrist must carry from it is practical: a matter that straddles the transition may be tried under the current procedure and evidence codes even where the offence and its defence are judged by the older penal law, so a report should cite whichever codes actually govern and never assume the newest code applies automatically.

Under the current evidence code, its expert-opinion rule makes the opinion of a specially skilled person a relevant fact whenever the court needs specialised knowledge, and unsoundness of mind is named in its illustrations; the current procedure code, through its classes-of-court provision, fixes the classes of criminal court a psychiatrist testifies before.

6	39
PROCEDURE-CODE SECTION FIXING THE CLASSES OF CRIMINAL COURT	EVIDENCE-CODE SECTION ADMITTING EXPERT OPINION

PITFALL

The recurring real-world error is a currency error, not a clinical one: a psychiatrist swears to or writes a report that grounds the admissibility of the opinion, or names the court, in a section of the Indian Evidence Act or the Code of Criminal Procedure. Those Acts have been replaced. The correct citations are the expert-opinion provision of the current evidence code and the classes-of-court provision of the current procedure code, and using the repealed numbers hands the other side an easy line of attack on an otherwise sound opinion.

23 · Legal aspects of seclusion, restraint and involuntary treatment

Why the marks sit here. Coercion is the point at which psychiatry is most likely to injure the very person it sets out to help, and it is therefore the point at which the law watches most closely. When a patient is shut in a room alone, held down, sedated to control behaviour, or treated over refusal, the ordinary architecture of clinical practice - liberty as the default and treatment by consent - has been suspended. The examiner's interest is not in whether these things ever happen, because they do, but in whether the candidate can say exactly what makes each of them lawful rather than an assault or a wrongful detention. This topic is the legal frame around the three coercive interventions: what the law permits, on what conditions, and with what safeguards attached. The moral reasoning behind that frame, and the rights lens that applies in prisons and custody, are developed elsewhere in this chapter; here the task is the legal skeleton.

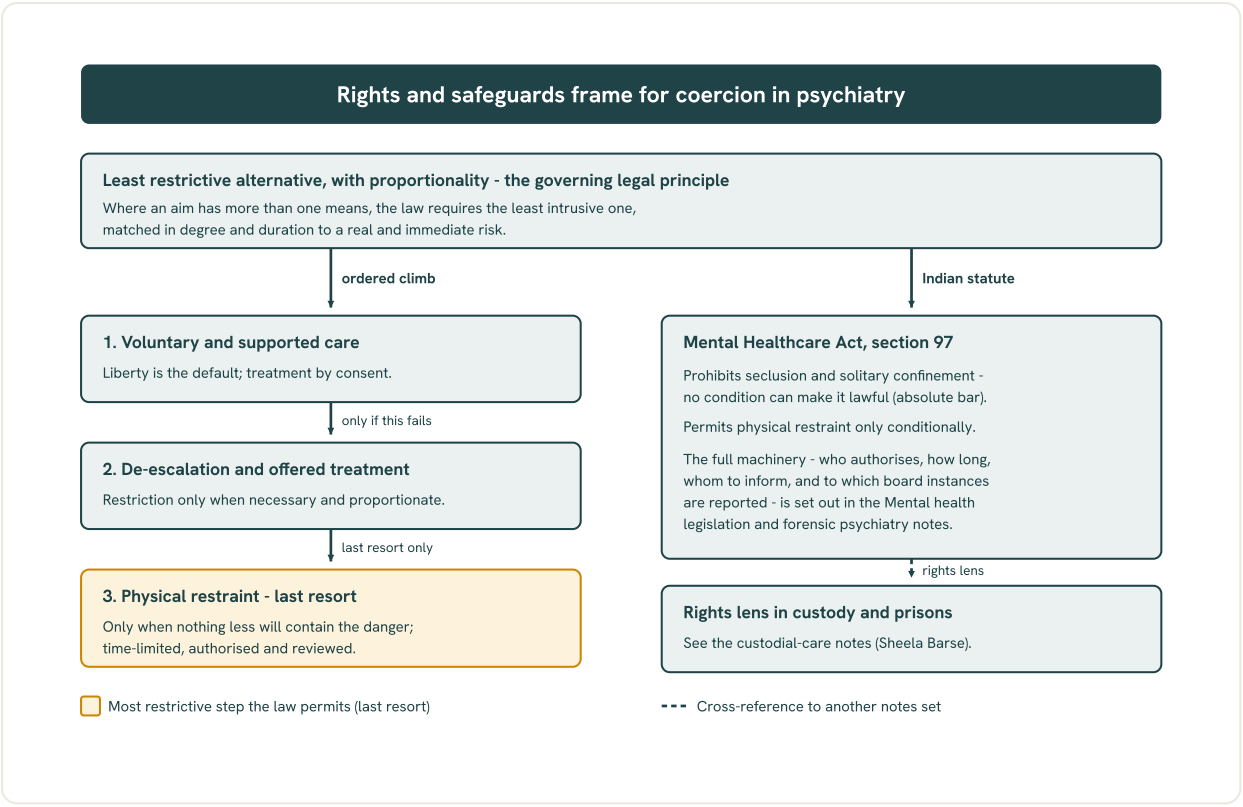


Fig 26.13. The rights-and-safeguards frame for coercion: the least restrictive alternative forces an ordered climb from voluntary care to time-limited, reviewed physical restraint, while Mental Healthcare Act section 97 bars seclusion and solitary confinement outright and permits restraint only conditionally.

23.1 The three coercive interventions and why the law singles them out

Three distinct interventions are gathered under this heading, and the first discipline is to keep them apart, because they carry different legal answers. **Seclusion** is the confinement of a person alone in a room or space they cannot freely leave; its extreme form, **solitary confinement**, isolates the person from all meaningful human contact. **Physical restraint** is the use of manual force or a mechanical device to restrict free movement. A third and quieter category is **chemical restraint**, the administration of medication whose purpose is to control behaviour or movement rather than to treat the underlying condition. Distinct again is **involuntary treatment**, the delivery of a medical intervention to a person who has not consented, or who has refused.

What unites them is that each is an exception to a legal default. The default is that an adult of sound understanding may not be confined, touched, or medicated without agreement; departing from that default requires positive legal authority, and the law grants that authority narrowly and conditionally. This is why coercion is examined as law and not merely as good practice: a restraint that is clinically understandable but legally unauthorised is still a battery, and a confinement that felt safe on the ward is still a false imprisonment if the conditions the statute demands were not met.

23.2 The least restrictive alternative as the governing legal principle

The single organising idea across the whole of coercive care is the **least-restrictive alternative**. It holds that where an aim can be achieved by more than one means, the law requires the means that intrudes least on the person's liberty, dignity and bodily integrity. It is not a counsel of perfection but a legal test with teeth: it makes the more restrictive option unlawful whenever a

less restrictive one would have worked. In practice it forces an ordered climb - environmental change, de-escalation and verbal engagement, offered medication, then, only if these genuinely fail, physical measures - and it treats each higher rung as justifiable only by the failure or inadequacy of the ones below it.

Its companion is **proportionality**: the degree and duration of any coercion must be matched to the seriousness and immediacy of the risk it answers, and no more. Proportionality is what stops the least restrictive option from being applied too hard or too long. Together they convert a vague clinical instinct into something a court can review after the fact: not "was the ward safer" but "was this the least intrusive step that would have contained the specific danger, and was it kept to the shortest span that danger required."

RULE **Coercion is lawful only as the least restrictive, proportionate means, and each form answers to its own threshold: physical restraint to a real and immediate risk, involuntary treatment to the conditions of the statutory pathway relied on.** Every coercive act must be justified twice over: that a less intrusive alternative was tried or genuinely unavailable, and that the intensity and duration were no greater than the danger demanded. A step that skips the ladder, or outlasts the risk, forfeits its lawfulness even if it was well intentioned.

Least	Nil	Exception
RESTRICTIVE ALTERNATIVE IS THE LEGAL DEFAULT	LAWFUL SECLUSION OR SOLITARY CONFINEMENT	INVOLUNTARY CARE DISPLACES CONSENT, NEVER RIGHTS

23.3 The rights and safeguards frame

The law does not simply permit coercion and walk away; it wraps every permitted instance in procedural safeguards whose function is to keep the intervention honest. These safeguards recur, in one form or another, across every jurisdiction and every code, and a candidate who can recite the frame can reconstruct almost any specific provision from first principles. The core safeguards are:

- **Necessity** - a lawful ground exists only on the test the governing provision itself sets: for physical restraint, that coercion is the sole realistic way to prevent serious, imminent harm; for involuntary treatment, the necessity written into the pathway relied on.
- **Proper authorisation** - the decision rests with a defined clinician, not with whoever is nearest or most senior on the floor.
- **Time-limitation** - the measure lasts no longer than the risk that justified it, with active review built in rather than a fixed licence.
- **Documentation** - the reasons, the alternatives tried, and the timing are recorded contemporaneously, because an unrecorded safeguard is indistinguishable from an absent one.
- **Notification** - the person's representative is told, so that coercion is never invisible to those outside the treating team.
- **External oversight** - instances are reported to an independent review body, moving accountability beyond the establishment that imposed the measure.

Reading down that list, the interventions sort themselves onto a continuum from tolerable-under-conditions to never-permitted, and the same axes explain why.

INTERVENTION	LEGAL STATUS	GOVERNING SAFEGUARD
Seclusion / solitary confinement	Prohibited outright	No condition can make it lawful
Physical restraint	Conditionally permitted	Necessity, authorisation, strict time-limit
Chemical restraint	A clinical description; its statutory position is not settled by the grounded text of the restraints and seclusion provision	The consent and involuntary-treatment rules governing the medication itself
Involuntary medication or treatment	Only under statutory authority	Applicable statutory pathway and decision-specific capacity; Board review where prescribed

IN INDIA

The Indian embodiment of this frame is the Mental Healthcare Act, whose restraints-and-seclusion provision is section **97**: it prohibits seclusion and solitary confinement absolutely, and permits physical restraint only conditionally. The full machinery of that section - who authorises, for how long, whom to inform, and to which body instances are reported - together with the Act's definitions, capacity provisions, advance directive, admission pathways and review boards, is set out in the Mental health legislation and forensic psychiatry notes and is named here rather than restated. The point to carry is structural: Indian statute encodes the continuum above, drawing the hard line at seclusion and hedging restraint with cumulative conditions.

23.4 Involuntary treatment as an exception to consent

Involuntary treatment raises a different legal question from restraint, because it engages the doctrine of consent directly. The starting position is that valid treatment requires the patient's informed agreement; the elements of that agreement - capacity, adequate disclosure, and voluntariness - are set out in this chapter's account of consent in psychiatry and are not re-derived here. Treatment without consent is lawful only where a specific legal authority displaces the ordinary requirement, and that authority depends on the applicable statutory pathway and on the patient's decision-making capacity, not on the diagnosis or the setting alone.

Two errors follow from losing sight of this. The first is to treat a mental illness as if it were itself the authority to override refusal; it is not, because many patients with serious illness retain capacity for the particular decision in front of them. The second is to assume that a lawful involuntary admission is a blanket warrant for any and all treatment. Admission answers the question of where the person may be kept; it does not by itself answer whether a given intervention may be imposed over refusal, which is a separate determination with its own conditions. The capacity standard, the advance directive that may speak for the patient's earlier wishes, and the admission categories themselves belong to the Mental health legislation and

forensic psychiatry notes; the legal principle to hold here is that involuntary treatment is a conditional exception and never a default that admission switches on.

PITFALL

The common clinical error is to read an involuntary admission as consent to everything that follows, and to medicate over refusal without a fresh, decision-specific capacity assessment. Admission and treatment authority are distinct legal questions; conflating them exposes the clinician to a claim of treatment without lawful authority even where the detention itself was sound.

23.5 Chemical restraint and the discriminations candidates miss

Chemical restraint is the category that most often escapes the frame, precisely because it looks like ordinary prescribing. A dose of a sedative can be a legitimate treatment of an underlying illness or a device to subdue difficult behaviour; the same drug, the same route, and only the purpose distinguishes them. Ethically the purpose matters more than the pharmacology: medication given to control behaviour rather than to treat is coercion in substance, and the safeguards that keep restraint honest - necessity, authorisation, time-limitation, documentation and review - are the right discipline to hold it to. Its legal authority is a separate question, because the statute's restraints-and-seclusion provision is written for physical restraint; medication over refusal has to be justified under the consent, capacity and involuntary-treatment rules that govern giving the drug at all. Calling it a "PRN" or writing it up as routine does not remove it from either frame.

The discriminations worth rehearsing are therefore three. Restraint answers an immediate danger, whereas treatment answers an illness over time. Restraint is measured against the least restrictive alternative and must climb the ladder of de-escalation first, whereas ordinary treatment is measured against consent and clinical indication. And restraint is time-limited by the risk, whereas a treatment course is governed by the condition. Blur these and a control measure is dressed up as care, which is both a legal exposure and, on the wards, a route to overuse.

TRAP **Treating sedation-for-behaviour as though it were outside the restraint safeguards.** Candidates and clinicians alike assume that because a drug is a treatment in other contexts, giving it here is treatment too. Purpose is what makes the label chemical restraint apt, and it is what the ethical safeguards attach to; the legal authority for giving the drug still has to be found in the consent, capacity and involuntary-treatment rules, however the dose is documented.

23.6 Documentation, oversight and liability

The safeguards frame is only as real as the record that proves it was followed, which is why documentation is the practical hinge of this whole topic. When a coercive act is later questioned - by a review body, a representative, or a court - the contemporaneous note of what danger was faced, what less restrictive steps were tried, who authorised the measure, and when it ended is the evidence that separates a lawful intervention from an actionable one. A coercive act that was in fact necessary and proportionate but was never recorded is, for the purposes of any later scrutiny, an act without a justification.

Liability flows along familiar channels. Coercion applied without a lawful ground can found a claim in the ordinary law of professional negligence, the standard-of-care analysis for which is developed in this chapter's treatment of professional negligence and is not restated here; coercion that is disproportionate or prolonged can breach the person's rights independently of any question of clinical skill. The rights lens that applies with particular force in prisons and custodial settings is taken up separately in this chapter. The through-line is that oversight is not an administrative afterthought but the mechanism by which the least restrictive principle is enforced after the event, when the clinical urgency that prompted the act has passed and only the record remains.

GOOD TO REMEMBER

Before any restraint, and while it is in force, write the ladder down: the danger, the less restrictive steps attempted, the authorising clinician, and the intended and actual end-point. This single habit satisfies the safeguards frame, shortens the intervention by keeping its end in view, and is the strongest protection against a later claim that coercion was imposed without lawful justification.

Every coercive intervention in psychiatry is lawful only as the least restrictive, proportionate, authorised and reviewable response to a genuine necessity; physical restraint answers a real and immediate risk while involuntary treatment runs through its own statutory conditions, and seclusion and solitary confinement have no lawful place at all.

Cross-cutting synthesis

24 · Cross-cutting synthesis

Every topic in this chapter is one question asked over and over. A patient says something in a consulting room. What happens to that sentence next - whether it is guarded, revealed to protect someone, spoken aloud in a witness box, or written into a record an inspector may later read - is not decided by the sentence. It is decided by who the psychiatrist is at that moment, and by what makes the telling lawful. Learn each of this chapter's topics on its own and you have a shelf of separate rules. See that they answer a single recurring question and you have the chapter, because the ethics, the consent, the confidentiality, the liability and the forensic role are not neighbours on a syllabus; they **interlock**, and the joint that holds them together is disclosure governed by role.

The marks for this synthesis are earned in the transitions, not in any one rule. An examiner who wants to separate a candidate who has memorised from a candidate who has understood gives a vignette that crosses roles: the treating doctor who is later summoned to court, the consent that turns out to be a capacity problem, the confidence that collides with a threat to a third person, the complaint that becomes a consumer matter, the accused a magistrate has ordered assessed. In every one of these, the facts do not change; the psychiatrist's relationship to them does, and with it the answer. This account owns that shared logic only. It names each rule in a clause and sends

you to the topic that teaches it in full; if it starts restating a section or a test, it has wandered into a sibling's territory.

Patient	Third party	Court	Regulator
CONFIDENTIAL BY DEFAULT, THE CLINICIAN'S OWN DUTY	A PROPORTIONATE DISCLOSURE THAT IS PERMITTED, NOT COMMANDED	A DISCLOSURE THE COURT'S OWN PROCESS CAN COMPEL	A RECORD REACHABLE ONLY UNDER A LAWFUL ORDER OR AN EXPRESS STATUTORY POWER

24.1 The two roles that decide everything

The organising fact of forensic ethics is that a psychiatrist can stand in one of two fundamentally different relationships to the same person, and the primary allegiance and much of what is owed change between them. In the first, the **treating clinician** owes their duties to the patient: to act for that person's welfare, to hold their confidences, to obtain their consent, to keep faithful records of their care. In the second, the **forensic evaluator** owes their primary duty not to the person in the chair but to the court that has asked for an opinion: to be objective, to serve the process of justice, to tell the tribunal what the clinical findings are even when they do not help the person being examined. This **dual role** is the spine of the whole chapter, and almost every discrimination the examination tests is a consequence of it.

The two roles pull in opposite directions on the one thing both handle, which is information. The treating role's instinct is to protect and withhold; the forensic role's obligation is to examine and report. That is why the same clinical detail is not one fact with one rule but a single fact whose governance shifts as the psychiatrist's relationship to the person shifts. The chapter's individual topics each sit on one side of this divide or describe a crossing between the sides, and the account of the expert witness elsewhere in this chapter, which separates the treating role from the expert role, is the place where the divide is drawn most sharply.

RULE **Ask the role before you answer the question.** No rule in this chapter can be applied until you have fixed which relationship the psychiatrist stands in. The role sets the duty, the duty sets what may be disclosed, and the same information carries a different answer depending on which of the two hats the psychiatrist is wearing when the question arrives.

24.2 One fact, several governances

Take a single piece of clinical information and watch how differently the law treats it as the setting changes. In the consulting room it is confidential, and the default duty not to reveal it is the clinician's own, owed to the patient. If that same information reveals a serious and specific danger to an identifiable other, it becomes something the clinician is permitted to reveal to avert the harm, a permitted **disclosure** that the Indian position allows without ever commanding; the full working of confidentiality and its recognised exceptions is taught in this chapter's account of confidentiality and its limits. Put the same clinician in a witness box under an order of the court, and the information can be compelled from them, because the authority over the telling has passed to the court's own process; being compelled makes them a witness, and the expert's duty to the tribunal arises only where that role has been separately defined. Written into the clinical file, that information becomes a record whose standards of keeping, and whose openness to

inspection by a regulator or a court, are the subject of this chapter's account of medical records and certification.

Nothing about the information itself changed across those four settings; the authority governing it did. This is the single most useful table to carry into the examination, because it turns a set of separate topics into one grid, and a vignette into a question of which column applies.

SETTING	WHO THE PSYCHIATRIST IS	WHAT GOVERNS THE INFORMATION	ON WHOSE AUTHORITY IT MAY BE DISCLOSED
THE CONSULTING ROOM	Treating clinician	The default duty of confidentiality	No one: it is kept, unless a recognised ground arises
A THREAT TO AN IDENTIFIABLE OTHER	Treating clinician exercising judgement	A permission to make a proportionate protective disclosure	The clinician's own bounded discretion, not a command
THE WITNESS BOX	Expert or compellable witness	The rules of evidence and the court's order	The court, which can compel the telling
THE CLINICAL RECORD	Record-keeper and certifier	Documentation and certification standards	The patient's consent, a lawful order, or an express statutory power of inspection
ANY OF THE ABOVE	Either role	Valid consent, where it can be and has been obtained	The patient, whose consent makes an otherwise closed disclosure lawful

24.3 Consent is the hinge, and capacity is the question under it

Running underneath the whole grid is **consent**, because a valid consent is the cleanest authority of all: within the scope of what the patient has actually authorised it can make lawful a disclosure that would otherwise be a breach, and it is the ground on which the treating relationship is built in the first place. This chapter teaches consent in full in its account of informed consent in psychiatry, with its elements and its special situations. The synthesis point is narrower and sharper: consent is not a signature, it is a state of the patient, and the moment you probe it you may find yourself asking a different question altogether.

That different question is **capacity**. A consent form is only as good as the decision-making ability of the person who signed it, so a consent question in a patient whose illness clouds judgement quietly becomes a capacity question, and a capacity finding is what determines whether the treating role can proceed on the patient's own authority or must fall back on the substituted machinery. The capacity determination itself, and the statutory scheme of advance directives, nominated representatives and admission that surrounds it, belong to the Mental health legislation and forensic psychiatry notes and are named here, not reworked. The seam to hold is the slide: an autonomy question about what the patient wants becomes a capacity question about whether they can decide, and only after that is answered does the disclosure or the treatment have a lawful footing.

GOOD TO REMEMBER

When a consent feels shaky, stop treating it as a consent problem and test it as a capacity problem. The two are asked in the same breath but answered by different tools, and the whole lawfulness of what follows - the treatment, the admission, the release of information to a family member - rests on getting that second question right rather than accepting the first answer at face value.

24.4 The handoffs a real case crosses

A single patient can walk the psychiatrist through most of this chapter. Real forensic difficulty comes not from any one rule but from the crossings between them, when a case moves from one role or forum to the next and the governing rule changes at the boundary. The recurring handoffs are these.

- **Treating clinician is summoned as a witness.** The doctor who has cared for a patient is called to speak about them in court. A summons does not by itself turn the treating clinician into the forensic expert: they ordinarily give evidence of fact and of the treatment they provided, and a separate expert role must be defined explicitly rather than assumed at the courtroom door. Keeping the two roles distinct is the discipline taught in this chapter's account of the expert witness.
- **A consent becomes a capacity question.** The autonomy the treating role respects turns out to depend on a decision-making ability the illness has compromised, and the answer moves from what the patient wants to whether they can decide, as above.
- **A confidentiality duty meets a duty to a third party.** The promise to the patient collides with the safety of an identifiable other, and the clinician must decide whether a permitted protective disclosure is warranted and how far it may go, a decision governed by proportionality and taught in this chapter's account of confidentiality.
- **A negligence claim becomes a consumer matter.** A grievance about care crosses from the language of professional negligence into a specific statutory forum with its own remedy, so the same allegation is litigated in a different place under a different frame; the standard of care and the forum are taught in this chapter's accounts of negligence and of the consumer-protection route.
- **An accused becomes a psychiatric subject by order.** A person facing trial is sent for assessment not by their own consent but by a court's direction, which converts a clinical encounter into a court-authorised examination whose procedural pathway this chapter teaches, while the substantive test of criminal responsibility belongs to the Mental health legislation and forensic psychiatry notes.

Notice that every handoff is a change in the authority over information or over the person: a duty owed to one party is joined, and to that extent limited, by a duty owed to another. That is why disclosure, and not any single doctrine, is the thread the chapter is strung on.

24.5 The forum, the code and the currency behind every answer

Two further layers sit behind the grid and quietly decide answers. The first is the forum: the place a dispute is heard shapes the remedy available, so a claim about deficient care is one thing framed as professional negligence and another routed into the consumer-protection forum, and an opinion is received under one set of rules in a courtroom that this chapter's account of the court and the rules of evidence sets out. The second is currency, and it is the trap that most often turns a correct-sounding answer wrong. The rules cited must be the ones actually in force. The professional-conduct code that governs a psychiatrist's ethics, taught in this chapter's account of the codes, is the operative one and not the later edition that was notified but held in abeyance. The substantive criminal law changed, and the framework and its savings rule are taught in this chapter's account of the penal-code transition; naming the superseded statutes as current is a currency error, not a substantive one, and it is caught all the same.

These two layers are why the synthesis is more than a tidy diagram. A candidate can identify the right role, the right duty and the right disclosure and still lose the mark by citing the wrong forum for the remedy or the wrong edition of the code for the duty. The frame tells you what the answer is about; the forum and the currency tell you whether the answer you have written is still the law.

IN INDIA

The Indian shape of this chapter is specific and examinable. Protective disclosure is a permission and not the positive duty of the American case law. The professional-conduct code in force is the earlier statutory edition, the later one being notified but not operative. Deficient medical service reaches a defined consumer forum. The criminal statutes have been recast, and the savings rule decides which version governs: the older penal law still governs offences committed before the change, while proceedings already pending at the change continue under the old procedure and evidence law. The child-protection and juvenile framework, and the general mental-health machinery, sit in the Child psychiatry: assessment, treatment, services and protection notes and the Mental health legislation and forensic psychiatry notes respectively; this chapter points to them rather than restating them.

PITFALL

The commonest real-world slip is not a wrong rule but a blurred role. A treating psychiatrist, asked casually by a lawyer or a relative, writes a forensic-sounding opinion about fitness or responsibility into a discharge summary, without a court's referral or any other properly defined retaining authority, and without flagging that they are no longer speaking as the treating doctor. The opinion then carries the weight of an expert's while resting on none of an expert's safeguards, and the confidences of treatment leak into a quasi-legal document. Fix the role in writing before you offer the opinion, or decline until the proper role and authority are in place.

24.6 How it interlocks: the master frame

Assemble the pieces and the chapter resolves into a single decision procedure that fits every vignette it can throw at you. Fix the role. Identify the information at stake. Ask what may be told,

to whom, and on whose authority. Check that the code, the statute and the forum you are relying on are the ones currently in force. Where a rule belongs to a sibling topic, apply it by name and reason from it rather than restating it. The reason this works is that the whole chapter was built on one seam: the psychiatrist's two roles and the single question of disclosure they govern between them.

MNEMONIC

Two hats, three questions

The master frame for any forensic-ethics vignette. First the **two hats**: is the psychiatrist the treating clinician, who owes duties to the patient, or the forensic evaluator, who owes candour to the court? Then, of the information in play, the **three questions**: **What** may be told, **to Whom**, and on **Whose authority** - the patient's consent, the clinician's bounded discretion, a court's order, or a regulator's power. Fix the hat, run the three questions, and every rule in this chapter falls into its place.

Fix the role first: it decides the duty, the duty decides what may be disclosed, and the same fact carries a different lawful answer under each hat.

TRAP **Answering a role-crossing vignette with a single rule.** Candidates read the clinical detail, reach for the one doctrine it looks like - confidentiality, or consent, or negligence - and answer as though the setting were fixed. The examiner wrote the vignette precisely because the setting moves, and the mark is for tracking the information across the crossing: what was confidential becomes compellable, what looked like consent was a capacity question, what began as negligence is heard as a consumer complaint. Name the role at each stage and the moving answer becomes visible; assume one role throughout and you answer only the first frame.

Apply and consolidate

25 · Applying the chapter

Why worked vignettes earn their marks. The examiner rarely asks you to recite a rule; they hand you a short case in which two rules pull in opposite directions and watch how you reason to a defensible answer. A vignette is therefore a test of judgement under a stated constraint, not of recall, and the candidate who has only memorised isolated provisions freezes precisely where the marks are. The cases below are deliberately built at the seams this chapter has been teaching, so that each one forces the same first move: work out which role the psychiatrist is in, then work out on whose authority anything may be done or disclosed. Everything else follows from those two questions.

These vignettes assert no new rule of their own. Each reuses only what the chapter has already established and cross-refers, by name, to the material owned elsewhere. Read each one as a rehearsal: cover the answer, decide what you would do and why, then check your reasoning

against the model. Between them the four cases span the four families of question this chapter can throw at you, and the closing case draws them back into a single frame.

25.1 How to read a medico-legal vignette

Before the individual cases, fix the method, because the same skeleton unlocks every vignette in this territory. The first and decisive move is to name the psychiatrist's **dual role**: are you the treating clinician, who owes duties of care, confidence and consent to the patient in front of you, or the forensic evaluator, who owes an impartial opinion to a court and owes the person examined no therapeutic loyalty? Almost every trap in this domain is baited by a scenario that quietly switches your role halfway through, or asks you to act in one role using the duties of the other.

With the role fixed, the rest of the reasoning is a short, ordered checklist you can run on any case:

- What exactly is the decision point, and who is asking for the decision - the patient, the family, an employer, a court?
- Which duty is in tension with which, and is one of them a default that may yield rather than an absolute?
- What is the governing authority - the patient's own valid consent, a statutory permission, or a court order - and is that authority actually present here?
- What is the least intrusive action that discharges the duty, and how will you record the reasoning so a later reviewer can follow it?

MNEMONIC

The four C's - Consent, Confidentiality, Conduct, Court

Every question this chapter can set falls into one of four families, and the four C's name them in the order the chapter taught them: **C**onsent and capacity; **C**onfidentiality and its limits; professional **C**onduct, negligence and boundaries; and the **C**ourt, where the psychiatrist becomes an expert and an accused is assessed. Under all four sits the one recurring question - what may be disclosed, to whom, and on whose authority. Place the case in its C, answer that question, and the vignette resolves.

RULE **Name your role before you answer.** Whether you are the treating clinician or the forensic evaluator determines every duty that follows, so it is the first line of any good answer, not an afterthought. A candidate who states the role explicitly has already earned marks and has protected themselves from the commonest way these vignettes are lost, which is answering in the wrong hat.

25.2 Vignette: consent and capacity in a special situation

A man in his thirties is brought to the emergency department by his family after a deliberate act of self-harm. He is now medically stable. He is drowsy, his attention drifts, and he is refusing admission and any further care, saying he wants to leave. The family are divided: some insist he

be kept, one pleads that he be allowed home. The decision point is sharp - may he be allowed to refuse, and if not, on whose authority is he held?

The reasoning a candidate must show turns on **capacity**, and the key insight is that capacity is decision-specific and time-specific, not a fixed property of the person. The task is to assess, at this moment and for this decision, whether he meets the statutory test of decision-making capacity, a test set out in the mental health legislation and taught in the Mental health legislation and forensic psychiatry notes, applied here rather than restated. A fluctuating sensorium immediately after an overdose is a classic special situation, but clouded consciousness does not by itself settle the question: the legislation starts from a presumption of capacity, so the refusal stands unless an immediate, documented assessment against that statutory test shows the required abilities are absent, and the correct response is not to override him permanently but to treat what is immediately necessary, protect him from foreseeable harm, and reassess capacity when he is lucid. The second thread is **voluntariness**: a decision squeezed by family pressure in either direction is not fully free, and that too must be weighed. Where capacity is genuinely absent and the risk is high, the lawful route is the involuntary pathway set out in the mental health legislation, not an open-ended clinical override; the machinery of admission, the capacity provisions and the safeguards belong to the Mental health legislation and forensic psychiatry notes and are applied, not reinvented, here.

The answer, then, is layered: give emergency treatment to the extent necessary to prevent serious harm; do not accept a refusal made without capacity as though it were valid; reassess capacity as the clinical picture clears and honour a capacitous refusal if one emerges; and, if involuntary care is needed, use the statutory pathway and its safeguards rather than force alone. One further point earns marks and protects the patient: the man and his nominated representative have a right to information they can actually understand about the nature of the illness and what the treatment involves, a right set out in the mental health legislation and owned by the Mental health legislation and forensic psychiatry notes; the explanation is pitched in plain terms he can take in - his risk, his current confusion and what the treatment is for - rather than left as unexplained clinical jargon.

25.3 Vignette: confidentiality and the duty to warn

A patient in ongoing treatment discloses persistent, detailed thoughts of seriously harming a named colleague, describing a specific and plausible plan. The colleague is identifiable. The decision point is one candidates reliably mishandle: must the psychiatrist warn the colleague, may they, or must they say nothing?

The reasoning must begin from the default, which is that **confidentiality** is owed, and then locate the edge at which it yields. The chapter's teaching on the **limits of confidentiality** is that what the law permits is the disclosure necessary to protect another person from harm, and even then it must be proportionate and minimal - enough to avert the harm, no more; the seriousness and specificity of the threat guide how far a proportionate disclosure may reasonably go. The distinctively Indian move, and the one the examiner is testing, is that this is a permission, not an American-style blanket mandate to warn: the mental health legislation permits a proportionate

disclosure in the interest of protecting a third party rather than imposing an automatic positive duty, and the exact statutory permission sits in the Mental health legislation and forensic psychiatry notes. Before breaching anything, the candidate should show they considered the alternatives that avert the danger without disclosure at all - intensifying treatment, or arranging admission so the risk is contained clinically.

The defensible answer is graded rather than reflexive: assess the seriousness and specificity of the threat; reduce the risk within the therapeutic frame where you can, and where disclosure is necessary to protect the person threatened from harm, make the narrowest disclosure that will do it, to those who can act on it, without delaying a protective disclosure the danger has already made necessary; and document the reasoning at every step, because the justification for the breach is itself examinable and later reviewable. Taking no reasonable protective step in the face of a credible, specific threat may expose the clinician to criticism, though the Indian position frames this as a permission to disclose rather than a positive command to warn; warning reflexively at the first hostile thought needlessly destroys the alliance and exceeds the permission.

GOOD TO REMEMBER

When you decide a disclosure is justified, disclose to the person who can actually reduce the risk and tell them only what they need to act - not the case history. Proportionality is measured by what averts the harm, and a breach wider than that is itself a fresh wrong, however good the original reason.

25.4 Vignette: professional conduct, negligence and boundaries

A psychiatrist volunteers at a free mental health camp and gives advice to an attendee who, months later, alleges she was harmed by that advice. Separately, over the same period, the psychiatrist has accepted a personal gift from a regular patient, begun exchanging friendly messages outside sessions, and drifted into a relationship that is no longer purely clinical. Two decision points sit in one vignette: is a free service beyond the reach of a consumer complaint, and has the psychiatrist crossed a professional line?

On the first, the reasoning must resist a tempting shortcut. Whether the encounter grounds a claim in **negligence** turns on whether a duty of care arose, whether the conduct fell below the standard expected of a reasonable practitioner, and whether that shortfall actually caused the harm alleged. Whether the consumer-protection forum is even available turns on how the service was charged for: a service given free to every attendee falls outside it, whereas free treatment given at an establishment that charges the patients who can afford to pay is within its reach - so the shortcut that a service given without a fee is always outside, and the opposite assumption that it is always inside, are both wrong, and an ordinary negligence action may lie regardless; the reach of that forum is taught with its own case law elsewhere in this chapter. On the second, the issue is a **boundary violation**, and whether these facts have already become one: gifts, out-of-session contact and dual roles mark the slow slide from a therapeutic relationship into a personal one, and how far along that slide a case has travelled is judged against the test taught in this chapter's account of boundaries, applied here rather than assumed. The reasoning to show is that

boundaries are protective of the patient, not merely proprieties, and that the earliest crossings are the ones to name.

TRAP **Treating the four-D mnemonic as the legal test of negligence.** The familiar teaching list - duty, dereliction of that duty, damage, and direct causation - is a memory aid, not the courts' formulation. The Supreme Court's own statement is tighter: it asks for a duty, a breach of that duty, and resulting damage, with causation embedded in the last, and it holds that criminal negligence needs more still - gross negligence coupled with a guilty mind. Reciting the D's as though they were the ratio, or blurring civil and criminal thresholds, loses the mark.

PITFALL

The recurring real-world error in conduct cases is citing the wrong professional code. The operative code a disciplinary body actually applies is the long-standing Medical Council of India professional-conduct regulations; the successor National Medical Commission practitioner-conduct regulations, though formally notified, were held in abeyance and are not in force. Answering, or worse advising, from the newer notified rules treats notification as though it were commencement, and it is confidently wrong.

25.5 Vignette: the forensic role, the expert and the accused

A psychiatrist has been treating a patient for some months. The patient is now charged with an offence, and the family asks the treating psychiatrist to appear in court and give an opinion on the patient's mental state at the time of the alleged act. The decision point is whether the treating clinician can, or should, also serve as the forensic evaluator in the same case.

The reasoning must foreground the dual-role conflict this whole chapter has been building toward. As the treating clinician the psychiatrist is an advocate for the patient's clinical welfare, bound by the alliance and by confidentiality; as an **expert witness** the same psychiatrist would owe an impartial opinion to the court, must set therapeutic loyalty aside, and gives opinion evidence that is distinct from the fact evidence a witness ordinarily offers. Holding both roles compromises each: the court cannot fully trust an opinion coloured by therapeutic allegiance, and the patient's trust is betrayed if their doctor becomes the instrument of their examination. Best practice is to separate the roles, so that an independent evaluator conducts the forensic assessment. The question the family poses - the patient's mental state at the time of the alleged act - is one of criminal responsibility, whose insanity-defence test and burden of proof are owned by and cross-referred to the Mental health legislation and forensic psychiatry notes, named, not restated, here. It is distinct from fitness to stand trial, which turns on the accused's present capacity to defend; the court-referral procedure for assessing an accused is taught in this chapter, and it is engaged by that present-capacity question alone, never by the question of the mental state at the time of the act. The rules of evidence that govern how the opinion is received are the court's, and the substantive criminal law now runs on the recodified penal, procedure and evidence statutes, with a savings rule deciding which regime applies to a given case - taught in full within this chapter's statute material.

The answer is to decline the conflated role, or at least to make the conflict explicit and let the court decide, and in any event to confine any opinion given to what is within competence and to disclose its limits. A treating psychiatrist dragged into the witness box against their own patient is the sharpest instance of the two hats colliding, and naming the conflict is itself the mark-worthy move.

IN INDIA

The forensic vignette is answered from Indian primary sources, and their currency is itself examinable. The older penal, procedural and evidence codes have been superseded by their successors, so an answer that names the historical statutes as current law is wrong; the offence date governs which penal code applies, while pendency at the point of transition governs procedure and evidence. Where a child is the survivor or the accused, the child-sexual-offences and juvenile-justice framework is not this chapter's to apply - it belongs to the Child psychiatry: assessment, treatment, services and protection notes.

25.6 The common thread across the four cases

One skeleton, four skins. Set side by side, the four vignettes are the same reasoning wearing different clothes. Each opens by fixing the role, each turns on a duty that is a default rather than an absolute, each is decided by locating the governing authority, and each is lost in the same way - by importing a foreign rule, a stale statute or the wrong hat. The table below lays the four domains on shared axes so the pattern is visible at a glance.

DOMAIN	THE DECISION POINT	THE GOVERNING FRAME	THE CLASSIC TRAP
Consent and capacity	May this refusal or agreement stand?	Capacity, voluntariness, and the statutory pathway when capacity is absent	Treating a clouded refusal as valid, or overriding without the lawful route
Confidentiality	May I, or must I, disclose?	A default of confidence, with a proportionate permission at its edge	Importing a foreign mandatory duty to warn instead of a permitted disclosure
Conduct and negligence	Did the conduct fall below what was owed?	Duty, breach and resulting damage; the current professional-conduct code	Reciting the four-D mnemonic as law, or citing the code held in abeyance
Court and the accused	In which role am I answering?	Treating role separated from the impartial expert opinion to the court	Serving as expert for one's own patient, or naming superseded statutes

Notice that the right-hand column is a single family of mistakes: each is a rule applied from the wrong place - the wrong country, the wrong version of a statute, or the wrong role. That is why the method in this closer leads with role and authority. Get those two right and the specific rule usually falls out; get them wrong and even a correctly remembered rule is deployed in the wrong case.

Every forensic-ethics vignette resolves to the same two questions - which role you are in, and on whose authority you may act or disclose - and naming both is the first mark of a defensible answer.

26 · Consolidation

A chapter you have read is not a chapter you can retrieve. This closing section is a self-test, and it works only if you use it as one. The prompts below are questions with no answers printed beside them, and that is deliberate: **active recall** - forcing an answer out of memory before you look it up - is what fixes material for an examination, and an answer sitting next to the question quietly converts the exercise back into rereading, which feels productive and teaches almost nothing. Cover the notes, work down the list, say or write your answer in full, and only then turn back to the topic that owns it to check yourself.

Everything asked here was taught earlier in this chapter; nothing new is introduced and no prompt reaches for a fact the chapter never covered. The questions are grouped into the three sub-areas the chapter is built from - professional ethics with consent and confidentiality, the special settings of disaster, prisoners and custody, and the forensic statutes with legal procedure - and each group ends where the material ends, so that a blank you draw is a topic to revisit, not a trick.

26.1 How to use this list

Before the questions, fix the frame that answers most of them. Two facts run under this whole chapter. The first is the **dual role**: at any moment the psychiatrist is either the **treating clinician**, who owes duties to the patient, or the **forensic evaluator**, whose duty runs to the court. The second is that almost every rule is really a rule about **disclosure** - what may be told, to whom, and on whose authority. Run each prompt through those two facts before you reach for a specific rule, and the specific rule will usually announce itself.

RULE **Retrieve first, review second.** The value of this list is destroyed the instant you read an answer before you have tried to produce one. Attempt every prompt from memory, out loud or on paper, and treat the checking as the reward for the attempt, not a substitute for it. A prompt you cannot answer marks the exact topic to reopen.

26.2 Sub-area one: professional ethics, consent and confidentiality

These prompts sweep the ethical foundations and the two constructs the chapter stresses hardest - consent and disclosure. Answer each fully before checking the owning topic.

1. Name the principles of biomedical ethics, and say what a clinician actually does when two of them pull in opposite directions in a psychiatric decision.
2. State the essential elements of a valid informed consent and name the Indian judgment that anchors them; then explain the moment a consent question quietly becomes a capacity question.

3. Recall the grounds on which the duty of confidentiality may be lifted, and state precisely how the Indian position on disclosing to protect an endangered third party differs from the American doctrine; name the leading Indian judgment on breaching confidentiality to protect an identifiable person at risk, and be clear about what it did and did not decide.
4. Give the teaching mnemonic for the components of negligence, then state the components in the Supreme Court's own formulation, and say what criminal negligence adds to the civil standard.
5. Name the test that fixes the standard of care and the later gloss that qualified it, and explain vicarious liability in a single sentence.
6. Identify the current statute under which a patient pursues a claim for deficient medical service, what it replaced, the landmark that brought medical service within it, and when a free service falls outside it.
7. Separate the treating role from the expert role - to whom does each owe its primary duty - and say why the expert is the courtroom's exception to the bar on opinion evidence.
8. State which edition of the professional-conduct code is operative and which was notified but held in abeyance, and which of the two carries the graduated levels of professional misconduct; then name the profession's own code of ethics and the meeting that adopted it.
9. Distinguish a boundary crossing from a boundary violation, describe the slippery slope between them, and say what makes a clinical record defensible and its certification truthful.

26.3 Sub-area two: disaster, prisoners and custody

Here the vulnerable population meets the coercive institution, and the answers are Indian statutes and Indian judgments. The clinical management of substance use in these settings is not asked, because it belongs to the Substance use disorders notes.

1. Describe the tiered command structure the disaster-management statute creates, and identify the tier a psychiatrist most often works within.
2. State what that Act means by disaster management, and name what is conspicuously absent from its scheme.
3. Explain the two mechanisms by which imprisonment both generates and worsens psychiatric disorder.
4. Say what the principal Indian prisons statute provides for mental health care, and why its position is a problem.
5. State the principle of equivalence of care and the problem of dual loyalty as they arise behind the wall.
6. Name the provision that authorises the transfer of a mentally ill prisoner for treatment, and the two doors it opens.
7. Recall the judgment holding that the non-criminal mentally ill do not belong in jail, and state its practical consequence.

8. Describe the custodial duty around self-harm and suicide, and how consent and confidentiality actually operate for a detained patient.

26.4 Sub-area three: forensic statutes and legal procedure

These prompts cover the recodified criminal-legal interface. Two doctrines the chapter deliberately does not teach - the insanity-defence test with its burden of proof, and the child-sexual-offences framework - are cross-referred, and the prompts respect that boundary.

1. State the savings rule that decides which criminal regime governs a case after the recodification: what governs the penal question, and what governs procedure and evidence?
2. The insanity-defence test itself, and the burden of proof, are taught in the Mental health legislation and forensic psychiatry notes; state only the correction this chapter makes - in which code does the defence now sit, and in which separate code does the burden sit?
3. Distinguish the legal meaning of consent in sexual-offences law from clinical informed consent, and outline the psychiatrist's role with a survivor; the child framework belongs to the Child psychiatry: assessment, treatment, services and protection notes and is only named.
4. Trace the procedural pathway by which an accused is sent for psychiatric assessment: which recodified statute now houses it, what happens at referral and report, and what follows a finding of incapacity - with the fitness criteria themselves left to the Mental health legislation and forensic psychiatry notes.
5. Say what makes a dying declaration relevant and admissible, and how the Indian rule departs from the common-law requirement of a settled expectation of death.
6. Admissibility is not reliability: state what the psychiatrist must assess about a declarant's mind, and the conditions that can cloud it.
7. Recall the statutory ladder of the criminal courts, and the rule of evidence that admits an expert's opinion at all.
8. Explain why the expert's opinion is a relevant fact and not a verdict, and the currency check you must run before testifying after the codes changed.

> **GOOD TO REMEMBER**
>
> Do not run this list once the night before. Retrieval strengthens memory most when it is spaced and repeated - sweep the three groups now, mark the prompts you missed, and return to those alone after a gap of some days. The prompts you answer cleanly need no revisiting; your time belongs to the blanks.

26.5 The currency check that flips answers

A right rule stated as the wrong version is a wrong answer. More marks are lost on this chapter to stale law than to genuine ignorance, because the ground has shifted twice and the superseded answers still read as natural. Before you accept any answer you have retrieved, ask whether the code or statute you named is the one actually in force. The grid below is the coverage map: read across each row to confirm you can answer the recurring question, name the currency or limit

that most often flips it, and place the neighbouring doctrine you must cross-refer rather than re-teach.

SUB-AREA	THE RECURRING QUESTION TO ANSWER FROM MEMORY	THE CURRENCY OR LIMIT THAT FLIPS THE ANSWER	THE NEIGHBOUR TO NAME, NOT RE-TEACH
ETHICS, CONSENT, CONFIDENTIALITY	Whose is the information, and on whose authority may it be disclosed?	Which conduct code is operative, and is protective disclosure a permission or a command?	the Mental health legislation and forensic psychiatry notes (capacity, advance directives, admission)
DISASTER, PRISONERS, CUSTODY	Who owes care to a detained person, and to what standard?	The principal prisons statute's want of a substantive care standard, and the authority that permits transfer	the Substance use disorders notes (substance use in custodial settings)
STATUTES AND PROCEDURE	In which role, and under which code now in force, is the opinion given?	Are you citing the recodified statutes or the superseded ones - and what does the savings rule say?	the Mental health legislation and forensic psychiatry notes (insanity test, burden) and the Child psychiatry: assessment, treatment, services and protection notes (the child framework)

PITFALL

The recurring real-world error this chapter exists to correct is a currency error. Treating the notified-but-suspended successor professional-conduct regulations as the operative code, or citing the superseded criminal, procedure and evidence statutes as current after the recodification, is confidently wrong in exactly the way that reads as right. A disclosure permitted under the Indian regime is also misremembered as a positive duty to warn imported from foreign case law. If a prompt above returns one of these, that is the topic to reopen first.

IN INDIA

Every answer on this list is an Indian primary-source answer, and most of them differ from the Western textbook default: protective disclosure that is permitted rather than commanded, an earlier statutory conduct code still in force while its successor waits in abeyance, a consumer forum that reaches into medical practice, and a criminal law recently recast with a savings rule. When a prompt tempts you toward the familiar Western answer, that temptation is itself the signal to recall the Indian position instead.

26.6 The master frame to run on any vignette

The whole chapter collapses into one short procedure you can run against any question it throws at you. It is not new content; it is the chapter's own spine, gathered into four moves so that a vignette becomes a sequence of decisions rather than a scramble for the one rule it resembles.

MNEMONIC

HATS

The master frame for any forensic-ethics question. **H**at: fix the role first - is the psychiatrist the treating clinician who owes duties to the patient, or the forensic evaluator who owes candour to the court? **A**uthority over the information: of what is in play, ask what may be told, to whom, and on whose authority - the patient's consent, the clinician's bounded discretion, a court's order, or a regulator's power. **T**est the currency: is the conduct code the operative one and not the suspended successor, and is the criminal, procedure or evidence code the version in force under the savings rule? **S**ource and sibling: read the primary source, and where a doctrine belongs to another chapter, name it and reason from it rather than restating it. Fix the hat, run the three, and every rule in this chapter falls into place.

TRAP **Recognition mistaken for recall.** Reading an answer and thinking "yes, of course" feels identical to knowing it, and it is not - recognising a stated answer is a far weaker trace than producing one unprompted. The candidate who reviews by rereading walks into the hall confident and empties out under a blank page. Cover the answer, force the retrieval, and let the failures on this list, not the successes, direct your last days of revision.

Fix the hat, ask what may be disclosed and on whose authority, and check that the code you cite is the one in force - and you can reason through any forensic-ethics vignette this chapter can set.

Previously asked

There is no indexed past-question bank for this chapter, so nothing in the table below is a catalogued past question and no board or year is claimed for any of them. Attributing a paper the index does not hold would be a fabrication, so in place of a board of origin each row is marked Representative, and the questions are written in the register an examiner uses. Forensic ethics, consent and legal procedure are examined heavily and in every form the paper allows, as long answers, as short notes and in the viva, so the list maps the examined spine of this chapter rather than one board's recent record. Read it as a high-yield revision map, not as a set of questions on record.

QUESTION	MARKS	ASKED
Enumerate the four principles of biomedical ethics and discuss how they come into conflict in a psychiatric decision, with an example of how such a conflict is resolved.	10	Representative
Discuss informed consent in psychiatric practice: its essential elements, the assessment of capacity to consent, and the special situations that complicate it.	10	Representative
Confidentiality and its limits in psychiatry. Discuss the duty to warn, the position under the Mental Healthcare Act, and the relevance of Tarasoff and of Mr X v Hospital Z.	10	Representative
Professional negligence and medical malpractice. Explain the four Ds, the standard of care, and the distinction between civil and criminal medical negligence in Indian law.	10	Representative
Medical services under the Consumer Protection Act. Short note.	*5*	Representative
The psychiatrist as an expert witness: the role, the distinction between opinion and fact evidence, and the conduct expected in court.	*5*	Representative
Boundary violations in the therapeutic relationship. Short note.	*5*	Representative
The Indian Psychiatric Society code of ethics and the current statutory professional-conduct code. Short note.	*5*	Representative
The insanity defence and the burden of proving it under the current criminal law, and the transition from the earlier codes on the first of July 2024.	10	Representative

QUESTION	MARKS	ASKED
Describe the procedure for the psychiatric assessment of an accused person, from the court's referral to the report and its consequences.	10	Representative
Sexual offences law and the psychiatric assessment of a survivor. Discuss the legal meaning of consent.	*5*	Representative
Mental health of prisoners: the transfer and treatment of a prisoner with mental illness, and the human-rights safe-guards in custodial psychiatry.	*5*	Representative
The legal aspects of seclusion, restraint and involuntary treatment, and the least-re-strictive principle. Short note.	*5*	Representative

The shape of these questions is worth reading before their content. A ten-mark question that opens with enumerate or describe wants a structured map rather than a definition, and the marks are won on the discriminations this chapter turns on: the difference between a permission to disclose and a positive duty to warn, the difference between the insanity defence and the burden of proving it, the difference between civil and criminal negligence, and the difference between the treating role and the forensic role. A short note carries fewer marks but the same demand for the exact provision and the exact modal verb, because a permission and a duty are not interchangeable and an answer that names a repealed code as the current law reads as one that has not opened the statute. This is the one part of the paper whose answer is checkable against a primary text, which is precisely why the examiner rewards the candidate who cites the current provision and marks down the one who cites the old one by reflex.

The quick review

One table, read down the left column and cover the right. Every line is taught in full somewhere above and nothing here is new: each is that provision's single must-hold line, the rule lifted from the passage that teaches it, so a line you cannot recover is a section to reread rather than a fact to memorise here. Modal verbs are load-bearing: an exception that permits disclosure is not a command to disclose, and where the statute says shall it is kept as shall. Currency is this chapter's spine. The operative professional-conduct code is the Medical Council of India (Professional Conduct, Etiquette and Ethics) Regulations 2002; the National Medical Commission RMP Regulations 2023 were notified, then held in abeyance, and are not operative. The criminal codes are the Bharatiya Nyaya Sanhita, the Bharatiya Nagarik Suraksha Sanhita and the Bharatiya Sakshya Adhiniyam, in force from 1 July 2024, with the

Indian Penal Code, the Code of Criminal Procedure and the Indian Evidence Act as their historical predecessors; the offence date governs the penal code and pendency governs procedure and evidence.

ASK	HOLD
PROFESSIONAL ETHICS, CONSENT AND CONFIDENTIALITY	
THE FOUR PRINCIPLES OF BIOMEDICAL ETHICS	Respect for autonomy, beneficence, non-maleficence and justice, developed by Beauchamp and Childress; each is a prima facie obligation to be balanced against the others when they conflict.
INFORMED CONSENT, THE THREE ELEMENTS (SAMIRA KOHLI)	Consent to treatment must be real and valid, which the Court defines by three elements: the patient must have the capacity to consent, the consent must be voluntary, and it must rest on adequate information about the nature of the treatment.
CONSENT SCOPE AND THE DISCLOSURE STANDARD (SAMIRA KOHLI)	Consent is confined to the specific procedure consented to, so consent for a diagnostic procedure is not consent for therapeutic treatment, and that unauthorised additional surgery benefited the patient is no defence; the disclosure standard adopted is the Bolam real-consent standard, not the higher Canterbury prudent-patient test.
CONFIDENTIALITY, THE RIGHT AND ITS LIMITS (MHCA S.23)	The person has a right to confidentiality and all health professionals a duty to keep the information confidential; the enumerated exceptions (to protect another from harm, to prevent a threat to life, on the order of the Board or a court, for public safety) permit disclosure, they do not command it.
DUTY TO WARN OR PROTECT, THE US ORIGIN (TARASOFF, 1976)	A therapist who determines, or under professional standards should determine, that a patient presents a serious danger of violence to another incurs an obligation to use reasonable care to protect the intended victim; the protective privilege ends where the public peril begins.
CONFIDENTIALITY AGAINST AN IDENTIFIABLE THIRD PARTY (MR X V HOSPITAL Z, 1998)	The Indian analogue: disclosure of the patient's HIV-positive status to the woman he was about to marry was held not to violate confidentiality or the right to privacy, because an identifiable person was saved from a real risk; the right to privacy is not absolute.
THE IPS CODE AND THE OPERATIVE CONDUCT CODE	The Indian Psychiatric Society code of ethics was approved at its Cuttack conference in 1989, the foundational Indian psychiatry-specific code; the operative professional-conduct code for doctors is the MCI 2002 Regulations, because the NMC RMP 2023 Regulations were notified, then held in abeyance, and are not operative.
NEGLIGENCE, THE FOUR DS AND THE COMPONENTS (JACOB MATHEW)	The teaching mnemonic is the four Ds (duty, dereliction, damage, direct causation); the operative law is Jacob Mathew's three essential components, duty, breach and resulting damage, with causation as the fourth element (the plaintiff must prove the breach caused the injury, from Bolitho).

ASK	HOLD
THE STANDARD OF CARE, BOLAM QUALIFIED BY BOLITHO	Bolam: a professional is not negligent if he acts in accordance with a practice accepted as proper by a responsible body of professional opinion (adopted in India via Jacob Mathew); Bolitho qualifies it, so that opinion protects only if it can withstand logical analysis.
CRIMINAL MEDICAL NEGLIGENCE (JACOB MATHEW)	Far higher than the civil bar: mens rea must be shown and the negligence must be gross or of a very high degree; the words rash or negligent act are read as qualified by grossly, and negligence that is neither gross nor of a high degree may ground a civil action but cannot found a prosecution.
CONSUMER PROTECTION ACT 2019 AND IMA V V.P. SHANTHA	The 2019 Act repealed the 1986 Act; service (s.2(42)) excludes any service rendered free of charge or under a contract of personal service, and deficiency (s.2(11)) includes any act of negligence causing loss or injury; IMA v V.P. Shantha holds paid medical service is service, while service rendered free of charge to everybody is not.
THE EXPERT WITNESS, OPINION VERSUS FACT (RAMESH CHANDRA AGRAWAL)	An expert is not a witness of fact; his evidence is of an advisory character, his duty being to furnish the court with the scientific criteria to test the conclusions so the judge can form an independent judgment; the court is not bound by the expert's opinion.
BOUNDARY CROSSING VERSUS BOUNDARY VIOLATION	A crossing is a minor, non-exploitative, discussable departure from the frame that may even help the patient; a violation is an exploitative, harmful departure that serves the clinician and betrays the fiduciary duty; the slippery slope carries one into the other, and sexual contact with a current patient is the paradigm violation, absolutely prohibited and never excused by apparent consent, because responsibility for the boundary rests always with the clinician.
RESEARCH, RECORDS AND TELEPSYCHIATRY ETHICS	Under the NMC 2023 framework (notified, then held in abeyance; the operative code is the MCI 2002): research on patients or volunteers must comply with ICMR guidelines and the New Drugs and Clinical Trials Rules 2018; a self-employed RMP keeps inpatient records for three years from the last contact and supplies them on request within five working days; telepsychiatry follows the Telemedicine Practice Guidelines.
DISASTER, PRISONERS AND FORENSIC SPECIAL TOPICS	
DISASTER MANAGEMENT ACT 2005 STRUCTURE	A three-tier ladder: the National Disaster Management Authority (s.3, Prime Minister ex officio Chairperson), a State Disaster Management Authority in every State (s.14, Chief Minister ex officio Chairperson) and a District Disaster Management Authority in every district (s.25, Collector or District Magistrate or Deputy Commissioner ex officio Chairperson); the Act's own definition does not name psychosocial or mental-health support as an express limb.

ASK	HOLD
PRISONERS WITH MENTAL ILLNESS (MHCA S.103)	An order directing admission of a prisoner with mental illness is sufficient authority; transfer to the psychiatric ward in the medical wing of the prison is the first option and suffices, and only where there is no such ward may the prisoner be transferred to a mental health establishment, with the prior permission of the Board.
THE REMOVAL WARRANT (PRISONERS ACT 1900 S.30)	Where a detained or imprisoned person appears to be of unsound mind, the State Government may, by a warrant setting forth the grounds, order his removal to a lunatic asylum or other place of safe custody for the remainder of the term; this is the provision MHCA s.103 cross-refers.
CUSTODIAL HUMAN RIGHTS (SHEELA BARSE)	The Supreme Court strictly prohibited confining non-criminal mentally ill persons in jails, treating such confinement as a violation of constitutional rights.
FORENSIC STATUTES AND LEGAL PROCEDURE	
SEXUAL OFFENCES, RAPE AND ITS PUNISHMENT (BNS S.63, S.64)	BNS s.63 (successor to IPC s.375) defines rape by four act-types under seven circumstances, the capacity circumstances including consent given when, by reason of unsoundness of mind or intoxication, she is unable to understand the nature and consequences, being under eighteen, and being unable to communicate consent, with a marital exception where the wife is not under eighteen; s.64 punishes rape with rigorous imprisonment of not less than ten years, extendable to life, and fine.
CONSENT IN SEXUAL-OFFENCES LAW (BNS S.63, EXPLANATION 2)	Consent means an unequivocal voluntary agreement, communicated by words, gestures or any verbal or non-verbal communication, of willingness to the specific sexual act; a woman who does not physically resist is not, by that fact alone, to be regarded as consenting.
THE PENAL TRANSITION, SECTION 22 VERSUS SECTION 108 (THE CORRECTION)	The insanity defence is BNS s.22 (formerly IPC s.84); the burden of proving it is BSA s.108 (formerly IEA s.105); they are separate sections in separate codes, so section 105 BSA is not the successor to s.84; the penal code follows the offence date, procedure and evidence follow whether the matter was pending at the transition.
PROCEDURE FOR ASSESSING AN ACCUSED (BNSS S.367 TO S.369)	Where the accused appears of unsound mind and incapable of making his defence, the court shall first try that fact on medical and other evidence and postpone proceedings, at the inquiry stage (s.367) or at trial (s.368); s.369 governs disposal, release on bail where a relative undertakes out-patient treatment, else kept where regular psychiatric treatment can be provided, with the action reported to the State Government. Successors to CrPC s.328 to s.330.

ASK	HOLD
THE DYING DECLARATION (BSA S.26)	A statement by a person as to the cause of his death, or the circumstances of the transaction that resulted in it, is a relevant fact when the cause of that person's death comes into question, and is relevant whether or not the maker was, at the time, under expectation of death (successor to IEA s.32(1)).
COURT STRUCTURE (BNSS S.6)	Besides the High Courts, every State has Courts of Session, Judicial Magistrates of the first class, Judicial Magistrates of the second class and Executive Magistrates; the Supreme Court is the constitutional apex above them.
EXPERT-OPINION EVIDENCE (BSA S.39)	When the court has to form an opinion on a point of science, art, foreign law or any other field, the opinions of persons specially skilled in that field are relevant facts and such persons are called experts; Illustration (b) covers the question of unsoundness of mind (successor to IEA s.45).
SECLUSION AND RESTRAINT, THE LEGAL ASPECTS (MHCA S.97)	Seclusion and solitary confinement are absolutely prohibited; physical restraint may only be used when it is the only means available to prevent imminent and immediate harm and is authorised by the psychiatrist in charge, kept no longer than absolutely necessary, never as punishment or for staff shortage, the nominated representative informed within twenty-four hours and every instance reported monthly to the Board (the least-restrictive principle).

References

Every specific in this chapter is bound to one of the sources below, and the count is the number of claim rows each carried. The statutory and case-law rows were read at the primary Act on India Code, at the primary judgment on Indian Kanoon, or at the primary notification of the National Medical Commission and the Gazette of India, rather than from any textbook summary, because a stale or paraphrased section changes what a clinician is legally obliged to do. Three currency positions were read at their current form and are load-bearing for this chapter: the operative professional-conduct code is the Medical Council of India Regulations of 2002, because the National Medical Commission Registered Medical Practitioner Regulations of 2023 were notified and then held in abeyance, so the 2023 code is named as drafted but not yet in force; the substantive criminal law was read at the Bharatiya Nyaya Sanhita, the Bharatiya Nagarik Suraksha Sanhita and the Bharatiya Sakshya Adhiniyam, in force from the first of July 2024, with the Indian Penal Code, the Code of Criminal Procedure and the Indian Evidence Act named as the superseded predecessors; and the consumer-protection route was read at the 2019 Act, not the 1986 Act. Of the 61 claim rows, 58 are recorded at verified confidence and 3 at partial, the latter authored from established ethical and clinical knowledge and checked by the adversarial content pass rather than bound to a single primary quote; 14 further specifics were declared as gaps and taught around rather than supplied from memory. The must-have-papers cross-check was NOT performed for this Paper III chapter, because the paper lists do not yet exist in the intel index; for Paper III the topic

bank plus the syllabus scaffolding is the completeness authority. This table records provenance, not proof: it says where each specific came from, not that the chapter's prose uses it correctly, which the content pass and the ship review test.

SOURCE	CLAIMS CARRIED
Indian Kanoon (primary Act and judgment text)	**27**
India Code, Ministry of Law and Justice (primary Act text)	**13**
Other primary source (verbatim quote and URL on file)	**13**
National Medical Commission and the Gazette of India (primary notification text)	**8**

PART VIII

VIII

ECT and Neurostimulation

Electroconvulsive therapy and the stimulation treatments: how they work, who they are for, and how they are given safely.

01 Orientation: the induced seizure and the stimulated brain

02 Electroconvulsive therapy: foundations and indications

03 Electroconvulsive therapy: technique and dose

04 Electroconvulsive therapy: effects, consent and course

05 Other neurostimulation therapies

06 Cross-cutting synthesis

07 Apply and consolidate

PAPER III

ECT and neurostimulation

Six bands . one complete notes document

Orientation: the induced seizure and the stimulated brain

1 · Orientation: the induced seizure and the stimulated brain

Electroconvulsive therapy is the most effective acute treatment available in severe mood and catatonic states, and its price is measured in cognition. A brief electrical stimulus crosses the skull of an anaesthetised and relaxed patient, a generalised cerebral seizure follows, and an illness unshifted by weeks of drug treatment can shift within days. From that standing and that price follows everything the chapter teaches: what the treatment is for, how it is delivered, what it costs, and who may lawfully have it.

This opening section is the chapter's **advance organizer**. It asserts no specific of its own: no dose, charge, threshold multiple, percentage or session count appears, because each belongs to its owner. What it owns is the shape: the standing of the treatment, the sequence in which the chapter delivers it, the non-ECT techniques read against it, and the Indian legal frame. The accompanying figure lays the same architecture out visually.

Most effective	No single law	Modified only
THE STANDING OF THIS TREATMENT IN SEVERE MOOD AND CATATONIC STATES	THE TRADES DIFFER BY PARAMETER AND BY PLACEMENT, SO NONE IS INHERITED	THE INDIAN LEGAL FRAME THE WHOLE CHAPTER SITS INSIDE

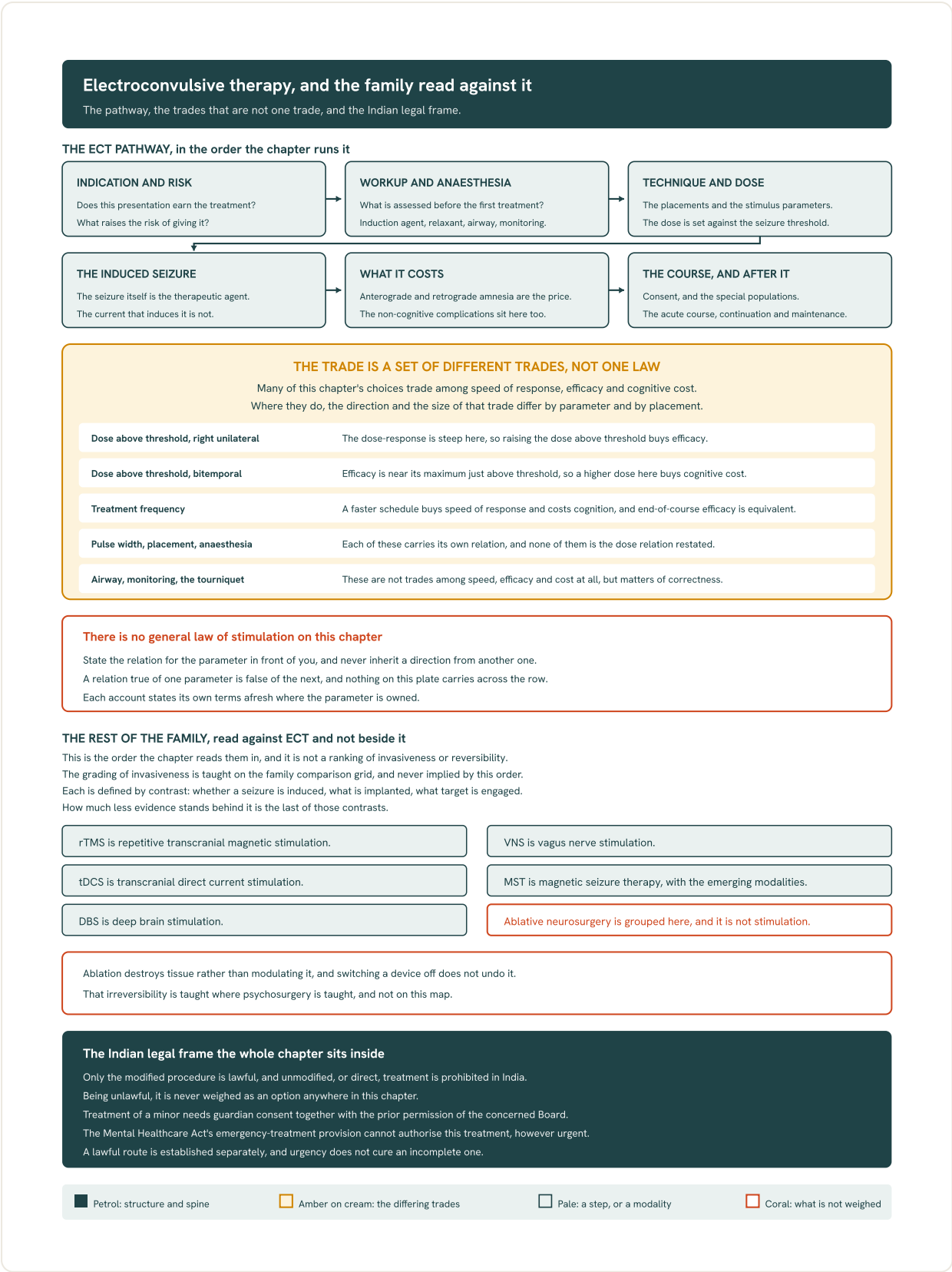


Fig 27.1. The chapter's architecture: the ECT pathway from indication through workup, technique, the induced seizure and its costs to the course and its maintenance; the trades that differ by parameter and by placement rather than following any single law; the rest of the neuromodulation family in a reading order that ranks nothing, with ablative neurosurgery grouped there but not stimulation; and the Indian legal frame the whole chapter sits inside.

1.1 What the treatment is, and where its power lies

The therapeutic agent is the **induced seizure**, not the current that induces it and not the convulsion once visible at the bedside. Modification abolishes the motor convulsion and leaves

the cerebral seizure untouched, so a treated patient lies still. Its power concentrates where illness is severe or immovable: severe depression, above all with psychotic features, food refusal or acute suicidal risk; catatonia, which responds better than almost anything in psychiatry responds to anything; acute and refractory mania; and defined presentations of schizophrenia, including the clozapine non-responder. The evidence under each belongs to the indications account.

The counterpart is a real and measurable effect on memory, and a smaller burden of non-cognitive complication, principally cardiovascular. Neither is a reason to withhold the treatment from a patient who needs it.

1.2 The structural fact the chapter turns on

Many of the choices in this chapter trade among speed of response, efficacy and cognitive cost, and where they do, the direction and the size of that trade differ by parameter and by placement. That is a structural fact, not a directional law. The chapter asserts no law covering all of these choices, because not every choice is such a trade at all: airway management, physiological monitoring and the tourniquet that isolates one limb from the relaxant are not purchases of efficacy at a cognitive price.

Its terms are stated afresh by the topic owning the parameter. The table below is not a rule but a demonstration that no rule applies across the row.

PARAMETER	WHAT THE RELATION ACTUALLY IS	STATED IN FULL BY
STIMULUS DOSE ABOVE THRESHOLD, RIGHT UNILATERAL PLACEMENT	The dose-response is steep, so raising the dose above the seizure threshold buys efficacy.	Stimulus dosing, and the placement comparison.
STIMULUS DOSE ABOVE THRESHOLD, BITEMPORAL PLACEMENT	Efficacy is already near-maximal at a low multiple of threshold, so a higher dose here largely buys cognitive cost alone.	The same accounts, stating it as differing by placement.
TREATMENT FREQUENCY	Buys speed of response and costs cognition. End-of-course efficacy is equivalent between the schedules, so a faster schedule is never listed among the choices that buy efficacy.	The acute course and its frequency.
PULSE WIDTH, ELECTRODE PLACEMENT, ANAESTHETIC CONDUCT	Each carries its own relation, none the dose relation restated.	Technique, and the workup and anaesthesia.
AIRWAY, MONITORING, THE TOURNIQUET	Not a trade among speed, efficacy and cognitive cost. Correctness, not currency.	The workup and anaesthesia.

RULE **State the relation for the parameter in front of you, and never inherit a general direction from a different parameter.** There is no general law of stimulation here. A sentence coupling how hard a treatment is made to work to what it costs in memory is never written on this chapter, however qualified, because a relation true of one parameter is false of the next, and the reader who carries it across will dose a patient on it.

MNEMONIC

DECIDE, DELIVER, LIVE WITH IT, LOOK OUTSIDE

Decide whether this patient should have the treatment at all. **Deliver** it: workup and anaesthesia, technique and dose, and the seizure that results. **Live with it**: what it costs, how consent is lawfully established, and how the course is sustained. **Look outside** to the non-ECT family, defined by contrast with what you have just read. Every section sits inside one of those movements.

1.3 The ECT pathway, in the order the chapter runs it

The ECT sections follow the sequence a resident moves through, and examiners ask about its joints.

- **Indication and risk.** Where the treatment came from and how it became modified; the competing accounts of how it works; the indications and their evidence; and the conditions that raise risk without barring it.
- **Workup and anaesthesia.** What is assessed before the first treatment, what is not routinely needed, and the anaesthetic conduct: induction agent, relaxant, airway and monitoring.
- **Technique and dose.** The placements and what distinguishes them; the parameters that define a stimulus; the threshold and the dose as a multiple of it; the placement comparison as a function of that multiple; and the modified procedure against the unmodified one.
- **The induced seizure.** What makes a seizure adequate, what to do when none follows, and what to do when one does not stop.
- **What it costs.** The anterograde and retrograde amnesias, how they are monitored and how they behave; and the non-cognitive complications.
- **The course, and life after it.** Consent as a lawful route; pregnancy, old age and adolescence; the acute course and its frequency; continuation and maintenance; and the drugs that move the threshold.

1.4 The rest of the family, read against ECT and not beside it

The chapter then reads the remaining modalities in this order: repetitive transcranial magnetic stimulation, transcranial direct current stimulation, deep brain stimulation, vagus nerve stimulation, magnetic seizure therapy with the emerging modalities, and ablative neurosurgery. That is a reading order and not a ranking of invasiveness or reversibility; the grading is taught on the comparison grid the cross-cutting synthesis owns.

Every device in this **neuromodulation** family is defined by contrast with what you have just read: whether a seizure is induced, what is implanted if anything, what target is engaged, and how

much less evidence stands behind it.

One member is not a member. The bank groups **ablative neurosurgery** with the stimulation modalities and this chapter follows it, but ablation is not stimulation. It destroys tissue rather than modulating it, and switching a device off does not undo it. That irreversibility is taught where psychosurgery is.

1.5 The Indian legal frame the whole chapter sits inside

A short list of statutory positions governs practice, each named in words, never renumbered. First, only the modified procedure is lawful. Unmodified, or direct, electroconvulsive therapy is prohibited in India. It is not the older technique, not the resource-limited compromise and not the weaker option: it is unlawful, and is never weighed as an option in this chapter. Second, treatment of a minor is gated: it requires guardian consent together with the prior permission of the concerned Board, sought in advance. Third, the Act's emergency-treatment provision cannot authorise this treatment, however urgent the clinical picture.

That third position is the trap most often examined. A patient can be in a state where the treatment is the correct and urgent answer while the emergency provision still cannot authorise it, so a **lawful route** is established separately and urgency does not cure an incomplete one. This is a point about treatment authority and not admission authority: a capacitous adult can consent to this treatment with no admission at all.

> **IN INDIA**
>
> The Indian frame is not a stricter version of a Western one but different in kind. A prohibition that elsewhere would be a professional standard is here a statutory bar, a treatment decision for a minor passes through a statutory body, and the urgency that would settle the question elsewhere settles nothing. Where a topic has an Indian answer, that is the answer.

1.6 The edges of the map: named here, taught elsewhere

An advance organizer is as much about what sits outside the frame as inside. Several bodies of material touched constantly here are owned by others, and are named rather than re-taught.

- Every Mental Healthcare Act provision touching this treatment and psychosurgery, the bar on the unmodified procedure, the minor's guardian-consent and Board-permission gate, the psychosurgery restriction and the emergency-treatment bar, belongs to the Mental health legislation and forensic psychiatry notes, each named here in words.
- The catatonia entity, the lorazepam challenge, malignant catatonia against neuroleptic malignant syndrome and the Bush-Francis rating belong to the Other psychotic disorders, delusional syndromes and catatonia notes.
- The mood-disorder algorithms, the staging of treatment resistance and the pharmacology of continued agents belong to the Mood disorders: pharmacotherapy notes.
- The schizophrenia resistance algorithm, clozapine and the antipsychotic adverse-effect burden belong to the Schizophrenia notes, which assign the clozapine-resistant evidence here.

Many of this chapter's choices trade among speed of response, efficacy and cognitive cost, and where they do the direction and size of that trade differ by parameter and by placement, so each account states its own relation; some are not such trades at all. It sits inside an Indian legal frame in which only the modified procedure is lawful, treatment of a minor is gated behind guardian consent and prior Board permission, and the emergency-treatment provision cannot authorise the treatment.

Electroconvulsive therapy: foundations and indications

2 · History and evolution of ECT

Electroconvulsive therapy is one of the few treatments in current psychiatric practice that was invented out of a therapeutic premise which was not borne out, fell into disrepute it had partly earned, and came back on evidence gathered decades later. It is also the shortest route to understanding the modern procedure: the anaesthetic, the relaxant, the monitored seizure and the documented consent were each added to answer a specific failure of what came before. Names and dates carry marks in this paper, so they are given with their attributions.

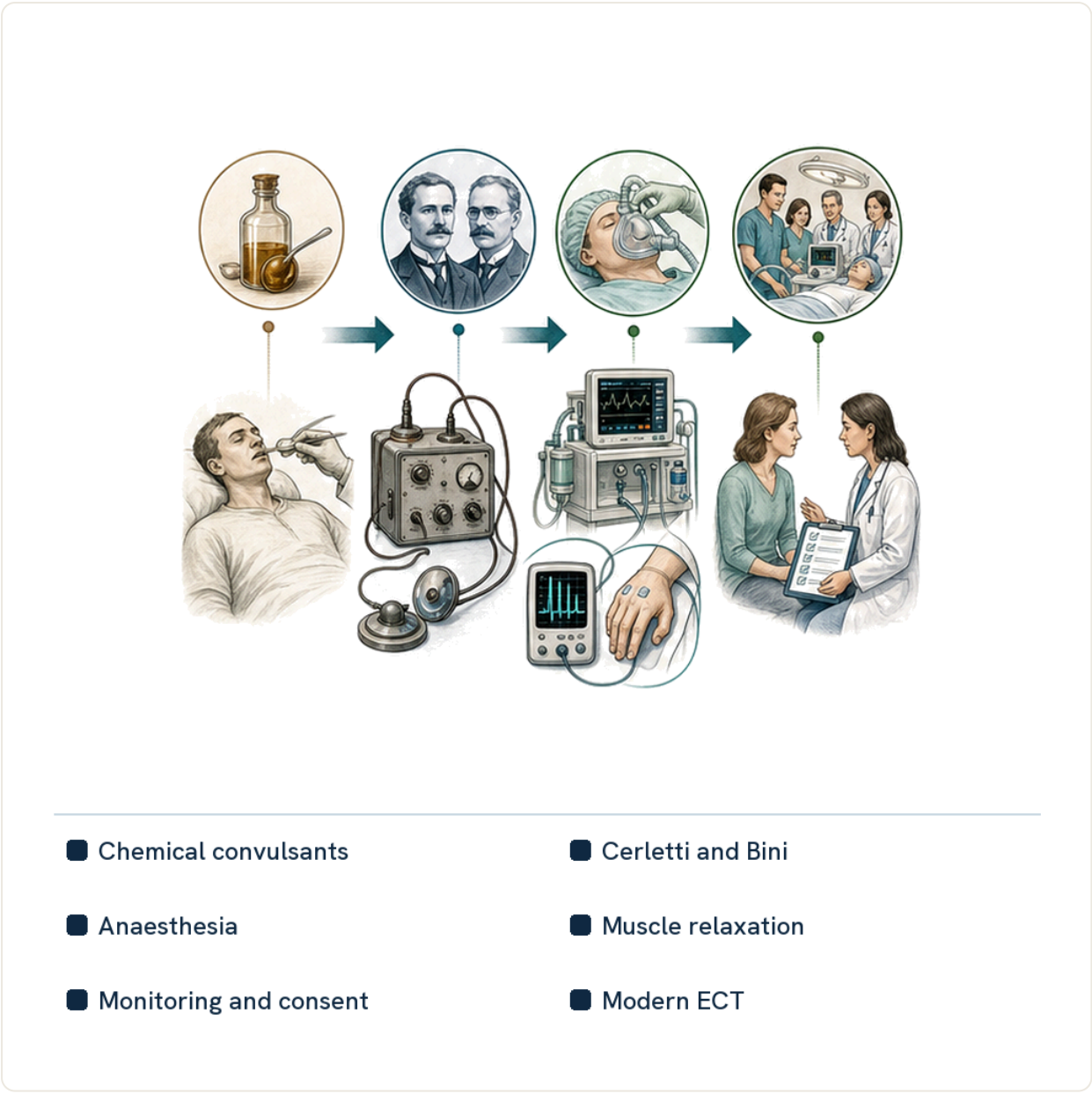


Fig 27.2 The evolution of electroconvulsive therapy runs from chemical convulsants and the work of Cerletti and Bini to anaesthesia, muscle relaxation, physiological monitoring and documented consent. Each addition answered a limitation of the earlier procedure.

This account owns the origin and evolution of convulsive therapy: the antagonism hypothesis, the chemical convulsants, Cerletti and Bini, the introduction of anaesthesia and muscle relaxation, the mid century decline, the modern reappraisal and the Indian arc. It does not teach why an induced seizure helps; the competing neurobiological theories, none of them settled, belong to this chapter's account of the mechanism of action and neurobiological theories of electroconvulsive therapy. It does not teach the technique contrast between modified and unmodified (direct) ECT, nor the Indian legal position on the unmodified form; both belong to this chapter's account of modified against unmodified (direct) ECT. It does not narrate the leucotomy story, which belongs to this chapter's account of psychosurgery, its history, current indications and ethics. Modern stimulus parameters and electrode placements appear nowhere in this account.

1934	1938	1943
THE FIRST DELIBERATE THERAPEUTIC CONVULSION IN A HUMAN BEING, PRODUCED CHEMICALLY	THE FIRST THERAPEUTIC SEIZURE INDUCED ELECTRICALLY, IN ROME	ELECTROCONVULSIVE THERAPY AT THE CENTRAL INSTITUTE OF PSYCHIATRY, RANCHI

2.1 The convulsion as a treatment, long before there was a device

Convulsive therapy is older than psychiatry's capacity to measure a convulsion, and a candidate who begins the story in the twentieth century has already misplaced it. Camphor given by mouth to induce convulsions and cure lunacy is attributed to the Swiss alchemist Paracelsus in the sixteenth century, and convulsions induced by chemical means, specifically camphor in oil, are documented in the eighteenth and nineteenth centuries. The idea that a seizure could relieve mental illness was inherited, not invented; what the twentieth century added was the deliberate production of one, in a named patient, for a named condition, on a stated rationale. That rationale is where the modern history begins, and it is where it first goes wrong.

2.2 Meduna and the schizophrenia and epilepsy antagonism hypothesis

In 1934 Ladislaw Meduna, a Hungarian psychiatrist, investigated a hypothetical inverse relationship between seizures and schizophrenia, drawing on neuropathological studies and on a review of a century of earlier work, and postulated a relationship between a lack of glial cells in people with schizophrenia and an overgrowth of those cells in people with epilepsy. The forename is written Ladislaw because that is how the source quoted here spells it; two other peer reviewed histories write Ladislas von Meduna, which is the form to expect in an answer, and the difference is a transliteration rather than a different person. This is the **schizophrenia and epilepsy antagonism hypothesis**, the founding premise of the entire treatment family this chapter teaches.

It did not rest on neuropathology alone. A dedicated history of the treatment in schizophrenia attributes to Gyula Nyiro, in 1929, the clinical observation from which the antagonism hypothesis followed. Different histories state what Nyiro actually reported in different ways, so the observation is attributed here without asserting any one version of its content.

The therapeutic premise was not borne out, and the two things that happened to it should be kept apart. Meduna's original theory of an antagonism between epilepsy and schizophrenia has been replaced by hypotheses about the mechanism of action of the treatment. Replaced is what the source says, and it is not the same as disproved: the same paper adds that subsequent research could not confirm the antagonism hypothesis, which is a failure to confirm rather than a refutation, and a 2022 position still argues the biological question is open on shared genetic and network findings. So the premise stopped being the reason to give the treatment, while whether epilepsy and schizophrenia stand in any antagonistic relation at all remains unsettled. Those hypotheses, none presented as settled, belong to this chapter's account of the mechanism of action and neurobiological theories of electroconvulsive therapy.

RULE **The hypothesis that produced convulsive therapy was mistaken, and that does not make the treatment mistaken.** Whether a treatment works is settled by trials of it; why it works is a question about mechanism; and the accuracy of the guess that led somebody to try it bears on neither. Convulsive therapy is psychiatry's cleanest example of a wrong reason producing a right treatment, which is why the origin story is worth knowing rather than skipping.

2.3 The chemical era, and why it ended

Meduna moved from hypothesis to patient quickly. The eightieth anniversary review dates the first human experiment, involving intramuscular camphor injections, to 2 January 1934; other histories give the day differently, and one dates the first camphor injections to the November of the preceding year, so not even the year is undisputed and that winter, rather than a day or a year, is the honest unit. Attribute the date rather than asserting it, and note that any interval measured from the start of this work inherits the same disagreement. Camphor in oil was injected into a patient with catatonic schizophrenia, causing a 60 second grand mal seizure; the patient recovered fully after a short series of such treatments, and five more patients were treated by the end of that year. Catatonia was therefore present at the origin of the treatment and remains among its strongest indications, taught in this chapter's account of the indications for electroconvulsive therapy.

Camphor was not the agent that carried the era. After about two months the intramuscular camphor injections were replaced by pentylenetetrazol, better known as **cardiazol** and marketed elsewhere as metrazol, which was less painful and had a lower latency of seizure induction. The chemical era ended for a reason a candidate should be able to state in one clause: the interval between the injection and the seizure remained unpredictable and frightening for the patient, and it is that latency which sent Cerletti looking for an electrical alternative. Electricity did not offer a better seizure. It offered a seizure whose timing the operator controlled.

2.4 Cerletti and Bini, Rome, 1938

Ugo Cerletti and Lucio Bini performed the first electrical induction of a seizure in a psychotic patient in Rome in April 1938, after animal studies in which they defined the parameters of an electrical stimulus they judged safe. The animal work is not decoration; it is the reason the pair could argue the stimulus was survivable before applying it to a person. One history dates the first stimulation to 11 April 1938, records that it did not produce an epileptic seizure, and dates a tonic clonic seizure at a higher voltage to 20 April. The year is agreed by every source opened for this chapter; the exact date is not, a useful marker that historical detail drifts where the substance does not.

The drift is visible in the patient too. A second independent history gives the same month and year and describes the patient as a 39 year old man treated at the Clinic for Mental and Nervous Diseases in Rome. The two accounts differ on how he came to the clinic. The discovery was reported publicly in August 1939, at the Third International Neurological Congress in Copenhagen, by Professor Lucio Bini, and that record is also the reason to write the forename as Lucio, since at least one contemporary peer reviewed source writes Luigi.

The stimulus of that first treatment is worth carrying for one reason only, which is contrast. It is recorded that no anaesthesia was used and that a first shock was delivered at 80 volts for one tenth of a second. Those are historical figures from the first treatment ever given, and they describe no device in use anywhere today. What happened after that first shock is deliberately not printed: the sources disagree not only on the DAY of these events but on their STRUCTURE, one account giving a failed attempt followed by a seizure some days later and another a single session of escalating shocks, and the number and escalation of the shocks lie in sentences no row here quotes. Both disagreements are declared as gaps rather than resolved into a sequence neither source describes.

TRAP **Quoting the figures of the first treatment as though they described a modern stimulus.** They record what was applied in Rome before anaesthesia, muscle relaxation, brief pulse waveforms, seizure monitoring or dosing against a measured threshold existed. Everything a candidate is examined on regarding the modern stimulus belongs to this chapter's accounts of electroconvulsive therapy technique and electrode placement and of stimulus dosing, the seizure threshold and adequate seizure criteria. A history figure written into a technique answer is a wrong answer, not an erudite one.

2.5 The modification: a relaxant first, then anaesthesia

What separates the treatment of 1938 from the treatment given today is not the electricity but what is given alongside it. Curare came first, introduced to stop the fracture and dislocation injuries of the unmodified convulsion, and muscle relaxation and anaesthesia were both in place by the early 1950s. Sources differ on the precise years, so the decade is the honest unit and a false precision is worse than none. The result is the treatment current Indian guidance defines: **modified ECT** is the modern form of electroconvulsive therapy in which the electrical stimulus is given under general anaesthesia and muscle relaxation.

This account stops there. How the modified and **unmodified (direct)** techniques differ in injury and in patient experience, and why the unmodified form was historically used, belong to this chapter's account of modified against unmodified (direct) ECT, as does the settled Indian position that the unmodified form is unlawful, its prohibition sitting in the Mental health legislation and forensic psychiatry notes' provision on treatment without anaesthesia and muscle relaxants. Here the unmodified technique is a historical stage and nothing else. The anaesthetic agents and the relaxant themselves belong to this chapter's account of the pre-ECT workup and anaesthesia.

AXIS	CHEMICAL CONVULSIVE THERAPY	THE FIRST ELECTRICAL ERA	MODIFIED ECT
BEGAN	1934	1938	the early 1950s
HOW THE CONVULSION WAS PRODUCED	Camphor by injection, then pentylenetetrazol	An electrical stimulus applied to the scalp	An electrical stimulus applied to the scalp
GIVEN ALONGSIDE	Nothing	No anaesthesia	General anaesthesia and muscle relaxation
WHAT FORCED THE NEXT STEP	An unpredictable and frightening latency to the seizure	Fracture and dislocation injuries of the convulsion	The current form
STATUS TODAY	Abandoned	Historical only, and unlawful in India	The standard technique

2.6 The mid century decline, and how much of it was earned

The decline is the part of this history a candidate is most often asked to explain, and the honest explanation has an earned half and an unearned half. The earned half is stated best by the American national consensus statement, in its own words. In the United States in the 1940s and 1950s the treatment was often given to the most severely disturbed patients in large mental institutions; as often occurs with new therapies it was used for a variety of disorders, frequently in high doses and for long periods; many of those efforts proved ineffective and some even harmful; and its use as a means of managing unruly patients, for whom other treatments were not then available, contributed to the perception of an abusive instrument of behavioural control.

Some of the disrepute attaches to identifiable practices, and naming them is the honest way to teach this. In **regressive ECT**, sessions were performed several times a day until the deliberate onset of an acute brain syndrome, with memory loss, confusion, disorientation, apathy and dysarthria. That was the point of the technique, not its complication. It is abandoned, and it is the sharpest available contrast with a modern course, taught in this chapter's account of the course, frequency and number of sessions.

The unearned half is that the fall in use ran well past the abuses that provoked it. Three forces drove the decline together: effective psychopharmacological medication arriving from 1952, the development of judicial and regulatory restriction, and public protest. Use was widespread during the 1950s and 1960s, with approximately 300,000 people a year receiving the treatment in the United States, dwindled significantly during the 1970s and early 1980s under the ascendancy of pharmacological approaches and increased public protest, and recovered in the late 1980s and 1990s once it became apparent that medication was not a panacea. Those figures are United States figures and must be labelled as such; no Indian utilisation figure is carried in this account.

Attitude, not evidence, did much of the work. Negative media portrayal and the earlier misuse contributed to the negative professional and public perceptions that attitude surveys record repeatedly, and that attitude has played an important role in decreasing use of the treatment in the developed world and in reducing access to it, which constitutes a violation of psychiatric

patients' right to an effective treatment. A candidate who can say that last clause out loud has understood why the history is taught at all.

2.7 The evidence led reappraisal, and why it is not finished

The turn back towards evidence has a datable institutional marker. Because research had intensified on effectiveness, indications, mechanism, adverse effects and optimum technique while remaining outside the mainstream of mental health research, the National Institutes of Health, together with the National Institute of Mental Health, convened a Consensus Development Conference on Electroconvulsive Therapy from 10 to 12 June 1985. That conference is where the treatment stopped being defended by assertion and started being assessed in public against data.

The evidence anchor came later. The 2003 systematic review and meta-analysis of electroconvulsive therapy in depressive disorders concluded that it is an effective short term treatment for depression, and probably more effective than drug therapy. This account carries the milestone only; the magnitudes and the cognitive costs belong to the items that own them.

The story has not closed. Despite that evidence base, global trends show a paradoxical decline in utilisation across the United States, Europe and Italy itself, where the procedure originated. The history therefore lands in the present rather than in an archive: the gap between what the evidence supports and what services deliver is the live problem, which is why stigma belongs in a clinical chapter at all.

2.8 The Indian arc

India did not receive this treatment late, and an Indian candidate should be able to say so with a date. The Central Institute of Psychiatry, Ranchi, was one of the first centres outside Europe to start cardiazol induced seizure treatment, in 1938, and electroconvulsive therapy in 1943. Two things follow:

- cardiazol treatment began at Ranchi in the same year as the first electrical induction in Rome;
- India took up the chemical era and not only the electrical one, so the Indian story has the same phases as the international one.

A second institution corroborates the decade without fixing a year. An institutional history of the Government Mental Hospital, Madras, places the arrival of electroconvulsive therapy and of insulin coma therapy, including modified insulin coma therapy, in the years 1939 to 1948, and attributes the lag to the emergence of the Second World War, which held over changes that were long overdue. This is why the Ranchi record carries the date here and the Madras record the corroboration.

What followed was not passive adoption. Over the past five decades Indian research on electroconvulsive therapy has produced more than 250 publications, with a notable increase following the 1989 national workshop. The country has been a producer of the evidence base it applies, and the workshop is the turning point a candidate can name.

MNEMONIC

CAMPHOR, CARDIAZOL, CERLETTI, CURARE, CRITICISM, CONSENSUS

The arc in order. **Camphor**, the first deliberate therapeutic convulsion, on a mistaken premise. **Cardiazol**, whose unpredictable latency ended the chemical era. **Cerletti**, with Bini, the first electrical induction. **Curare**, the relaxant that began the modification anaesthesia completed. **Criticism**, the mid century decline. **Consensus**, the evidence led reappraisal that has still not restored utilisation.

Convulsive therapy began from a false premise about antagonism between epilepsy and schizophrenia, was produced first chemically by Meduna and then electrically by Cerletti and Bini in Rome, and became the modern procedure only when a muscle relaxant and then general anaesthesia were added by the early 1950s; it fell out of use for reasons partly earned by overuse and practices such as regressive ECT, partly imposed by new drugs, regulation, protest and stigma; and the reappraisal that followed left an evidence base strong enough to expose a decline in use that continues in spite of it. India entered the story at the beginning, at Ranchi, and has generated evidence about the treatment ever since.

3 · Mechanism of action and neurobiological theories of ECT

Electroconvulsive therapy is among the most effective treatments in psychiatry, and nobody has established how it works. That is the state of the evidence, not a gap in the resident's reading, and the field says so: a review of the neurobiology concludes that the cause and effect relationship between the findings and the therapeutic effects could not be established with absolute certainty, and it is not very prudent to assume a single mechanism that can explain the therapeutic effect. The examinable answer is therefore not a mechanism but a set of competing accounts, each with the observations behind it and the observation it cannot reach, none promoted to a fact.

Owned here in full: why the induced seizure helps, across the anticonvulsant and seizure-threshold, neuroendocrine and hypothalamic, monoamine and receptor-sensitivity, neurotrophic and neuroplastic, and network and connectivity accounts. Named and not re-derived, each with its own account in this chapter: the seizure threshold and how the stimulus is set against it; the placements; the cognitive adverse effects; the indications outside depression; and magnetic seizure induction. The division is strict: the seizure appears here only as a candidate therapeutic mechanism, never as a dosed event.

five	unclear	62 patients
COMPETING ACCOUNTS, OF WHICH THE NETWORK ACCOUNT IS THE NEWEST	THE EXACT NEUROBIOLOGICAL MECHANISMS, IN A REVIEW'S OWN WORD	IN THE TITRATION STUDY THAT SPLIT THE ANTICONVULSANT EFFECT FROM RESPONSE

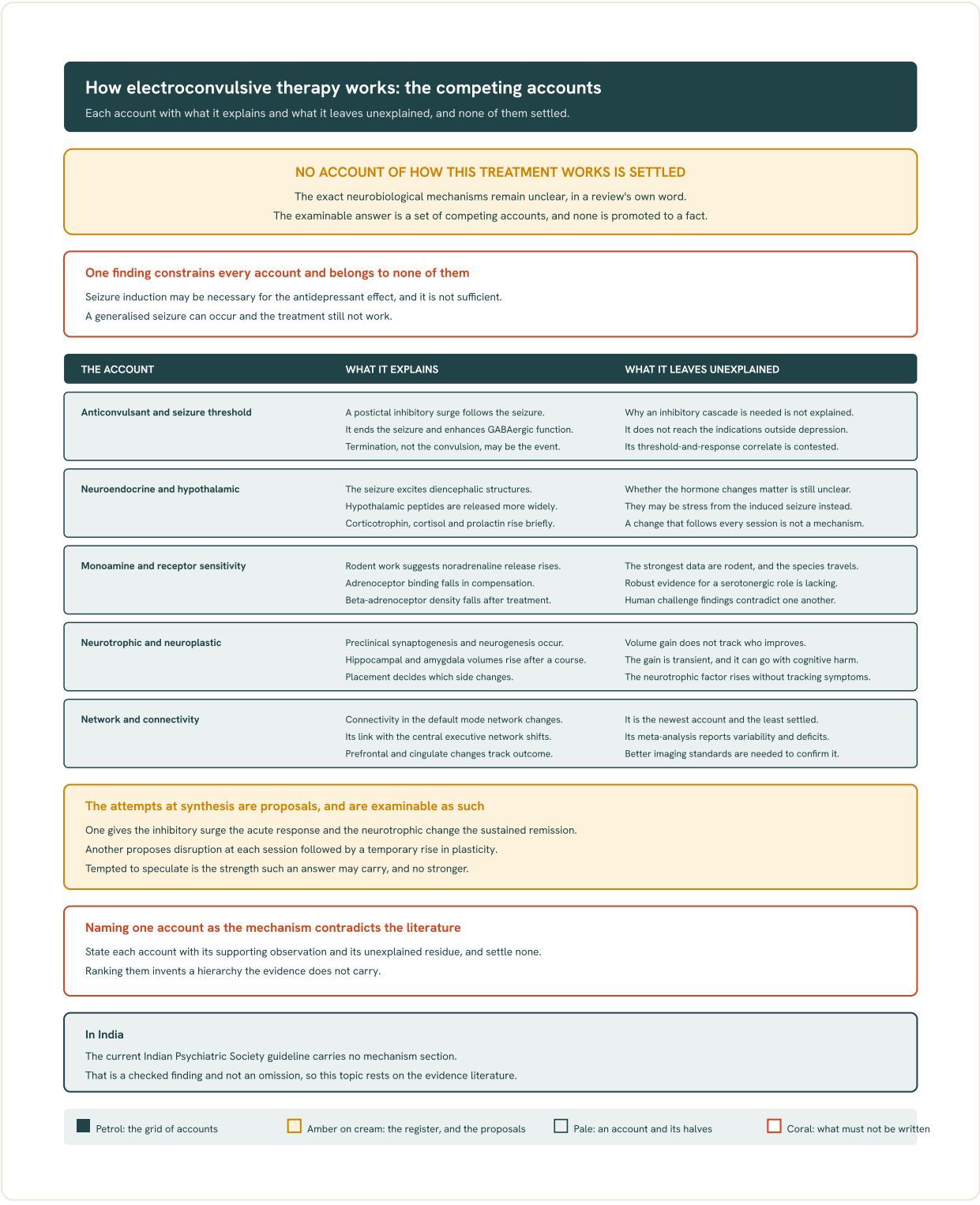


Fig 27.3. The competing neurobiological accounts of how electroconvulsive therapy works, each set beside the observation that supports it and the residue it leaves unexplained, with the finding that seizure induction may be necessary and is not sufficient constraining all of them, the attempts at synthesis stated as proposals, and no account marked as settled.

3.1 The register this topic is written in

The confidence available to every account is fixed first: the commonest error is not naming the wrong theory but naming a real one in the wrong voice. An independent review reaches the same place: the exact neurobiological mechanisms underlying the efficacy of the treatment remain unclear. A candidate who writes that the mechanism of action is the anticonvulsant hypothesis has contradicted the literature, whatever else the answer contains.

One structural finding constrains every account and belongs to none of them. Seizures induced by low-dose right unilateral stimulation lacked antidepressant efficacy, so seizure induction may be necessary but insufficient for antidepressant effects. A generalised seizure occurred and the treatment did not work. Any account that treats the bare occurrence of a seizure as the therapeutic event is under-determined, and the question becomes what kind of seizure, where it began and what followed it. The dose that makes right unilateral stimulation effective, and the placement comparison, belong to this chapter's accounts of stimulus dosing and of the placements.

RULE **State each account with its supporting observation and its unexplained residue, and settle none of them.** These accounts describe changes at different levels of organisation and on different timescales, and several may be describing parts of one process without any having been shown to cause the benefit. Ranking them invents a hierarchy the evidence does not carry.

IN INDIA

There is no Indian guideline position to quote here, and that is a checked finding, not an omission. The current Indian Psychiatric Society clinical practice guideline for electroconvulsive therapy declares its aim as enabling consistent, safe and effective practice in applicable psychiatric disorders; its full text carries no mechanism section and no neurobiological hypothesis, and every hit on the word anticonvulsant is pharmacological. Current Indian guidance controls Indian practice questions; on mechanism it has nothing to control, so this topic rests on the evidence literature.

3.2 The anticonvulsant hypothesis, stated as the hypothesis

The **anticonvulsant hypothesis** is a claim about therapeutic action and must be learnt in that form. It contends that the antidepressant effect is mediated by a postictal inhibitory surge in regions of the prefrontal cortex, which both terminates the immediate seizure and enhances GABAergic function. It derives from the GABA deficit model of affective disorders, so it is a hypothesis about inhibition rather than convulsion.

So read, it explains two things nothing else here explains as neatly: why the therapeutic event might be the **postictal inhibitory surge** and the seizure's termination rather than the convulsion, and why a stimulus initiating seizure activity in prefrontal regions might work when one initiating in motor cortex does not. The word throughout is might.

TRAP **Writing "the anticonvulsant hypothesis is that the rise in seizure threshold across a course correlates with clinical response" as the definition.** That states a contested empirical correlate and calls it a definition, in the one topic where nothing may be presented as settled. The hypothesis is the postictal inhibitory account above; the correlate is a separate observation, taught next, and disputed by the literature of the people who proposed it.

3.3 The contested correlate: does the rise in threshold track response

Across a course the seizure threshold tends to rise, though not in every patient, and the exception matters here because the argument below is built on the size of the rise. That rise, its magnitude

and its clinical consequences belong to this chapter's account of stimulus dosing, the seizure threshold and adequate seizure criteria, and are not restated. What belongs here is the mechanistic question laid on top of it: if the treatment works by being anticonvulsant, the size of the anticonvulsant effect ought to predict who improves. Two literatures answer differently.

AXIS	POSITION A: THE RISE TRACKS OUTCOME	POSITION B: IT DOES NOT
THE CLAIM	The magnitude of the change in seizure threshold over the course is associated with therapeutic outcome, particularly with right unilateral treatment, in the review that advanced the hypothesis	No relation between the rise in threshold and either therapeutic response status or speed of response, in a prospective titration study of 62 depressed patients
ITS AUTHORS' CAVEAT	Evidence associating the anticonvulsant and antidepressant effects has accrued, but critical experiments augmenting and blocking the anticonvulsant action in relation to efficacy should still be conducted	The same study confirms the anticonvulsant effect and concludes only that it is not tightly coupled to therapeutic efficacy
STANDING NOW	Subsequent investigations have not replicated key findings of the anticonvulsant hypothesis, and studies have failed to reproduce the correlation between seizure threshold increases and antidepressant response	

Position B is the more useful record, because it separates what a careless answer welds together: the anticonvulsant effect is real and was confirmed in the same study that refused the correlation, while the coupling of that effect to who improves is what was not found. Two further lines of negative evidence sit beside the failed replications, both at review level: spectroscopy studies of GABA concentration report either no change or increases unrelated to antidepressant outcome, and a study of plasma neuroactive steroids that modulate GABA receptor function found no change. That is what makes the correlate contested rather than merely old.

3.4 What the anticonvulsant account does not explain

Two conceptual limits come from the same review that recorded the failed replications. The account does not provide a rationale for why an inhibitory cascade should be necessary for antidepressant response, and it does not account for the treatment's efficacy in psychiatric disorders other than major depression. The second limb is load-bearing: the indications taught in this chapter's account of the indications and the evidence base include catatonia, mania and treatment-resistant schizophrenia, and a mechanism framed wholly as an antidepressant mechanism cannot carry them. Offering it as the mechanism offers a mechanism for one indication only, which is why the plural in theories is not a hedge.

3.5 The neuroendocrine and hypothalamic hypotheses

The **neuroendocrine hypothesis** is the oldest formal account here, best quoted in its originating form. Its authors postulated in 1980 that the antidepressant efficacy of convulsive therapy results

from the increased release and more widespread cerebral distribution of hypothalamic peptides with behavioural effects. Its base was the observation that neuroendocrine abnormalities characterise endogenous depression and are reversed by convulsive therapy.

What it observes is well established and frequently examined. The treatment has been hypothesised to enhance release of hormones from the hypothalamus into cerebrospinal fluid and blood through excitation of diencephalic structures, and there is a transient and selective increase in secretion of adrenocorticotrophic hormone, cortisol and prolactin that returns to baseline in a few hours. The prolactin surge is the item most residents are asked about, and it is a genuine consequence of the induced seizure.

PITFALL

Offering the prolactin surge as the mechanism. The source that records it declines to: whether these changes in hormone levels have therapeutic implications, or are manifestations of stress related to the induced seizure and secondary to other changes in the brain, is still unclear, and it is not known how changes in hormone levels affect the amelioration of symptoms. A change that follows every treatment is evidence that the treatment was delivered; it becomes a mechanism only when shown to differ with clinical outcome, and that step has not been taken.

3.6 The monoamine and receptor-sensitivity accounts

The **receptor-sensitivity account** reads the treatment as an antidepressant of a familiar kind, acting on monoamine transmission and receptor sensitivity. Its strongest data are preclinical, and the species travels with the claim. Results from studies on rodents suggest that the therapeutic effect may be mediated through an increased release of noradrenaline, indicated by a compensatory reduction in alpha-2 adrenoceptor binding, most marked in frontal cortex regions connected to the amygdala and hippocampus. The classical companion is a controlled rodent experiment in which electroconvulsive shock produced down-regulation of both the cyclic AMP response and beta-adrenoceptor density in rat cortex. Human data in the same literature are observations rather than mechanisms: reduced dopamine transporter binding is reported in major depressive disorder, and a treatment series elevates cerebrospinal fluid metabolites of monoamine neurotransmitters.

The serotonergic limb is where answers most often overreach, and the source is blunt. Robust evidence for the direct involvement of the serotonergic system in electroconvulsive therapy is lacking at this point of time, and further research in this domain might throw light on its implications. The same source calls the rodent receptor-sensitivity data ambiguous and the human challenge findings contradictory. No receptor-subtype direction or binding figure is carried, because none is grounded well enough to print.

3.7 The neurotrophic and neuroplastic account

This is the account a resident is most likely to state as fact, and the one whose caveats are most explicit. **The neurogenesis hypothesis** holds that the therapeutic effects depend on increasing the number of neurons or the connections among neurons, on a preclinical base:

- synaptogenesis markers;
- granule cell and mossy fibre sprouting;
- newborn cells in the dentate gyrus;
- growth factor signalling including brain-derived neurotrophic factor.

One observation inside it speaks to the seizure's standing as the therapeutic agent, and the review draws the inference itself: epileptic seizures induce similar neurogenesis effects in the absence of electrical stimulation, so if neurogenesis drives efficacy, this argues for the seizure, and not the electric field, driving efficacy.

The human test has been indirect, through blood **brain-derived neurotrophic factor**. A systematic review and meta-analysis of the preclinical and clinical literature concluded that electroconvulsive stimulation in rodents and the treatment in humans increase concentrations of this factor, but this is not consistently associated with changes in behaviour; in its human pooling, plasma rose and serum did not. A later review summarised two recent meta-analyses as finding that the factor increases after treatment, but with considerable heterogeneity and no clear relationship between change in the factor and change in depressive symptoms, and across treatment-resistant depression interventions peripheral levels increased overall with no association with depressive symptoms, making peripheral measurements of the total factor inadequate predictors of treatment response. The newest meta-analysis explains the disagreement rather than resolving it: the anaesthetic used and the time the blood sample was taken greatly influence measured levels, and the biological matrix and specific methodological variables affect the measurement, reinforcing the need to standardise future studies.

The structural limb carries the most orderly finding and the sharpest caveat. The largest neuroimaging dataset on this treatment showed a highly significant dose-dependent effect on hippocampal volume scaling with the number of sessions, with lead placement determining laterality: bilateral stimulation changed both hippocampi similarly, while right unilateral stimulation acted more focally on the right. A meta-analysis of limbic structures agrees: both right and left hippocampal and amygdala volumes increased after treatment, and meta-regression found age, the percentage responding and the percentage in remission negatively associated with volume increase in the left hippocampus.

Then the caveat that governs the limb. In the same dataset greater enlargement went with worse outcome, and that negative relation lost significance once session number was controlled for, because non-responders received more sessions. Either reading refuses the assumption the field had carried: this represents a major deviation from the common assumption of a positive association between treatment-induced volume enlargement and clinical improvement, and gross volume increase of the hippocampus by itself is not a meaningful biomarker for positive therapeutic response. The authors' own word for it is epiphenomenon, and the meta-analysis reaches the same caution: the treatment increased brain volume in the limbic structures, and the clinical relevance of that increase needs further investigation.

The change also does not last: follow-up imaging at six months showed hippocampal volumes had decreased back to pre-treatment levels, and the change was unrelated to antidepressant or cognitive outcomes. And it does not run in one clinical direction: two studies have shown that increases in hippocampal volume with treatment correlated with adverse cognitive effects, the mechanism-side counterpart of this chapter's account of the cognitive adverse effects. A change that is real, orderly, reversible, unrelated to benefit and sometimes associated with harm is a poor candidate for what makes the treatment work.

3.8 The network and connectivity accounts

The **network and connectivity account** is the newest and least settled, and its observations are functional rather than structural. Whole-brain analysis revealed significant effects on functional connectivity in various networks, including the default mode network, the central executive network, the sensorimotor network and the cerebellar posterior lobe, with connectivity increased within the default mode network and between it and the central executive network, aligning with previous reports that the treatment can normalise the connectivity between them. Its outcome linkage is regional rather than global: specific prefrontal and cingulate connectivity changes have been linked to therapeutic outcomes.

Its meta-analysis states its limits before its findings. There was considerable variability as well as a few key deficits in the preprocessing and analysis of the neuroimages and in the reporting of results across the included studies. What it reports is bounded in the same breath: the brain regions noted are reasonably specific and distinguished and had significant changes in resting-state functional connectivity after a course for depression, and more studies with better neuroimaging standards should be conducted to confirm these results.

One trial supplies the dissociation that earns the account its place. Right hippocampal connectivity increased, or normalised, after the series and correlated with depressive symptom reduction, while the hippocampal subfields were unchanged relative to the comparison group. Read the second half precisely, because it is not a claim that the volumes stayed still: the subfield volumes rose but did not separate the patients from the comparison group, so what failed was the discrimination and not the change. Function moved with the illness where structure, having moved, did not distinguish anyone. The conclusion those authors drew carries its later fate with it: they suggested that increased hippocampal functional connectivity and volumes may be biomarkers for response, and the volume part of that suggestion is what the larger dataset above did not support.

3.9 Holding the accounts together without settling them

The attempts at synthesis are proposals, and are examinable as such. Abbott and colleagues argue for integrating the anticonvulsant and neurogenesis hypotheses, and the shape of the integration is temporal: they contend that a frontal inhibitory surge and subsequent reductions in metabolism and perfusion are key to an acute response, but that neurotrophic changes in the medial temporal lobes are required for sustained remission. That gives each account a phase rather than a verdict.

A second model runs the same logic across the whole course. In response to the disruptive effects of each session, the brain exhibits a temporary enhancement of neuroplasticity, leading to increased brain tissue volume and enhanced connectivity, and the combination of disruption and neuroplastic effects leads to a rewiring of neural circuits associated with depressive symptoms. Its own review reports it as a proposed model, and it is written here in that voice; its corollary about electric field dosing belongs to this chapter's accounts of stimulus dosing and of the placements.

The register the field chose for its own synthesis is worth copying. Integrating the evidence, one review writes that it is tempted to speculate that the treatment may have neuroplastic effects resulting in the modulation of connectivity between and among specific large-scale networks that are altered in depression. Tempted to speculate is the strength an answer may carry, and no stronger.

MNEMONIC

A NEW MAN NEEDS NETWORKS

Anticonvulsant, **NEW**roendocrine, **MAN**oamine, **NEE**urotrophic, **NETWORK**. A sound-alike, not an initialism; the order is the order in which they are taught here, not of date and not of merit. Note in particular that the anticonvulsant account heads the mnemonic while the neuroendocrine hypothesis is the oldest formal account carried on this page, so the sequence is not chronological.

No account of how electroconvulsive therapy works is established, and the field says so in its own words; the seizure may be necessary and is not sufficient; the anticonvulsant hypothesis is the postictal inhibitory account, not the disputed threshold-and-response correlate; the neuroendocrine rise, the rodent receptor changes, the neurotrophic factor and the hippocampal volume gain are real observations not shown to track benefit; and connectivity, the newest account, states its own methodological limits beside its findings, so the strongest register available is that of its reviewers, who were tempted to speculate.

4 · Indications for ECT (depression, mania, catatonia, schizophrenia, emergencies)

An indication for electroconvulsive therapy settles one question only, whether this presentation earns the treatment, and never the second, whether there is a lawful route to give it. The set is short and stable in outline across the major guidelines: severe depression, particularly with psychotic features, food refusal, stupor or acute suicidal risk; catatonia; acute and refractory mania; schizophrenia, where the sources openly disagree; and the psychiatric emergency, where urgency is highest and the statutory position most easily misread.

Owned here in full: why each indication earns ECT, its evidence, and the distinction between a clinical emergency and a statutory route. Named and not re-derived: the risk profile and the contested status of absolute contraindication; the acute course and its schedules; continuation and maintenance treatment; consent as it is taken in Indian practice, where the lawful routes are enumerated; and the special populations. The catatonia entity, its signs and aetiology, the lorazepam challenge, the malignant catatonia against neuroleptic malignant syndrome

differential and the structured rating scale belong to the Other psychotic disorders, delusional syndromes and catatonia notes. The mood ladders are the Mood disorders: pharmacotherapy notes'; the resistance algorithm and clozapine itself the Schizophrenia: management, antipsychotics and adverse effects notes'.

0.91	80 to 100%	Grade B
EFFECT SIZE FAVOURING REAL OVER SIMULATED ECT IN DEPRESSION	RESPONSE ACROSS THE CATATONIA SERIES, THE STRONGEST INDICATION HERE	THE BEST GRADE ANY CLOZAPINE AUGMENTATION STRATEGY REACHES

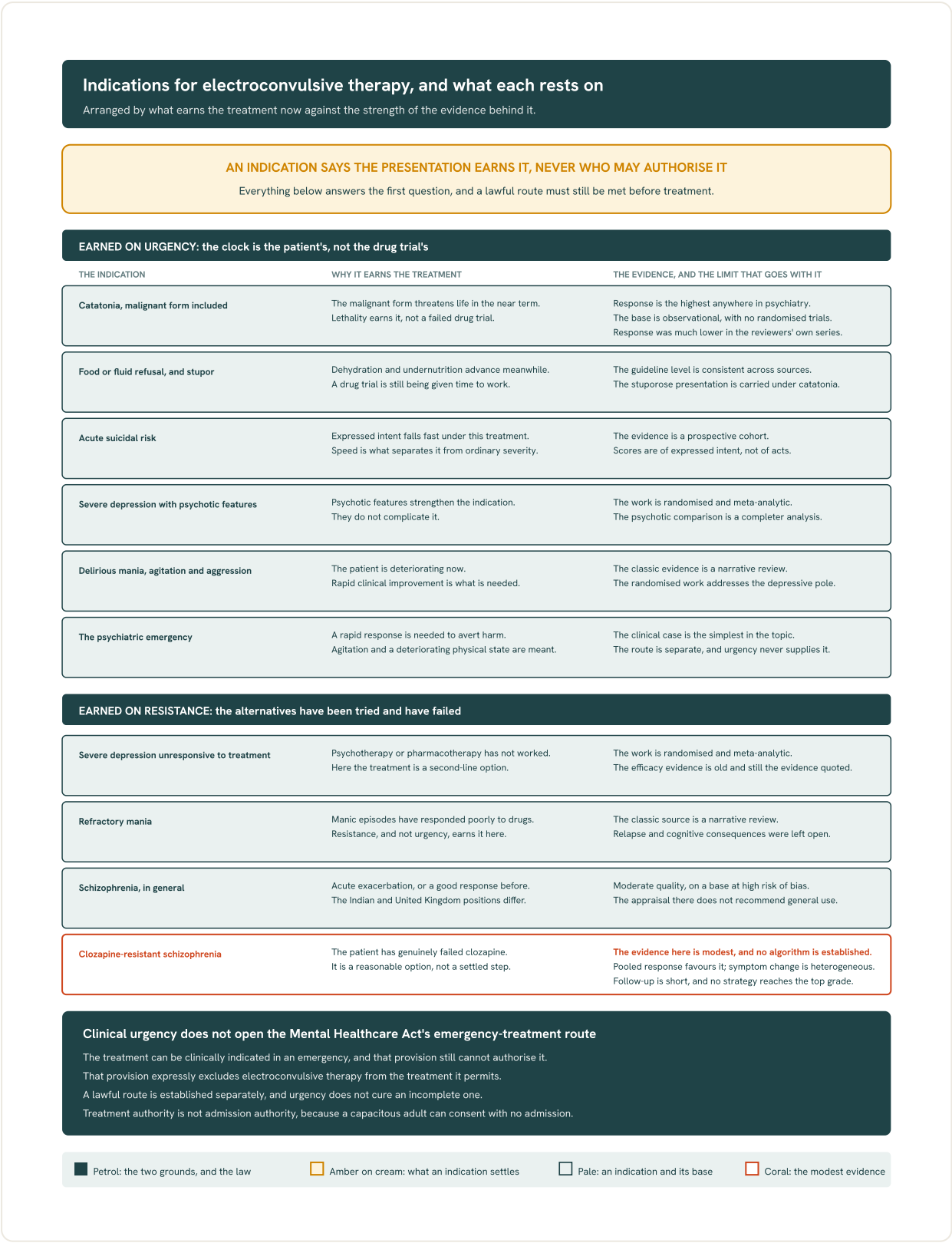


Fig 27.4. The indications for electroconvulsive therapy set out by what earns the treatment now against the strength of the evidence behind each: catatonia, food or fluid refusal, acute suicidal risk, psychotic depression, delirious mania and the psychiatric emergency on urgency; unresponsive depression, refractory mania, schizophrenia and the clozapine-resistant patient on resistance, that last one modest and with no established algorithm; and, along the foot, the statutory point that clinical urgency does not open the emergency-treatment route.

4.1 What an indication settles, and what it leaves open

An **indication** is a clinical judgment that a presentation is of the kind ECT treats and that benefit against risk favours giving it. It is not an authority to treat. Everything below answers the

first question; the second belongs to this chapter's account of consent, and the statutory provisions it turns on are named in words here and numbered only in the Mental health legislation and forensic psychiatry notes.

Weight the guideline before leaning on it. The current Indian Psychiatric Society guideline controls Indian practice questions, and records its own method: it was prepared by a consensus-based recommendation method, no formal systematic literature search was conducted, and it states in terms that it is a guidance document for practitioners rather than a directive or mandatory instruction. Where an effect size is at stake the number therefore comes from the trial, and the guideline carries the practice position.

RULE **An indication says the presentation earns ECT; it never says who may authorise it.** Each must still meet a lawful route before a treatment is given, and a strong answer to one question is no answer to the other.

4.2 Severe depression: food refusal, stupor and acute suicidal risk

Depression carries the strongest evidence, and within it one group of features moves ECT from a later option to a first one. A peer-reviewed review of the guideline position states it in a sentence: most guidelines recommend ECT as the first-line treatment for a severe depressive episode with psychotic features, catatonia, high suicide risk, or food or fluid refusal, and as a second-line treatment for a severe episode unresponsive to psychotherapeutic or pharmacological intervention. **Food refusal** earns its place because it puts a physiological clock on the decision: dehydration and undernutrition advance while a drug trial is still being given time to work. The Indian guideline's wording for it is poor oral intake, and its Table 1 depression rows read poor oral intake, high suicidal risk, a high level of distress requiring rapid symptom remission, psychotic features, melancholic features, peripartum depression, treatment resistance, and severe mixed affective features.

Depressive **stupor** needs care, because no source in this fragment's evidence list uses that term: both grounded statements carry it under catatonia, where a stuporose depressive presentation sits nosologically. It is written here as the catatonic pole of a severe depressive episode, immobility with failing intake being an indication on two grounds at once.

The efficacy evidence is old and still the evidence quoted, from the United Kingdom ECT Review Group's meta-analysis. Real ECT beat simulated ECT, 6 trials and 256 patients, standardised effect size minus 0.91 with a 95% confidence interval of minus 1.27 to minus 0.54. ECT beat pharmacotherapy, 18 trials and 1144 participants, standardised effect size minus 0.80 with a 95% confidence interval of minus 1.29 to minus 0.29. The negative sign is the direction of benefit, the effect being measured on depression scores.

Psychotic features strengthen the indication rather than complicate it, and that is measured. The collaborative remission study reported on 253 patients: remission among completers **87%** overall, **95%** in psychotic against **83%** in non-psychotic depression, with improvement more robust and appearing sooner in the psychotic patients. Those are completer rates, which the source says of itself.

Acute suicidal risk earns ECT on speed, which is what distinguishes it from ordinary severity. Expressed suicidal intent was scored before every session in 444 patients with unipolar depression: 131 patients, 29.5%, reported suicidal thoughts and acts at baseline, and the score fell to 0 after 1 week, or three treatments, in 38.2% of them, after 2 weeks, or six treatments, in 61.1%, and by the end of the course in 80.9%. The authors' conclusion is examinable: for a patient at risk, ECT should be considered earlier than at its conventional last-resort position.

TRAP **Quoting the NICE technology appraisal as current guidance for ECT in depression.** Its recommendations on depression were removed from that document and replaced by the depression guideline published in 2009, while its recommendations on catatonia, prolonged or severe manic episodes and schizophrenia did not change. It remains quotable for those and never for depression.

4.3 Catatonia: the strongest indication, on the weakest design

Catatonia earns ECT on two grounds worth keeping apart: response, better here than anywhere else in psychiatry, and mortality, since in the malignant form it is the near-term lethality of the presentation, not the failure of a drug trial, that earns the treatment. The guideline's catatonia rows carry that split, listing catatonia resistant to a benzodiazepine trial, a good response in past episodes, and malignant catatonia with a risk of imminent mortality.

A systematic review of ECT in catatonic patients reports **response rates ranging from 80% to 100%** across the retrospective observational studies, effective in all forms of catatonia including after benzodiazepines have failed, and above any other treatment in psychiatry. Inside the same review, a record review of 178 patients across 270 episodes used ECT alone in 55 patients, about 30%, resolving catatonic symptoms in 85%; where malignant catatonia was suspected, response was 89%, 9 of 11.

The counterweight comes from the same review. In the reviewers' own series ECT improved 59% of cases although pharmacotherapy had failed in 85% of the patients, attributed to a high prevalence of psychotic disorders, to ECT being reached only after two months of pharmacotherapy, to prior antipsychotic exposure, and to neurological comorbidity in one third. Both halves belong: the indication is the strongest on the list, and its design limit is the limit of its whole evidence base, these being observational series rather than randomised trials.

The boundary is exact in both directions. The entity, the lorazepam challenge, the differential against neuroleptic malignant syndrome and the structured rating scale are named here and taught in the Other psychotic disorders, delusional syndromes and catatonia notes. The technique stays on this chapter, split three ways: why the presentation earns ECT, which is this account; the stimulus dose, which is its dosing account; and the schedule, including the accelerated daily or initially twice-daily one used in life-threatening presentations, which is its account of the acute course. The assembled protocol for malignant catatonia has exactly one owner there, and no second copy is built here.

4.4 Mania, acute and refractory

The manic indication is not only about resistance. The Indian guideline's mania rows are a need for rapid clinical improvement, persisting or clinically significant agitation and aggression, treatment-resistant mania, severe mixed affective symptoms, and delirious mania. Some are urgency claims and some resistance claims, earning the treatment differently: agitation and delirious mania because the patient is deteriorating now, resistance because the alternatives have failed.

The classic evidence is a review of published experience over fifty years, which concluded that ECT is associated with remission or marked clinical improvement in 80% of manic patients and is effective for patients whose manic episodes have responded poorly to pharmacotherapy. Cite it for what it established, not as current practice: it is a narrative review rather than a meta-analysis, more than thirty years old, and its authors left relapse, cognitive consequences and the choice of placement for further study. Its observations on the seizure threshold in mania and on course length belong to this chapter's dosing and schedule accounts.

The modern randomised counterpart addresses the depressive pole, which is the trap here. A systematic review with exploratory meta-analysis of randomised trials in treatment-resistant bipolar disorder found ECT similarly effective for treatment-resistant bipolar depression as for treatment-resistant unipolar depression, odds ratio 0.919 with a 95% confidence interval of 0.44 to 1.917. It supports the refractory affective indication and says nothing about mania. The United Kingdom appraisal reaches mania from the other side, its surviving recommendation 1.1 permitting ECT only to achieve rapid and short-term improvement of severe symptoms after an adequate trial of other treatment options has proven ineffective, or where the condition is considered potentially life-threatening, in catatonia and in a prolonged or severe manic episode.

4.5 Schizophrenia, and the clozapine-resistant patient

Here two authoritative sources say different things, and the skill is to state both with their provenance rather than pick.

QUESTION	INDIAN PSYCHIATRIC SOCIETY GUIDELINE (2023)	NICE TECHNOLOGY APPRAISAL 59 (2003, UPDATED 2009)
SCHIZOPHRENIA IN GENERAL	Listed: acute psychosis requiring high-intensity management; acute exacerbations of positive psychotic or affective symptoms; good response in past exacerbations; postpartum psychosis	Recommendation 1.9: the current state of the evidence does not allow the general use of ECT in the management of schizophrenia to be recommended
RESISTANT AND CLOZAPINE-RESISTANT	Listed as treatment-resistant schizophrenia and as clozapine augmentation in clozapine-resistant schizophrenia	Not addressed by its terms; the statement is about general use

The randomised evidence for treatment-resistant schizophrenia is thinner than either position implies. The Cochrane review pooled 15 studies and 1285 participants and rated moderate-quality evidence that added ECT improves medium-term clinical response against standard care

alone, risk ratio 2.06 with a 95% confidence interval of 1.75 to 2.42, in 819 participants across 9 studies, with no clear advantage on other outcomes and 14 of 15 studies, 93.3%, at high risk of bias. Against clozapine added to standard care, the risk ratio for clinically important response was 1.23 with a 95% confidence interval of 0.95 to 1.58, from 162 participants in a single low-quality study, no clear difference either way.

For the clozapine-resistant patient the pooled result is favourable and the appraisals of it are not. The largest meta-analysis found adjunctive ECT superior on study-defined response at the post-ECT assessment, 53.6% against 25.4%, risk ratio 1.94 with a 95% confidence interval of 1.59 to 2.36 and a number needed to treat of 3, while remission at that assessment was 13.3% against 3.7%, a number needed to treat of 13 with a 95% confidence interval of 6 to 100. Response is common, remission is not, and the remission interval is too wide to carry precision. Heterogeneity was high: I-squared of 86% for symptomatic improvement at the post-ECT assessment and 95% at endpoint.

The best-known randomised trial is small and single-blind. In an intent-to-treat sample of 39 participants, 20 given ECT plus clozapine and 19 clozapine alone, 50% of the ECT plus clozapine patients met the response criterion and none of the clozapine group did; response in the crossover phase was 47%. Its own conclusion anchors what this chapter must say: further research is required to determine the persistence of the improvement and the potential need for maintenance treatments.

Three appraisals keep that at its true strength.

- A synthesis of six systematic reviews concluded that ECT probably augments response to clozapine, but that whether it leads to cognitive adverse effects cannot be determined because the certainty of the evidence is very low.
- A review of 46 studies of 25 augmentation strategies called ECT highly promising while adding that its conclusions are tempered by generally short follow-up periods and poor study quality.
- A meta-review of 21 meta-analyses found that no strategy met Grade A criteria and that augmentation with ECT for persistent positive symptoms met Grade B.

RULE **State the clozapine-resistant indication as modest, and say that no algorithm is established.** The effect sizes are real and the certainty behind them is not: heterogeneity is high, the trial base small and mostly single-blind, follow-up short, no strategy at the top grade. Offer it as a reasonable option in a patient who has genuinely failed clozapine, never as a step on a settled ladder.

4.6 The psychiatric emergency, and the authority it does not confer

The clinical half is the simplest statement in the topic. ECT is a first-line treatment when a rapid or definitive response is needed to avert harm to self or others, and acute suicidal risk, agitation, catatonia and a deteriorating physical status secondary to a psychiatric condition are among the situations meant. The list is examples rather than a closed set, and the guideline adds that every

indication is individualised against clinical need, the patient's preferences and the putative risk of adverse effects.

The statutory half is where a resident is most likely to be taught something unlawful, and the error is precise enough to name. ECT can be clinically indicated in an emergency, and the Mental Healthcare Act's provision on emergency treatment cannot authorise it, because that provision expressly excludes electroconvulsive therapy from the treatment it permits. Both statements are true and not in conflict. What follows is that a lawful route must be established separately, and that urgency does not cure an incomplete route. No emergency doctrine supplies the authority the Act withholds.

The second half is the one most often lost: TREATMENT authority is not ADMISSION authority. A capacitous adult can consent to ECT with no admission at all, so urgency never converts the question into whether the patient must first be admitted. The routes, and what each does and does not authorise, are enumerated in this chapter's account of consent for ECT in Indian practice. Every provision of the Act touching ECT and psychosurgery, including those on emergency treatment, the nominated representative and the statutory gate for a minor, belongs to the Mental health legislation and forensic psychiatry notes: named in words here, numbered only there.

TRAP **Writing emergencies into the indication list and stopping there.** A list that says ECT is indicated in an emergency, with nothing beside it, teaches a resident to reach for the Act's emergency-treatment provision and treat under it, which is not lawful. The paired error runs the other way: assuming that because that route is closed, an admission must be arranged first. It need not be, if the adult before you has capacity and consents.

MNEMONIC

NOT EATING, NOT MOVING, NOT SAFE, NOT WORKING

Not eating is food or fluid refusal and the clock it starts. **Not moving** is catatonia, the malignant form earning the treatment on mortality. **Not safe** is acute suicidal risk, where speed of relief is the point. **Not working** is treatment resistance across depression, mania and schizophrenia. A fifth line belongs with the four: none is a lawful route, and each still needs one.

4.7 Each indication at its true strength

INDICATION	THE EVIDENCE, AND THE LIMIT THAT GOES WITH IT
SEVERE DEPRESSION WITH PSYCHOTIC FEATURES	Randomised and meta-analytic; the psychotic comparison is a completer analysis
FOOD OR FLUID REFUSAL, AND THE STUPOROSE PRESENTATION	Guideline-level and consistent; carried nosologically under catatonia
ACUTE SUICIDAL RISK	Prospective cohort; scores are of expressed intent, not of acts
CATATONIA, MALIGNANT FORM INCLUDED	Very high response but entirely observational, and much lower in the reviewers' own series, whose size is not stated
ACUTE AND REFRACTORY MANIA	A narrative review; the randomised work addresses the depressive pole
SCHIZOPHRENIA, GENERAL	Two authoritative sources disagree; moderate quality on a base at high risk of bias
CLOZAPINE-RESISTANT SCHIZOPHRENIA	Modest, no algorithm: pooled response and remission favour it with no heterogeneity, the heterogeneity belongs to the continuous symptom-change outcome, and follow-up is short
THE PSYCHIATRIC EMERGENCY	Clinically clear; the statutory route is separate and never supplied by urgency

PITFALL

Answering with one undifferentiated list. These indications do not stand on evidence of one kind: catatonia on observational series, depression on randomised and meta-analytic work, mania on a narrative review, the clozapine-resistant patient on a small and heterogeneous trial base. An answer that grades them reads as clinical judgment; one that recites them cannot say which would survive a challenge.

ECT is indicated where the presentation is of the kind it treats and benefit against risk favours it: severe depression, most strongly with psychotic features, food refusal or acute suicidal risk; catatonia, on the strongest response evidence in psychiatry and the weakest design; acute and refractory mania; schizophrenia, where the Indian and United Kingdom positions differ and both are stated; the clozapine-resistant patient, modest with no established algorithm; and the psychiatric emergency, where the clinical case is strongest and the Act's emergency-treatment provision still cannot authorise treatment.

5 · Contraindications and high-risk conditions for ECT

A contraindication is a statement that a treatment must not be given at all, and the difficulty here is that the field does not agree on whether electroconvulsive therapy has one. Two positions are in print, each from a named source with a date, and a candidate who has met only

one will be wrong in one of two directions: barring a patient who could have been treated, or taking a patient with an intracranial mass and papilloedema to the suite. This account states both, gives the physiology behind the older one, and teaches each condition that raises risk beforehand with its modification.

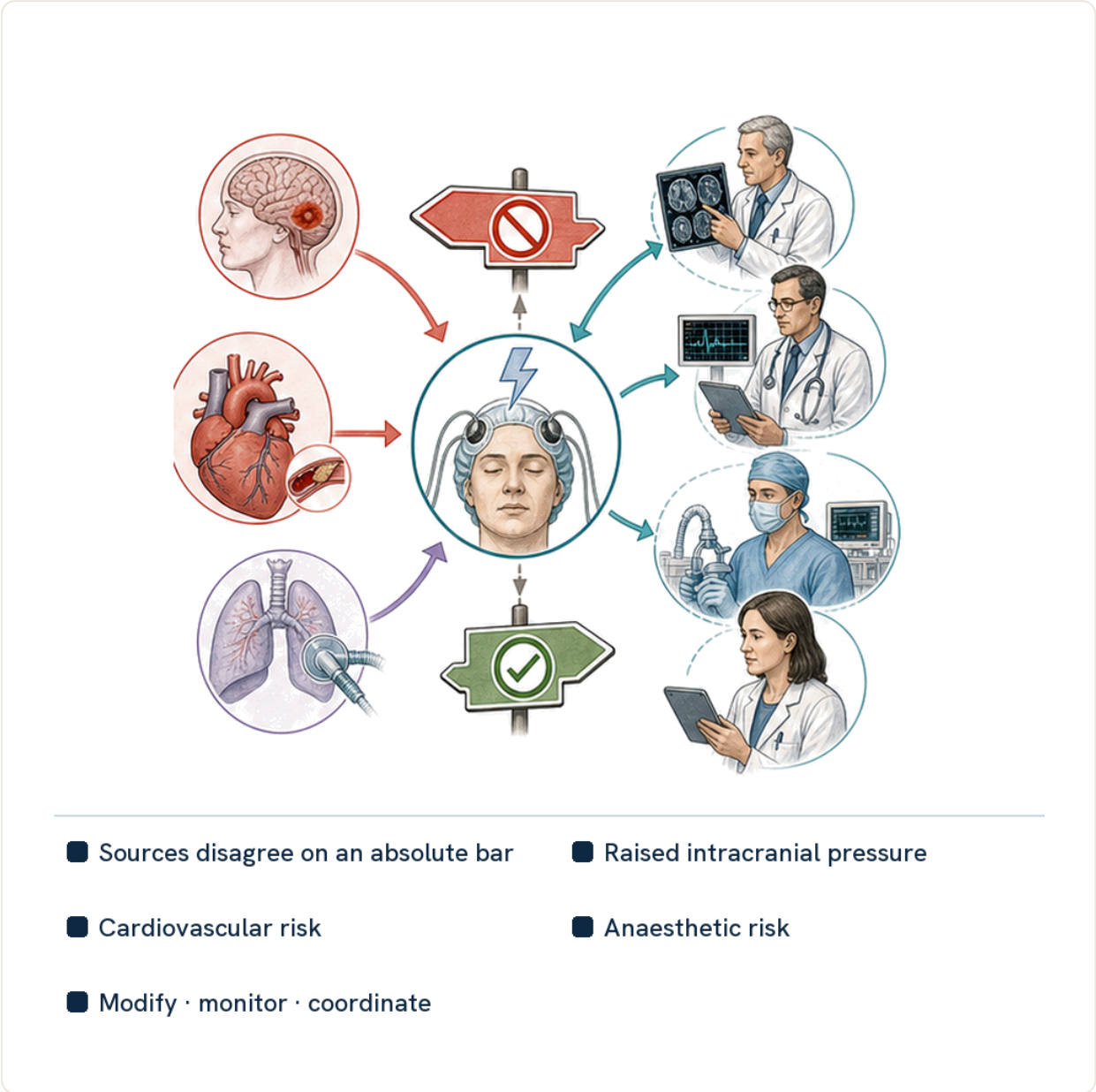


Fig 27.5 Published sources differ on whether ECT has an absolute contraindication. Raised intracranial pressure and major cardiovascular or anaesthetic risk demand individual assessment, risk modification, monitoring and coordinated specialist planning.

Owned here is the risk profile before treatment: the contested status of absolute contraindication, the intracranial question the dispute turns on, and the high-risk conditions. Named and not re-taught, each owned by another account in this chapter: the complications that actually occur, by the other complications and adverse effects of electroconvulsive therapy; the workup and anaesthetic conduct that manage these risks, by the pre-ECT workup and anaesthesia, its agents, muscle relaxant and airway; the clinical grounds, by the indications for ECT; and pregnancy, age and comorbidity as populations, by ECT in special populations. Risk beforehand against complication afterwards: two objects, not one.

1980	74 percent	one patient
THE YEAR POSITION TWO WAS CONCLUDED, AND STILL A COMMON EXAM KEY	COMPLICATIONS IN THE REPORTS OF ECT WITH AN INTRACRANIAL NEOPLASM BEFORE 1984	THE WHOLE DIRECT EVIDENCE ON ECT WITH RAISED INTRACRANIAL PRESSURE ALREADY PRESENT

5.1 Two positions, with their provenance and their dates

Both are written out, because the disagreement is real and this account does not settle it.

Position one is the modern task-force position: there are no absolute contraindications to electroconvulsive therapy, and every listed condition is a risk to be quantified and managed with the anaesthetist. It reaches this page through a peer-reviewed anaesthesia review of 2022, which attributes it to the American Psychiatric Association consensus statement of 2001. The two halves must not be split: in the very next breath the same passage names uncontrolled hypertension, coronary artery disease, congestive heart failure, aortic stenosis, implanted cardiac devices, atrial fibrillation, obstructive lung disease, asthma and increased intracranial pressure with or without mass lesions as conditions carrying a relatively high risk that may result in death during treatment. Position one is not a claim that nothing is dangerous; it is a claim about where the danger is adjudicated.

The position holds at the current end. A review of electroconvulsive therapy in intracranial pathology, published in 2025, concludes that no absolute contraindications have been established, frames the transient rise in intracranial pressure as the reason the question keeps being asked, and calls its own evidence base very sparse, mostly case series and short retrospective studies. It also states what modern practice is: a decision made case by case by a team involving both the psychiatric and the neurosurgical services.

Position two is that raised intracranial pressure with a space-occupying lesion is an absolute contraindication. It is standard in Indian teaching and common as an examination key, and it has a provenance: it is the conclusion of the last large review before the modern case literature, by Maltbie and colleagues in 1980, recorded as such by the 2020 review that set out to test it.

A limitation is shared, and neither side is graded above the other on it: neither the task-force text of 2001 nor the review of 1980 was opened at source. What is established is what a later peer-reviewed paper reports each to hold.

RULE **Write both positions with their dates, and never present "no absolute contraindication" as settled and uncontested.** The modern position is a claim about method, that risk is quantified and managed rather than made prohibitive in advance. A reader given it as a licence, without what the older position was protecting against, has been taught something unsafe.

5.2 The physiology that makes position two reasonable

Position two is not superstition, and its mechanism is examinable. Electroconvulsive therapy induces a rise in cerebral blood flow, in intracranial pressure, in intraocular pressure and in cerebral oxygen consumption. Where compliance is normal those rises are transient and settle. The whole of position two is what the same rises mean in a patient whose compliance has already been consumed by a mass.

The chain from the general rise to the specific danger runs in a fixed order, first proposed by Carter in 1977. Seizure activity raises blood pressure and cerebral blood flow; that increases the oedema around the tumour; the oedema raises intracranial pressure further; neurological signs follow. The 2020 review treats this as the likely cause of the more prominent adverse events in its own series, and records that a corticosteroid was given to 12.5 percent of its patients to reduce the risk of acute oedema, saying only that it is therefore possible such premedication lowers the risk. No agent dose belongs here: drug conduct is the workup and anaesthesia item's.

Two honesties travel with this mechanism. No magnitude is available: no grounded source states how large the rise in intracranial pressure is, and the review describing the rises says the mechanisms behind them are incompletely understood, so direction and transience are taught and size is not carried. And the word herniation appears in none of the sources this account rests on. The grounded chain ends at neurological signs; herniation is the endpoint the older teaching was written to prevent, and naming it as the feared outcome is legitimate while asserting it as a documented consequence is not. That gap is declared, not closed. The same sentence grounds the ocular limb, which is why raised intraocular pressure and retinal detachment sit in the set below.

5.3 The outcome data each position was reading

Position two was a reading of outcomes, not an opinion. In reports published up to 1984 on treatment in patients with intracranial neoplasms, complications were recorded in **74 percent** of 38 patients and death in **8 percent** of 29 patients. The denominators differ, so these are not two proportions of one sample. The source supplies the confound itself: some who died had aggressive tumours such as glioblastoma, so attribution to the treatment is not clean. The figures reach this page through a safety review of 2025 reporting an earlier review, which bounds them without doubting them.

The modern series behind position one is small. Across reports from 1984 to 2019 there are 40 patients. Adverse effects occurred in **15 percent** and all were reversible; none died from treatment; the authors judged it beneficial in 36 of the 40 patients, which is 90 percent. The decisive sentence sits in that paper: only one patient was reported to have had raised intracranial pressure before the procedure, and came through without adverse effect. That is the closest the literature comes to answering this item's question, and it is one patient.

TRAP **Reading the difference between the two eras as pure progress in technique.** The comparison is not like for like and the modern authors say so. The tumour was known beforehand in 72.5 percent of modern cases, allowing precautions, and neurological symptoms preceded treatment in 12.5 percent of them against 45.7 percent of the older group, which held more aggressive tumours. The modern series is safer partly because it is a different population.

5.4 Where Indian practice actually sits

The current Indian guideline, of 2023, gives its high-risk conditions in a table headed *clinical conditions requiring caution while administering ECT*, grouped into four systems, and its running text introduces the physical examination as the way to identify any **relative contraindications**.

Raised intracerebral pressure with an intracerebral space-occupying lesion heads the cerebral group. The Indian guideline therefore sits with position one, and that framing is itself the finding.

Its operative instruction is sharper than either slogan. For a symptomatic intracranial mass, and for recent ischaemic or haemorrhagic stroke, it says treatment may warrant postponement until the risks of complications are minimised: a relative bar with a condition attached. The same row states that cerebral implants and foreign bodies are not an absolute contraindication and that treatment may be given in consultation with neurologists. Its electrode-placement instructions belong to this chapter's account of ECT technique and electrode placement, its relaxant instruction to the workup and anaesthesia item.

IN INDIA

Two Indian facts point in opposite directions and both are true. Indian *teaching* writes raised intracranial pressure with a space-occupying lesion as an absolute contraindication; the current Indian *guideline* does not. Give the guideline position, and name the taught position with its date.

5.5 How the intracranial condition is actually found

The condition this item turns on is usually not looked for in advance. Routine neuroimaging before a course is not mandatory and its yield is very low: one retrospective study found a single abnormal scan preventing treatment out of 108 scans done as routine pre-treatment imaging, which is 0.93 percent. Selective imaging is suggested for patients at risk: a prior aneurysm, a heritable aneurysm disorder, headache, and age above 60 with hypertension or smoking. What triggers imaging afterwards is any new neurological symptom: significant lateralisation of the seizure, a transient postictal paralysis, aphasia or a secondary seizure.

What is mandatory is the bedside examination. The Indian guideline of 2023 makes fundoscopy a mandatory part of the pre-treatment physical examination. That is the practical link: **papilloedema** is what raised intracranial pressure looks like at the bedside, and the examination exists, in the guideline's words, to identify relative contraindications and prevent complications.

5.6 The high-risk conditions, and the modification that manages each

The set below is explicitly open: the safety review supplying the last row introduces its own list with the word *include*, marking it as not closed. Neither list is the answer to what the high-risk conditions are.

SYSTEM GROUP	CONDITIONS NAMED	MODIFICATION THAT MANAGES IT
CEREBRAL	Raised intracerebral pressure with an intracerebral space-occupying lesion; unstable cerebral aneurysm; recent intracerebral haemorrhage or stroke; and phaeochromocytoma, which sits in this row only because the source table's column layout puts it here, its hazard being a catecholamine-driven hypertensive surge rather than anything cerebral	Postponement of a symptomatic mass and of recent stroke until risks are minimised; shunt patency confirmed; blood pressure held with short-acting parenteral antihypertensives in aneurysm
OCULAR	Raised intraocular pressure; retinal detachment	The induced rise in intraocular pressure is the mechanism, transient in the ordinary case
CARDIAC	Recent myocardial infarction; poor cardiac output; unstable arrhythmias; high anaesthetic risk (ASA level 4 or 5); third degree burns	Wait 4 to 6 weeks after infarction; blood pressure controlled with short-acting agents; anticoagulation considered in valvular disease; restimulations limited in heart failure, with functional capacity assessed; pacemakers safe with cardiology consultation
NEUROMUSCULAR	Spinal injuries; bone fractures; recurrent dislocations	Managed through the relaxant and the technique, both owned by the workup and anaesthesia item
NAMED BY THE MODERN REVIEW	Recent myocardial infarction; intracranial aneurysm above a threshold size; proximal deep vein thrombosis; phaeochromocytoma; systemic infection	Avoided or given with high caution on a favourable risk-benefit ratio; deep vein thrombosis singled out for extreme precaution, fatalities being associated with it

Three entries need their detail, because each is where a memorised line goes wrong. The **infarction window** is the plainest conflict here after the intracranial one: the Indian guideline of 2023 says consider waiting 4 to 6 weeks; the safety review of 2025 writes it as an infarction within the last 4 weeks. The disagreement is stated, not resolved.

The **aneurysm** is not theoretical. Across 27 published cases, treatment was safe with secured and unsecured aneurysms up to 2.1 cm, with one fatal exception: a patient died of subarachnoid haemorrhage after rupture of an anterior cerebral artery aneurysm of 1.9 cm, 2 days after a tenth right unilateral treatment, the peri-ictal pressure having risen sharply despite a short-acting agent. The review states that treatment is not universally safe in aneurysm and that risk rises with size. Note the consequence for any threshold: the paper names aneurysms larger than 1 cm as high risk, yet the fatal one was larger and safe cases are reported above it. Size is a gradient, not a cut-off.

The **mass** is not one thing. A mild mass effect does not appear to preclude treatment provided there is no midline shift, and the largest tumour reported without adverse effect measured 8.1 by 7.6 by 4.1 cm. That is what makes position one operable at the bedside. It does not retire position two, and this account must not be read as doing so: position two's claim is that the PRESENCE of an intracranial mass is an absolute bar, and recasting that claim as really being about midline shift would resolve the chapter's flagship conflict in the permissive direction on evidence that is a series of case reports. No source here defines when a mass effect stops being mild, none quantifies a midline shift, and no such threshold is asserted, so the discriminator is not available as a bedside rule.

PITFALL

Printing any of these lists as the complete set. The task-force passage quoted earlier for position one adds conditions the Indian table does not carry as such, so severe pulmonary compromise, decompensated heart failure and severe valvular disease belong on any honest version. A vascular malformation liable to rupture with a pressure surge is often taught here too; no source grounded for this account names it, so it is flagged rather than printed as established.

5.7 Pregnancy: on the risk list, not the contraindication list

Pregnancy is not a contraindication to electroconvulsive therapy, and the distinction this item exists to draw appears here in its cleanest form. Two instructions travel with that: pregnancy testing in all women of reproductive age, and fetal exposure to anaesthetics minimised. The risk side is stated alongside, not instead: guidance holds that risks may be enhanced during pregnancy, in older people and in children and young people, and fatalities including fetal deaths have been reported after treatment in the presence of pregnancy among other conditions, with the caveat that attribution is not established in every case. How treatment is then modified belongs to this chapter's account of ECT in special populations, and the statutory position on minors to its account of consent for ECT and the legal aspects under the Mental Healthcare Act.

5.8 What stands in place of a contraindication list

Guidance from the appraisal tradition does not answer this item with a list at all. It requires a documented assessment of the risks and potential benefits to the individual, and names what that assessment must weigh:

- the risks associated with the anaesthetic;
- current comorbidities;
- anticipated adverse events, particularly cognitive impairment;
- the risks of not having the treatment.

It gives a procedure, not a set of barred conditions, which is itself evidence about where the guideline tradition sits.

The last element is the one a contraindication list silently omits, and it is why the modern position can be stated as risk quantification rather than prohibition: a patient in catatonic stupor who is not eating carries a risk from not being treated that no table of conditions records. The

cognitive limb belongs to this chapter's account of the cognitive side effects of ECT; owned here is the framework.

MNEMONIC

Two dates, four systems, one patient

Two dates: position two is 1980, position one is 2001 and later. **Four systems**: the Indian caution table runs cerebral, ocular, cardiac and neuromuscular, and the list is open. **One patient**: the single reported case treated with raised intracranial pressure already present is the whole of the direct evidence.

5.9 The anaesthetic considerations, and the consequence this item must point at

Every condition here is managed with the anaesthetist rather than adjudicated alone, which is what position one means in practice. The high anaesthetic-risk class in the Indian cardiac group is an anaesthetic judgement inside a psychiatric guideline, and managing the aneurysm patient's blood-pressure surge is an anaesthetic act. The evaluation and investigations, fasting and the medication review, pre-oxygenation and the airway, the induction agent and muscle relaxation in full all belong to this chapter's account of the pre-ECT workup and anaesthesia. No agent, no dose and no step of the sequence is restated here.

One consequence must be pointed at rather than left implied. A patient in whom a cerebrovascular event is managed rather than barred carries a neuromuscular-blockade consequence, and that consequence belongs in full to the workup and anaesthesia item, which states its window and grounds it.

RULE **Do not carry the word "recent" across from this item to the blockade question.** Recency here marks the cardiovascular and cerebral risk of the induced seizure, highest close to the event and falling with time. The neuromuscular-blockade risk after a cerebrovascular event does not run in that direction, and it is not discharged by the event ceasing to be recent. Nothing here says a patient is past the blockade risk because the stroke is old; that window is the workup and anaesthesia item's to state and ground.

Electroconvulsive therapy has two positions on contraindication and both are written with their dates: no absolute contraindication, from the task-force tradition of 2001 and the reviews following it, and the intracranial mass as an absolute bar, from the last large review before the modern literature in 1980, still standard teaching and a common key. The mechanism behind the older position is the induced rise in cerebral blood flow and intracranial pressure, and the chain from seizure to peritumoural oedema to neurological signs. The current Indian guideline files raised intracranial pressure under caution and instructs postponement rather than prohibition; every other high-risk condition is quantified and managed with the anaesthetist, each carrying its own modification.

Electroconvulsive therapy: technique and dose

6 · Pre-ECT workup and anaesthesia (agents, muscle relaxant, airway)

Modified ECT is a general anaesthetic given in order to induce a seizure, which puts most of the treatment's physical risk in the anaesthetic room rather than at the stimulus dial. The psychiatrist neither prescribes nor gives it, but selects the patient, orders the workup and reads a seizure the induction agent has shaped. What is examinable is what must be settled before a course, and when the usual relaxant must not be used.

Owned here: the evaluation and its investigations, fasting and the medication review, pre-oxygenation and the airway, the induction agents, neuromuscular blockade in full, the anticholinergic question, the tourniquet method, and recovery. Named but not re-derived: the seizure threshold and stimulus dose, which belong to this chapter's account of stimulus dosing; the conditions that raise risk beforehand, to the risk profile; the interactions, to concurrent medication.

2, 6, 8 HOURS OF FASTING FOR CLEAR LIQUIDS, LIGHT MEALS, AND FRIED OR FATTY FOOD	**7 to 10** DAYS AFTER A DENERVATING INJURY AT WHICH HYPERKALAEMIC RISK PEAKS	**Not mandatory** THE ROUTINE PRE-ECT BLOOD PANEL, PER THE CURRENT INDIAN GUIDELINE

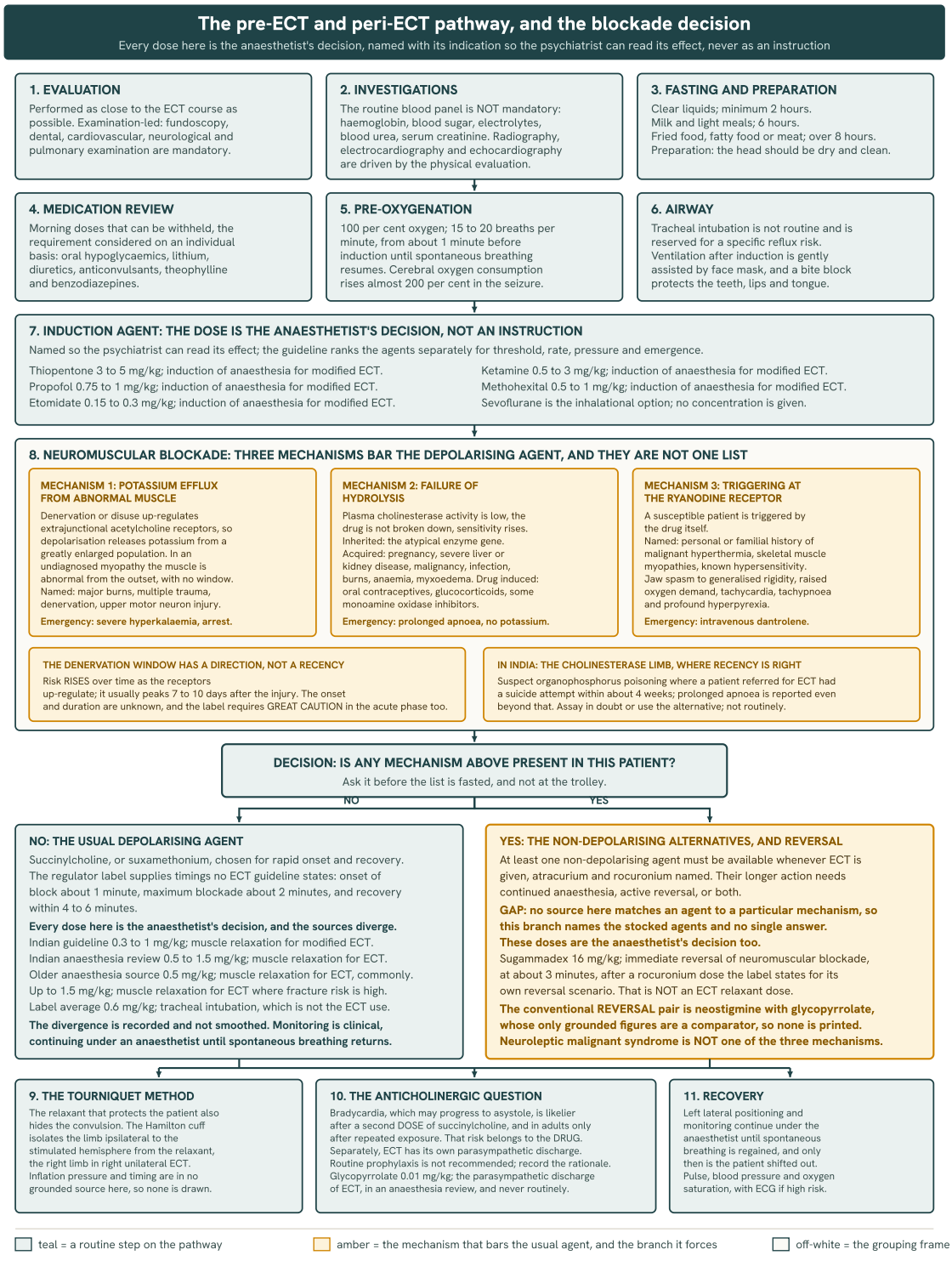


Fig 27.6. The pathway before and around a treatment, with neuromuscular blockade drawn as a decision rather than a default: on one branch the usual depolarising agent, on the other the non-depolarising agents that must be stocked, taken when any one of the three mechanisms named on the plate bars the depolarising agent. Three things are deliberately absent from that branch. No grounded source here matches a particular alternative agent to a particular barring mechanism, so it names the stocked class and declares the gap, not one drug. It carries no relaxant dose for any alternative agent, the one rocuronium figure being the reversal label's own antecedent and marked as not an ECT dose. And the neuroleptic malignant syndrome preference is not here, because it is not one of the three mechanisms and the item's text records that succinylcholine given for ECT in it is described as safe. Every dose shown is named with its indication as the anaesthetist's decision rather than as an instruction.

6.1 The evaluation before a course

The **pre-ECT evaluation** is a joint fitness-for-anaesthesia assessment whose first rule is timing: the guideline requires it be performed as close to the ECT course as possible, because a workup done weeks earlier certifies a patient who no longer exists.

The examination is asked as it stands. Fundoscopic examination is mandatory along with other systemic examinations, and so are dental evaluation for loose or missing teeth, cardiovascular examination for arrhythmias, assessment for neurological comorbidities and pulmonary clinical evaluation. Fundoscopy is the window on raised intracranial pressure, taken up by the risk-profile account; loose teeth matter because the masseter contracts whatever the relaxant does.

6.2 The investigations: what is required, and what is not

Candidates fail this by reciting a battery. The guideline states that for general anaesthesia haemoglobin, blood sugar, electrolytes, blood urea and serum creatinine would facilitate detection of common risk-enhancing comorbidities but are not mandatory, and radiography, electrocardiography, echocardiography and other tests are indicated on the physical evaluation.

RULE **Pre-ECT investigation is driven by the clinical evaluation, not by a fixed list.** The mandatory content sits in the examination, not the laboratory; the tests that earn a place are those a finding asked for, an electrocardiogram because an arrhythmia was heard, a potassium level because the relaxant question is live.

6.3 The morning of a treatment: fasting and the medication review

Fasting is graded by what was eaten, and the intervals are quoted, not recalled: ECT is given fasting, after **2 hours from clear liquids, 6 hours from milk and light meals, and over 8 hours from fried food, fatty food or meat**. The same guideline table adds one preparation step alongside the intervals, outside the passage quoted here: the head should be dry and clean for the procedure, which is a scalp and electrode-contact requirement and not a fasting one.

The review is drug by drug that morning. The morning dose of oral hypoglycaemics, lithium, diuretics, anticonvulsants, theophylline and benzodiazepines can be withheld, considered on an individual basis. The opposite list is forgotten: scheduled antihypertensives, thyroxine, antiemetics, antireflux drugs, antianginals, bronchodilators and anticholinergics should not be withheld and can be taken orally 2 hours before the procedure with small sips of water. Which drug moves the threshold belongs to concurrent medication.

6.4 In the suite: pre-oxygenation, the airway and what must be stocked

Pre-oxygenation answers a measured demand, because cerebral oxygen consumption increases almost 200% during the seizure, so the recommendation is ventilation with 100% oxygen at 15 to 20 breaths per minute, from approximately 1 minute before induction until spontaneous breathing resumes. Hyperventilation may prolong the seizure; its threshold effect belongs to stimulus dosing.

Intubation is not routinely required unless there are specific risk factors for reflux, ventilation after induction is gently assisted with a face mask, and a bite block protects the teeth, lips and

tongue. That source predates current consensus and is carried for want of a plainer one. The bite block is the step most often left out of an answer: the stimulus contracts the masseter by a route the relaxant misses. The room is stocked: at least one non-depolarising agent such as atracurium or rocuronium must be available alongside succinylcholine.

6.5 The induction agent: rankings that do not run in the same order

The induction agent decides how easily a seizure is obtained, how long it runs, how the circulation behaves and how fast the patient wakes, and the guideline gives these as separate rankings.

RANKING	ORDER AS THE GUIDELINE GIVES IT
SEIZURE THRESHOLD, PROCONVULSANT TO ANTICONVULSANT	ketamine, etomidate, methohexital, sevoflurane, thiopentone, propofol
PROPENSITY TO INCREASE HEART RATE	ketamine, methohexital, thiopentone, etomidate, propofol
PROPENSITY TO INCREASE MEAN ARTERIAL PRESSURE	ketamine, etomidate, methohexital, thiopentone, propofol
EMERGENCE TIME, LONGEST TO SHORTEST	ketamine, etomidate, thiopentone, methohexitone, propofol, sevoflurane

Read together they show the trade: ketamine sits at the proconvulsant end of the threshold ranking and the worst end of rate, pressure and emergence, and propofol the reverse on threshold, rate and pressure, with sevoflurane alone shorter than propofol on emergence. Each figure below is the anaesthetist's decision, named so the psychiatrist can read its effect on the seizure, never as an instruction.

- **Thiopentone.** 3 to 5 mg/kg for induction in modified ECT, owned by the anaesthetist and not taught here as a prescribing instruction: fast acting, reduces seizure duration less than propofol, increased arrhythmia risk.
- **Propofol.** 0.75 to 1 mg/kg for induction in modified ECT, owned by the anaesthetist: shortens seizure duration and raises the threshold, but better haemodynamic stability in cardiovascular risk, and quicker emergence, against injection pain.
- **Etomidate.** 0.15 to 0.3 mg/kg for induction in modified ECT, owned by the anaesthetist: prolongs seizure duration and may reduce the threshold, useful where it is high, against a hyperdynamic response, longer emergence and adrenocortical suppression.
- **Ketamine.** 0.5 to 3 mg/kg for induction in modified ECT, owned by the anaesthetist: seizure effect unclear with a modest enhancing effect, sedative and analgesic, against emergence phenomena, poorer haemodynamic stability and raised intracranial pressure.
- **Methohexital.** 0.5 to 1 mg/kg for induction in modified ECT, owned by the anaesthetist: the gold standard, whose problem in India is sparse availability.
- **Sevoflurane.** The inhalational option, comparable to thiopentone, useful where venous access is difficult, with better haemodynamic stability, enhancing muscle relaxation, and in

pregnancy reducing uterine contraction. Enhanced muscle relaxation is listed as a general advantage of the agent, not as a property of its use in pregnancy. The guideline gives no concentration, so none is supplied.

Propofol with ketamine, called ketofol, can balance seizure duration against haemodynamic effect; short-acting opiates or dexmedetomidine spare dose but need more evidence in ECT; and the differential effects of anaesthetic agents are dependent on their dose. Calling an agent proconvulsant is therefore a statement about a dose.

6.6 Neuromuscular blockade, part one: the depolarising agent

Succinylcholine, or suxamethonium, is the depolarising blocker for modified ECT, chosen for rapid onset and recovery. The label supplies timings no ECT guideline states: blockade develops in about 1 minute, maximum blockade may persist about 2 minutes, and recovery follows within 4 to 6 minutes. Read the middle figure as the label writes it: what persists for that interval is the MAXIMUM of the block and not the block itself, so nothing on this page promises breathing when it elapses. Its average of 0.6 mg/kg is for tracheal intubation, not ECT, an indication owned by anaesthetic practice and named only so it is never taken for ECT. Monitoring is clinical: it continues under an anaesthetist until spontaneous breathing is gained.

The ECT dose is not agreed, and the divergence is recorded, not smoothed. The Indian psychiatry guideline gives **0.3 to 1 mg/kg** for relaxation in modified ECT, owned by the anaesthetist. An anaesthesia review gives **0.5 to 1.5 mg/kg** for relaxation in ECT, also owned by the anaesthetist. An older one gives 0.5 mg/kg as the commonest relaxant dose in ECT, owned by the anaesthetist, and alone names who needs more: up to 1.5 mg/kg for relaxation in ECT in severe cachexia, osteoporosis or skeletal injury, owned by the anaesthetist. Fragile bones need more relaxation, not less.

6.7 Neuromuscular blockade, part two: the mechanisms that bar the depolarising agent

The situations that contraindicate a depolarising blocker do not share a mechanism, and the difference is not academic, because the emergency each produces is treated differently. The routes are potassium efflux from abnormal muscle, driven after denervation or disuse by up-regulated **extrajunctional acetylcholine receptors**; failed hydrolysis where **plasma cholinesterase**, or pseudocholinesterase, is deficient; and ryanodine-receptor triggering in **malignant hyperthermia**. One hyperkalaemia story across all three prepares the wrong emergency.

MECHANISM	WHAT GOES WRONG	CONDITIONS NAMED, WHICH IS NOT A CLOSED LIST	THE EMERGENCY
POTASSIUM EFFLUX FROM ABNORMAL MUSCLE	Receptors up-regulate after denervation or disuse, so depolarisation releases potassium from a greatly enlarged population; in an undiagnosed myopathy the muscle is abnormal from the outset	Major burns, multiple trauma, extensive denervation of skeletal muscle, upper motor neuron injury; the label adds chronic abdominal infection, subarachnoid haemorrhage, degeneration of the nervous systems	Severe hyperkalaemia which may result in cardiac arrest
FAILURE OF HYDROLYSIS	Plasma cholinesterase activity is diminished, the drug is not broken down, and sensitivity rises	Genetic abnormalities of plasma cholinesterase; pregnancy, severe liver or kidney disease, malignancy, infection, burns, anaemia, myxoedema; oral contraceptives, glucocorticoids, certain monoamine oxidase inhibitors, organophosphate insecticides	Prolonged block with apnoea. No potassium is involved, and no grounded source here states the management, so none is printed
TRIGGERING AT THE RYANODINE RECEPTOR	A susceptible patient is triggered by the drug	Personal or familial history of malignant hyperthermia, skeletal muscle myopathies, known hypersensitivity	Masseter spasm progressing to generalised rigidity, increased oxygen demand, tachycardia, tachypnoea and profound hyperpyrexia, treated with intravenous dantrolene sodium as an adjunct to supportive measures

The potassium mechanism reaches a patient by more than one route, and their timing differs. After denervation or disuse the receptors must change first, so a window opens and widens. In an undiagnosed myopathy there is none: the boxed warning records rare reports of acute rhabdomyolysis with hyperkalaemia, ventricular dysrhythmias, cardiac arrest and death after succinylcholine in apparently healthy paediatric patients later found to have undiagnosed skeletal muscle myopathy, most frequently Duchenne muscular dystrophy, which bears on the adolescent treated under the statutory gate for minors that the Mental health legislation and forensic psychiatry notes carry. Where potassium is already high no receptor change is needed: the label directs great caution in electrolyte abnormalities and digitalis toxicity, because succinylcholine may then cause cardiac arrest due to hyperkalaemia.

RULE **The hyperkalaemic danger of a denervating insult RISES over time as receptors up-regulate, so recency is not the marker of safety.** Note what the label does NOT say: it does not certify the early period as low risk. It requires GREAT CAUTION during the acute phase and contraindicates the agent after it, so both phases carry an instruction and neither is a clearance. The label states the direction plainly: the risk increases over time and usually peaks at 7 to 10 days after the injury, depends on its extent and location, and its precise onset and duration are not known. The contraindication matches, applying after the acute phase of injury. Since the duration is unknown, this account teaches direction and peak and prints no date of safety.

TRAP **Reading a hemiplegic patient's blockade risk off the recency of the stroke inverts the window and clears exactly the wrong patient.** The recency wording attached to a cerebrovascular or cardiac event in this chapter's account of the risk profile concerns the risk of the induced seizure, highest close to the event. Blockade risk runs the other way. Letting one set the other refuses the relaxant before the receptors have up-regulated, where the label still requires great caution and prints no interval of safety, and hands a depolarising agent to the established hemiplegic in whom danger has built for weeks.

MNEMONIC

POTASSIUM, PROLONGED, PYREXIA

One P for each mechanism, and none shares an emergency with another. **Potassium** is the denervation, disuse and abnormal-muscle route, ending in hyperkalaemic arrest. **Prolonged** is the cholinesterase route, where the emergency is prolonged apnoea and no source here states its management. **Pyrexia** is malignant hyperthermia, treated with dantrolene. The mechanisms are the whole set; the conditions inside each are not, so a patient absent from a list has not been cleared.

IN INDIA

The cholinesterase mechanism has an Indian limb, and is the one place recency is the right marker. Where a patient referred for ECT has a suspected or known suicide attempt within 4 weeks, organophosphorus poisoning should be suspected; prolonged apnoea is reported even after 4 weeks; the pseudocholinesterase level may be assessed in doubt or a non-depolarising agent used; routine determination is not recommended. In renal disease, non-depolarising agents can be preferred, and in haemodialysis patients potassium should be done within 24 hours before ECT. Note the strength difference. the guideline frames its list, adding severe widespread burns, hypercalcaemia and severe neuromuscular disease, as situations in which non-depolarising relaxants may be considered, while the label states several as contraindications.

6.8 Neuromuscular blockade, part three: the alternatives and their reversal

A contraindication is useful only with a replacement, and here the replacement is a class rather than a name. The **non-depolarising blockers** named for ECT are atracurium, mivacurium and rocuronium, whose shared cost is that their relatively prolonged action will need continued anaesthesia, active reversal after treatment, or both. What the guideline settles is stock and not selection: at least one non-depolarising agent such as atracurium or rocuronium must be available alongside succinylcholine.

TRAP **Answering "which agent replaces succinylcholine" with a single drug name.** The three barring mechanisms are not one list, and no source carried in this chapter matches a particular alternative to a particular mechanism, so no one agent can be the answer to all three. The honest answer names the class, says at least one member must be stocked, and leaves the choice within it to the anaesthetist on the mechanism in front of them. Naming one agent silently answers the cholinesterase-deficient patient too, which is the limb where a wrong choice reproduces the prolonged block the substitution exists to avoid.

One agent is reported as the usual practical choice, and it is named as that rather than as the answer to a mechanism. Mivacurium is the drug most often administered as an alternative to succinylcholine during ECT, which is a statement about ECT practice in general and not about which mechanism has barred the depolarising agent in the patient in front of you. Its figures follow for that reason alone. Seizure modification is inadequate at 0.08 mg/kg of mivacurium for relaxation in ECT, owned by the anaesthetist and quoted only for what follows. At least 0.15 mg/kg should be used for relaxation in ECT, owned by the anaesthetist, because a dose trimmed to shorten the block buys an unmodified convulsion under a patient who looks paralysed. A second source disagrees with that figure rather than supporting it, and the disagreement is the honest state: only a full intubating dose, 0.2 mg/kg, gave effective relaxation during ECT, and higher doses caused histamine release and hypotension. Read the two together as a range of opinion on what is adequate, never as one figure evidencing the other. Atracurium at 0.5 mg/kg needed more time to reach a satisfactory train-of-four ratio.

Reversal changed that. Rocuronium and vecuronium were generally given only as precurarising agents, but could theoretically be used with sugammadex. **Sugammadex** encapsulates the relaxant rather than inhibiting an enzyme: 16 mg/kg is recommended where blockade must be reversed soon, approximately 3 minutes after a single 1.2 mg/kg dose of rocuronium, owned by the anaesthetist, and that timing is what makes the alternative usable. Its one reported use in ECT is a single case, never a schedule: the train-of-four ratio recovered to 0.9 within 2 minutes and the first breath within 3 minutes. The conventional REVERSAL pair, which is not a relaxant, is neostigmine with glycopyrrolate, whose only grounded figures are a trial comparator and are not printed. Read the next sentence against that distinction, because the preference belongs to the relaxant and not to the reversal: after neuroleptic malignant syndrome it is rocuronium with sugammadex that is called the more promising method of muscle relaxation, although the same source states that evidence is lacking for a shared pathophysiology with malignant hyperthermia and that succinylcholine given for ECT in it is safe: caution, not a proven contraindication.

GOOD TO REMEMBER

Ask the relaxant question before the list is fasted, not at the trolley. Is there a denervating or disuse lesion, and how long ago was the insult, remembering that risk RISES toward the peak this page states in the rule above and that the acute phase carries its own caution, so recency is not safety in either direction? What may have lowered cholinesterase: organophosphate, liver or renal disease, pregnancy, a family history of prolonged apnoea? Has anyone in the family had malignant hyperthermia?

6.9 The anticholinergic question

Two separate routes slow the heart here and the sources attach them to different things. The first is the stimulus: an anaesthesia review names an initial parasympathetic discharge of ECT as what an anticholinergic is given to antagonise. The second belongs to the drug, not to the stimulus: the incidence of bradycardia, which may progress to asystole, is higher after a second dose of succinylcholine; in adults it is seen only after repeated exposure; and pretreatment with an anticholinergic such as atropine may reduce bradyarrhythmias. Read the second as a dose effect, because that is what the label describes: it says nothing about a second electrical stimulus. A restimulation may carry both, a further discharge and, where a second dose of relaxant is given with it, the label's raised bradycardia risk, and that is why the session that goes to restimulation is a cardiac event as well as an electrical one.

The guideline settles it against routine use. Routine prophylactic use of anticholinergics such as atropine or glycopyrrolate, and of beta blockers, calcium channel blockers, nitrates, hydralazine and ganglionic blockers for cardiovascular stability, is not recommended, and wherever used the rationale should be noted. An anaesthesia review is permissive: glycopyrrolate at 0.01 mg/kg is preferred to antagonise the initial parasympathetic discharge of ECT, intramuscularly at least 3 minutes before the procedure or intravenously just before induction, owned by the anaesthetist and named only so the psychiatrist recognises what is given. It benefits patients on beta blockers and those whose threshold is unset.

6.10 The tourniquet method, recovery and monitoring

The **Hamilton cuff method** exists because the relaxant that protects the patient from a convulsion also hides it. It monitors motor seizures by isolating the ipsilateral limb from muscle relaxants, the right limb in right unilateral ECT, and is preferred in modified ECT because it indicates generalisation. The inflation pressure and its timing are in no grounded source.

Recovery is physiological, not timed. Left lateral positioning and monitoring in the suite continue under an anaesthetist until spontaneous breathing is gained, and only then is the patient shifted to the recovery room. There, pulse rate, blood pressure and oxygen saturation are monitored, with the electrocardiogram in high-risk patients, the example being cardiac disease. Postictal confusion is measured, not waited out: orientation and gait are assessed for recovery to baseline or near baseline before shifting the patient out.

Recovery is a staffed competency, not a room. The guideline specifies a recovery nurse trained in post-anaesthesia care, able to monitor vital signs, pulse oximetry and electrocardiogram, give oxygen, fluids and suction, and support disorientation, delirium or agitation.

The evaluation is done as close to the course as possible and is examination-led: fundoscopy, dental, cardiovascular, neurological and pulmonary examination are mandatory, the blood panel is not, imaging and cardiac tests are indication driven. Fasting is graded at 2, 6 and 8 hours. The induction agent is chosen against separate rankings, ketamine proconvulsant but worst for rate, pressure and emergence. Succinylcholine is the usual relaxant, barred by separate mechanisms whose emergencies differ: potassium efflux from abnormal muscle, failed cholinesterase hydrolysis producing apnoea, and ryanodine triggering treated with dantrolene. Denervation risk RISES over time, with the onset and the duration expressly unknown and great caution required in the acute phase too, and peaks at 7 to 10 days, so recency is never the marker there. A non-depolarising agent must be stocked and never under-dosed.

7 · ECT technique and electrode placement (bilateral, right unilateral, bifrontal)

Two things are decided before any current flows in electroconvulsive therapy: where on the head the two electrodes sit, and what shape of electricity passes between them. The placement is fixed entirely by bony landmarks; the waveform and the electrical parameters fix what the stimulus contains; the impedance test says whether the circuit on the head is the one intended, and the monitoring says what the brain did with it.

Owned here in full and defined nowhere else: each electrode placement with its landmarks and geometry, the stimulus waveform, the electrical parameters that define a stimulus, impedance testing, and the monitoring of the induced seizure. Named and never re-derived, each with its own account elsewhere in this chapter: the comparison between the placements, a dose-dependent trade-off, in the notes on bilateral against right unilateral treatment; the threshold, titration and the adequate-seizure criteria, in the notes on stimulus dosing; the amnesias, in the notes on cognitive side effects; the anaesthetic conduct, in the notes on the pre-ECT workup.

three	four	100 to 3000
MEMBERS OF THE BILATERAL CLASS IN THE CURRENT INDIAN GUIDELINE	ELECTRICAL PARAMETERS THAT TOGETHER DEFINE A STIMULUS	OHMS: THE STATIC IMPEDANCE WINDOW ON ONE NAMED DEVICE

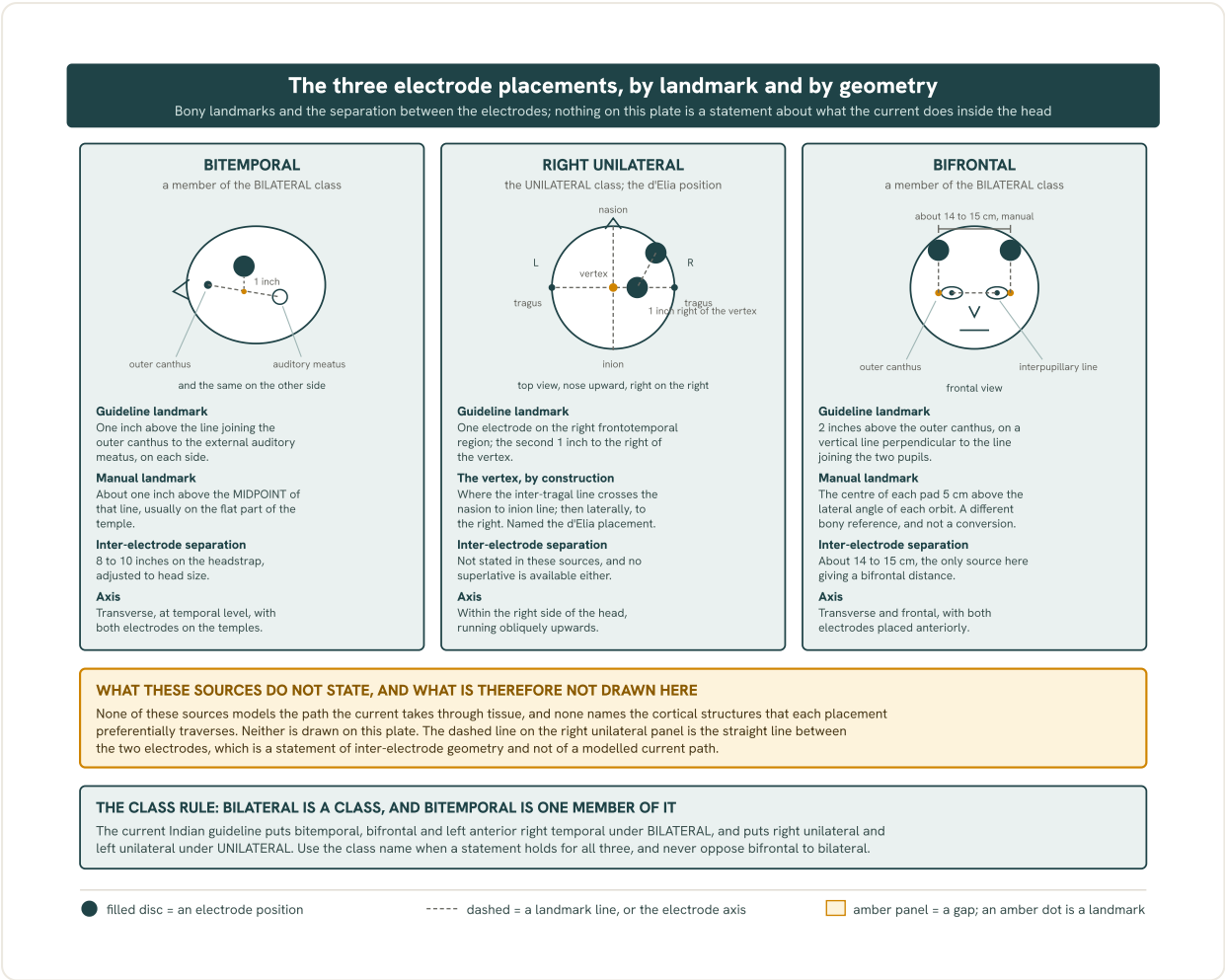


Fig 27.7. The three placements drawn by their bony landmarks and by the separation between their electrodes: bitemporal one inch above the line from outer canthus to external auditory meatus, and above the midpoint of that line in the device manual, with the electrodes eight to ten inches apart on the headstrap; right unilateral in the d'Elia position, one electrode right frontotemporal and the second one inch to the right of the vertex, the vertex itself constructed from the inter-tragal line crossing the nasion to inion line; and bifrontal two inches above the outer canthus in the guideline, five centimetres above the lateral angle of the orbit in the manual and about fourteen to fifteen centimetres apart, two measurements against two bony references rather than one figure converted, with bitemporal and bifrontal both members of the bilateral class, and no current path or traversed cortical structure drawn because no source here states one.

7.1 Bilateral is a class of placements, not one placement

The taxonomy must be right before any landmark is learnt, because every later comparison is phrased in it. The current Indian guideline classifies placements under two headings, Bilateral and Unilateral. Bilateral has three members: bitemporal, bifrontal and left anterior right temporal. Unilateral has two: right unilateral and left unilateral. **Bilateral** therefore names a class; **bitemporal** is one member of it, not a synonym for it.

The consequence is what gets examined. **Bifrontal** is a bilateral placement, not a third option outside the bilateral class. Written the other way it makes the placement comparison unreadable, since a sentence contrasting bilateral with bifrontal contrasts a class with one of its members. That comparison belongs to the notes on bilateral against right unilateral treatment; this fragment answers only the prior question, which is what each placement physically is.

RULE **Bilateral is the class; bitemporal, bifrontal and left anterior right temporal are its members.** Use the class name when a statement holds for all three and the member name when it does not, and never oppose bifrontal to bilateral. The guideline's numbered headings are the authority, not usage.

7.2 Bitemporal: the classical placement

The Indian guideline of 2023 calls bitemporal the classical method and defines it by one line on the face: an electrode in the frontotemporal region, one inch above the imaginary line joining the outer canthus and the external auditory meatus, and the same on the other side.

The guideline does not say which point on that line is meant. The manufacturer's manual does, and adds the separation: about one inch above the mid-point of that line, usually on the flat part of the temple, with the electrodes **8 to 10 inches** apart on the perforated headstrap, by head size. The guideline gives the height above the line, the manual the point on it and the distance; neither is complete alone.

7.3 Right unilateral in the d'Elia position

The right unilateral montage is two points far apart, the second defined by a construction rather than by a bone. One electrode sits on the right frontotemporal region and another 1 inch to the right of the vertex, the vertex being where two imaginary lines cross, one joining the two tragi and the other joining nasion to inion. The construction is examinable in itself: inter-tragal line, nasion to inion line, their crossing, then laterally to the right.

The manual states the eponym: for right unilateral placement the d'Elia placement is recommended. The same manual carries the conduct, which is not incidental: the skin over the right temple is cleaned and dried and the pad applied to bare skin, then the hair near the vertex is parted and the scalp moistened thoroughly with saline. Hair lies under one of these electrodes and not the other, which is why the saline step attaches to the vertex electrode and why that is the one that misbehaves on the impedance check.

7.4 Bifrontal, and two landmarks that must not be merged

Bifrontal puts both electrodes over the frontal regions, and two independent statements of where are carried here. The Indian guideline puts them 2 inches above the outer canthus, on an imaginary vertical line perpendicular to the line joining the two pupils. The device manual puts the centre of each pad 5 cm above the lateral angle of each orbit, about 14 to 15 cm apart, the only source here giving a bifrontal inter-electrode distance.

These are two measurements, not one measurement in two dresses. The units differ and the bony reference differs with them: the outer canthus is the soft-tissue corner of the eye, the lateral angle of the orbit a point on bone. They land close together on a real head and remain separate quotations from separate documents. Nothing here converts one into the other, because a converted figure is an arithmetic step by the author rather than a quotation, putting on the page a number that neither source states.

PITFALL

Converting the bifrontal landmark out of one source's units into the other's and reporting the result as though a guideline had said it. Both are printed against their own bony references, so the reader can quote whichever document a question asks about. The same discipline governs every parameter here: quote the source, name it, and neither average nor convert between sources.

7.5 What the landmarks fix, and what they do not

Geometry is what a landmark buys. Bitemporal puts both electrodes on the temples, so the axis between them runs transversely at temporal level; bifrontal puts both anteriorly, so the axis is transverse and frontal; right unilateral puts one at the right temple and the other just right of the vertex, so the axis lies within the right side of the head and runs obliquely upwards, and the wide separation is what makes this the long-distance montage over the non-dominant side.

What these sources do not state matters as much, because the temptation is to supply it from memory: none models the path the current takes through tissue, and none names the cortical structures each placement preferentially traverses.

AXIS	BITEMPORAL	RIGHT UNILATERAL	BIFRONTAL
CLASS	Bilateral	Unilateral	Bilateral
GUIDELINE LANDMARK	One inch above the line from outer canthus to external auditory meatus, each side	Right frontotemporal, plus 1 inch right of the vertex	2 inches above the outer canthus, on the perpendicular to the interpupillary line
MANUAL LANDMARK	About one inch above the mid-point of that line	Named as the d'Elia placement; vertex scalp moistened	Centre of each pad 5 cm above the lateral angle of the orbit
SEPARATION CARRIED HERE	8 to 10 inches	Not stated in these sources, and no superlative is available either: both separations that ARE stated, in the bitemporal and bifrontal columns of this row, exceed the span from a right temple electrode to a point one inch right of the vertex	About 14 to 15 cm

7.6 Waveform: sine wave, brief pulse, ultrabrief pulse

The **stimulus waveform** is the shape of the electricity in time. The original sine-wave stimulus had a long pulse width of 8.3 ms and was inefficient, using more energy than neurons require in order to discharge; the square-wave brief pulse of 0.5 to 1.5 ms that replaced it reduced cognitive side effects while keeping efficacy. The Indian guideline states the modern position as a recommendation, not as history: a brief or ultrabrief pulse is strongly recommended and should

be given with a constant current device, and sine-wave and constant voltage systems are not recommended in modern practice, on safety grounds.

The bands are where the sources disagree, so each is stated with its body. The Indian guideline of 2023 defines brief pulse as 0.5 to 2 ms and ultrabrief as 0.2 to 0.4 ms. The Australian and New Zealand college guideline of 2019 defines brief pulse as 0.5 to 2.0 ms and ultrabrief as 0.25 to 0.3 ms. The two GUIDELINE brief-pulse bands agree, as the two quoted sentences above show, and it is that agreement and no wider one that may be claimed: a third and narrower brief-pulse upper bound, from a meta-analysis, appears elsewhere in this chapter, so a candidate who memorises the narrowest answers wrong against both guidelines. The ultrabrief bands do not agree at all. An answer giving any one band as the definition without naming its body has adopted a source silently.

The guideline attaches a relation to pulse width, and it holds for pulse width only. Pulse width is likely to have a linear effect on cognitive adverse effects, broader widths being associated with worse ones; an ultrabrief pulse of 0.3 ms has a cognitive advantage over brief pulses with right unilateral placement in depressive disorders, though antidepressant efficacy may be compromised with it; and a lower brief-pulse range of 0.5 to 1 ms may be considered optimal for a rapid clinical effect. The college guideline bounds where that has been shown: for ultrabrief bilateral treatment the published evidence is very limited and efficacy is lower than with brief-pulse bilateral treatment. Both are statements about pulse width inside a placement, and neither licenses carrying this direction across to another parameter. No comparison between placements is made here.

7.7 The four parameters, and why charge alone is not the dose

A stimulus is a tuple, not a number. The arithmetic comes first: electrical charge = current intensity x pulse width x pulse frequency x train duration. The guideline then warns against the natural misreading of its own equation. Charge is generally treated as a linear measure and the chief parameter of dosing, but that approach is faulty: the four parameters in combination, along with electrode placement and the frequency and duration of sessions, are what should be considered in choosing a protocol. Two stimuli of equal charge built from different parameters are different stimuli.

Current intensity is the parameter that is not moved. Historically 500 to 1000 mA has been used, most devices default to 800 to 900 mA, and current correlates linearly with tolerability, cognitive effects and seizure quality, but is held constant during dose incrementation. Low-amplitude stimulation is named in the same paragraph as investigational, its clinical utility yet to be understood; that status is the teaching point and no current band for it is carried.

Pulse frequency is the counterintuitive one. It is the number of biphasic pulses per second, the inverse of the interpulse interval, ranging from 20 to 240 pulses per second, that is 10 to 120 Hz of bidirectional pulse pairs. Lower frequencies are more efficient: a seizure is elicited at a lesser charge with a lower frequency when all else is held constant. That sits awkwardly beside how

devices behave: many increment the dose by raising frequency, so the default increment works against efficiency in the patient whose threshold is already high.

Train duration is the parameter that is moved. It is the most commonly modified parameter for setting the dose; most devices offer 0.2 to 8 s and some up to 16 s; no limit has been examined or recommended for the highest duration; and charge is raised by lengthening the train until the device's limit is reached. What multiple of the measured threshold that charge should be belongs to the notes on stimulus dosing.

MNEMONIC

CURRENT, WIDTH, RATE, TRAIN

The four parameters in the order of the charge equation. **Current** is held constant. **Width** names the waveform brief or ultrabrief. **Rate** is more efficient when lower, the opposite of the intuition. **Train** is the one moved to change the dose.

7.8 One device's specification, read as a device's

Hardware bounds the tuple. One widely used constant-current device specifies a 0.9 A constant current limited to 450 V; 10 to 70 Hz in 10 Hz increments, extending to 140 Hz in the low pulse-width programs; a pulse width of 0.25 to 1.5 ms in 0.25 ms increments, with 0.3 ms available; a train duration of 0.08 to 8.00 s; and a standard maximum output across 220 ohms impedance of 504 mC, that is 99.8 joules.

TRAP **Quoting a device's maximum output, or any of its bounds, as a universal figure.** Every value above belongs to one named device at one revision of its manual; another device has other bounds. The guideline bands for pulse width are the general statement; a specification is not. Write the device's name beside its numbers, or do not write them.

7.9 Impedance: static, dynamic, and why the check is not housekeeping

Two impedances are measured and they are not the same measurement. Stimulation has to overcome the combined resistivity of scalp, skull and other tissues. Static impedances are measured before stimulation using high-frequency alternating pulses, dynamic impedances during passage of the stimulation current, and static impedance can partly be influenced by skin preparation. **Static impedance** is thus the pre-stimulus check the operator can act on, **dynamic impedance** a property of the treatment itself.

The static test has a window and an interpretation at each end. It checks the quality of the skin-to-electrode contact; on one named device the reading should be greater than 100 ohms and less than 3000 ohms before the stimulus is administered, and a reading below 100 ohms suggests a short circuit, probably in the stimulus cable. The ends fail differently: too low says the current has found a path that is not the patient, too high that it will struggle to find one.

The check earns its place because contact quality reaches the seizure. In a single-centre retrospective analysis of 78 patients across 1757 bifrontal sessions from 2012 to 2020, static and dynamic impedance were strongly correlated, and dynamic impedance was significantly related

to Maximum Sustained Power and to the Average Seizure Energy Index but to no other seizure quality criterion; aiming for low static impedance might reduce dynamic impedance, so good skin preparation is recommended. The design bounds the claim: retrospective, one centre, bifrontal treatment only.

GOOD TO REMEMBER

A high static reading calls for a sequence, not a shrug.

- Press each electrode firmly against the skin again, especially the vertex electrode in unilateral treatment.
- Moisten the hair and scalp under the vertex electrode with saline.
- Recheck the skin preparation steps.
- Only then replace the pads, the lead-wires and the stimulus cable, in that order.

7.10 Monitoring the induced seizure

Three records are taken of one event: cortical, muscular and cardiac. What the guideline requires at the station is specific. Vitals monitoring calls for a sphygmomanometer, a reflex hammer, oxygen saturation and ECG, alongside the apparatus with its bite block and the electroencephalogram and ECG monitors.

For the cortical record the montage is specified. The electroencephalogram is a direct measure of seizure activity and is recommended wherever available; bilateral recording from at least two channels, FP1 and FP2, referenced to the ipsilateral mastoid is preferred, and where only one channel is available a contralateral channel is preferred. The fallback is contralateral because a channel over the non-stimulated side is the one that can show generalisation.

The motor record is neither optional nor a substitute. Electroencephalogram recording can carry artefacts from muscle movement and from technical problems, so motor monitoring should always supplement it. The instrument for seeing a motor seizure in a relaxed patient is the isolated-limb method: the Hamilton cuff method is recommended for monitoring motor seizures by isolating the limb ipsilateral to the stimulated hemisphere, the right limb in right unilateral treatment, from the muscle relaxant. The side is the point of the method, not a detail of it: a convulsion in the limb ipsilateral to the stimulated hemisphere is evidence that the seizure crossed to the other hemisphere and generalised. The cuff as anaesthetic conduct belongs to the notes on the pre-ECT workup; only its use as an instrument for reading the seizure is taught here.

A modern device consolidates this onto one trace, with four recording channels: 1 and 2 for the electroencephalogram, 3 for the electromyogram and 4 for the ECG. From those it computes named indices, the postictal suppression index with a range of 0 to 100 per cent, the average seizure energy index, maximum sustained electroencephalogram power and coherence with the time to peak of each, the Duke University measures, power spectral analysis, and peak heart rate. The range of the suppression index is grounded; no threshold on it is, and none is invented. What counts as an adequate seizure belongs to the notes on stimulus dosing.

IN INDIA

The current Indian Psychiatric Society guideline, published in 2023, settles four choices on this page: a brief or ultrabrief pulse from a constant current device; the placement landmarks quoted above, bifrontal among them in inches; a two-channel electroencephalogram referenced to the ipsilateral mastoid; and motor monitoring always supplementing it. Where a device manual or a college guideline states a different figure, name the document beside it.

Bilateral is a class containing bitemporal, bifrontal and left anterior right temporal; unilateral contains right unilateral and left unilateral. Bitemporal sits one inch above the line from outer canthus to external auditory meatus, above its mid-point in the manual; right unilateral is the d'Elia position, right frontotemporal plus one inch right of the vertex; bifrontal is two inches above the outer canthus in the guideline and five centimetres above the lateral angle of the orbit in the manual, two statements and not a conversion. A stimulus is current intensity, pulse width, pulse frequency and train duration together, and the seizure is read on the electroencephalogram, on an isolated limb and on the ECG at once.

8 · Bilateral versus right unilateral ECT (efficacy versus cognitive trade-off)

The choice between a bilateral placement and right unilateral placement is the decision in a course of electroconvulsive therapy most often carried in memory as a fixed ranking, and a fixed ranking is the one thing it is not. Whether right unilateral treatment is as good as bilateral treatment has no answer until the dose is named, because the two have different dose-response relations. Written as a ranking the comparison is memorable and clinically false; written as a function of the multiple of seizure threshold it is correct and usable.

Owned here in full: the trade-off between efficacy and cognitive cost across the placements, the evidence base behind it, where bifrontal placement sits within it, and how the choice is made for a given patient. Named here and not re-derived, each with its own account in this chapter: what each placement is, with its landmarks, geometry and current path; what the seizure threshold is and how it is titrated; and the amnesias themselves, their course and their monitoring. This account states only how placement and dose move that cognitive cost, never what the cost consists of.

17% against 65%	792	6 times
RESPONSE NEAR THRESHOLD, RIGHT UNILATERAL AGAINST BILATERAL, IN THE TRIAL THAT SEPARATED DOSE FROM PLACEMENT	PATIENTS IN THE POOLED COMPARISON FINDING NO DIFFERENCE ONCE THE MULTIPLE IS HIGH	THRESHOLD, ABOVE WHICH RIGHT UNILATERAL PLACEMENT NO LONGER HOLDS A COGNITIVE ADVANTAGE OVER BITEMPORAL

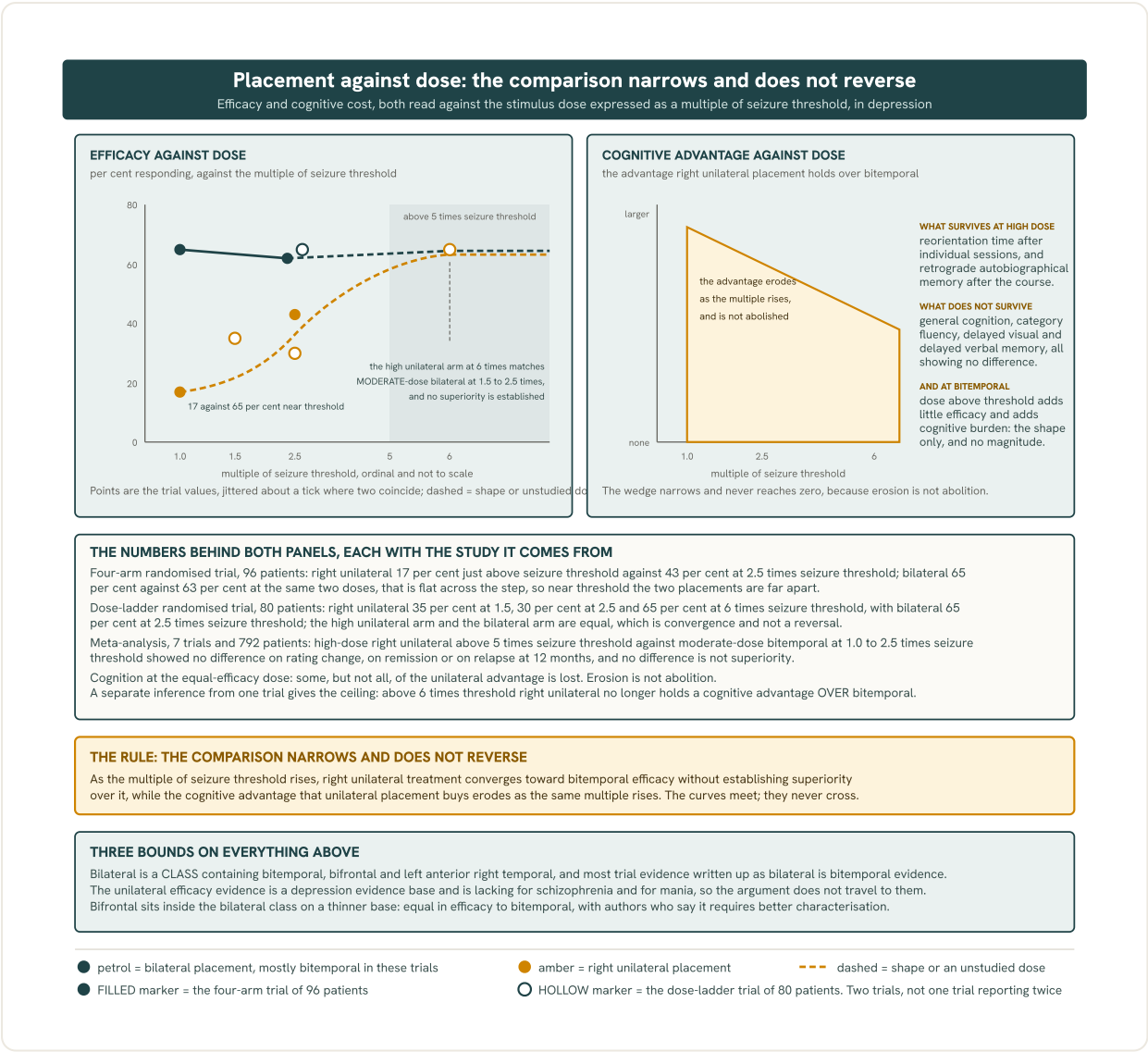


Fig 27.8. Efficacy and cognitive cost read as functions of the stimulus dose expressed as a multiple of seizure threshold, rather than as a fixed ranking of the placements. On the left, bilateral response is already near its maximum at a low multiple and stays flat, while right unilateral response is markedly inferior near threshold and rises to meet it at six times seizure threshold, so the two lines converge and never cross and no superiority of right unilateral over bitemporal placement is established. Read the meeting point precisely, because the geometry invites a stronger claim than the evidence carries: no bilateral arm in any trial here was dosed above two and a half times threshold, so the bilateral line is drawn solid only across the doses actually studied and dashed beyond them, and the match at six times is high-dose right unilateral against MODERATE-dose bilateral rather than two arms compared at the same dose. On the right, the cognitive advantage that unilateral placement buys narrows as the same multiple rises but is not abolished, surviving in reorientation time and in retrograde autobiographical memory and not in general cognition, category fluency or delayed visual and verbal memory. Both halves are stated together, and all of it is a depression evidence base.

8.1 Bilateral is a class of placements, not a placement

The terminology has to be settled before the comparison can be read, because two words are used across this literature as though they were interchangeable and they are not. **Bilateral** is a class of placements, and it has three members, not two: the current Indian guideline lists **bitemporal**, **bifrontal** and left anterior right temporal placement under the bilateral heading. Bitemporal is one member of it. Bifrontal is another member of the same class, so it is not a third option sitting outside a bilateral pair, and the word pair is itself the error, because the class is a set of three. Left anterior right temporal placement is the member most often dropped from an answer, and

dropping it is how a candidate ends up with a two-member class. What each placement is, where its electrodes sit and which way the current runs, is taught in this chapter's account of the placements themselves and is not restated here.

The distinction earns its place because of what it does to the numbers. Most of the trial evidence written up as bilateral is bitemporal evidence: the programmes used the standard bitemporal montage and their reports call it bilateral. A figure carried under the class word is a class-level figure and stays one. Every claim below names which of the two its evidence rests on; evidence about bilateral electroconvulsive therapy is never read here as evidence about bitemporal placement; and no class-level effect size is attached to bifrontal or to bitemporal individually. Where a source pooled the class and never reported the split, the within-class breakdown is not carried here and is recorded as a declared gap, because an inferred breakdown would be indistinguishable on the page from a measured one.

EVIDENCE	LABEL THE SOURCE USES	WHAT THE CLAIM RESTS ON
THE FOUR-ARM DOSE-BY-PLACEMENT TRIAL	Bilateral	Bitemporal, since that programme used the standard bitemporal montage: bitemporal evidence under the class word
THE TRIAL OF HIGH-DOSE RIGHT UNILATERAL AGAINST A ROBUST BILATERAL COURSE	Bilateral	The class; the comparator is not separated into its members, so no figure from it is narrowed here
THE 2017 META-ANALYSIS OF CONVERGENCE AND RESIDUAL COGNITIVE ADVANTAGE	Bitemporal	Bitemporal, named as such by its authors, which makes it the cleanest source here
THE 2003 META-ANALYSIS OF BILATERAL AGAINST UNILATERAL	Bilateral	The class, pooled across doses: class-level and dose-mixed on both axes
THE BIFRONTAL META-ANALYSIS	Bifrontal, bitemporal and right unilateral, separately	The three named separately, which is why it is used here for bifrontal

8.2 Near threshold the two placements are far apart

The bottom of the dose range is anchored by one double-blind randomised trial, and its design is what makes it decisive. 96 depressed patients were assigned to right unilateral or bilateral treatment at either a low dose, just above the seizure threshold, or a high dose at 2.5 times the threshold. What the multiple of threshold is, and how the threshold beneath it is measured, belongs to this chapter's account of stimulus dosing and is taken as read.

The results are two relations and not one, which is the teaching point. For right unilateral placement the **dose-response relation** was steep: **17 per cent responded at the low dose against 43 per cent at the high dose**. For bilateral placement it was flat across the same step: **65 per cent at the low dose and 63 per cent at the high dose**. Near threshold, right unilateral treatment is markedly inferior and bilateral efficacy is already near its maximum. A later meta-

analysis states the settlement plainly: the effectiveness of right unilateral ECT depends on the strength of the electrical dose above the seizure threshold, and it is relatively ineffective at the doses nearer threshold, 1.0 to 2.5 times the seizure threshold, used in bitemporal ECT.

The asymmetry is stated per placement, and per placement is the only way it is true: with right unilateral placement, stimuli much higher than the seizure threshold are necessary for effective treatment, while in bilateral ECT they add little to efficacy while increasing the cognitive burden of the treatment. Two cautions travel with that sentence. It is an introductory assertion in a paper about thresholds, not the finding of a trial that randomised dose and measured cognition at bitemporal placement, so its shape may be taught and no magnitude attached to it. And its direction holds for this parameter only; no general law about work and cost is inherited from it anywhere in this chapter.

RULE **As the multiple of threshold rises, right unilateral treatment converges toward bitemporal efficacy without establishing superiority over it, while the cognitive advantage that unilateral placement buys erodes as the same multiple rises.** Both halves are said together or neither is said usefully. The first alone sells a high unilateral dose as free, which it is not, since the cognitive advantage is what is spent to buy the efficacy. The second alone sells it as pointless, which it is not, since a clinically meaningful advantage survives at the top of the range. The comparison narrows and does not reverse.

8.3 At a high multiple the comparison narrows

The convergence was established by a second double-blind randomised trial with a wider dose ladder. 80 depressed patients were randomised to right unilateral treatment at 50, 150 or 500 per cent above the seizure threshold, or to bilateral treatment at 150 per cent above it. Convert those before reading on, because the rest of this chapter speaks in multiples and the commonest error here is to read the largest of them as five times threshold rather than six: 50, 150 and 500 per cent above threshold are 1.5, 2.5 and 6 times threshold, and the bilateral arm at 150 per cent above threshold is 2.5 times it. **High-dose right unilateral and bilateral treatment were equal in response rate at 65 per cent, and roughly twice as effective as the low-dose arm at 35 per cent or the moderate-dose arm at 30 per cent**. That is convergence and not a reversal: the two placements meet, and no superiority of right unilateral treatment over bilateral treatment is established anywhere in it.

The pooled position agrees, and it is also the source that names its comparator properly. Seven trials and 792 patients compared high-dose right unilateral treatment, above 5 times the seizure threshold, with moderate-dose bitemporal treatment at 1.0 to 2.5 times threshold, and found no difference on depression rating change, with a Hedges's g of -0.03 and a 95 per cent confidence interval of -0.17 to 0.11; on remission, with a risk ratio of 1.06 and an interval of 0.93 to 1.20; or on relapse at 12 months, with a risk ratio of 1.42 and an interval of 0.90 to 2.23.

Two readings of that are wrong in opposite directions. No difference is not superiority: every interval straddles the null, so the wording is **convergence without established superiority**, and calling high-dose unilateral treatment better than bitemporal treatment goes past the evidence.

Nor is no difference an argument for a low unilateral dose, since the result is conditional on the high multiple.

8.4 What the higher multiple costs, and what it does not

The cognitive advantage is not free of the dose either, and the same meta-analysis states the erosion and its limit in one sentence, which is the form to reproduce: some, but not all, of the cognitive advantage of right unilateral ECT is lost when it is given at a dose sufficient to achieve equal clinical efficacy with bitemporal ECT. Erosion is not abolition, and that is why the placement is still chosen at a high multiple rather than abandoned once the efficacy gap closes.

What survives is domain-specific, and it is grounded in two domains and no others. Right unilateral treatment kept an advantage on reorientation time after individual sessions, a mean difference of -8.28 minutes with a 95 per cent confidence interval of -12.86 to -3.70, and on retrograde autobiographical memory after the completed course, a Hedges's g of -0.46 with an interval of -0.87 to -0.04, while there were no differences for general cognition, category fluency, or delayed visual and verbal memory. A claim of a broad cognitive advantage at high dose is therefore not available; a claim of a real one in named domains is.

The trial evidence carries the counterweight most directly. In the week after the randomised phase, bilateral treatment produced greater impairment than any dosage of unilateral treatment on several measures of anterograde and retrograde memory, and at two months the retrograde deficits were greatest among the patients treated bilaterally. Greater than any dosage means the advantage was not abolished even at the top of the ladder, and the later assessment means it was not merely a same-week effect. What those impairments are and how they are tracked belongs to this chapter's account of the cognitive cost; only their movement with placement and dose is settled here.

The ladder has a ceiling on this axis, drawn from a single trial rather than a pooled estimate. The only included study that favoured bitemporal placement on autobiographical memory, and not significantly, had dosed right unilateral treatment at 8 times the seizure threshold, from which the authors infer that there is no cognitive advantage in going beyond 6 times threshold for right unilateral ECT. It is their inference from one trial, and it gives the practical top of the useful range.

TRAP **Answering which placement is better without being told the dose.** The question is under-specified and the examiner usually knows it. Near threshold the bilateral placements are clearly better; at a high multiple the efficacy difference is not demonstrable and part of the cognitive advantage has gone with it. Naming the multiple before answering is most of the examinable content.

8.5 Why an older pooled estimate says bilateral is better

A resident who has read the older literature meets an apparently contradictory finding, and it is not a contradiction. The 2003 systematic review and meta-analysis found bilateral treatment more effective than unilateral treatment across 22 trials and 1408 participants, with a standardised effect size of -0.32 and a 95 per cent confidence interval of -0.46 to -0.19, that is a

small to moderate advantage for bilateral placement. Its trials did not separate high-dose unilateral treatment from low-dose and moderate-dose unilateral treatment. This chapter's reading of that is that the review pooled across the very variable the comparison turns on, so a pooled estimate over a mixture of doses answers a different question from a comparison at a stated multiple; the reading is stated as a reading, because the review does not describe its own placement analysis in those terms. What the review does say about dose it says separately, and it points the same way: high dose ECT is more effective than low dose. The older figure is cited for what it established when it was published and never as current practice.

8.6 Where bifrontal placement sits, and how thin its evidence base is

Because bifrontal placement is a member of the bilateral class, the question is not whether it beats the class but where it sits inside it. A meta-analysis comparing bifrontal with bitemporal and with right unilateral treatment found efficacy equal between bifrontal and bitemporal, with a Hedges's g of 0.102 and a confidence interval of -0.110 to 0.313, and equal between bifrontal and right unilateral, with a standardised mean difference of -0.12 and an interval of -0.378 to 0.139; post-treatment decline on the Mini-Mental State Examination was less for bifrontal than bitemporal, with a g of 0.89 and an interval of 0.054 to 1.724, but not less than for right unilateral; and the authors conclude that bifrontal treatment is not more effective than the other two and, given the longer experience with them, requires better characterisation. That last clause answers how the evidence bases differ in size: the bifrontal one is younger and thinner, not contrary.

The current Indian guideline takes a stronger position, recorded beside the meta-analysis rather than merged with it. Clinical trials have shown that bifrontal is equally if not more effective than bitemporal placement, but with lesser cognitive effects, in patients with mania, depression as well as schizophrenia. Under the precedence this series declares, the guideline controls Indian practice questions; it does not dissolve a meta-analytic finding that bifrontal treatment is not more effective and needs better characterisation. The disagreement is named and deliberately not resolved.

GOOD TO REMEMBER

Do not let the class word do the arguing. If a source says bilateral, ask which member it used; if it says bitemporal, that is a claim about one member only; and if a figure was pooled over the class, it stays a class figure and may not be handed to bifrontal or to bitemporal alone.

8.7 How the choice is actually made for a patient

The dose-dependent comparison is the second question at the bedside and not the first, because it is an argument about one diagnosis. The evidence for the efficacy of unilateral ECT is available only for depression, and it is lacking for the other common indications, namely schizophrenia and mania. Every trial and meta-analysis above is a depression study, so carrying the convergence argument to a patient treated for schizophrenia or mania exceeds the evidence, and in Indian practice, where schizophrenia is a common indication, that limit does real work.

Where the indication permits the choice, the working rule is that **dose is matched to placement** rather than set once for the machine. A current college guideline states that bitemporal and unilateral treatment are both effective when dosed adequately, that cognitive side-effects are greater with bitemporal placement and with higher stimulus doses, and that doses up to 6 times threshold can maximise the efficacy of unilateral treatment while doses at 1.5 times threshold are usually sufficient for bilateral treatment. Read the unilateral figure as an upper bound and not as a range, because an upper bound is the only form this passage of the college guideline gives. The same guideline states that multiple a second time, in its dosing footnote, in a form that carries a FLOOR as well as a ceiling, and it is the floor that disagrees with the current Indian guideline. Both college forms and the Indian figure, with the disagreement between them, belong to this chapter's account of stimulus dosing and are printed there with their bodies and years. What must not happen here is what the open-ended form invites: quoting it alone reads as agreement and dissolves a disagreement that is real. The multiples themselves and how the threshold beneath them is titrated belong to this chapter's account of stimulus dosing, where those figures are taught with their sources and their disagreements.

Selection is not only cognitive. One grounded non-cognitive reason decides real cases: bifrontal treatment has less impact on cardiac rhythm during the stimulus than the other forms, so it is worth considering in a patient at risk of an arrhythmia induced by the treatment.

- **Indication first.** Depression admits the whole argument. Schizophrenia and mania do not, on the unilateral evidence base as it stands.
- **Then the cognitive stake.** The higher it is for this patient, the stronger the case for right unilateral placement dosed properly rather than dosed near threshold.
- **Then the medical constraint.** An arrhythmia risk is a positive reason to consider bifrontal placement, independent of any cognitive argument.

IN INDIA

Two facts shape this choice here more than the trial literature does. The unilateral evidence base is a depression evidence base, and schizophrenia is a common indication, so a bilateral placement is the default for many patients on grounds of evidence rather than habit. And the current Indian guideline, published in 2023, is more favourable to bifrontal placement than the meta-analytic literature is; quote both, with the body and the year attached to each.

MNEMONIC

CLASS, MULTIPLE, INDICATION

Before comparing placements, name the **class**: bilateral is a class of three, bitemporal, bifrontal and left anterior right temporal, so say which of them the evidence used. Before ranking them, name the **multiple** of seizure threshold, because the ranking is a function of it and has no fixed answer without it. Before carrying the ranking to the patient in front of you, name the **indication**, because the unilateral evidence base is a depression evidence base.

PITFALL

Teaching the comparison as bilateral works better, unilateral is kinder. It is compact, it is what most candidates say, and it is wrong twice over: true only near threshold on the efficacy half, and overstated on the cognitive half at the doses right unilateral treatment is actually given at. Give the dose-dependent form, with both halves stated together.

Bilateral is a class of three placements, bitemporal, bifrontal and left anterior right temporal, and most trial evidence written as bilateral is bitemporal evidence. Near threshold, right unilateral treatment is markedly inferior while bilateral efficacy is already near maximal. As the multiple of threshold rises, right unilateral treatment converges toward bitemporal efficacy without established superiority over it, while the cognitive advantage that unilateral placement buys erodes without being abolished, surviving in reorientation time and retrograde autobiographical memory. The comparison narrows and does not reverse. Bifrontal placement sits inside the bilateral class on a thinner evidence base, and the choice is made on the indication first, then the cognitive stake, then the medical constraints.

9 · Stimulus dosing, seizure threshold and adequate seizure criteria

Almost every decision in a course of electroconvulsive therapy is expressed in units of one measured quantity, the electrical dose at which this patient's brain will seize. The seizure threshold is neither a device setting nor a property of the diagnosis. It is measured in the individual patient, differs enormously between patients, moves within the same patient across a course, and the treatment dose is written as a multiple of it. A resident who can define it, set it, dose against it and judge the seizure that followed can run a course.

Owned here in full: the determinants of the threshold, how the stimulus is set, the dose as a multiple of threshold, the rise across a course, the restimulation rules and the criteria for an adequate seizure. Named here and not re-derived, each with its own account in this chapter: what each placement is and the parameters that define a stimulus; the efficacy against cognition comparison between placements; the amnesias and their monitoring; which drugs move the threshold; and why an induced seizure helps.

12-fold	1.5 to 6	47%
RANGE IN THRESHOLD BETWEEN PATIENTS IN THE TRIAL THAT QUANTIFIED IT	TIMES THRESHOLD: THE DOSE IS A MULTIPLE, SET BY PLACEMENT AND PULSE WIDTH	AVERAGE RISE IN THRESHOLD BY THE SIXTH TREATMENT WHEN IT WAS RE-TITRATED

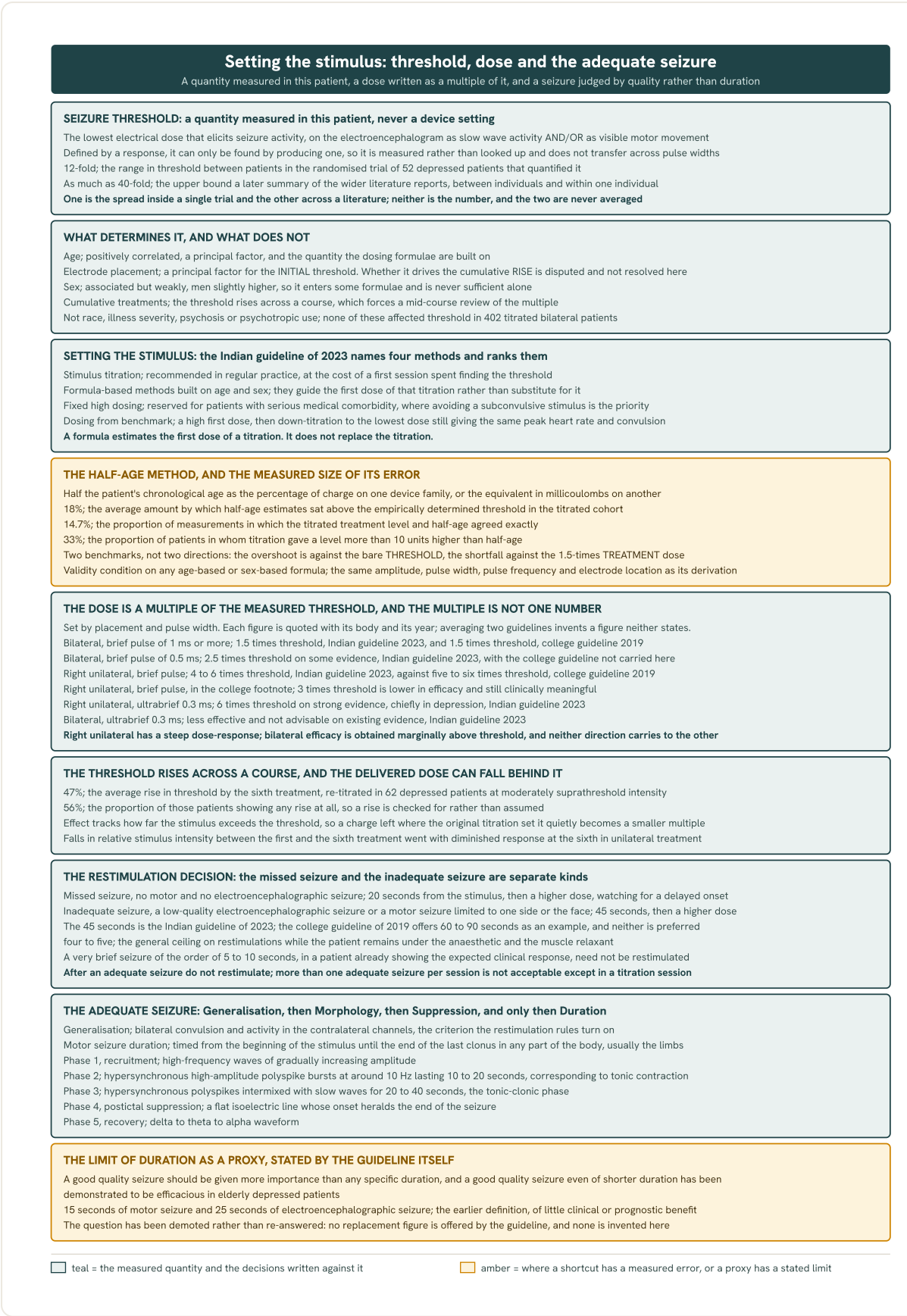


Fig 27.9. The seizure threshold is measured by titration, varies enormously between patients and rises across a course in only some of them; the dose is a multiple of it, sized by placement and pulse width and not by one rule; a formula estimates only the first dose and its two reported errors are measured against two different benchmarks rather than running in two directions; and adequacy is judged by generalisation, electroencephalographic morphology and postictal suppression, the classical duration criteria being retired with no replacement figure offered.

9.1 A measured quantity, not a machine setting

The **seizure threshold** is the lowest electrical dose which elicits seizure activity, as seen on the electroencephalogram, that is slow wave activity, and/or visible motor movement. The disjunction is load-bearing and is quoted as the guideline writes it: either sign will do, and reading it as a requirement for BOTH would make the ordinary case of an electroencephalographic seizure without visible movement under adequate relaxation look subthreshold, which is exactly the reading the missed-seizure rule below contradicts. The definition has consequences. Being defined by a response, it can only be found by producing one, so it is measured rather than looked up. Being defined against a particular stimulus, it is a property of the patient and the waveform together, so a threshold obtained at one pulse width does not transfer to another. And being a floor rather than a treatment, it produces a seizure without necessarily treating the illness, which is why the prescription is a multiple of it.

Stimulus titration turns the definition into a number: a low stimulus is given, and if no seizure follows the dose is stepped up within the same session until one does. That dose is this patient's threshold for this session.

9.2 What determines the threshold, and how wide the range is

The examinable fact is that the threshold does not behave like a constant. The randomised trial that quantified it titrated 52 depressed patients to just above threshold and found a **12-fold** range in the minimum intensity needed to produce a seizure, with sex, age, placement and cumulative treatments each associated with it. A later summary of the wider literature puts the reported variation, between individuals and within one individual across conditions, at **as wide as 40-fold**, which is an upper bound and not a point value. One is the spread inside a single trial, the other across a literature; neither is the number.

In 402 patients receiving bilateral treatment with dose titration, threshold correlated with age and was slightly higher in men, while race, severity of illness, psychosis and psychotropic use did not affect it.

DETERMINANT	WHAT THE EVIDENCE SAYS, AND HOW IT BEARS ON DOSING
AGE	Positively correlated; a principal factor, and what the formulae are built on
ELECTRODE PLACEMENT	A principal factor; bilateral carried a higher initial threshold and a greater cumulative rise, so a threshold measured under one placement does not carry to another
SEX	Associated but weakly; men slightly higher. Enters some formulae, never sufficient alone
CUMULATIVE TREATMENTS	Associated; threshold rises across the course, forcing mid-course review of the multiple
MEDICATION AND ELECTRICAL PARAMETERS	Each contributes; pulse width, frequency and stimulus duration matter, so a formula holds only in the parameter set it came from
RACE, SEVERITY, PSYCHOSIS, PSYCHOTROPIC USE	Did not affect threshold in the large titrated cohort; never a reason to start higher

9.3 Setting the stimulus: the methods and their ranking

The current Indian Psychiatric Society practice guideline, published in 2023, names four ways of arriving at a dose and ranks them. **Stimulus titration** is recommended in regular practice, at the cost of a first session spent finding it. **Formula-based methods**, built on age and sex, guide the first dose of that titration rather than substitute for it. **Fixed high dosing** is reserved for patients with serious medical comorbidity in whom avoiding a subconvulsive stimulus is the priority. **Dosing from benchmark**, a high first dose then down-titration to the lowest dose still producing the same peak heart rate and tonic-clonic convulsion, is the better alternative where fixed high dosing is used.

The titration runs at different speeds: larger increments in elderly patients, smaller in adolescents and younger adults.

RULE **A formula estimates the first dose of a titration; it does not replace the titration.** A formula approximates across a population a quantity that is measured in an individual, which is why the guideline says to use it for the first dose and then titrate.

9.4 The half-age formula, and the size of its error

The **half-age method** estimates the stimulating dose from the patient's chronological age, using half that age as the percentage of charge on one device family, or the equivalent in millicoulombs on another, as the starting point at the first session. The device clause is part of the formula: the same numeral means a different delivered charge on a different device. The standing criticism is that it is a gross estimate, unaccommodating to individual variation in threshold and less sensitive than dose titration.

That criticism has been measured. In the large titrated cohort, half-age estimates averaged **18%** above the empirically determined threshold; the titrated treatment level and half-age agreed

exactly in only 14.7% of measurements; and titration gave a level more than 10 units higher than half-age in 33% of patients. Those two figures are measured against two different quantities, and reading them as two directions of one error is the mistake this paragraph exists to prevent. The overshoot of **18%** is half-age measured against the bare THRESHOLD, and it is the authors' own summary figure, taken from a passage this claim row does not quote. The shortfall in 33% of patients is measured against the titrated TREATMENT dose of 1.5 times threshold, with more than 10 units the margin that counts as a shortfall. A figure a fifth above the threshold is by construction below a level set at half again as much, so the two are one direction read off two benchmarks. What follows for practice is only that the formula overshoots the threshold on average, which is its residual use, since fewer stimulations are then needed.

The Indian guideline attaches a validity condition to every age-based or sex-based formula. The stimulus must have the same amplitude, pulse width, pulse frequency and electrode location as the derivation it came from, all four together, and medications and anaesthetic agents move the threshold in any case.

TRAP **Quoting a formula as though its number carried across devices, waveforms and drug regimens.** A formula is valid only inside the parameter set it was derived in, and the commonest error is to treat half the age as a universal constant rather than a percentage of charge on a named device family at a named pulse width.

9.5 Dose as a multiple of threshold, and why the multiple differs

The therapeutic dose is prescribed as a multiple of the measured threshold, and that multiple is not the same number everywhere. It is set by placement and pulse width, because the dose-response relation differs between them. In right unilateral treatment that relation is steep: stimulation at threshold has relatively low efficacy, and markedly suprathreshold dosing is what achieves efficacy over a course. In bilateral placements efficacy is already obtained marginally above threshold, which is where the guidelines set it, so raising a bilateral dose further is not where bilateral efficacy comes from; what a higher dose does to cognition belongs to this chapter's account of the cognitive cost. Carrying one direction across the placements, either way round, is how this topic is taught wrongly.

PLACEMENT AND PULSE WIDTH	INDIAN PSYCHIATRIC SOCIETY GUIDELINE (2023)	AUSTRALIAN AND NEW ZEALAND COLLEGE GUIDELINE (2019)
BILATERAL, BRIEF PULSE OF 1 MS OR MORE	Marginally suprathreshold, 1.5 times threshold	Effective at that level or just above, 1.5 times threshold
BILATERAL, LOWER BRIEF PULSE OF 0.5 MS	Some evidence suggests 2.5 times threshold	Not carried here
RIGHT UNILATERAL, BRIEF PULSE	4 to 6 times threshold	five to six times threshold, with a footnote recording 3 times as lower but still clinically meaningful
RIGHT UNILATERAL, ULTRABRIEF 0.3 MS	Strong evidence for 6 times threshold, chiefly in depression	Not carried here
BILATERAL, ULTRABRIEF 0.3 MS	Less effective and not advisable on existing evidence	Not carried here

The right unilateral brief-pulse cell is where the sources disagree. The Indian guideline of 2023 gives 4 to 6 times the threshold; the college guideline of 2019 gives five to six times, its footnote recording 3 times threshold as lower in efficacy but still clinically meaningful. One structural difference travels with that disagreement and the table above cannot show it: the Indian figures are stated under pulse-width conditions, while the college's two multiples are given in sentences that attach no pulse-width condition at all, so filing them in a pulse-width row is this chapter's arrangement and not the college's. Each belongs in an answer with its body and year attached. Averaging them would invent a figure neither states, and the lower bound stops markedly suprathreshold dosing being read as the only thing that works. One caution travels with the Indian multiples: the increment ought to be made at fixed amplitude, pulse frequency and pulse width, but most devices cap train duration and raise pulse frequency instead, so the guideline says its figures should be read with that in mind.

9.6 The titration session and its narrow exception

The guideline is explicit that markedly suprathreshold stimulation is not necessary on the first day of titration even for unilateral treatment, and might be considered only in extremely rare life-saving conditions such as neuroleptic malignant syndrome or intractable seizures. The shape of the exception matters: a life-threatening presentation can justify abandoning stepwise measurement for a dose that will certainly work.

A consistency note is owed. The Other psychotic disorders, delusional syndromes and catatonia notes have already told the reader that malignant catatonia is treated with liberal stimulus dosing to induce well-generalised seizures. The guideline sentence is consistent with that in shape, carving out the life-threatening case, but it names neuroleptic malignant syndrome and intractable seizures and not malignant catatonia. The earlier statement is therefore supported by analogy rather than by naming.

9.7 The threshold rises, and the dose can fall behind it

The threshold is not fixed even within one patient. The study that measured this re-titrated at the first and the sixth treatments in 62 depressed patients treated at moderately suprathreshold intensity. The threshold rose by approximately **47%** on average, but only 56% of patients showed any rise at all. Each part matters: the average rise is large enough to count, and nearly half showed none, so a rise is checked for rather than assumed. There it went with increasing age and not with gender, electrode placement or initial threshold, which sits in tension with the earlier trial's finding that bilateral treatment carried the greater cumulative rise. The tension is recorded, not resolved.

The clinical consequence is what gets examined. Therapeutic effect tracks the degree to which the stimulus exceeds the threshold, so if the threshold climbs while the delivered charge stays where the original titration set it, the relative stimulus intensity quietly falls. In a separate cohort, falls in relative stimulus intensity between the first and the sixth treatments were associated with diminished response at the sixth in unilateral treatment, which is where the steep unilateral dose-response predicts the drift will bite.

> **GOOD TO REMEMBER**
>
> If a responding patient stalls mid-course, ask whether the seizure is still adequate and whether the charge is still the multiple it was meant to be. Frequency of treatment is a separate lever: it buys speed of response at a cognitive price, with equivalent efficacy at the end of the course, and belongs to this chapter's account of the acute course and its schedules.

9.8 Restimulation: the missed seizure and the inadequate seizure

Failure at the trolley must be separated by kind, because each kind has its own rule. A **missed seizure** is no seizure at all: if there is no motor and no electroencephalographic seizure even after **20** seconds from completion of the stimulus, restimulation may be attempted at an increased dose, and a delayed-onset seizure should be watched for.

An **inadequate seizure** is a seizure that happened but was not good enough: a low-quality electroencephalographic seizure, or a motor seizure that did not generalise, limited to one side of the body or to the face. The Indian guideline directs restimulation at a higher dose after **45** seconds, and bounds the attempt as follows.

- **How many.** Restimulation may be attempted while the patient remains under the anaesthetic and the muscle relaxant, generally four to five times.
- **The cost of more time.** A top-up dose of anaesthetic can be requested to extend the window, but top-up doses reduce the quality of the seizure obtained.
- **When not to chase.** If the seizure is very brief, of the order of 5 to 10 seconds, and the patient is showing the expected clinical response, restimulation need not be administered.

The delay before the second stimulus is the second disagreement, and each source is stated as it stands. The Indian guideline of 2023 gives 45 seconds. The college guideline of 2019 offers 60 to 90 seconds as an example rather than a rule, and gives the reason the delay is bounded above as

well as below: if it is too long a top-up dose becomes necessary, and the resulting seizure could be poor, negating the benefit while potentially worsening cognition. Neither figure is preferred here.

The sources agree at the other end: restimulation on the same day after an **adequate seizure**, which is multiple monitored electroconvulsive therapy, is not recommended by the Indian guideline, and the college guideline holds that delivering more than one adequate seizure per treatment session is not acceptable practice except in a session where threshold is being determined.

IN INDIA

Indian practice is governed by the Indian Psychiatric Society's current guideline, published in 2023: titration is recommended, the formula is only a starting point for it, quality outranks duration, and the classical numeric criteria are named as retired. Where a college guideline gives a different figure, as for the right unilateral multiple and the restimulation delay, name both with their bodies and years.

9.9 The adequate seizure, and the limits of duration

Adequacy is judged on the motor seizure, the electroencephalographic seizure and what follows, with duration the weakest signal rather than the definition. **Motor seizure duration** is timed by an explicit convention: the time from the beginning of the stimulus until the end of the last clonus in any part of the body, which usually ends in the limbs. A good-quality motor seizure moves through induction during or soon after stimulation, tonic contraction, bilateral convulsions, a gradual ending, a comatose stage, then return of consciousness.

The ictal electroencephalogram runs in numbered phases, and it is morphology rather than length that carries the information.

- Phase 1, recruitment: high-frequency waves of gradually increasing amplitude.
- Phase 2: hypersynchronous high-amplitude polyspike bursts at around 10 Hz lasting 10 to 20 seconds, corresponding to tonic contraction.
- Phase 3: hypersynchronous polyspikes intermixed with slow waves for 20 to 40 seconds, the tonic-clonic phase.
- Phase 4, **postictal suppression**: a flat isoelectric line, whose onset heralds the end of the seizure.
- Phase 5, recovery: delta to theta to alpha waveform.

Generalisation is read off the same trace: a good-quality seizure shows activity in the contralateral channels, which is the criterion the restimulation rules turn on.

MNEMONIC

Generalised, Morphology, Suppression, then Duration

Judge the seizure in that order: whether it **Generalised**, in the limbs and the contralateral channels; whether the **Morphology** moved through its phases; whether **Suppression** followed, the flat isoelectric phase whose onset marks the end; and only then how long it lasted, because **Duration** is the weakest signal.

The limit on duration is stated by the guideline itself. A good quality seizure should be given more importance than any specific duration, and a good quality seizure even of shorter duration has been demonstrated to be efficacious in elderly depressed patients. The classical numeric definition, still a common exam key, is named and retired in one breath: the earlier definition of 15 seconds of motor seizure and 25 seconds of electroencephalographic seizure is found to be of little clinical or prognostic benefit. No replacement figure is offered and none is invented here: the question has been demoted, not re-answered.

PITFALL

Reciting the retired numeric criteria as the current definition of an adequate seizure. They are worth knowing because they are still asked, but the guideline finds them of little clinical or prognostic benefit. Write them as the earlier definition, say that quality rather than a new number replaced them, and invent no replacement.

TRAP **Treating a generalised seizure as proof that the treatment was adequate, and any seizure as proof that the dose was right.** A generalised seizure is necessary for a therapeutic effect and not sufficient for one, which is why the dose is a multiple of threshold rather than whatever charge produced a convulsion. The paired error is to restimulate a patient who has already had an adequate seizure to chase a longer one.

The seizure threshold is the lowest electrical dose that produces a seizure in this patient at this session; it varies enormously between patients, rises across a course in only some of them, is best measured by titration with a formula used only to pick the first dose, and carries a treatment dose set as a multiple sized by placement and pulse width rather than by one rule. Adequacy is judged by generalisation, electroencephalographic morphology and postictal suppression, duration being the weakest signal.

10 · Modified versus unmodified (direct) ECT

Modified electroconvulsive therapy is the treatment given under anaesthesia with a muscle relaxant, and in India it is the only lawful form of it. The contrast with the unmodified or direct technique is therefore not a preference between two ways of doing the same thing. It is the difference between current practice and a practice the statute has closed, and a candidate who treats it as a matter of resources or of taste has misread the strongest legal statement in this chapter. What is examinable is the mechanical reason modification exists, what the unmodified

technique cost the patients who received it, and the fact that the bar on it is legal rather than advisory.

Owned here: the technique contrast, why the unmodified form was once used, what it cost in injury and in the patient's experience of being treated, what modification does and does not abolish, and the settled Indian legal position. Named but not re-derived: the anaesthetic agents, the muscle relaxant, the airway and the equipment of the room, which belong to this chapter's account of the pre-ECT workup and anaesthesia; the introduction of anaesthesia and muscle relaxation as historical events, to its account of the history and evolution of the treatment; the seizure threshold, the stimulus dose and every criterion of seizure adequacy, to its account of stimulus dosing; consent as it is actually taken, to its account of consent and the legal aspects; and the prohibiting provision itself, with its number, its wording and its classification, to the Mental health legislation and forensic psychiatry notes.

2 per 100,000	Unlawful	86 against 50
FRACTURE RISK PER ECT UNDER MODIFIED TECHNIQUE	THE STANDING OF UNMODIFIED ECT IN INDIA, NOT MERELY INADVISABLE	PER CENT CONSENTING TO A FUTURE COURSE, MODIFIED AGAINST UNMODIFIED

10.1 What modification actually modifies

Modification adds two things, an anaesthetic and a muscle relaxant, and of the two it is the relaxant whose target is the convulsion rather than the treatment. Both are required, and the statutory bar admits no reading on which relaxant alone would count as modified. The rationale runs in three steps. First, during the motor seizure the muscles of the trunk and limbs contract forcefully and repetitively, predisposing to injuries to muscles, joints, teeth and bones. Second, that motor seizure is irrelevant to the therapeutic action of the treatment. Third, it is therefore abolished by an intravenous muscle relaxant given after the anaesthesia in the ECT premedication. The middle step carries the whole argument: nothing therapeutic is surrendered when the convulsion is removed, so modification is not a concession to comfort or to appearances. It deletes the mechanism of injury and leaves the mechanism of benefit standing.

Two consequences are worth holding apart. The first is anatomical. What the relaxant abolishes is the **motor seizure**, the visible convulsion of trunk and limb; the cerebral seizure the stimulus induces is untouched by it, and a patient whose limbs are still is still having the seizure that treats them. That is why modification does not weaken the treatment, and why an isolated-limb tourniquet exists as a way of watching a convulsion that has been abolished everywhere else. The second is procedural. The relaxant follows the anaesthetic rather than preceding it, and the agents on that trolley, their doses, their contraindications and the airway conduct around them belong to this chapter's account of the pre-ECT workup and anaesthesia, which owns the tourniquet method too and which names the same relaxant this account's source names, succinylcholine.

10.2 What the unmodified technique was, from an Indian record of it

Unmodified, or direct, electroconvulsive therapy is the same stimulus given with neither anaesthesia nor a relaxant, so the generalised convulsion runs its course in the patient's body. It

appears in this chapter in two capacities only, as a historical practice and as an unlawful one, and it is described here rather than gestured at because a description written from the modern side alone softens into a list of theoretical hazards. The record used is a retrospective review of **637 patients treated between 1990 and 1995** at an Indian institute. Nothing in the ledger establishes that its author worked that service, and the receipt in fact shows the cohort reported from a different institution than the one where the patients were treated, so the record's authority rests on what it documents rather than on the author's proximity to it.

The technique is recorded plainly. All the patients were given ECT with an unmodified, bitemporal, sine wave device; there were two doctors, a junior and a senior resident, with multiple nursing and ward staff, but no anaesthetist; Boyle's apparatus was used for mandatory pre-ECT oxygenation and after care; and careful manual restraining of patients during the convulsion was done at all vulnerable joints by multiple ward staff and trainee nurses. The last of those is the sentence to remember. **Manual restraint** at the vulnerable joints was the physical substitute for a muscle relaxant, and it is the reason joint and bone injury is the characteristic harm of the technique. Bone rather than long bone: the injuries this record actually names are a cervical vertebral compression fracture, a dental extraction, a jaw dislocation and back muscle spasm, and not one of them is a long bone. Force applied across a joint against a muscle contracting maximally is not only a safeguard; it is a second path by which load reaches the same bone.

Why the technique was used at all is answered by the arrangement that record describes rather than by any argument advanced in its favour. The treatment came first and its modification came later, a chronology this chapter's account of the history and evolution of electroconvulsive therapy carries; until an anaesthetist could be put in the room, what remained available was the original technique. The series shows that economy exactly: a separate ECT station in each ward, a spacious room holding one ECT table, the ECT machine, Boyle's apparatus and an attached recovery space, staffed by residents, nurses and ward staff. Treatment could be given at ward level, in volume, without competing for anaesthetic manpower or theatre time. No row in this claim list states that rationale in so many words, so it is read off the arrangement and named as an inference rather than asserted as a finding.

10.3 What it cost: the injuries, case by case

The same series lists the injuries that ended a course, and they fall into four families that map exactly onto the tissues the rationale above named.

- **Bone.** Surgical emphysema developed in a 26-year-old woman in whom the radiograph taken after ECT revealed a compression fracture of the fourth cervical vertebra, managed conservatively with a cervical collar.
- **Tooth.** A traumatic dental extraction occurred at the first ECT session in a 45-year-old woman with an acute psychosis.
- **Joint.** Recurrent jaw dislocation occurred in a 28-year-old woman with recurrent mania, who had a past history of safe treatment with ECT.

- **Muscle.** Severe back muscle spasm, with no fracture on radiography, was the reason ECT was discontinued in two more young male patients.

The list teaches more than the injuries themselves. The patient with recurrent jaw dislocation had been treated safely in the past, which disposes of the intuition that a course completed without incident predicts the next one: this risk is per session and mechanical, not a settled property of the person. The dental extraction happened at the very first session, so no accumulation of treatments was needed to produce it. And the back-spasm cases carried no radiological fracture at all, which is the reminder that a normal film does not mean an uninjured patient.

10.4 The rate that series reported, and the caveat that never leaves it

The same paper reports its overall outcome, and the two halves of that report are quoted together or not at all. **637 patients, 6.94 per cent of total admissions, received ECT with meticulous standard of care except the provision of anaesthesia; satisfactory improvement was noted in 95.45 per cent of patients, with no noticeable or reported complication in 89.05 per cent, and premature termination of ECT for complications in 2.19 per cent**. Read on its own, that is the most misusable paragraph in this chapter.

Its author does not leave it on its own. Regarding complications, he writes, there must be under-reporting for not having any screening tool, only the noticeable side effects having got recorded in the files; even so, the serious complications were much less than those reported prior to the 1960s. The consequence is exact rather than rhetorical. **Under-reporting** of that kind makes a complication-free figure an upper bound on safety and not a measurement of it, because the numerator was assembled from whatever happened to be noticed by a busy ward. Musculoskeletal complications were recorded in ten patients, of whom five were severe enough to stop the course, and no film was taken in the rest, which limits the fracture count in the same direction. The series is admitted here for what it establishes about a historical practice. It is not evidence about current practice and it does not qualify the statutory bar by any degree.

TRAP **Quoting the complication-free figure from this series as though it showed the unmodified technique to be acceptably safe.** The author says in the next breath that complications were necessarily under-reported, so the figure bounds what was noticed rather than what occurred. And a perfectly measured figure would settle nothing here, because the technique is barred by statute: its measured harm rate is a fact about history, never an argument about what to do on Monday.

10.5 What it was like for the patient

Injury counts are not the whole cost, and the comparison that reaches the rest was made prospectively in 100 euthymic bipolar patients, 50 of them treated with modified and 50 with unmodified ECT. The majority of all patients, 78 per cent, were satisfied with treatment and 88 per cent with the outcome, without significant differences between the modified and unmodified groups; forgetfulness at 70 per cent and headaches at 57 per cent occurred in all groups, the only significant difference in forgetfulness being that it was reported by more manic patients treated with unmodified ECT. Stop before that final clause and the difference between the techniques

looks like a matter of decorum, which is why the clause is carried: the one adverse-effect difference the source reports runs against the unlawful technique.

The difference sits in what the patients feared and in what they would agree to again. Depressive and manic patients treated with unmodified ECT reported concerns of brain damage and of physical harm significantly more frequently, and **while 86 per cent of patients treated with modified ECT consented to a future treatment, this fell significantly, to 50 per cent, after unmodified ECT**. That is the shape of the finding and it should be kept: satisfaction did not separate the groups, willingness to go through it again did, and by a wide margin. The cohort is Turkish, from a country that mandated modified ECT in 2005, so it is carried for the direction of its finding rather than as an Indian figure.

10.6 What modification buys, and the one place it does not reach

Well-modified treatment produces markedly diminished skeletal muscle contraction and therefore minimal skeletal and dental risk, and the population figures are small enough to be worth quoting exactly. **The fracture risk with modified ECT is 2 events per 100,000 ECTs, and on recent data alone the risk may be as low as 0.36 events per 100,000 ECTs; the dental fracture risk with modified ECT is 0.02 per cent per ECT and 0.17 per cent per ECT course**. Those figures are what make the older injury reports legible. They describe the same treatment with the motor seizure taken out of it.

The residual risk is not spread evenly and part of it is in the operator's hands. Pre-existing bone and dental disease increase the risk; good seizure modification, proper use of bite blocks and effective jaw immobilisation during ECT reduce it. That the **bite block** and **jaw immobilisation** appear on a list of what protects a patient under modern technique is the tell: the jaw is the one place the relaxant does not reach, because the masseter is driven by direct stimulation of the muscle rather than through the neuromuscular route the relaxant blocks. **Seizure modification** is accordingly a quality with degrees rather than a box that has been ticked, and the equipment and airway conduct that deliver it belong to this chapter's account of the pre-ECT workup and anaesthesia.

> **GOOD TO REMEMBER**
>
> Quote the fracture figures as what they are, population rates under well-conducted modified technique. They do not transfer to a patient with known bone or dental disease, in whom the same review states the risk is higher, and the assessment that finds that disease before a course belongs to the pre-ECT workup rather than to this contrast.

10.7 The Indian position: unlawful, not inadvisable

In India the question of modified against unmodified treatment was settled by Parliament rather than by preference. The statute prohibits electroconvulsive therapy given without muscle relaxants and without anaesthesia. The provision that says so, its number, its text and its place in the scheme of prohibited and restricted procedures belong to the Mental health legislation and forensic psychiatry notes, and are named here rather than renumbered, because a chapter that

reprints a section number it did not itself ground is how a legal fiction enters a syllabus. What this account states is the consequence for technique, and it is blunt. Direct treatment is not a rougher version of the same thing that a hard-pressed unit falls back on; it is unlawful. The bar the legislation notes carry admits no exception, so no degree of urgency turns the direct technique into something a clinician is entitled to weigh.

IN INDIA

The working form of that rule in a district hospital is a timetabling rule and not a clinical one. Where no anaesthetist is available today, what changes is the day of the treatment and never the technique of it. The statutory conditions attached to consent for ECT, including who consents for whom, sit with this chapter's account of consent and the legal aspects and with the Mental health legislation and forensic psychiatry notes. What belongs here is the narrower point that the law fixes the technique itself, not merely the paperwork around it.

RULE **In India the modified technique is not the better of two ways to give electroconvulsive therapy; it is the only lawful one.** Everything the unmodified technique is taught for is historical: what it was, what it injured, and what it felt like to receive. Write it in the past tense, name the statutory bar in words and attribute it to the Mental health legislation and forensic psychiatry notes, and never write a sentence in which a clinician is choosing between the two.

AXIS	MODIFIED ECT	UNMODIFIED (DIRECT) ECT: HISTORICAL, AND UNLAWFUL IN INDIA
STANDING TODAY	The lawful form of the treatment	Prohibited by statute, per the Mental health legislation and forensic psychiatry notes
WHAT HOLDS THE BODY	An intravenous muscle relaxant, given after the anaesthesia	Manual restraint at all vulnerable joints by ward staff
MOTOR SEIZURE	Abolished; the cerebral seizure is untouched	Ran to completion in the trunk and limbs
SKELETAL AND DENTAL COST	2 skeletal fractures per 100,000 ECTs, with dental fracture a separate and much commoner cost at 0.02 per cent per ECT, which is an order of magnitude above the skeletal figure and is the one to compare against the opposite cell	Cervical compression fracture, dental extraction, jaw dislocation, back spasm
WOULD ACCEPT IT AGAIN	86 per cent	50 per cent

MNEMONIC

SLEEP, SLACK, SHIELD

Sleep is the anaesthetic and **slack** the muscle relaxant that abolishes the motor seizure; the statute requires them, and their absence is precisely what the word unmodified meant. **Shield** is the bite block with effective jaw immobilisation, which good practice adds because the masseter contraction is driven directly by the stimulus and not through the junction the relaxant blocks. The agents behind the first pair belong to the pre-ECT workup and anaesthesia account, never to this one.

Modification abolishes the motor seizure and nothing therapeutic: the relaxant follows the anaesthetic, the cerebral seizure is untouched, and the injuries of the unmodified technique were mechanical, running from cervical spine to tooth to jaw to back muscle. In India the modified form is not the safer choice but the only lawful one, and the provision that says so is named in words, never renumbered, from the Mental health legislation and forensic psychiatry notes.

Electroconvulsive therapy: effects, consent and course

11 · Cognitive side effects of ECT (anterograde and retrograde amnesia)

The cognitive cost of electroconvulsive therapy is the adverse effect that decides whether a patient consents, whether a course is finished and whether the treatment keeps its place in practice, and it is not one deficit but several running on different clocks. Merging them is the commonest error here: the evidence that one recovers comes from a corpus that could not measure another, so a candidate who has fused them will quote a real finding about the wrong phenomenon. This account holds them apart, gives the modifiers and the monitoring, and reports the persistence question as contested.

Owned here is the cognitive cost in full: the three phenomena, patient-reported memory loss, the modifiers, the monitoring, and the contested status of persistent retrograde deficit. Named and not re-taught, each owned by another account in this chapter: what each placement is and waveform, by technique and electrode placement; the efficacy-against-cognition trade, by the placement comparison; the threshold and stimulus dose, by stimulus dosing; frequency and the schedule, by the acute course; a confusional state past its window, by complications; concurrent drugs, by drug interactions.

5 to 45 minutes	29 percent to 55 percent	6 to 12 months
ORIENTATION GENERALLY RETURNS WITHIN THIS WINDOW AFTER AN ADEQUATE SEIZURE	PATIENTS REPORTING PERSISTENT MEMORY LOSS ON THE STRICT DEFINITION	FOLLOW-UP OVER WHICH AUTOBIOGRAPHICAL LOSS STAYED STABLE, NOT RECOVERING

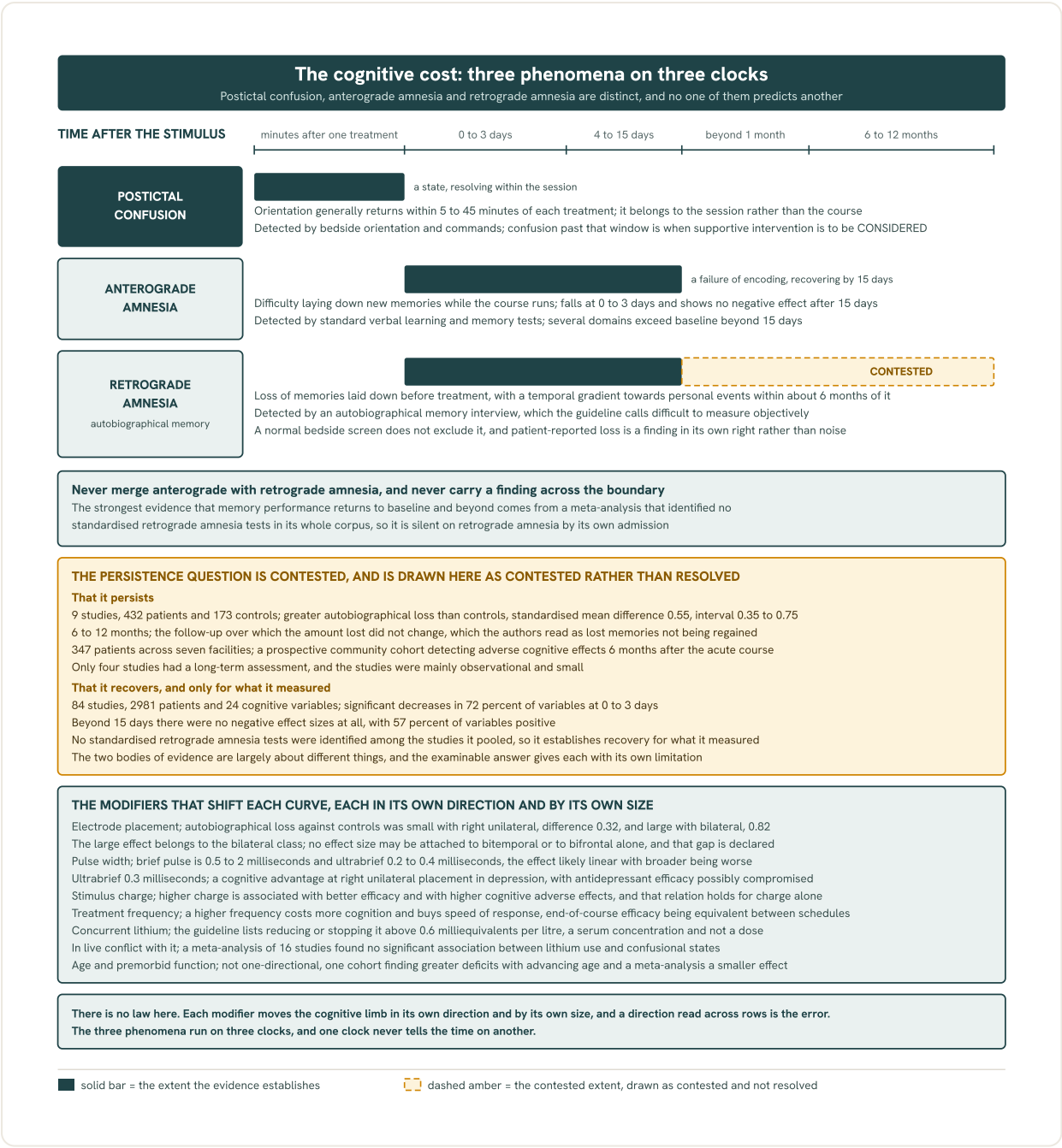


Fig 27.10. The cognitive cost is three phenomena on a common time axis and not one deficit: postictal confusion, a state resolving within minutes of each treatment; anterograde amnesia, a failure of encoding that falls in the first days after a course and recovers with several domains exceeding baseline; and retrograde amnesia, a loss of what was already encoded, with a gradient towards events near the treatment, hard to measure, and of contested persistence, the plate marking that persistence as contested rather than settling it, while each modifier shifts its own limb in its own direction and by its own size.

11.1 Three phenomena, not one deficit

They separate once asked what was lost and when it was laid down. **Postictal confusion** is the disorientation of the minutes after each induced seizure, expected after every treatment and belonging to the session rather than the course. **Anterograde amnesia** is difficulty laying down new memories while the course runs, so the treatment period itself becomes patchy. **Retrograde amnesia** is loss of memories laid down before treatment, and its most studied form is **autobiographical memory**, the record of the patient's own life events. A state, a failure of

encoding, and a loss of what was already encoded: no one predicts another, and a patient can pass a bedside screen and still describe a hole in the year before treatment.

RULE **Never merge anterograde with retrograde amnesia, and never carry a finding across the boundary.** The strongest evidence that memory performance returns to baseline and beyond comes from a meta-analysis that identified no standardised retrograde amnesia tests in its whole corpus. It is silent on retrograde amnesia by its own admission, and quoting its headline as reassurance about lost life memories is the most examinable misuse of evidence here.

AXIS	POSTICTAL CONFUSION	ANTEROGRADE AMNESIA	RETROGRADE AMNESIA
TIME COURSE	Orientation generally returns within 5 to 45 minutes of each treatment	Falls at 0 to 3 days, no negative effect after 15 days	Measurable from the end of the course, with a gradient towards recent events
HOW IT IS DETECTED	Bedside orientation and commands	Standard verbal learning and memory tests	An autobiographical memory interview; the guideline calls it difficult to measure using objective cognitive tests
PROGNOSIS	Resolves within the session	Recovers, several domains exceeding baseline	Contested, and reported as contested

11.2 Postictal confusion, and where it stops being normal

Confusion after an induced seizure is part of the procedure until it outlasts its window. The current Indian guideline states that patients generally regain orientation within 5 to 45 minutes after an adequate seizure, and that confusion with poor response to commands, with or without behavioural agitation, continuing past that period or very severe within it, is when supportive intervention is to be CONSIDERED, which is the guideline's own strength and not a requirement. The window is both reassurance and alarm; the intervention belongs to the account of complications.

Confusion is not one state either. The cleanest separation comes from a prospective cohort of 145 adults aged 55 or over treated for a major depressive episode; the population is part of the number, and these are not general adult figures. At least one subtype occurred in **55.9 percent**. Postictal agitation, at 29.5 percent, and **prolonged time to reorientation**, at 28.3 percent, were common; postictal delirium, at 5.9 percent, and **interictal delirium**, arising between treatments rather than after one, at 4.2 percent, were not. Recurrence separated them further, which changes the plan for the next treatment: 66.7 percent for interictal delirium and 50.0 percent for prolonged reorientation, against 12.5 percent for postictal delirium. The authors note that their instruments were not designed to measure subtypes during a course.

11.3 Anterograde amnesia: the deficit that recovers

This limb has the strongest evidence and the most reassuring answer, and it reassures only about itself. A meta-analysis of 24 cognitive variables across 84 studies and 2981 patients found

significant decreases in **72 percent** of variables at 0 to 3 days. From 4 to 15 days all but one confidence interval included zero or showed a positive effect, and beyond 15 days there were no negative effect sizes at all, with 57 percent of variables positive; processing speed, working memory, anterograde memory and some executive functions improved beyond baseline.

A domain map of 91 studies and 3762 individuals across 11 cognitive domains gives the same shape with the domains named: no significant change in global cognition on a bedside screen within 24 hours of the last treatment, small to medium decreases at 1 to 28 days in autobiographical memory, verbal fluency and verbal memory, and improvement on almost all domains beyond 1 month. The deficit is therefore domain-specific rather than global, and a bedside screen is the wrong instrument for finding it.

11.4 Retrograde amnesia: the distinct phenomenon

This is the limb patients care about and tests are worst at. The Indian guideline says both halves in one sentence: it is among the most distressing adverse effects, and difficult to measure using objective cognitive tests. A normal bedside screen therefore does not exclude it.

Its shape is not random. A systematic review across 15 studies established a **temporal gradient**: the memories predominantly affected are of personal events near the treatment, within about 6 months of it, rather than of the distant past. The same review names three technique features that reduce autobiographical loss, each taught elsewhere in this chapter: a brief pulse rather than a sine wave stimulus, unilateral rather than bilateral placement, and titration of the current against the patient's own seizure threshold.

The reviewers add a confound that travels with the whole literature: the direct effect of the depressive state on memory is not controlled for, a depressed patient recalling their own life poorly before any treatment. That is why the size of the effect is hard to pin down, and it is not a reason to discount a patient's account.

11.5 The persistence question, which stays contested

Whether retrograde deficit persists must not be answered crisply. Two bodies of evidence point in opposite directions, each honest about its limits, and both are set out rather than adjudicated.

That it persists. A meta-analysis of 9 studies, 432 patients and 173 controls found greater autobiographical loss in treated patients than controls, a moderate pooled standardised mean difference of 0.55, 95 percent confidence interval 0.35 to 0.75. The decisive finding is stability, not size: the amount lost did not change between the end of treatment and follow-up at 6 to 12 months, which the authors read as lost memories not being regained. Their limits travel with it: only four studies had a long-term assessment, so none was possible on long-term effects, and the studies were mainly observational and small. The second pillar is a prospective community cohort of 347 patients across seven facilities: it detected adverse cognitive effects 6 months after the acute course, with bilateral placement giving more severe and persisting retrograde amnesia than right unilateral.

That it recovers. The recovery meta-analysis is the strongest statement on the other side, and its bearing here is bounded by a sentence in its own results: no standardised retrograde amnesia tests were identified among the studies it pooled. It establishes recovery for what it measured, not for a variable nobody measured. The two bodies of evidence are largely about different things.

TRAP **Answering "does memory loss after electroconvulsive therapy persist?" with a single word.** "No" quotes a recovery result from a corpus with no retrograde instrument in it. "Yes" states as settled a finding resting on a handful of long-term assessments in observational studies. The examinable answer gives each side with its limitation and says the question is open.

11.6 Patient-reported memory loss, a finding and not noise

Patient-reported memory loss diverges from measured loss, and the divergence is itself what must be taught. In the review above, objective measures placed autobiographical loss under 6 months after treatment while subjective accounts placed it beyond 6 months. A descriptive systematic review of 35 studies of patients' own views found at least one third reporting persistent memory loss, rates on the strict definition running from 29 percent to 55 percent, and the rate did not depend on whether the study was clinician-led or patient-led. It concluded that the professional statement for patients then current, holding that over 80 percent were satisfied and that memory loss was not clinically important, was unfounded. That review is dated 2003 and its target is a statement of that period, not a current college position.

The Indian guideline gives the practice rule directly: subjective assessment of memory impairment is to be given due importance alongside objective assessment and to be part of routine cognitive assessment. Its explanation of why report exceeds measurement is a caution about instruments, not about patients: some cognitive domains are difficult to assess reliably and sensitively with standard tools, which can lead to higher subjective reporting. It names four contributors: that insensitivity; functional impact larger than measured severity; decline belonging to the illness and becoming visible once insight returns; and preoccupation with psychopathology.

RULE **Where patient report and objective testing diverge, the divergence is the finding, not a reason to discount the report.** The guideline offers its contributors as explanations of the gap and never as grounds for dismissal, and the first of them says the tests are insensitive. An answer that files persistent memory complaints under "subjective" and moves on has failed the item.

11.7 The modifiers that shift each curve

Each modifier moves the cognitive limb in its own direction and by its own size. The relation established for one parameter is the relation for that parameter, and reading a direction across rows is the error this chapter prevents.

MODIFIER	WHAT IS GROUNDED ABOUT ITS COGNITIVE EFFECT	REST OF IT TAUGHT BY
ELECTRODE PLACEMENT	Against controls, autobiographical loss was small with right unilateral, standardised mean difference 0.32, interval 0.06 to 0.57, and large with bilateral, **0.82, interval 0.49 to 1.15**. Bilateral is the source's own word and names a class. The Indian guideline separately holds bifrontal to have lesser cognitive effects than bitemporal in mania, depression and schizophrenia, and right unilateral lesser cognitive adversities	Technique; the placement comparison
PULSE WIDTH	Brief pulse is 0.5 to 2 milliseconds, **ultrabrief pulse** 0.2 to 0.4 milliseconds; the effect is likely linear, broader being worse. An ultrabrief pulse of 0.3 milliseconds has a cognitive advantage over brief pulses with right unilateral placement in depressive disorders, the guideline adding in the same breath that antidepressant efficacy may be compromised	Technique and waveform
STIMULUS CHARGE	Higher charge is associated with better efficacy and higher cognitive adverse effects, with the guideline's caution that charge is not a linear measure but a combination of several electrical parameters. The relation holds for charge alone	Stimulus dosing
TREATMENT FREQUENCY	A higher frequency costs more cognition. It buys speed of response and is not an efficacy lever, end-of-course efficacy being equivalent between the schedules	The acute course
CONCURRENT LITHIUM	The guideline lists reduction or stopping of drugs such as lithium, at serum levels above 0.6 milliequivalents per litre, among the steps for cognitive effects. A serum concentration, not an administered dose, and in live conflict with the meta-analysis below	Drug interactions

MODIFIER	WHAT IS GROUNDED ABOUT ITS COGNITIVE EFFECT	REST OF IT TAUGHT BY
AGE AND PREMORBID FUNCTION	Not one-directional. The community cohort found greater deficits with advancing age, lower premorbid intellectual function and female gender; the autobiographical meta-analysis found higher age associated with a smaller effect; the domain map found verbal fluency worse in younger adults	Special populations

The lithium row is a genuine conflict and is written as one. A meta-analysis of 16 studies found no significant association between lithium use and confusional states on its primary model, an odds ratio of 2.09 reaching significance at 2.38 only on a sensitivity model with a different estimator, and no significant differences in global cognition, autobiographical memory or verbal fluency. Its authors state that current evidence does not show a significant increase in cognitive side effects and that methodological limitations preclude definitive conclusions. Both are reported.

PITFALL

Narrowing the placement figure from bilateral to bitemporal. The large effect belongs to the bilateral class, and bifrontal is itself a bilateral placement, so the pooled corpus is not bitemporal only. No effect size may be attached to bitemporal or to bifrontal individually from this evidence, and the source reports no within-class breakdown; the gap is declared, not filled. The guideline's separate statement that bifrontal is gentler than bitemporal neither corrects nor is corrected by a meta-analysis that never separated them.

11.8 How cognition is monitored across a course

Monitoring starts before the first treatment. The Indian guideline requires a **baseline cognitive assessment**, so later change can be attributed, then sorts instruments by what they see. The Hindi Mental Status Examination and the Mini Mental Status Examination are named as simple tools not sensitive to the subtle change associated with treatment; the Montreal Cognitive Assessment battery and the Brief ECT Cognitive Screen as used internationally; the Battery for ECT-Related Cognitive Deficits as validated in the Indian population and recommended at initiation and across the course. Instruments are named only; no content, scoring or cut-off is reproduced.

The cadence is stated: progress in clinical symptoms and in cognitive and other adverse effects is monitored at least once a week while the course runs. A second, differently sourced standard is a United Kingdom technology appraisal of 2003 requiring cognitive function to be monitored on an ongoing basis and at a minimum at the end of each course. Two provenance facts travel with it: its recommendations on depression were replaced in 2009 by the national depression

guideline, while those on catatonia, prolonged or severe manic episodes and schizophrenia have not changed.

What is monitored matters as much as how often: the domain map states that a bedside global screen has extremely limited utility for tracking change, and recommends that assessment cover autobiographical memory, verbal fluency and verbal memory.

IN INDIA

The Indian position is more specific in two examinable ways. It names a battery validated in the Indian population and recommends it at initiation and through the course, rather than leaving instrument choice open. And it directs that patient-reported impairment be given due importance alongside objective testing, making the patient's account a required part of the record.

11.9 What is done when cognitive effects appear

The Indian guideline gives a seven-step menu for cognitive adverse effects during a course, used singly or in combination. Each step is a cognitive-management decision here; the parameter behind it is taught by the account named above.

1. Space the sessions out.
2. Switch to unilateral placement.
3. Switch to a briefer pulse width.
4. Reduce the stimulus dose.
5. Reduce or stop drugs known to affect cognition, such as lithium above 0.6 milliequivalents per litre.
6. Reduce the anaesthetic where it has been given high.
7. Terminate the course where the risks outweigh the benefits.

The guideline attaches a caution that makes this a judgement rather than a checklist: the decision is balanced against the possible reduction in effectiveness these steps carry. A patient made cognitively comfortable and left depressed has not been helped.

IN PRACTICE

Take a baseline before the first treatment, so a later complaint has something to be compared against. Ask about life memories specifically, not only orientation and word lists: the instrument that finds retrograde loss is a conversation about the patient's own past. And when a patient reports a hole the tests do not show, record it as a finding.

MNEMONIC

THREE CLOCKS

Minutes for postictal confusion, orientation generally back within 5 to 45 minutes. **Days to weeks** for anterograde amnesia, worst at 0 to 3 days and recovered beyond 15 days. **Months, and contested** for retrograde amnesia. One clock never tells the time on another.

The cognitive cost is three phenomena on three clocks: postictal confusion, resolving within minutes of each treatment and a complication only when it outlasts its window; anterograde amnesia, measurable in the days after a course and recovering to baseline and beyond; and retrograde amnesia, predominantly for events near the treatment, hard to measure, and of contested persistence, the two sides being a stable autobiographical loss at long-term follow-up and a recovery meta-analysis with no retrograde instrument. Patient-reported loss is a finding in its own right, assessed routinely and weighed alongside testing. The risk is shifted by placement, pulse width, charge, frequency, concurrent medication, age and baseline function, each in its own direction. Cognition is assessed at baseline and watched at least weekly with a sensitive instrument, and the seven-step menu is what is done when the cost appears.

12 · Other complications and adverse effects of ECT (cardiovascular, prolonged seizure)

The complications of electroconvulsive therapy are the events that occur during and after a treatment that was correctly indicated and correctly given. They are a different object from the conditions that make a patient risky before the first stimulus, and they are examined separately: one question asks what happens in the suite and the recovery room and what is done about it, the other asks whom you should hesitate to treat. This account answers the first.

Owned here: the cardiovascular sequence and its arrhythmia and ischaemia risk, the cardiac-event and mortality estimates, prolonged and tardive seizures, postictal agitation and delirium, headache, muscle soreness and nausea, dental and musculoskeletal injury, anaesthetic complications, and the emergence of mania on treatment. Named here and taught elsewhere in this chapter: the conditions that raise risk beforehand, by contraindications and high-risk conditions for ECT; the induction agents, relaxant and airway, by pre-ECT workup and anaesthesia; the threshold and the stimulus dose, by stimulus dosing, seizure threshold and adequate seizure criteria; the drugs that move the threshold, by drug interactions with ECT; and the whole cognitive limb, anterograde and retrograde amnesia, by cognitive side effects of ECT.

1 in 50	180 seconds	2.1 per 100,000
PATIENTS DEVELOPING A MAJOR ADVERSE CARDIAC EVENT OVER A COURSE	THE INDIAN DEFINITION OF A PROLONGED SEIZURE, WHICH IS NOT THE POINT AT WHICH TERMINATION IS ATTEMPTED	DEATHS ATTRIBUTED TO THE TREATMENT, PER TREATMENT GIVEN, IN THE POOLED INTERNATIONAL REVIEW

12.1 The cardiovascular sequence, in its fixed order

The cardiovascular effect is not one event but a sequence produced by autonomic nervous system activation, and the order is the examinable part. **Parasympathetic discharge** comes first: an initial **10 to 15 seconds** of vagal outflow in the tonic phase, with bradycardia and occasional asystole. The **sympathetic surge** follows in the clonic phase, a pronounced response of hypertension, tachycardia and other arrhythmias, peaking **1 minute** after the stimulus and generally resolving within **5 to 10 minutes**.

Bradycardia in the seconds after the stimulus is expected physiology, not a surprise, which is why antimuscarinic premedication is decided in advance, agent and dose belonging to the workup and anaesthesia account. The same activation raises cerebral metabolic rate, cerebral blood flow and intracranial pressure, and intraocular and intragastric pressure with them; what that means in a patient who already has a space-occupying lesion is the contraindications account's question.

PITFALL

Teaching the sympathetic surge as the whole cardiovascular story. A candidate who names only hypertension and tachycardia has dropped the phase that produces asystole, and with it the reason an antimuscarinic is considered at all. Give both phases, in order.

12.2 Why the same surge lands differently on different hearts

The sequence is the same in every patient and the consequence is not. Major depression may itself alter autonomic nervous system activity and increase the risk of arrhythmia and of sudden cardiac death, so the surge does not land on a neutral baseline. The treatment may also cause an acute rise in **QT dispersion**, which may predispose to arrhythmia in its own right. A third contribution is the workup and anaesthesia account's to teach: all the induction agents used prolong the QT interval. Three contributions, one patient, one moment.

12.3 How often a cardiac event actually happens

The quantified answer comes from a systematic review and meta-analysis of 82 studies covering 106,569 patients and 786,995 ECT treatments. Approximately **1 in 50 patients**, or 2 percent, develop a major adverse cardiac event, and the risk per treatment is approximately **1 event in 200 ECT treatments**. Those two round numbers are the review's own glosses on one pair of model estimates, and the estimates are 25.83 per 1,000 patients and 4.66 per 1,000 treatments on its Poisson model. Read them as the composite and not as a component of it: this is one finding written twice, once as a rate and once in round terms, and a page that prints both as though the precise pair were a sub-rate of the round pair states a part larger than its whole. The review's two estimators disagree substantially on the per-treatment figure, so a printed number owes the reader its model.

Both denominators travel together. The per-patient figure is proportionally higher because most patients receive a whole series, and because a course is usually stopped once a serious event has occurred.

GOOD TO REMEMBER

A rate quoted without its denominator is not a small imprecision, it is a different fact. Told it is two percent, a patient hears the risk of the whole course; told one in two hundred, they hear tomorrow morning. Say which you are answering.

12.4 Mortality: two estimates measuring two different things

There is no single mortality figure, and a resident who has memorised one has usually memorised it without its construct. The two pooled estimates carried here are not interchangeable.

AXIS	ALL-CAUSE DEATH AFTER TREATMENT	DEATH ATTRIBUTED TO TREATMENT
WHAT IS COUNTED	Any death within 30 days, whatever its cause; cardiac death was 29 percent of deaths	Deaths judged related to treatment, which is an act of attribution
CORPUS	41 studies, within the meta-analysis that produced the cardiac-event figures	15 studies, 32 countries, 766,180 ECT treatments, 16 ECT-related deaths
ESTIMATE	**0.42 per 1,000 patients** and **0.06 per 1,000 treatments**, Poisson model	**2.1 per 100,000 treatments**, 95 percent interval 1.2 to 3.4
WHAT TRAVELS WITH IT	Dropping the studies that reported only that no adverse events occurred raised it to 0.75 per 1,000 patients	In the 9 studies published after 2001, covering 414,747 treatments, there was 1 reported ECT-related death
ITS LIMIT	The authors state a death may follow treatment without being caused by it	A death not judged related never enters the numerator

The comparator the second review offers is what a frightened patient is asking about: it sets its figure beside a reported general-anaesthesia mortality of 3.4 per 100,000 for surgical procedures, and concludes that death caused by this treatment is extremely rare. One gap is declared rather than filled: the older textbook estimate expressed per patient rests on a task-force document this account could not open, and is not reproduced here.

TRAP **Quoting one figure as the mortality of electroconvulsive therapy.** The two differ by an order of magnitude and neither is wrong: one counts every death in a fixed window, the other only deaths judged caused by treatment, and the denominators differ too. State the construct and the denominator with the number, or do not state the number.

12.5 The prolonged seizure: two numbers doing two different jobs

This is the most commonly mistaught parameter in the chapter, and the error is always that the two figures are collapsed into one. The Indian guideline defines a **prolonged seizure** as a seizure longer than **180 seconds**. In the same sentence it states that termination can be attempted if a seizure extends beyond **120 seconds**, and that conditional wording is the guideline's own. One figure answers what counts as prolonged and is a definition; the other answers when you may act and is a permission.

RULE **The definitional threshold and the action threshold are separate numbers doing separate jobs, and the action threshold sits earlier.** A seizure is called prolonged past one figure; termination may be attempted past a shorter one. Collapse them, in either direction, and you have taught either a delay in acting or an intervention on a seizure that has not met the definition.

Before any drug, airway and respiration are monitored closely until the seizure has completely stopped. The guideline then names the classes that may terminate it: a benzodiazepine,

phenytoin, valproate, or a barbiturate, which is usually the anaesthetic agent already used for induction. That last detail is the practical one, because the drug is already drawn up. Its next steps are to stop theophylline or lithium temporarily or consider alternatives, and to consider shifting to an anticonvulsant anaesthetic agent; which drug moves the threshold in which direction belongs to the drug interactions account.

No dose is supplied by the guideline for any terminating agent, and none is supplied here: that gap is declared rather than filled from a remembered emergency protocol. Where prolonged seizures recur across a course the guideline suggests considering a reduction in stimulus dose, with its own caution attached: seizure duration is highest near the threshold dose, so raising the dose may in some situations shorten the seizure rather than lengthen it. The threshold itself belongs to the stimulus dosing account. **Status epilepticus** is named by the guideline in its emergency drug tray and among the differential diagnoses for recurrent postictal delirium, alongside the non-convulsive prolonged seizure, which is a seizure continuing without motor accompaniment and is therefore found by suspicion in a patient who does not reorient. No treatment-specific protocol and no frequency is given for either, and none is invented here.

IN INDIA

These thresholds are the Indian guideline's and are the ones to give in an Indian examination. They are a guideline convention rather than a physiological constant, and definitions differ between traditions. The other traditions' documents could not be opened here, so this account states the Indian figures with their attribution and claims nothing about what replaces them elsewhere.

12.6 Tardive seizure, and the seizure with nothing to see

A **tardive seizure** is a seizure happening within hours of an ECT session, after the patient has recovered from the treatment itself. Other causes of a seizure must be investigated rather than assumed away: a patient having a course can also have hypoglycaemia, an electrolyte disturbance or an intracranial event. The manifestations may be non-motor, which is the point residents miss, so a nurse watching for a convulsion will not see it. The seizures need to be aborted with anticonvulsant medicines, with no agent and no dose named by the source.

12.7 Postictal agitation and delirium

Postictal agitation is the acute agitated confusional state on emergence. A systematic review and meta-analysis of 21 articles and 66,047 patients, whose corpus was restricted to patients aged 18 or over and so is an all-adult figure rather than a late-life one, found a mean incidence of **13.9 percent** at the patient level and **12.4 percent** at the session level, rising to 18.0 percent and 16.5 percent once studies at high risk of bias in outcome measurement are removed, which are the figures its authors recommend using. Older reports range from about 8 percent to 65 percent, a spread produced by differing definitions, procedures and populations. Of the 7 prognostic factors meta-analysed none reached significance, so there is no validated predictor, and about 34 percent of those who have had it may have it again. One cross-reference belongs with these figures, because the chapter carries a higher one and a reader meeting both should not read a contradiction: this chapter's account of the cognitive side effects reports postictal agitation

at a substantially higher rate in a cohort restricted to later life, and the difference between the two is the population and not the phenomenon.

The Indian guideline's management sequence runs in this order, and the order is the answer.

1. Secure a safe environment, maintain airway, breathing and circulation, and protect the intravenous line.
2. Reduce environmental stimuli, with gentle, temporary physical restraint only where needed to prevent self-harm.
3. Give an intravenous benzodiazepine or an anaesthetic agent where agitation is persistent or severe. No agent is named and no dose given for this step.
4. Use a low-dose antipsychotic where the benzodiazepines have been ineffective.
5. In recurrent cases evaluate physical causes: electrolyte imbalance and infection are the two named.
6. Consider a non-convulsive prolonged seizure, status epilepticus or a tardive seizure as differentials.
7. For recurrence, a prophylactic higher dose of anaesthetic or benzodiazepine may be considered.

One prescribing number appears in that ladder and it is the only one this account carries. The guideline's worked example of the low-dose antipsychotic step is haloperidol given intramuscularly at **2 to 5 mg**, a prescribing decision owned by the treating team and not taught here, with a repeated dose when necessary, for postictal delirium with agitation where benzodiazepines have been ineffective. It is printed so a psychiatrist recognises what has been given and why, not as an instruction: that prescribing decision is the anaesthetist's, and the agents used earlier in the ladder are the workup and anaesthesia account's. Two flags travel with it. Its receipt is a professional body's guideline and not a drug regulator's product label, which was not read here. And the guideline states no starting dose, no ceiling and no minimum interval between repeats, so the tuple is incomplete, and an incompleteness left visible is safer than one closed from memory. Postictal confusion shades into the cognitive effects proper, and that limb, anterograde and retrograde amnesia, is the cognitive side effects account's.

12.8 Pain: headache, muscle soreness and nausea

These are the complications the patient actually reports, grouped by the guideline as pain appearing as headache, muscle soreness or joint pain. **Headache** is generally mild and treated with simple analgesia if severe, paracetamol, aspirin and the non-steroidal anti-inflammatory drugs being named without a dose attached to any of them. **Muscle soreness** has a pattern worth knowing: it is intense after the first session and would not be much with later sessions, so a patient warned in advance is not frightened by it. Intense fasciculation from the depolarising relaxant contributes, and a reduction of relaxant dose or a change of relaxant may be considered, which belongs to the workup and anaesthesia account. Nausea and vomiting generally travel with the headache and answer the same analgesia, with antiemetic options named where severe. No

incidence figure for any of the three is available here; that absence is declared rather than filled with a remembered percentage.

12.9 The injury that survives modification

Modification abolishes almost all of the musculoskeletal injury of the convulsion, and residents conclude from that it abolishes all of it. **Temporomandibular joint dislocation** follows uncoordinated contraction of the temporalis, pterygoid and masseter muscles, and happens with modified ECT because those muscles are stimulated directly by the current. Direct stimulation does not travel through the neuromuscular junction the relaxant is blocking, so the masticatory muscles are not protected by the blockade protecting everything else. Prevention is mechanical: firm holding of the jaws during the stimulus. A dislocation is examined for and relocated.

The recovery-room evaluation adds tongue bite and mucosal injury, and musculoskeletal injuries including fractures and dislocations; the pre-treatment examination makes dental evaluation for loose or missing teeth mandatory, which belongs to the workup and anaesthesia account. No rate for any of these injuries is given here, and injury under modified against unmodified technique is the modified versus unmodified ECT account's.

12.10 Anaesthetic complications, and what the recovery room watches

Anaesthetic complication is a category in its own right, and the Indian guideline treats it as one twice. It plans for it at the pre-anaesthetic evaluation, where investigations or interventions are arranged for conditions carrying a substantial risk of complications related to general anaesthesia. And it records it afterwards: the procedure record has a remarks row for any complication during or after treatment, and the footnote defining that row opens with prolonged seizures and apnoea as a single paired entry, then bradycardia or tachycardia, hypotension or hypertension, and post-ECT confusion or delirium, with a requirement to write how each was handled. **Apnoea** is the anaesthetic limb of that list and the recovery-room list adds aspiration. Why apnoea happens and in whom is the workup and anaesthesia account's.

No frequency exists for any anaesthesia-specific complication here, and none may be inferred from a guideline asking for the event to be documented: a documentation requirement is evidence that the event happens, not an incidence. In the recovery room, pulse, blood pressure and oxygen saturation continue to be monitored, electrocardiography in patients with a history of cardiac disease, feeding is avoided until full consciousness returns, and orientation and gait are assessed before the patient is shifted out.

MNEMONIC

AAA, then TEN

The recovery room watches for Agitation or delirium, Aspiration and Arrhythmia, then Tardive seizure, Enuresis or encopresis, and Neuroleptic syndrome. The three A's need action within minutes; the last three are what a tired team stops looking for once the patient is quiet.

12.11 Treatment-emergent mania

The emergence of mania during a course is a recognised adverse effect, and the whole of the current Indian guideline's direction on it is one clause: ECT may be continued or the frequency reduced based on clinical needs. There is no stopping rule, no threshold and no incidence figure, and what a reduction in frequency costs belongs to the course, frequency and number of ECT sessions account.

The published evidence behind any more confident answer is small. A systematic review searching from 1980 to August 2020 screened 1,662 articles and found 12 articles describing the treatment course of emergent hypomania or mania, in **17 patients** altogether. Nine of those patients had no known history of a manic or hypomanic episode and carried a unipolar diagnosis, which is the clinically useful fact in the record: the switch is not confined to patients already known to be bipolar. Four treatment courses were identified, and the authors state the available data are insufficient to support definitive conclusions. The incidence is therefore not established, no percentage is printed here, and antidepressant switch rates are not carried across to a different intervention in a different population.

> The complications that occur are a separate object from the conditions that raise risk beforehand: the cardiovascular sequence runs parasympathetic first and sympathetic second within a short window; roughly one patient in fifty has a major adverse cardiac event over a course and roughly one event occurs per two hundred treatments; mortality has two estimates measuring two constructs, neither quotable without its denominator; the prolonged seizure carries a definitional threshold and a separate, earlier action threshold, with terminating agents named by class and no dose; and postictal agitation, tardive seizure, pain, injury under modification, apnoea and aspiration, and emergent mania complete the list, each with a management step and, where no figure is grounded, a declared absence.

13 · Consent for ECT and legal aspects under MHCA

Consent for electroconvulsive therapy in India is not an act of signing but the establishment of a lawful route, and the commonest way a resident goes wrong is to treat it as a form. The Act defines what informed consent means, names who may give it in each situation a ward produces, closes one route absolutely, gates another behind a statutory body, and imposes a duty to follow the instruction a patient wrote before losing capacity.

Owned here is the practice: what the patient is told, how capacity is judged and recorded, who consents when the patient cannot, re-consent, withdrawal, and the emergency distinction. Provisions below are named in words and never renumbered; the numbering, the prohibited-against-restricted classification and the review Board's machinery are the Mental health legislation and forensic psychiatry notes'. Consent as doctrine is the Forensic ethics, consent and legal procedure notes'. The technique contrast is this chapter's account of modified against unmodified (direct) ECT; the clinical modifications its account of ECT in special populations.

seven days	an application	ten cases
THE INTERVAL AT WHICH THE PATIENT'S CAPACITY IS REVIEWED AGAIN, THE CONSENT ITSELF NOT BEING WHAT THE ACT PUTS ON REVIEW	THE ONLY LAWFUL EXIT FROM A DIRECTIVE THAT REFUSES THIS TREATMENT	THE WHOLE INDIAN OPERATIONAL RECORD OF THE BOARD GATE FOR MINORS

13.1 What the Act means by informed consent

The Act carries its own definition of **informed consent**, stricter than ward habit. It is consent given for a specific intervention, without force, undue influence, fraud, threat, mistake or misrepresentation, obtained after disclosing adequate information including the risks and benefits of that intervention and the alternatives to it, in a language and manner the person understands. Four requirements are asked at once, and the first decides this topic: consent is intervention-specific, so a general consent taken at admission is not consent to electroconvulsive therapy, and the alternatives limb is the one most often dropped.

13.2 The emergency, and the authority the Act withholds

Here a resident is most likely to be taught something unlawful. Electroconvulsive therapy can be clinically indicated in an emergency. The Act's provision on emergency treatment cannot authorise it, because that provision expressly excludes electroconvulsive therapy from the treatment it permits. Neither statement qualifies the other. What follows is that a lawful route must be established separately, and that urgency does not cure an incomplete route.

The second half is the one most often lost: treatment authority is not admission authority. A capacitous adult can consent to electroconvulsive therapy with no admission at all, so urgency never converts the question into whether the patient must first be admitted. That is a proposition about what the Act does not require rather than anything it states affirmatively: what could be grounded is only that the Indian guideline's pre-treatment evaluation form asks the clinician to record whether the patient is an outpatient or an inpatient, so outpatient treatment is contemplated in Indian practice. That absence is offered here as the absence it is.

RULE **Urgency changes the timetable, never the route.** A patient who is not eating, catatonic or acutely suicidal earns speed in arranging a lawful route: capacity assessed now, the directive looked for now, the application filed today. Urgency never earns a shorter route.

13.3 The lawful routes, and the limit that travels with each

The Act supplies a small set of routes, each with its own trigger and its own ceiling. A route taught without its limit is how this topic goes wrong.

ROUTE	WHERE THE AUTHORITY COMES FROM	THE LIMIT THAT TRAVELS WITH IT
THE CAPACITOUS ADULT	His own informed consent, capacity deemed present	Neither a proxy nor a past document displaces it; a decision others think unwise is not incapacity
THE ADULT LACKING CAPACITY	The supported-admission provision: directive first, then his own consent with the representative's support	Substituted consent only where nearly total support is needed, only temporarily, recorded, capacity reviewed every seven days
THE ADVANCE DIRECTIVE	His own written instruction, invoked when he ceases to have capacity	Runs in either direction and more often bars than authorises; a valid refusal binds the team, the only exit an application to the Board
THE NOMINATED REPRESENTATIVE	Appointed in writing, or by the Act's deemed order of precedence	He does not displace a capacitous adult's own consent; his duties bind him to the patient's wishes
THE MINOR	The legal guardian, the nominated representative by operation of law	Treatment needs the guardian's informed consent and prior permission of the concerned Board, with no clinician discretion

13.4 The first route: the adult who has capacity

The default route is the patient's own consent, and the Act starts from a presumption. Every person, including a person with mental illness, is deemed to have **capacity** to make decisions regarding his mental healthcare or treatment, the test being functional and disjunctive: to understand the relevant information, or to appreciate any reasonably foreseeable consequence of deciding or not deciding, or to communicate the decision by any means. Named in words here; the statutory definition is the Mental health legislation and forensic psychiatry notes'. And a decision perceived by others as inappropriate or wrong does not, by itself, mean that the person lacks capacity, which forecloses the commonest shortcut of all: reading a refusal as proof that the patient cannot decide.

The limit is stated twice. A patient admitted on his own request is not to be given treatment without his own informed consent, and the establishment may not require a nominated representative's consent or presence in order to admit him; separately, a capacitous decision overrides any advance directive he wrote earlier. Taking the relative's signature as well is a habit, not a requirement. That statement is drafted about the patient admitted on his own request; no provision stating the limit generally for a person not admitted could be grounded, and the gap is declared.

13.5 The second route: the adult who lacks capacity

Where capacity is absent the Act does not simply hand the decision to the family. It routes treatment through its **supported admission** provision, and the order of authority there is fixed:

an advance directive, if any, is taken into account first, and then the informed consent of the patient with the support of his nominated representative. Only where he needs nearly total support in deciding may the representative temporarily consent to the treatment plan on his behalf, and then the consent is recorded in the medical records and his capacity reviewed every seven days.

Substituted consent is therefore a rolling, revisable state: a course over several weeks crosses that review more than once. The provision is drafted for a person admitted under it, and no free-standing treatment-consent provision for an adult lacking capacity and not admitted could be grounded; that too is a declared gap.

13.6 The third route: the advance directive, which more often says no

A resident who meets the **advance directive** only as a way of saying yes will treat a refusal as an obstacle to work around. Every person who is not a minor may make a directive in writing specifying the way he wishes to be treated for a mental illness and the way he wishes not to be; it is invoked only when he ceases to have capacity and lapses when capacity returns; a capacitous decision overrides any directive he wrote earlier; and a directive made contrary to any law in force is void from the beginning. It therefore runs in either direction, and the refusing limb is the commoner one in practice: the instrument working, not a defect. The void limb disposes of a directive purporting to authorise treatment given without anaesthesia and muscle relaxation, prohibited outright: this chapter's account of modified against unmodified (direct) ECT.

Now the provision this topic most needs. It is the duty of every medical officer in charge of a mental health establishment, and of the psychiatrist in charge of a person's treatment, to give treatment in accordance with that person's valid advance directive, subject only to the Board-review provision. That is a duty, not a consideration to be weighed, and it reaches the treating psychiatrist directly. A valid directive refusing electroconvulsive therapy binds the treating team: there is no bedside-override limb in it, no urgency limb and no senior-clinician limb.

Where a mental health professional, a relative or a care-giver desires not to follow a directive, the Act tells him to apply to the concerned Board. The Board gives an OPPORTUNITY OF HEARING to all concerned parties, including the person whose directive is in question, and may uphold, modify, alter or cancel it against five considerations: voluntariness; whether he meant it to apply to circumstances such as these; whether he was sufficiently informed; whether he had capacity then; and whether its content is contrary to other laws OR CONSTITUTIONAL PROVISIONS. Both of those are worth reading exactly. An opportunity of hearing is the natural-justice formula and is not the same as a promise that everyone is heard, and the fifth consideration carries a constitutional limb that a shortened list drops. The intention limb is what an ECT case usually turns on. The route out of a refusal is that application, never a bedside decision to disapply the directive, and urgency creates no exception. No statutory time limit appears on the face of the provision, so how quickly a Board sits is not promised.

The Act does put emergency treatment beyond the reach of a directive; that cannot open a route to electroconvulsive therapy over a refusal, because the emergency-treatment provision itself

forbids its use. The exclusion is real and, as to this treatment, empty. And a practitioner is not liable for unforeseen consequences of following a valid directive, and is not liable for not following one if he was never given a copy: that turns on possession of the document, not on his view of its merits.

TRAP **Meeting the advance directive only as a route to yes.** Its commoner operation is to bar a treatment, and the refusing directive is a form the statute names first. A resident who has met only the authorising face reads a refusal as a clinical problem to solve, and solving it clinically is the unlawful act.

13.7 The fourth route: the nominated representative, and the ceiling on the role

The **nominated representative** may be appointed by the person himself in writing, and where nobody has been appointed the Act supplies a deemed order of precedence: the individual named in the advance directive, a relative, a care-giver, a person appointed by the Board, and finally a state welfare official. What the role obliges is not proxy preference: he must consider the person's current and past wishes, life history, values, cultural background and best interests, and give particular credence to the person's own views.

Authority without a limit teaches a resident to collect the wrong signature.

- A nominated representative does not displace a capacitous adult's own valid consent.
- He substitutes where capacity is absent; he cannot consent over a capacitous patient's refusal.
- Where he consents for a patient who lacks capacity but is audibly protesting, what the patient says must be weighed.

13.8 The fifth route: the minor, and the gate that leaves no discretion

A person aged below eighteen is not considered capable of giving consent for treatment, and consent for admission and for interventions is obtained from the nominated representative. For a minor the Act fixes who that is: the **legal guardian** is the nominated representative, unless the concerned Board orders otherwise on an application showing that he is not acting in the minor's best interests or is otherwise unfit, when it may appoint a suitable willing individual instead.

The gate has limbs that bind together: the informed consent of the legal guardian, and prior permission of the concerned Board. The current Indian recommendations state it and its consequence in one breath: where a psychiatrist recommends this treatment for a minor under specific clinical conditions, guardian consent and prior permission from a Mental Health Review Board are mandatory, and the Act gives the clinician no discretionary powers for using electroconvulsive therapy in minors. They record the worry the gate creates, that delay or disapproval could impede treatment of suicidal risk and catatonia, and answer it with process rather than an exception: the minors-specific instance of the teaching that urgency does not cure an incomplete route.

What the gate costs in practice has been reported once. One tertiary centre described the first six months of operating it: ten cases, a written summary submitted in each, the caregivers' informed consent sought first and permission after that, a response within a few days without inordinate

delay or objection, and permission denied in no case. That is a single-centre series from an institute with its own Board, and not a national expectation.

The Indian guideline adds what the statute does not: oral or verbal **assent** from the minor as the age permits, alongside written informed consent from the parents or nominated representative, and concurrence by two independent psychiatrists, or a psychiatrist and a physician. That concurrence is professional and not statutory, and presenting it as part of the gate misstates the law.

A minor cannot make an advance directive, but the legal guardian can make one for the minor, and since the instrument runs either way it can bar this treatment as readily as request it. If the minor attains the age of eighteen during the hospital stay he is to be classified as an independent patient, that is communicated to him, and treatment continues on that footing or as a patient requiring high support. Where the Board has displaced the guardian, guardian and representative differ, and whose consent the gate then requires is unanswered by the sources.

IN INDIA

A pair of Indian facts is routinely conflated. The statute supplies the gate for a minor: guardian consent and prior permission of the concerned Board. The guideline supplies more: the minor's own assent, and a second psychiatrist's concurrence. Name which is which.

13.9 The consent as it is taken, documented, re-taken and withdrawn

The Indian guideline states the conversation and its documentation. Written informed consent is taken before treatment begins, on the principles of shared decision-making. It covers the anticipated benefits and the possible short-term and long-term adverse effects in this individual, including the risks of the anaesthesia as well as of the treatment, plus the type of treatment, the modification procedure, the electrode placement and expected outcomes. Unless the patient disagrees, caregivers are made part of the process. Where the patient lacks the capacity to consent, that is documented; any advance directive is examined; and, in accordance with that directive, consent MAY be obtained from the nominated representative. The permissive form is the guideline's own: the representative route is conditional on what the directive says, not an automatic next step.

Read the order, because it is the Act's order too: the directive is examined first, and the representative's consent comes after it and in accordance with it, never instead of it.

Re-consent is given as triggers rather than as an interval: consent is taken again when the patient regains the capacity to consent, when a minor attains the age of eighteen, and before continuation or maintenance treatment is initiated, the clinical condition, the purpose and the character of the treatment having all changed by then. That indication itself is this chapter's account of continuation and maintenance ECT.

The guideline states the right in the patient's own terms: he may refuse consent now, and may withdraw consent during the course of treatment, and in either case the best available alternative

treatments will be provided without any prejudice. That second half is the part residents omit, and it makes the right real rather than nominal.

RULE **Record the route, not only the signature.** The note should say which route was used: capacity present and consent taken from the patient; or capacity absent, the directive looked for and recorded, and the representative's consent taken temporarily with the review date entered; or the guardian's consent with the Board's permission on file.

MNEMONIC

ADULT, ABSENT, ADVANCE, AGENT, AGE

Adult: the capacitous adult's own consent, an unwise choice not being incapacity. **Absent**: capacity absent, so the supported route, substituted consent temporary and recorded, with the patient's CAPACITY reviewed every seven days. **Advance**: the directive, which runs either way and binds when it refuses, the exit being an application to the Board. **Agent**: the nominated representative, who never displaces a capacitous adult. **Age**: the minor, needing guardian consent and prior permission of the concerned Board.

PITFALL

Writing the emergency into the answer as though it were a route. It is a clinical urgency, never a source of authority, and the Act's emergency-treatment provision excludes this treatment by name. The paired error runs the other way: assuming that because that route is closed the patient must be admitted first. He need not be.

Consent for this treatment is the establishment of a lawful route, measured against the Act's definition of informed consent: intervention-specific, voluntary, and informed as to risks, benefits and alternatives. The routes are the capacitous adult; the adult lacking capacity, under the supported provision with substituted consent temporary and recorded and the patient's capacity reviewed every seven days; the advance directive; the nominated representative; and the minor, through guardian consent with prior permission of the concerned Board. Each carries a limit: no proxy and no past document displaces a present capacitous decision, and a valid directive refusing this treatment binds the team, the only exit an application to the Board. The emergency provision is not a route to this treatment, a lawful route must be established separately, and urgency does not cure an incomplete one. Consent is written, taken again when capacity returns and before continuation treatment, and may be withdrawn at any point without prejudice.

14 · ECT in special populations (pregnancy, elderly, adolescents)

A special population does not change what electroconvulsive therapy is; it changes the plan built around it, meaning who else evaluates the patient, what is monitored, which ordinary choice is deliberately reversed, and what the conversation before treatment must contain. The four special populations are different problems: pregnancy an evidence problem before a

technique one, old age a selection problem in which the usual instinct runs backwards, the minor a legal problem, comorbidity a co-management one.

Owned here is the clinical modification each population requires, and nothing else. Named below and not re-taught: the anaesthetic conduct being modified, owned by the pre-ECT workup and anaesthesia; the consent practice being varied, owned by consent for ECT and the legal aspects; and likewise the cognitive cost, the conditions raising risk beforehand, concurrent drugs, the titration and the placement comparison. The statutory gate on ECT for a person under eighteen belongs to the Mental health legislation and forensic psychiatry notes; it is named here in words and never renumbered.

20 weeks THE GESTATION PAST WHICH THE SETTING CHANGES, NOT THE TECHNIQUE	**no randomised trials** IN THE LARGEST SYNTHESIS OF ECT IN PREGNANCY	**0.35** OLDER AGE AS A PREDICTOR OF RESPONSE, AS A STANDARDISED MEAN DIFFERENCE

14.1 Pregnancy: the modification, the monitoring and the threshold

The Indian guideline states its own scope before its list. These steps are most applicable in the second and third trimesters, and the risk evaluation is a joint activity of the psychiatrist, the anaesthetist and the obstetrician. That is structural, not courteous: each item follows from a physiological change an obstetrician reads better.

Hydration is maintained through the fast, with intravenous fluid if dehydration is noted. A **left lateral or pelvic tilt** maintains aorto-caval circulation, the supine gravid uterus otherwise cutting venous return just as a surge is induced. Pre-oxygenation is provided but hyperventilation avoided, the instruction most often got backwards: blowing off carbon dioxide favours the seizure in ordinary practice, while here placental oxygen delivery governs. An H2 blocker or antacid is considered against the raised aspiration risk. The anticholinergic line is a trade and not a prohibition: routine anticholinergic premedication is avoided even though the guideline concedes in the same sentence that it would reduce the risk of foetal arrhythmias. Memorise the first half and you have a rule; carry both and you have a decision. The agents and sequence are the workup and anaesthesia account's; no dose appears here.

Monitoring is doubled. Doppler or cardiotocography is used for the foetus before, during and after treatment, alongside maternal vitals. Then the threshold: after 20 weeks of gestation, treatment should preferably be given where obstetric support is available, with **tocolytics** and preferably a **tocodynamometer** to hand against induced labour or abortion. The guideline hedges with preferably twice, and the hedge is carried rather than tightened. Past that gestation what changes is the room, not the treatment.

14.2 The comparative claim, and the three things it does not say

The sentence a resident will meet is that ECT is safe and effective in pregnancy and is a preferred option, given its lesser risk of teratogenicity compared to many psychotropics. It supplies a comparator, a class and not a drug: many psychotropics. A domain: teratogenicity. A direction: lesser, for ECT.

It does not supply the gestational window in which the comparison holds, nor the illness severity at which it holds, nor any graded strength of evidence. It says nothing about outcomes other than teratogenicity, which matters because the register evidence below points the other way on preterm delivery and the newborn's condition at birth. Those absences cannot be filled from another source here, so they are not.

RULE **Never write that ECT is often the safer option in pregnancy without stating what it is safer than, in which period of the pregnancy, for which severity of illness, and at what strength of evidence.** The published sentence is bounded on one axis only, and the bare version silently promises a general safety finding no source here states.

14.3 What the pregnancy evidence base is, and what it cannot settle

The largest and most recent synthesis included 82 reports carrying information on more than 1,300 pregnancies and deliveries, and its composition is the point: 57 were case reports and 14 were case series, the remainder non-randomised or retrospective. There are no randomised trials, so a clinical position rests on the weakest available design.

What it reports is reassuring in shape: the most frequent adverse events were generally mild and transient. But the same synthesis records, across the reviewed reports, 1 placental abruption, 21 premature deliveries, 6 congenital malformations and 4 stillbirths. Then the authors state the limit themselves, in the sentence that must travel with every reassuring one: because information was limited, causal links between modified ECT and many of these adverse events were difficult to establish, and no inference could be drawn about differential effectiveness or safety between important patient subgroups or across variations in technique.

That cuts both ways and residents usually take one. The harms cannot be confidently attributed to the treatment; neither can the reassurance. A literature that cannot establish causation cannot establish its absence, so the reassuring picture and its limit are one object, never taught apart.

14.4 The register cohort, and why the comparator decides the answer

The largest observational study inside that review is a Swedish population-based register cohort of 793, propensity-score matched. On effectiveness it reassures: response rates matched those of non-pregnant women receiving ECT. On obstetric outcome, the control group decides the answer.

Premature delivery ran at 14.4 per cent against 9.0 per cent compared with psychiatrically hospitalised pregnant women not given ECT, an odds ratio of 2.33, confidence interval 1.15 to 4.73, which is significant. Against the second, additional pregnancy control group it ran at 10.9 per cent, odds ratio 2.16, confidence interval 0.75 to 6.22, which does not exclude no effect. A low 5 minute Apgar score behaves identically: 9.3 per cent against 2.1 per cent, odds ratio 3.68, confidence interval 1.58 to 8.55 against the first, and 2.2 per cent, odds ratio 2.53, confidence interval 0.59 to 10.90 against the second. The same table carries the finding that cuts the other way, and it travels with the rest: none of the reported preterm births occurred in close time proximity to treatment, which weakens the causal link. These figures are attributed to the review's own table at the review's year, the primary study not having been opened here.

The reviews then disagree for methodological, not empirical, reasons. An overview identified 9 articles, of which 5 met inclusion criteria, covering 32 to 339 patients, foetal deaths ranging from 2 to 12. 1 of the 5 recommended ECT only as a last resort while the others called it relatively safe, the split attributed to differing inclusion criteria and differing attribution of adverse events, and that is read at abstract level here. Reviewers of overlapping literature reached opposite recommendations because they counted differently: the question is unsettled at the level of method, not of data.

TRAP **Quoting a risk figure without its comparator.** Every significant obstetric signal here loses significance when the control group changes, and every one keeps its point estimate. Carry the preterm figure without its comparator and you report a hazard the study does not establish; carry only the non-significant comparison and you report a safety it does not establish.

14.5 What the uncertainty puts into the consent conversation

The perinatal review draws an explicit consequence from its own uncertainty, and it is a consent instruction rather than a treatment one. Modified ECT is an important option for severe perinatal depression, and informed consent practice should reflect the knowledge gaps identified in the review as well as the well-known side effects, and should be set against the substantial adverse consequences of untreated or undertreated maternal depression. That supplies the honest comparator for the risk discussion and makes the gaps a required disclosure: not a reason to withhold, not a reason to soften the account, but content the woman is entitled to. How consent is taken, meaning capacity, the nominated representative, re-consent and withdrawal, is the consent for ECT and legal aspects account's.

14.6 The elderly: not merely tolerable candidates but preferentially good ones

Start with the effect size, because the order matters. A meta-analysis screened 2193 articles and included 34. Older age predicted remission at a standardised mean difference of 0.26 and response at 0.35, at P less than 0.001. Psychotic features predicted remission at an odds ratio of 1.47 and response at 1.69; severity predicted response at 0.19 but not remission. The authors conclude that ECT is particularly effective in patients with depression with psychotic features and in elderly people with depression, and the Indian guideline agrees from practice: response rates in elderly depression exceed those in mixed-age populations.

Carry that first, and as an effect size rather than an impression, because everything below is a burden to be managed and a resident who meets the burdens first reads this section as reasons to withhold. Age is a positive predictor; the burdens are separate facts about the same patient, not the price of the benefit.

High seizure threshold, missed seizures, medical comorbidity and postictal delirium are all commoner in old age. The cognitive concern is located rather than generalised, which is the guideline's most careful sentence here: cognitive adverse effects are of greater concern primarily when ECT is indicated for dementia-related behavioural disturbance. That is a statement about one indication, not a blanket caution about age. The amnesias and how cognition is tracked are the cognitive side effects account's.

The modifications follow, each owned elsewhere. Propofol may be avoided and anticonvulsants minimised, the agents being the workup and anaesthesia account's. Non-convulsive shocks are minimised, for which a higher initial dose and faster increments may be considered; the titration is the stimulus dosing account's, and increments means the electrical dose, never the number of treatments in a week. Right unilateral or bifrontal placement is preferred to bitemporal, a preference inside a comparison the bilateral versus right unilateral account owns, and age does not reverse it. A lower range of brief or ultrabrief pulse may be considered. One number sits alongside: concomitant lithium above 0.6 is avoided for the risk of **postictal delirium**. The unit is a separate point and gets its own sentence rather than an interruption inside that clause. The guideline prints it here as 'mq/l', which is a typographical error for milliequivalents per litre; the error is reproduced rather than silently repaired, because substituting the unit one believes was meant is how a wrong number enters a chapter, and the same guideline spells the same unit 'meq/l' at the second place the same figure appears, which this chapter's account of drug interactions with electroconvulsive therapy carries.

14.7 Adolescents and minors: the gate first, then the four headings

For a person under eighteen the statutory question is answered before any clinical one. That gate, its prohibition and the narrow exception that opens it, are taught in full by this chapter's own account of consent for electroconvulsive therapy and the legal aspects, which is where to go for them; the Mental health legislation and forensic psychiatry notes own only the numbering and the wider classification of the provisions. The gate is named here rather than restated, and is never renumbered. Nothing below creates an exception to it: the criteria decide whether ECT is the right treatment, never whether it may lawfully be given.

The clinical frame sets out four headings, all of which must be satisfied.

- Heading A is specific clinical features: high risk to self from active suicidal ideas or behaviours, high risk to others from severe repetitive aggression, catatonic features, or long illness with inadequate response.
- Heading B is the adequacy of pharmacological or psychotherapeutic intervention.
- Heading C is that alternatives, including other medications, other routes and other brain stimulation methods, were considered and not found suitable.
- Heading D is that medical contraindications for modified ECT have been ruled out by pre-anaesthetic check-ups, where the word modified is doing real work, modified being the only lawful form in India.

Heading B is the one to learn, because the urgent case is answered there. It is satisfied when recommended treatments have been used in adequate dose and duration with inadequate change; or when recommended treatments have been initiated but would take time to be effective, during which time the clinical features might pose a significant risk to the patient; or when the child is not tolerating the up-titration required to reach recommended doses. The middle limb answers the objection that a child cannot wait for a drug to work: the waiting itself can be the risk, stated as a clinical criterion inside the gate, not a shortcut around it.

TRAP **Reading urgency as a legal exception.** Heading B answers the urgent case clinically and leaves the statutory position untouched; a fast clinical justification is not an authority to treat. The reverse error is as common: treating the gate as a reason to conclude that ECT is unavailable to a young person in a dangerous state.

One thing genuinely reverses here, on a single physiological fact. **Prolonged seizures** are commoner in this age group, so proconvulsant or seizure-neutral induction agents such as etomidate and ketamine are best avoided. Elsewhere those agents are reached for precisely to protect a poor seizure; here that virtue is the hazard. Their comparative effects belong to the workup and anaesthesia account, and no dose is stated. The same guideline records that the literature is limited, that no differential efficacy or safety has been shown, and that a second psychiatrist's opinion is useful.

IN INDIA

The published Indian experience is uncontrolled tertiary-centre case series, which is what it must be called before its rates are read. The first reported 25 patients below the age of 18 over 12 years, with catatonia the commonest indication at 68 per cent, and after a mean of 10 treatments the response rate was 76 per cent. A later series from the same group covered 51 individuals up to 19 years of age over 7 years, a mean of 8 treatments producing significant improvement in 86 per cent. At a third centre, twenty-two children treated over a ten-year period, the youngest aged 10, had prolonged seizure as the commonest side effect at close to 35 per cent.

The international series agree on the shape and the mechanism. Fifty-one adolescents of mean age around 16, in a United States series covering 1991 to 2013, had bitemporal treatment over a mean of 9 sessions with clinically significant improvement in 77 per cent, and it records that prolonged seizure duration is common in young people and declines with age across adolescence. That age gradient is why the anaesthetic choice changes. A Swedish national register covering 118 young people under 19, from 2012 to 2016 used right unilateral placement over a mean of 7 sessions, and fifty-seven per cent responded adequately, adverse effects in 25 per cent being minor. The placements differ between the series and that difference is not a recommendation.

14.8 Physical comorbidity: co-management, organ by organ

Here the population is an organ, and the modification takes one form: optimise it before, protect it during, share the decision with its specialist. The conditions raising risk beforehand, and the interval after a recent infarction, are the contraindications account's.

SYSTEM	WHAT IS MODIFIED	WHY
CARDIAC	Blood pressure optimally controlled, with short-acting antihypertensives during treatment if needed; anticoagulation considered in valvular disease; multiple restimulations avoided in congestive heart failure, with functional capacity assessed by 2D echocardiogram and treadmill test; short-acting parenteral antihypertensives in aneurysm; conduction defects and pacemakers generally safe, given only in consultation with cardiologists	A brief surge is met with agents of equally brief effect
CEREBRAL	Postponement after recent ischaemic or haemorrhagic stroke and with a symptomatic intracranial mass until the risk of complications is minimised; patency of a ventriculo-peritoneal shunt confirmed; after craniotomy, electrodes placed away from the site to avoid a very high charge density; depolarising muscle relaxants avoided in multiple sclerosis; cerebral implants and foreign bodies not an absolute contraindication, treatment given in consultation with neurologists	An opened skull conducts differently, and a defect concentrates charge
RENAL	Adequate muscle relaxation, with non-depolarising agents preferred; in haemodialysis patients, serum potassium measured within 24 h before treatment	A depolarising relaxant releases potassium a failing kidney cannot excrete
RESPIRATORY	Hypoventilation avoided, since it leads to respiratory acidosis, hyperkalaemia and further acid-base imbalance; theophylline discontinued 24 h before treatment, for the risk of prolonged seizures and status epilepticus	Ventilation is supplied, not spontaneous, so its adequacy is a decision

PITFALL

Reading the two relaxant lines as one rule. One avoids a depolarising agent in multiple sclerosis, the other prefers a non-depolarising agent in renal disease: two members of an open group reached by different routes, not one instruction generalised.

MNEMONIC

Room, rate, reversal, ruling, review

Room: past the stated gestation, pregnancy changes where treatment happens, not how. **Rate**: in the elderly the response rate leads. **Reversal**: in minors the agents chosen elsewhere to protect a seizure are avoided. **Ruling**: the gate is statutory and comes first. **Review**: comorbidity is co-managed with the organ's specialist.

The examinable core is a habit, not a list: say what the plan changes, name who else is in the decision, and state the evidence at the strength it has. The comparative claim in pregnancy never travels without the three things it does not say; the elderly get their effect size first and their burdens second; the minor gets the gate named, then the four headings.

15 · Course, frequency and number of ECT sessions

An acute course of electroconvulsive therapy is a schedule rather than a single decision, and the schedule settles how fast the patient recovers, what that costs in memory and when treatment stops. How often treatments are given is the parameter most often remembered as an efficacy lever, and it is not an efficacy lever. A much faster schedule exists for presentations that kill within days, bought with mortality rather than impatience.

Owned here in full: the acute course and every schedule on it, treatment frequency and the twice-weekly against thrice-weekly comparison, the accelerated schedule for life-threatening presentations, the number of treatments by indication, judging response, the mid-course decision and stopping, with the malignant catatonia protocol assembled end to end. Named and not re-derived, each with its own account here: why catatonia and its malignant form earn the treatment; the seizure threshold, its titration and the adequate-seizure criteria; and the cognitive cost. Continuation and maintenance treatment begin where this ends. The catatonia entity, the lorazepam challenge, the malignant catatonia against neuroleptic malignant syndrome differential and the rating scale are the Other psychotic disorders, delusional syndromes and catatonia notes'.

2 to 3 per week	8 to 12	3 to 5 days
THE INDIAN ACUTE-COURSE FREQUENCY, A RANGE AND NOT ONE SCHEDULE	TREATMENTS BEFORE AN INDIAN COURSE MAY BE CALLED A FAILURE	OF DAILY OR TWICE-DAILY BILATERAL TREATMENT OPENING A MALIGNANT CATATONIA COURSE

15.1 The acute course, and what treatment frequency means

The acute course is the block of treatments that brings the present episode to remission, described by three things: how often treatments are given, how many, and what stops them. **Treatment frequency** is the first, and it is a construct rather than a schedule, because the guidelines state it as a range. The Indian guideline gives the acute course as **2 to 3 sessions per week**, and its consent supplements state what the patient is told, ECT on alternate days or twice a week for about 2 to 3 weeks.

A policy guideline adds the spacing rule, that ECT is usually given two or three times per week in an acute course, spaced as evenly as possible across the week. Two schedules dominate within it, the **twice-weekly schedule** and the **thrice-weekly schedule**, and what separates them is not how well the course works.

15.2 What the faster schedule buys, and what it does not

Two double-blind randomised trials carry the comparison, each holding anaesthetics constant with a weekly simulated treatment in the slower arm. The first found that both schedules significantly improved depression scores, with no difference in outcome either 1 week or 1 month after the series ended, while response to ECT three times a week was significantly faster and cognitive effects more prominent. The replication found no significant difference in antidepressant outcome, with significantly more rapid response on the thrice-weekly schedule, associated with more severe memory impairment.

Their joint synthesis adds what decides the teaching: the antidepressant effect of the two schedules at the end of the course was equal, while the thrice-weekly schedule induced more severe memory impairment even when the number of treatments in the series did not differ significantly. The cost belongs to the spacing, not to receiving more treatments, so it cannot be argued away by pointing at the total. The reviewers give the rule with its premise: when rapid improvement is clinically warranted, thrice-weekly ECT may be preferred, given that both schedules are equally efficacious.

RULE **Treatment frequency buys SPEED of response, and it is not an efficacy lever: both schedules reach equivalent efficacy at the end of the course, and the faster one reaches response sooner at a higher cognitive price.** Written the other way round it teaches a resident to impose extra cognitive injury for a gain that does not exist. **Speed of response** is a real good where the illness is racing; where it is not, the price is paid for nothing.

15.3 How thin the evidence beneath that rule is

The only meta-analysis confirms the efficacy half and prices the slower schedule in days: twice-weekly ECT produced a similar change in depression score, with a statistically significant longer duration of treatment of roughly 4.8 to 6.5 days. It fixes the lower bound too, since thrice-weekly ECT was significantly more efficacious than once-weekly ECT, and reports no cognitive endpoint, corroborating the efficacy and duration halves only.

Outside depression the trade is half established. The one comparison in schizophrenia, a retrospective series of 43 patients, found more rapid response on the thrice-weekly schedule, equal effectiveness, and no significant difference in cognitive impairment at the end of the study: the speed finding reproduces, the cognitive one does not. Nothing newer exists, since a review of trials to March 2019 found no original research study examining the issue of frequency of ECT sessions among its 30 studies. The rule rests on trials from the 1990s and on consensus, and saying so is part of teaching it.

15.4 Which schedule each tradition actually recommends

The shorthand is a two-camp story, the United Kingdom twice weekly and North America thrice weekly, and the sources do not support it. What is grounded is practice: in the United States and Israel thrice-weekly ECT is a common practice, while in the United Kingdom twice-weekly sessions are commonplace. Practice is not recommendation, and the American position is itself a range: the task force recommends twice or thrice weekly sessions, cautioning that more frequent sessions could result in higher cognitive deficits and that frequency should be reduced if cognitive effects are of serious concern. The United Kingdom limb ties higher frequency to lethality, not impatience: the college handbook recommends twice weekly for bilateral and for unilateral ECT, with thrice-weekly bilateral reserved for life-threatening illness and only while the threat is high.

One exception inverts that and stops the twice-weekly preference reading as a blanket law: given the slower speed of response already seen in ultrabrief ECT, that form should routinely be given three times per week. Where no source settles a jurisdiction's recommendation the gap is declared: none states thrice weekly as a North American recommendation.

15.5 The accelerated schedule, and what buys it

Twice against thrice weekly is not the whole of frequency, and what it omits matters when the clock is short. In malignant catatonia the course opens on an **accelerated schedule**: in view of the life-threatening potential of malignant catatonia, bilateral treatments daily or twice daily for 3 to 5 days are often required to achieve a rapid result, followed by ECT at conventional frequencies until complete resolution. Why the presentation earns treatment is this chapter's account of the indications, and the entity and its differential are those catatonia notes'. The schedule is assembled here and nowhere else.

The same guideline grades it, with trigger, endpoint and step-down: if there is partial or no response to lorazepam within 48 to 72 hours, institute bilateral ECT once or twice daily for up to 5 days until malignant catatonia abates, followed by ECT three times per week until sustained improvement, usually 5 to 20 treatments in total. Its grade is D, expert consensus and not trial evidence, part of the teaching. A second jurisdiction corroborates it, introducing ECT with closer spacing, that is successive days, for rare severe and life-threatening states such as malignant catatonia, then resuming at 2 or 3 per week, but not twice-daily treatment, which rests on the consensus guideline alone.

The comparable emergency is not handled identically: in neuroleptic malignant syndrome, if clinical features persist, consider bilateral ECT three times weekly or, in severe cases, once or twice daily until the syndrome abates, then three times per week until sustained improvement, to a total of 5 to 20 treatments, graded C. Accelerated dosing opens the malignant catatonia course and is held in reserve here.

What buys the extra cognitive cost is mortality, and the evidence is survival data. Across five series, 51 of 54 patients treated with ECT survived, whereas only 6 of 14 given antipsychotics and supportive care recovered, and timing decided the rest: **16 of 19 patients receiving ECT**

within 5 days of onset survived, while none of 14 starting beyond that 5-day point recovered. These are historical series inside a current guideline, cited for what they established, not as a practice parameter. The trade is the chapter's usual one, priced differently: where the competing risk is death within days, speed outweighs the cognitive cost, and that cost is this chapter's account of the cognitive effects.

STEP	MALIGNANT CATATONIA	NEUROLEPTIC MALIGNANT SYNDROME
TRIGGER TO TREAT	Partial or no response to lorazepam within 48 to 72 hours	Clinical features persist
PLACEMENT AND STIMULUS	Bilateral, the stimulus dosed liberally to secure a well-generalised seizure; threshold, titration and adequacy are this chapter's dosing account	Bilateral, under the same account
OPENING FREQUENCY	Daily or twice daily, for 3 to 5 days	Three times weekly by default, once or twice daily in severe cases
ENDPOINT OF THAT PHASE	Until malignant catatonia abates	Until the syndrome abates
STEP-DOWN	**Step-down** to three times per week until sustained improvement	Three times per week until sustained improvement
TOTAL AND GRADE	Usually 5 to 20 treatments, grade D	A total of 5 to 20 treatments, grade C

TRAP **Giving malignant catatonia the ordinary twice-weekly or thrice-weekly course.** The decision to treat is right and the schedule too slow, which in a presentation whose survival turns on how early treatment starts is a wrong answer with a right diagnosis attached.

15.6 How many treatments, and by which indication

No source fixes a course length in advance: the number of ECTs should not be predetermined but should be based on the needs of individual patients. Around it sit the examinable figures. The task force gives **6 to 12 sessions for depression**, higher where the protocol changed and in schizophrenia, and practice sits inside it, the mean number of ECT sessions being between 6 and 10 in most studies, which its reviewers say cannot be read without knowing why courses stopped.

In catatonia practice was wider than any recommendation: most studies reporting frequency described ECT three times weekly, ranging between daily and twice weekly, with sessions from 3 to 35 and a mean of 9, and no data on the superiority of these protocols. For non-malignant acute catatonia the guideline sets a floor, that where ECT is administered in acute catatonia it should be given at least two times weekly, tying the count to response, risks and side effects. Direction is grounded where a number is not: in general the response to ECT is seen after more sessions in schizophrenia than in depression and mania.

15.7 Judging response, the mid-course decision, and stopping

Two rhythms of assessment run through a course. The Indian guideline requires a structured, indication-specific symptom rating tool weekly wherever feasible, and a clinical assessment after every ECT, preferably within 24 hours and certainly before the next session, with symptoms and cognitive and other adverse effects monitored at least once a week. A policy guideline sets another cadence, clinical assessments at least twice per week, with structured rating scales before commencing and at the end: the difference is jurisdictional.

The **mid-course review** carries two thresholds, not to be merged. Technique changes first: **switching unilateral to bilateral, or ultrabrief to brief pulse, may be considered after a risk-benefit analysis if improvement is not noted after four to eight sessions**. Failure is declared much later, since a minimum of 8 to 12 ECT sessions should be provided in acute courses before considering failure of response, with continuation beyond 12 sessions decided after a risk-benefit analysis. The United Kingdom handbook is stricter and conflicts with that floor: bilateral ECT for depression may be stopped if there is no improvement at all during the first six treatments, and continued to 12 sessions where there is some. Both are printed and the conflict named, not resolved.

Clinically, ECT may be terminated at any time if complete clinical improvement or remission is achieved, and the course is generally stopped as soon as remission is achieved, or if initial improvement remains unchanged for two additional sessions. Current United Kingdom depression guidance has two limbs: stop ECT for a person with depression immediately if the side effects outweigh the potential benefits, or when stable remission has been achieved. The endpoint is **stable remission** and not response, the wording of the superseded appraisal: assess clinical status after each session and stop when a response has been achieved, or sooner on adverse effects, monitoring cognitive function at a minimum at the end of each course, which stays quotable for catatonia, a prolonged or severe manic episode and schizophrenia only.

- **After every treatment.** A clinical assessment, before the next one.
- **Once a week.** A structured rating tool where feasible, plus adverse effects.
- **At the mid-course review.** If nothing has moved, change technique before changing the verdict.
- **At remission.** Stop; current depression guidance ends on remission, not response.
- **Before calling it a failure.** Count what was given; the Indian floor is high.

> **GOOD TO REMEMBER**
>
> Cognitive concern is a reason to slow a course down, not only to change the placement: both the task force and the policy guideline say to reduce the frequency where cognitive effects are a serious concern. Slowing costs time to remission and not the eventual result.

IN INDIA

Three numbers come from the current guideline, the last two from a single passage: two to three sessions per week, the minimum of eight to twelve sessions before failure is considered, and the four to eight session point at which technique changes instead. The last two are routinely confused, the earlier changing placement or pulse width, the later changing the verdict. Schizophrenia is common here and responds after more sessions, so a long course may be ordinary for it.

MNEMONIC

SOONER NOT STRONGER, DYING BUYS DAILY, COUNT BEFORE YOU CALL IT FAILED

Sooner not stronger is the frequency question: the faster schedule reaches response earlier and costs more memory, and both finish in the same place. **Dying buys daily** is the accelerated regimen: lethality, not impatience, pays for the added cognitive cost, and the schedule steps down once the emergency abates. **Count before you call it failed**: change technique at the earlier threshold, and count what was given before declaring failure.

PITFALL

Writing a faster schedule into an answer as though it made the course more effective, which it never does. The consequence is clinical: the resident who believes it imposes avoidable memory impairment on a patient who would have reached the same end point anyway.

The acute course runs at two to three treatments a week, and treatment frequency buys speed of response rather than efficacy: both schedules reach equivalent efficacy at the end of the course while the faster reaches response sooner and costs more cognitively, established in depression, not schizophrenia. Malignant catatonia and comparable life-threatening presentations open instead on an accelerated schedule of daily or twice-daily bilateral treatment for a few days, triggered by failure of the lorazepam trial, run until the syndrome abates and stepped down to three times a week, because mortality pays for the cognitive cost. No course length is fixed in advance; response is assessed after every treatment and rated weekly; technique changes at the earlier non-response threshold and failure only at the later; the course stops at stable remission.

16 · Continuation and maintenance ECT

An acute course of electroconvulsive therapy buys a remission and does not keep it, and what is put in place in the weeks after the last treatment decides whether the remission survives. A patient left with nothing active after remission is at very high risk of relapse, heaviest in the first weeks. Continuation and maintenance treatment answers that fact: medication continued, or treatment on a lengthening interval, or both. It is examined as a sequence of intervals, written here.

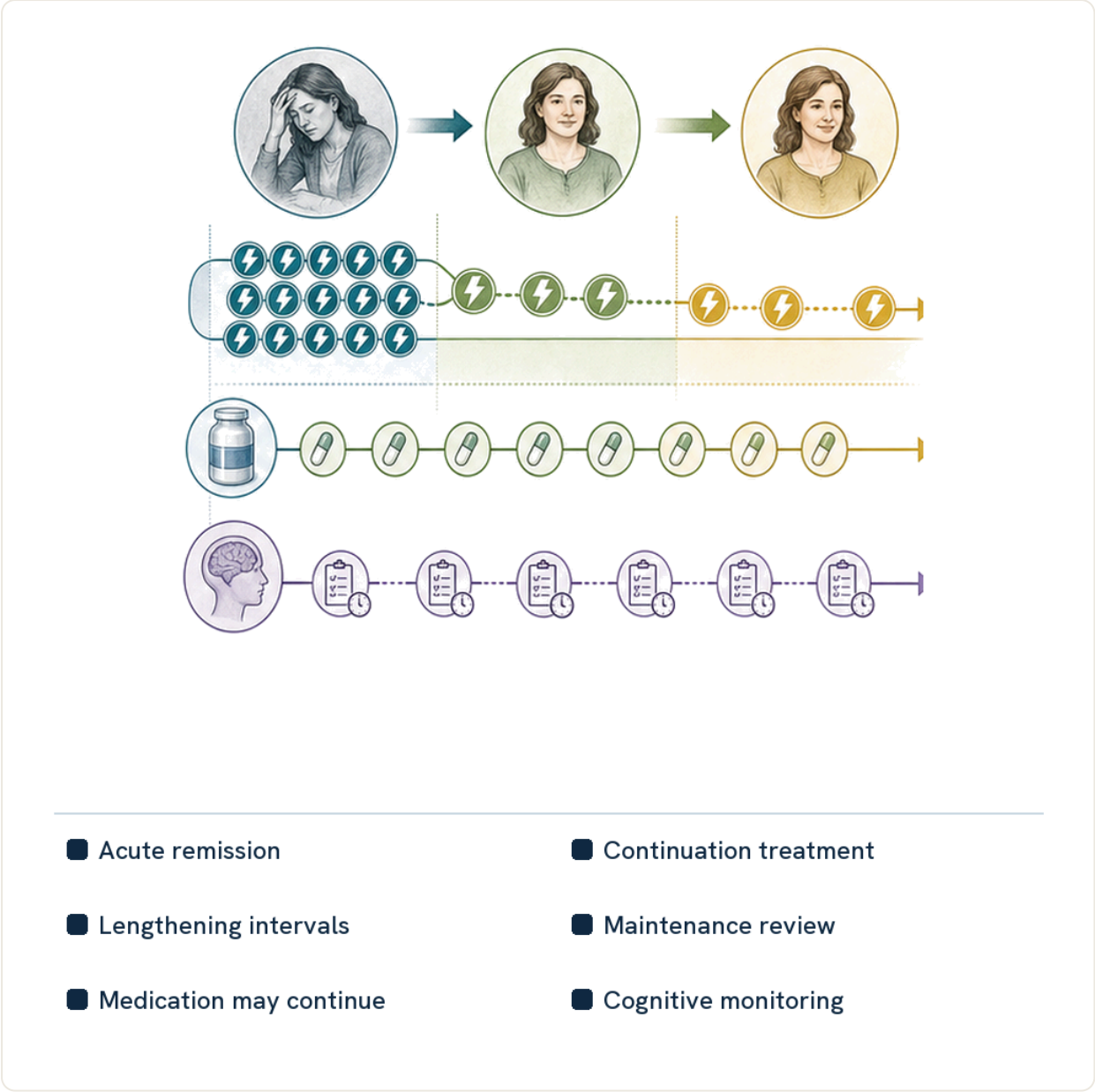


Fig 27.11 An acute ECT course produces remission but does not secure it. Active continuation treatment begins immediately, treatment intervals may lengthen into maintenance, medication may continue, and ongoing need and cognition are reviewed.

Owned here in full: the relapse problem after a successful course, the continuation pharmacotherapy that must follow it, and continuation and maintenance electroconvulsive therapy itself, meaning its indications, its tapering schedule of intervals, its maintenance interval, its duration and review, its cognitive monitoring, its evidence and the unsettled question of its stimulus dose. Named and not re-derived, each owned elsewhere in this chapter: the acute course and its frequency, which end where this section begins; the seizure threshold and its titration; the amnesias; and the drugs that move the threshold. The choice of continuation drug belongs to the Mood disorders: pharmacotherapy notes.

84%	1 to 12 weeks	3 to 6 months
RELAPSE AFTER A SUCCESSFUL COURSE WHEN NOTHING ACTIVE FOLLOWS IT	THE MAINTENANCE INTERVAL BAND, ONCE THE CONTINUATION PHASE IS OVER	HOW OFTEN COGNITION IS REASSESSED ON A MAINTENANCE COURSE

16.1 The problem this section exists to answer

The trial that defines the problem randomised remitters to placebo, nortriptyline, or nortriptyline with lithium. Over 24 weeks the relapse rate was **84%** on placebo, 60% on nortriptyline alone and 39% on the combination. Two readings follow. Without active treatment virtually every remitter relapses within 6 months of stopping, so no acute course ends without a continuation plan. And the danger is front-loaded: on the combination, all but one relapse occurred within 5 weeks of the end of the course, while on placebo or nortriptyline alone relapse accrued throughout. The weeks straight after the last treatment are the ones that need cover, which is what every schedule below is for.

16.2 Continuation pharmacotherapy, and whether ECT does better

Continuation pharmacotherapy is the default and is not optional. The current United Kingdom depression guideline of 2022 states that if depression has responded to a course, the clinician should start or continue antidepressant medication or a psychological intervention to prevent relapse and to provide ongoing care, and consider lithium augmentation of the antidepressant. Which antidepressant, at what dose, and how the lithium augmentation is set up are the Mood disorders: pharmacotherapy notes'.

Whether continued treatment beats continued drugs was tested head to head: 201 patients who had remitted with bilateral treatment, randomised to continuation electroconvulsive therapy or to continuation lithium with nortriptyline for 6 months. Relapse was 37.1% in the continuation electroconvulsive therapy arm and 31.6% in the drug arm, with no significant difference in overall survival curves or in time to relapse. Both beat a historical placebo control, and both had limited efficacy, with more than half of patients either relapsing or dropping out.

TRAP **Writing continuation electroconvulsive therapy as the stronger option because it is more intensive.** The head-to-head trial found no difference in relapse or in time to relapse against continuation drugs. It is an alternative for the patient in whom drugs have failed, are not tolerated or are refused, not an upgrade for everyone who responded.

16.3 Continuation and maintenance: two phases, one line between them

The two words are not interchangeable, and the boundary between them is a duration. **Continuation electroconvulsive therapy** follows the **index course** and consolidates the improvement obtained; **maintenance electroconvulsive therapy** begins beyond that line and prevents a new episode. The Indian guideline draws the line at 6 months and names the conditions in which either is used: major depressive disorder, bipolar disorder and schizophrenia. Who earns an acute course at all is this chapter's account of the indications. A second guideline draws the same line and adds the operative instruction: if patients remain well during the continuation phase, the interval between treatments should be progressively extended.

AXIS	CONTINUATION PHASE	MAINTENANCE PHASE
WHEN IT RUNS	From the end of the index course, up to 6 months of remission	Beyond 6 months from the treated episode
PURPOSE	Consolidating what the index course obtained	Prophylaxis against a further episode or recurrence
INTERVAL	Weekly to monthly, extended progressively while the patient stays well	**One session every 1 to 12 weeks**, and occasionally less frequently
SETTING	Both are generally administered as outpatient treatments	
CONSENT	Obtained again before either begins, because the clinical condition, the purpose and the character of the treatment have all changed	

The consent row is not a formality: what has changed since the first conversation is the condition, the purpose, now relapse prevention rather than rescue, and the treatment's own character, meaning its frequency and its endpoint. The statutory machinery is this chapter's account of consent and the law.

16.4 The taper: the schedule of intervals, in order

This is the schedule the reader was promised, and it begins where the acute course ends; this chapter's account of the acute course and its frequency stops there. The Indian guideline states the sequence plainly: an effective acute course is gradually tapered down from twice a week to weekly, then fortnightly, then monthly, tailored to the patient's clinical needs. Two instructions travel with it: the course should not be prefixed, and it should be planned dynamically and scheduled on periodic clinical review. Once the continuation phase is over, **maintenance is usually given at a frequency ranging from one session every 1 to 12 weeks**, with pharmacological and psychological alternatives weighed in the risk to benefit analysis while it is planned. Three named schedules fill it in, differing in how much is fixed in advance.

SCHEDULE	THE INTERVALS, IN ORDER	WHAT IT IS FOR
STEP-DOWN ECT	One treatment 1 week after the index course is completed, a second 2 weeks after the first, then a continuation protocol if required	Bridging the end of the index course; relapse rates can be lower than with abrupt cessation
FIXED SLOW TRANSITION	Weekly for 4 weeks, then every 2 weeks for 2 months, then monthly thereafter	The trial-derived fixed taper, and the most concrete sequence available
SYMPTOM-TITRATED SCHEDULE	4 continuation treatments over 1 month, then further treatment only as needed under a symptom-titrated algorithm, alongside continued medication	The flexible alternative; it gave better mood outcomes than medication alone at 24 weeks with no significant difference in global cognitive screening

One indication carries a tighter band. In bipolar disorder, more frequent sessions may be required than for other indications, with inter-treatment intervals as short as one to three weeks. The same guideline settles a question that arises there: mood switches occur at a rate similar to that seen with antidepressant medication, concurrent lithium may reduce the risk, and in general a switch is not an indication to stop treatment.

MNEMONIC

TWICE, WEEKLY, FORTNIGHTLY, MONTHLY

The taper in the order it is asked for: from the acute schedule of **twice** a week, down to **weekly**, then **fortnightly**, then **monthly**, and out into the maintenance band. Each step down is earned at a review rather than reached on a calendar, which is why the course is never prefixed.

16.5 The principle that governs every interval

A resident who memorises the intervals and not the principle will schedule the wrong patient wrongly. The guideline states that the optimal timing and frequency of continuation and maintenance treatment is yet to be determined and probably varies between individuals, and gives the aim that orders the section: to extend the inter-treatment interval and minimise the cumulative number of treatments, in order to reduce the risk of cognitive side-effects. What is managed is cumulative exposure; the **inter-treatment interval** is how. The opposite failure is named too: adhering rigidly to a pre-defined transition schedule is problematic, and pursuing a fixed goal of an inter-treatment interval of one month, especially too quickly, may result in relapse, particularly in patients with rapid-cycling bipolar disorder, or depressive illness with a history of early relapse after treatment.

RULE **The maintenance course is scheduled to the patient, not to a target interval.** Lengthening the interval keeps cumulative treatments low, which is what limits cognitive risk; but a fixed transition pursued too fast precipitates relapse in the patients who needed treatment most. One practice avoids both errors: set the next interval at a review of this patient, not in advance.

16.6 Maintenance ECT is not given alone

Medication continues through the maintenance course rather than being replaced by it. The guideline directs that maintenance treatment should be given in conjunction with an antidepressant, unless there is a specific contraindication such as poor tolerability in an individual patient, and that lithium as a relapse-prevention strategy after a course has a strong evidence base and can be used together with maintenance treatment. The interval does one more job here: lithium is safer during maintenance than across an acute course precisely because treatments are much further apart, fortnightly to monthly rather than two to three times a week. Why lithium is a concern across an acute course, and how the threshold-moving drugs are handled around each treatment, are this chapter's account of concurrent medication and drug interactions.

16.7 The stimulus dose at maintenance: an open question, not a schedule

What the threshold is, and how titration measures it, is this chapter's account of stimulus dosing and the seizure threshold. The question that follows belongs here: when sessions are weeks apart, is the dose set at the original titration still the right dose? It is a real question because the threshold moves. It rises across a course of frequently repeated treatments and returns to baseline 6 months after treatment stops, leaving the continuation and maintenance window, longer than a few days and shorter than 6 months, unexamined. Three pieces of evidence bear on it, and none is a rule.

- **The series that framed it.** A retrospective study of 19 patients whose treatments were separated by at least 14 days found significant changes in seizure duration when treatments were separated by more than 60 days, read by its authors as **a fall in threshold or a loss of anticonvulsant action after 2 months, and as an indication to re-titrate after that time**. Its limits are part of the answer: the measured quantity was seizure duration, not the threshold, and the design was retrospective and small.
- **Lowering the dose on purpose.** A unit whose device was capped at 614 mC, 60% of the maximum possible output, asked whether the lower dose gave its maintenance patients better seizure quality, which is the direction that makes the positive finding an argument for re-titration rather than against it. In 15 patients, lowering the energy delivered increased seizure quality overall, which the authors read as an argument for re-titration during maintenance.
- **What is actually done.** In usual clinical practice a constant stimulus dose is delivered through the maintenance course, and the threshold is not re-titrated even when the interval between two successive sessions is longer. The same report describes a stable long-term maintenance patient whose threshold had fallen, which is why the practice is worth questioning.

Evidence on the effect of continuation and maintenance regimens on the threshold is scant, and there are no clear guidelines on the duration after which it has to be recalculated; the authors suggest periodic re-titration, which would prevent unwarranted high stimulus dosing and thereby reduce the risk of cognitive adverse effects.

TRAP **Quoting a re-titration interval as though a guideline had set one.** The figures come from a small retrospective series and a single-unit report, and the sources state that no clear guideline exists. Answer with the shape of the question: the dose is usually carried forward unchanged, the threshold may have moved by the time it is used, and periodic re-titration is reasonable practice rather than a schedule.

16.8 Cognitive monitoring across a maintenance course

The obligation is stated as an interval, and examined in that form. Patients receiving continuation or maintenance treatment must have regular cognitive assessment with a standardised instrument, every 3 to 6 months, or more frequently if significant or worsening deficits are identified, or if the patient is on lithium. The **standardised cognitive assessment** is the instrument; the interval lever is the intervention. What the deficits are, how anterograde and

retrograde amnesia differ in mechanism, course and prognosis, and how far a retrograde deficit persists, are this chapter's account of the cognitive side effects.

The monitoring is required because the evidence does not settle the question. Screening scores remain unchanged or increase during continuation or maintenance treatment. But neuropsychological testing of 11 patients treated for depression for an average of 3 years, with almost 2 months between treatments, identified deficits in learning and frontal function compared with controls, while studies of treatment given across a lifetime have shown no evidence of cumulative cognitive deficit. A screening instrument and a neuropsychological battery do not ask the same question, which is the likeliest reason they disagree, and why the obligation is to measure this patient.

GOOD TO REMEMBER

Three things are checked at every maintenance review: whether the illness is still quiet at the current interval, whether cognition has been formally assessed within the required window, and whether the patient is on lithium, which tightens that window. If the interval has been stretched and symptoms have broken through, shorten it and review again before concluding the treatment has failed.

16.9 How long it runs, and what ends it

No source located sets a fixed duration for maintenance treatment, and inventing one is how this question is usually answered wrongly. What is set instead is review: the need for maintenance treatment must be regularly reviewed and documented, and plans to continue or to cease should be made in consultation with the patient and their family. In that guideline's jurisdiction statutory consent also expires and must be renewed, turning the review into a fixed stop. The Indian position arrives there by another route: consent is taken again before continuation or maintenance begins, and the course is planned dynamically at periodic review rather than prefixed.

IN INDIA

Quote the Indian Psychiatric Society guideline of 2023: continuation and maintenance divided at the six-month line; the taper from twice a week to weekly, to fortnightly, to monthly; maintenance at one session every one to twelve weeks; no prefixed course, planned dynamically at periodic review; and fresh consent before continuation or maintenance begins, because the condition, the purpose and the character of the treatment have all changed.

PITFALL

Carrying a foreign statutory consent expiry into the Indian frame. One guideline's review point is a consent validity period set by that state's own mental health legislation, not an Indian rule. The Indian requirement is fresh consent before continuation or maintenance begins, with no stated expiry.

Relapse is the rule when nothing active follows a successful course, so continuation pharmacotherapy is started or continued in every case, and continuation electroconvulsive therapy is an alternative to it rather than an upgrade. The taper runs from twice a week to weekly, to fortnightly, to monthly, then into a maintenance band of one session every one to twelve weeks, tighter in bipolar illness; it is never prefixed, the aim is to lengthen the interval and minimise cumulative treatments, and the course is held to standardised cognitive assessment every three to six months and to a documented review deciding each time whether it continues.

17 · Drug interactions and concurrent medications with ECT

Concurrent medication is the part of an electroconvulsive therapy course that is settled before any current is set, because almost every patient arrives already taking drugs that change the seizure, change the anaesthetic, or change what the treatment does to them. A drug interaction here is never one fact. It carries a direction on the seizure, a consequence for the patient, and a management step, and the three come apart: a drug can shorten every seizure without harming anyone, and another can be dangerous while leaving the seizure untouched.

Owned here is the interaction: which drug moves the seizure in which direction, what follows, and how each class is managed. Named and not re-derived, each owned elsewhere in this chapter: the threshold itself and how a stimulus is set against it, by the account of stimulus dosing and the seizure threshold; the induction agents, the relaxant and the airway, by the account of the pre-ECT workup and anaesthesia; postictal confusion and amnesia, by the account of the cognitive side effects; and the continuation drug and maintenance schedule, by the account of continuation and maintenance ECT. No titration method and no induction dose appears here.

24 hours	600 mg a day	0.6
THE INDIAN PRE-TREATMENT DISCONTINUATION INTERVAL FOR THEOPHYLLINE	THE CLOZAPINE BAND AT WHICH THE THRESHOLD IS KNOWN TO FALL	THE ELDERLY SERUM LITHIUM LEVEL, IN MILLIEQUIVALENTS PER LITRE, ABOVE WHICH CONCOMITANT LITHIUM IS AVOIDED; THE GUIDELINE'S OWN SPELLING OF THAT UNIT IS DISCUSSED BELOW

17.1 Four classes, four different consequences

The controlling Indian statement asks for the psychotropic drugs that can interfere with anaesthesia and treatment to be evaluated beforehand, and it maps four classes to four distinct consequences:

- anticonvulsants increase the seizure threshold;
- antipsychotics such as chlorpromazine and clozapine are **pro-convulsant**, which is to say they lower it;
- lithium increases the risk of postictal delirium;
- tricyclic antidepressants increase the risk of cardiac adverse events during treatment and anaesthesia.

Read that for its structure, not as a list of drugs. Only the first two entries are threshold statements. The lithium entry is about the brain after the seizure and the tricyclic entry about the heart during the anaesthetic; neither says anything about how easily a seizure is produced.

RULE **State the direction on the seizure and the consequence for the patient as two separate claims, then the management step.** A drug that raises the threshold threatens the treatment: the seizure may be short or absent and the course may fail. A drug that lowers it threatens the patient: the seizure may not stop. A drug that does neither may still be the most dangerous thing on the chart.

17.2 The morning list, one instrument in two halves

The Indian guideline gives the bedside decision as two lists read together. On the **withhold half**, the morning dose of oral hypoglycaemics, lithium, diuretics, anticonvulsants, theophylline and benzodiazepines can be withheld, with the requirement considered on an individual basis. On the continue half, scheduled antihypertensives, thyroxine, antiemetics, antireflux drugs, antianginals, bronchodilators and anticholinergics should not be withheld and can be taken orally 2 hours before the procedure with small sips of water.

The withhold half is not a threshold list: the oral hypoglycaemic is held because the patient is fasting and the diuretic because of volume and electrolytes, neither having anything to do with the seizure. The continue half holds blood pressure, thyroid state, gastric acid, coronary perfusion and airway calibre, whose omission destabilises a patient about to be anaesthetised. Withholding one of those that morning is as much an error as continuing an interacting drug.

17.3 The drugs that raise the threshold

Benzodiazepines increase the seizure threshold, decrease seizure duration, decrease the potential efficacy of treatment and possibly increase cognitive side effects. The third of those matters most: it threatens whether the course works, not merely seizure length. Where the drug has been taken routinely the impact on adequacy may be smaller; it also adds sedation at induction.

Stop the benzodiazepine before the course where possible; a long-acting one may need some days. Where abrupt cessation risks a withdrawal seizure, taper and cease early in the course; that is safe because treatment is itself anticonvulsant. Non-benzodiazepine hypnotics act the same way close to a treatment. Where the drug cannot be stopped, two workarounds are named: a higher stimulus, whose setting belongs to the account of stimulus dosing and the seizure threshold, or reversal. Flumazenil 0.4 to 1.0 mg intravenously immediately before treatment is that reversal, a prescribing decision owned by the anaesthetist and not taught here, for the patient on high doses or unable to tolerate discontinuation; the figure is the anaesthetist's prescribing decision, printed so the psychiatrist knows what is being reversed, not as an instruction issued here.

Anticonvulsant mood stabilisers behave as their name promises: threshold up, seizure expression and duration down, efficacy possibly reduced. Where the anticonvulsant is only augmenting an antidepressant it should be withdrawn before the course begins. In bipolar disorder that is balanced against the risk of a manic swing. If it is continued, the dose can be reduced to the lower

end of the therapeutic range, and it is common practice to withhold the evening dose before each treatment and delay the morning dose until after recovery. The patient taking it for **epilepsy** is handled with the neurologist and carries an instruction that must never be dropped: the dose may fall further as the course proceeds, because treatment is itself potently anticonvulsant, and it must be restored to pre-treatment levels when the course ends.

TRAP **Teaching anticonvulsant reduction as settled practice.** The same guideline that advises withdrawal records the evidence against it: full-dose anticonvulsant through a course of bitemporal treatment gave faster recovery in bipolar disorder without deterioration in seizure quality (Rakesh and colleagues, 2017), and continuing sodium valproate did not affect seizure duration or recovery from mania (Haghighi and colleagues, 2013). The direction of the class effect is not in doubt; the instruction to reduce or withhold is contested for mania and should be written as contested.

17.4 Lithium, the interaction most often examined

No source carried here states that lithium moves the threshold in either direction, which is not the same as a finding that it leaves the threshold alone, and the silence is why it is misfiled so often. Its mechanism sits at the brain: treatment increases the permeability of the blood brain barrier and lets more lithium in at an unchanged serum concentration. With a narrow therapeutic index that is enough to produce toxicity in a patient whose blood level reads as therapeutic, and reports of severe confusion concentrate at the higher end.

The full interaction carries four consequences: delirium, prolonged seizures, toxic lithium levels and **prolonged neuromuscular blockade**. The last is not a psychiatric event; the relaxant and the management of a prolonged block belong to the account of the pre-ECT workup and anaesthesia, and it is named here so it is discussed with the anaesthetist beforehand rather than discovered on the list. The same source states, against a common teaching, that the combination is not an absolute contraindication and may be considered in certain EMERGENCIES where the benefits clearly outweigh the risks. The emergency restriction is the source's own and is the difference between a narrow carve-out and general permission.

Indian practice attaches a figure to the elderly patient: concomitant high-dose lithium **above 0.6** is avoided because of the higher risk of postictal delirium, and the same figure returns in the management of cognitive adverse effects, as the level above which lithium should be reduced or stopped. Both are population-qualified; neither is a general prohibition. The unit takes one sentence of its own, because the guideline is not consistent about it: it spells the unit 'mq/l' in the elderly bullet and 'meq/l' in the cognitive bullet, both mean milliequivalents per litre, the first is a typographical error, and both renderings are reproduced here rather than replaced by the unit this chapter believes was meant, since silently correcting a source is how a wrong number enters a chapter.

Suspend lithium before the course if clinically safe. If it is maintained, omit the evening dose before each treatment and delay the morning dose until after recovery, or run a lower regular dose at the lower end of the range. In bipolar disorder the risk of a manic swing on withdrawal makes this a weighing rather than a default. Case reports in ELDERLY patients indicate that

holding lithium for only 24 hours may still leave a level sufficient to contribute to delirium, and the population is part of the finding rather than a detail, so an omitted dose is not by itself a guarantee.

17.5 The drugs that lower it, and a divergence about theophylline

On the other side of the ledger, theophylline and bupropion can increase seizure duration and should be ceased before the course commences where possible. Theophylline is the more dangerous because of where it is met: a patient treated for asthma or chronic obstructive pulmonary disease, where the drug is doing necessary work and cannot simply be deleted.

Two grounded sources handle it differently and this account states the divergence rather than choosing. The Indian guideline gives a flat interval: theophylline is to be discontinued 24 hours before treatment because of the risk of prolonged seizures and status epilepticus. The second source gives no interval at all, says only that it should be ceased where possible, and names bupropion in the same breath. Carry the Indian interval into an Indian examination, and notice that the other source stops the drug without a clock and adds one the Indian sentence does not.

The interaction literature sharpens this. There are reports of status epilepticus after treatment, with high theophylline levels during treatment associated with status epilepticus, making this level-dependent rather than a presence-or-absence signal. Its management ladder ends somewhere more useful than stopping: taper the theophylline and continue bronchodilators and inhaled glucocorticoids, or reduce to the lowest therapeutic level and monitor closely, treating an exacerbation in the standard way before proceeding. That is substitution rather than withdrawal, and it is the asthmatic patient's answer. One thing must not be merged into it: the Indian guideline names theophylline again after a prolonged seizure has happened, as something to stop temporarily, and that is reactive, not a second version of the prophylactic interval.

17.6 Antipsychotics continued through a course

Antipsychotics are commonly continued and are generally well tolerated. Two hazards are named. Clozapine has many reports of safe use and also a risk of prolonged seizures and confusion, because it lowers the threshold; patients on it may also be at risk of tachycardia and of aspiration from hypersalivation. Typical antipsychotics can produce electrocardiographic abnormalities, QTc prolongation in particular.

The clozapine effect is dose-dependent and the band is stated: the threshold falls **usually at doses above 600 mg a day**, and a dose reduction before treatment may be considered on that basis. That figure is a prescribing decision belonging to the treating team, printed only to locate where the threshold effect becomes real; the indication for combining clozapine with treatment belongs to the account of the indications for ECT.

17.7 Antidepressants continued through a course

Antidepressants have generally been administered safely during treatment, with risks and benefits discussed with the patient; the class differences are what an examination wants. Tricyclic antidepressants carry reports of adverse cardiac effects, specifically QRS prolongation, atrioventricular block and hypotension, together with confusion and excessive sedation.

Venlafaxine carries reports of prolonged asystole and hypotension, with a dose signal: a possible increased risk of asystole **at doses above 300 mg a day**, again a prescribing matter for the treating team rather than an instruction here. The counterweight travels with it: a controlled study found nortriptyline and venlafaxine not associated with an increase in cardiac events compared with placebo (Sackeim and colleagues, 2009). Selective serotonin reuptake inhibitors are generally considered safe.

Monoamine oxidase inhibitors carry a rule rather than a caution. Their use with treatment has been associated with blood pressure changes, hyper-reflexia and seizures, and the patient taking one is at increased risk of hypertensive crisis if given a sympathomimetic agent or pethidine, so those agents are avoided during the course. Bupropion belongs with the threshold-lowering drugs above, and status epilepticus has been reported with its concomitant use.

One fact points forward. The majority of patients with a major depressive episode who respond are likely to relapse within six months without continuation pharmacotherapy, and it is standard practice to commence an antidepressant, usually from a different class, during or just before the end of the course. Which drug, on what schedule, and the maintenance course itself belong to the account of continuation and maintenance ECT.

17.8 The anaesthetic interactions

Several interactions above reach into the anaesthetic room: sedation at induction from the benzodiazepine, prolonged action of neuromuscular blocking agents from lithium, cardiac events from the tricyclics and venlafaxine, and two agents barred by the monoamine oxidase inhibitor rule.

The one a resident meets is in an elderly patient on a dementia drug. Acetylcholinesterase inhibitors may potentiate the bradycardia produced by the electrical stimulus and by suxamethonium, and they potentiate its muscle relaxant effect, particularly rivastigmine, which also inhibits butyrylcholinesterase, the enzyme that metabolises suxamethonium. The relaxant and the management of a prolonged block are the pre-ECT workup and anaesthesia account's in full; what belongs here is naming the drug that causes it, so its continued use is discussed with the anaesthetist rather than assumed. There are numerous case reports of the safe use of donepezil and rivastigmine during a course, and a systematic review indicated rivastigmine may even protect against treatment-induced cognitive impairment (Henstra and colleagues, 2017): an interaction to plan around, not a reason to stop the drug.

17.9 The ledger in one table

DRUG OR CLASS	DIRECTION ON THE SEIZURE	CONSEQUENCE	MANAGEMENT ACROSS A COURSE
BENZODIAZEPINES AND Z-DRUGS	Threshold up, seizure shorter	Course efficacy threatened; possibly more cognitive burden; sedation at induction	Stop early, long-acting ones days ahead; taper if withdrawal seizures threaten; else higher stimulus or flumazenil
ANTICONVULSANT MOOD STABILISERS	Threshold up, expression and duration down	Efficacy possibly reduced	Withdraw if only augmenting; balance against manic relapse; else low in range, doses withheld around treatment; restore at the end in epilepsy
LITHIUM	Not stated by the grounded sources	Postictal delirium, prolonged seizures, toxicity, prolonged neuromuscular blockade	Suspend if safe; else omit the evening dose, delay the morning dose, or run low in range
THEOPHYLLINE	Seizure longer; a threshold direction is not stated by the grounded sources	Prolonged seizure and status epilepticus, level-dependent	Indian interval beforehand, or taper with inhaled therapy substituted; sources diverge
BUPROPION	Seizure longer; a threshold direction is not stated by the grounded sources	Status epilepticus reported	Cease beforehand where possible; no interval carried
ANTIPSYCHOTICS (CLOZAPINE, CHLORPROMAZINE)	Threshold down (chlorpromazine and clozapine)	Prolonged seizures and confusion; tachycardia and aspiration risk with clozapine; QTc prolongation with typical agents	Usually continued; dose reduction considered in the high clozapine band
TRICYCLICS AND VENLAFAXINE	Neither direction	Cardiac events and confusion; asystole reports with venlafaxine, unconfirmed in a controlled study	Continued after weighing risk and benefit
MONOAMINE OXIDASE INHIBITORS	Neither direction	Blood pressure changes, hyper-reflexia, seizures; hypertensive crisis with sympathomimetics or pethidine	Continued, those agents barred
ACETYLCHOLINESTERASE INHIBITORS	Neither direction	Bradycardia potentiated; block prolonged, most with rivastigmine	Continued after discussion with the anaesthetist

MNEMONIC

UP, DOWN, AND NOT THE THRESHOLD AT ALL

Up: benzodiazepines and anticonvulsants, which threaten the course. **Down**: clozapine and chlorpromazine, theophylline and bupropion, which threaten the seizure ending. **Not the threshold at all**: lithium, the tricyclics and venlafaxine, the monoamine oxidase inhibitors and the acetylcholinesterase inhibitors, whose dangers are delirium, the heart, a crisis and a block. That third group is the one candidates lose.

A drug interaction across a course is three statements: a direction on the seizure, a consequence for the patient, and a management step. Benzodiazepines and anticonvulsant mood stabilisers raise the threshold and threaten the efficacy of the course, and are stopped, tapered or timed around each treatment. Clozapine, chlorpromazine, theophylline and bupropion lower it and threaten a seizure that does not stop. Lithium moves it in neither direction and is still the most examined interaction, because treatment lets more of it into the brain at an unchanged serum level, bringing delirium, toxicity and a prolonged block. Antipsychotics and antidepressants are usually continued, each class carrying a hazard rather than a prohibition. The threshold itself and the conduct of the anaesthetic are other accounts' in full.

Other neurostimulation therapies

18 · Repetitive transcranial magnetic stimulation (rTMS): mechanism, indications, parameters

Repetitive transcranial magnetic stimulation puts an electrical current into cortex without touching the skin, and it is dosed so that the current never becomes a seizure. That second half separates it from everything the electroconvulsive therapy half of this chapter has taught. The examinable weight sits in the parameters, because rTMS is prescribed as a set of values that travel together rather than as a dose, and each is referenced to a measurement taken from the patient's own cortex, the motor threshold, which a candidate must define, obtain and keep separate from the threshold this chapter has already taught.

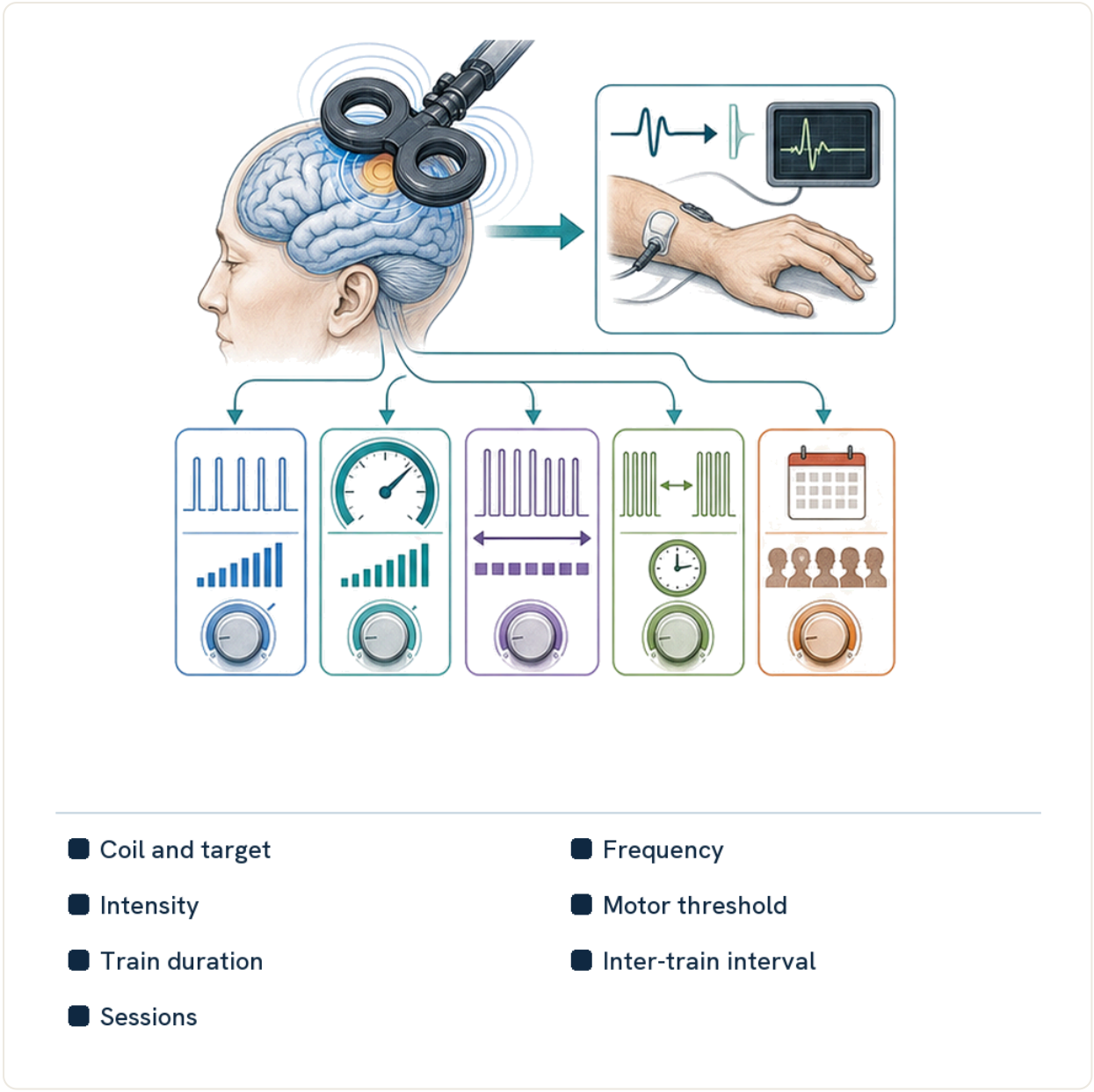


Fig 27.12 Repetitive transcranial magnetic stimulation is prescribed as a linked set of coil, target, frequency, intensity, train, interval and session parameters. Intensity is referenced to the individual's motor threshold, which is distinct from an ECT seizure threshold.

This account owns rTMS and nothing else, from the induction mechanism to the safety limits. It does not grade rTMS against the other devices of this band; that comparison, across invasiveness, target, reversibility, evidence and Indian availability, belongs to this chapter's cross-cutting synthesis and its band grid, and each of the other five items teaches its own device. The seizure threshold and the stimulus dose belong to this chapter's account of stimulus dosing, the seizure threshold and adequate seizure criteria, and why an induced seizure helps to its account of the mechanism of action and neurobiological theories of electroconvulsive therapy; both are named for contrast, neither re-derived.

5 of 10	**120%**	**7 per 100,000**
POSITIVE TRIALS THAT DEFINE THE MOTOR THRESHOLD	OF MOTOR THRESHOLD, THE INTENSITY OF THE CLEARED DEPRESSION PROTOCOL	STANDARDISED SEIZURE RISK PER SESSION, PROTOCOLS POOLED

18.1 Electromagnetic induction, and why the magnetic field is not the stimulus

Electromagnetic induction is the principle the technique rests on, and the chain runs in a fixed order. A high-voltage, high-current discharge system drives a transducing coil, and the discharge produces a strong, time-varying magnetic field at right angles to the coil, peaking at 1 to 2.5 Tesla and lasting under about 1 millisecond. With the coil tangential to the head, that field penetrates scalp and skull with minimal attenuation, and in the conductive tissue beneath it induces a secondary eddy current whose electrical field is perpendicular to the magnetic field and opposite in direction to the current in the coil.

The name of the technique misleads, and its defining source says so. The magnetic field does not stimulate cortical neurons; it serves only to induce an electrical current in neural tissue, and it is that induced electrical current that depolarises cortical axons and triggers action potentials at suprathreshold intensities. At the neuronal level the excitation is the same as with conventional electrical stimulation, and induction buys freedom from direct electrical contact with the skin. Because the brain is not homogeneous, tissue conductivity distorts the induced currents, so exact distributions can be modelled but never read off the coil position.

18.2 Sub-convulsive by design: how rTMS differs from ECT

Conventional therapeutic rTMS is **sub-convulsive** by design, not by accident. The current international safety consensus states the contrast in the form this chapter needs: in conventional rTMS the goal is to select parameters that minimise seizure risk, whereas the modality that uses the same induction to treat by producing a seizure selects parameters efficient at inducing one, and that modality is taught in this chapter's account of magnetic seizure therapy and the emerging neuromodulation techniques. In rTMS a seizure is an adverse event, not the therapeutic mechanism.

Two consequences of that absence must be held apart, because collapsing them is the error this chapter's axis rule forbids. The first is **cognitive**: at therapeutic intensity rTMS does not produce the amnestic syndrome that follows a course of electroconvulsive therapy, and the reason is structural: that syndrome follows the induced generalised seizure, and rTMS induces none. The second is **safety**: an unintended seizure can still occur, at a rate quantified below, and the published safety limits exist to bound it. These are different currencies, and the absence of the first neither abolishes nor excuses the second.

18.3 The motor threshold, and how it is determined

The **motor threshold** is what every rTMS intensity is referenced to, and it is measured in this patient rather than looked up. The international practical guide defines it by a relative-frequency criterion, the Rossini criterion: the lowest stimulus intensity, given as a percentage of maximum stimulator output, required to induce a motor evoked potential in **5 out of 10** trials. It is obtained with single-pulse stimulation at the optimal site over the hand area of the primary motor cortex. Two thresholds are defined and are not interchangeable: the **resting motor threshold**, read with the muscle relaxed, and the **active motor threshold**, read during tonic contraction, each with its own amplitude criterion. Those criteria, the contraction level and the step sizes of the standardised search are not carried here. The Indian guideline states the same

construct as an operator uses it, and adds the caveat that matters in a busy clinic: a threshold read by eye rather than by electromyography comes out significantly higher, and an inflated threshold inflates every intensity derived from it.

AXIS	INTERNATIONAL PRACTICAL GUIDE	INDIAN THERAPEUTIC GUIDELINE
CRITERION	Motor evoked potential in 5 of 10 trials	Response in at least 50 percent of stimuli, usually 5 of 10
MUSCLE	A hand muscle at the optimal motor site	Abductor pollicis brevis or first dorsal interosseous, contralateral
DELIVERY	Single pulse, figure-of-eight coil	Single pulse, graded small to high, every 5 seconds

RULE **The rTMS motor threshold and the ECT seizure threshold are different constructs, and neither may be carried across to the other.** The motor threshold is a corticospinal excitability measurement, read from a hand muscle with single pulses over motor cortex, expressed as a percentage of the stimulator's maximum output, and used to set a deliberately sub-convulsive intensity. The seizure threshold is the stimulus dose at which an adequate generalised seizure is produced, and all of it, including dose expressed as a multiple of threshold, belongs to this chapter's account of stimulus dosing, the seizure threshold and adequate seizure criteria. They share a word and nothing else: different physiology, different instrument, opposite purpose.

GOOD TO REMEMBER

Treat the motor threshold as perishable. It would ideally be measured before every session; in practice the value set before the first may carry through that week. Re-determine it if sessions fall more than a week apart, if medication doses change, after heavy alcohol or substance intake, or if the patient reports headache or scalp pain.

18.4 The stimulation parameters, and frequency

The **stimulation parameters** are target, intensity as a percentage of motor threshold, frequency, train duration with its intertrain interval, and total pulses per session and per course. The two protocols cleared for depression share a target and an intensity and agree on nothing else.

PARAMETER	FIGURE-OF-EIGHT COIL PROTOCOL	H1 COIL DEEP TMS PROTOCOL
DEVICES NAMED	Neuronetics NeuroStar, Magstim Rapid2, MagVenture MagVita	Brainsway Deep TMS
TARGET AND INDICATION	Left dorsolateral prefrontal cortex, major depressive disorder in adults	
INTENSITY	120 percent of motor threshold	120 percent of motor threshold
FREQUENCY	10 Hz	18 Hz
TRAIN DURATION	4 seconds	2 seconds
INTERTRAIN INTERVAL	26 seconds	20 seconds
PULSES (PER SESSION)	**3,000**	1,980

Protocols are conventionally divided at 1 Hz, with **high-frequency rTMS** above that figure and **low-frequency rTMS** at or below it. The direction of effect is the teaching point, not any single value: low frequencies reduce cortical excitability and faster frequencies increase it. Both cleared protocols are high-frequency and left-sided. The practice band of intensities around the labelled figure, and the specific low-frequency value, are not carried here. Train structure carries its own safety-relevant direction: shorter trains with longer intertrain intervals are less likely to induce a seizure, so a protocol is never described by its frequency alone.

MNEMONIC

Target, Intensity, Frequency, Train, Total

The five values that define an rTMS prescription: **Target**, by a stated localisation method; **Intensity**, as a percentage of motor threshold; **Frequency**; **Train** duration with its intertrain interval; and **Total** pulses and sessions.

TRAP **Quoting a pulse count from one protocol beside a frequency from the other, or presenting either tuple as the general settings of rTMS.** A candidate who writes one set of standard rTMS parameters has described a protocol no regulator cleared and no trial ran. Name the coil geometry, the device family and the indication whenever a value is quoted.

18.5 Coils, devices, and finding the target

Coil choice is a focality decision. The **figure-of-eight coil** is the most commonly used and the most focal; H coils serve deep TMS; double-cone and round coils are larger and less focal. The safety consequence is that the larger, less focal designs are more efficient at producing a seizure than the focal figure-of-eight, which is why the seizure-inducing modality of this band uses them and conventional rTMS does not. Whether the choice changes outcome is thinner than it looks: efficacy and acceptability across NeuroStar, MagPro and Magstim in depressive disorders did not differ significantly, on response ($p = 0.12$), discontinuation ($p = 0.84$) or remission ($p = 0.07$). H1 against figure-of-eight coils showed a larger reduction in depression severity in the H1 studies

and a trend to higher remission the other way, differences the authors deem not clinically relevant on a low volume of studies with no placebo control.

Targeting the dorsolateral prefrontal cortex uses four methods:

- The **centimetre rule**, placing the coil a fixed scalp distance anterior to the motor cortex, classically 5 cm, with slightly longer distances also used.
- The International 10-20 electroencephalography system, in which F3 is the left dorsolateral prefrontal site.
- Stereotactic frames.
- Neuroimage-guided frameless neuronavigation.

The consensus preference is explicit: the method most practical in time and accuracy is head measurement to identify F3 using 10-20 coordinates. What moved practice off the centimetre rule was error: in a trial informed by magnetic resonance imaging the coil had to be moved forward to the longest quoted distance in a substantial minority, the proportion not carried here. The Indian guideline agrees, calling neuroimaging more accurate and the 10-20 system a cost-effective alternative.

18.6 Theta-burst stimulation

Theta-burst stimulation patterns the pulses instead of spacing them evenly, and the values a candidate is examined on belong to two different protocols. The original neurophysiological parameters, described in 2005 and used by most subsequent work, are 3-pulse bursts at 50 Hz, the bursts repeated at 5 Hz, the theta rhythm the technique is named for, at 80 percent of the active motor threshold, typically over motor cortex. The therapeutic protocol differs: the pivotal depression trial targeted the left dorsolateral prefrontal cortex and referenced its intensity to the resting motor threshold, the safety update recording it as an exception to the usual intensity range, which is not carried here. The Indian guideline names three sub-forms: intermittent, continuous and intermediate theta-burst stimulation.

TRAP **Reading a theta-burst intensity across from the active motor threshold to the resting one, or quoting the original neurophysiological intensity as the depression dose.** The two reference intensity to different thresholds, so an intensity here is meaningless unless its threshold is stated in the same breath. On safety, the honest position is that a seizure has been recorded with the original parameters, and that theta-burst within the usual intensity range can be regarded as safe.

18.7 The acute course, the indication and the evidence

A course of rTMS is measured in weeks of daily attendance, and the whole course is the treatment. The consensus position is that a standard acute course lasting **20 to 30 treatment sessions over 6 weeks** will very likely be needed to achieve results consistent with the published regulatory trials. Two things follow. The full course, not a fraction of it, reproduces the trial result, so a patient stopped early has not had the treatment that was studied; and extension trials indicate that non-responders to a standard 20 to 30 session course may still respond if daily

sessions continue. The weekly cadence, session length and time to early symptom change are not carried here. The indication both grounded protocols carry is major depressive disorder in adults, under a United States clearance rather than an Indian one; the Indian guideline covers therapeutic rTMS across a wider set of neuropsychiatric disorders whose individual indications and evidence are not enumerated here.

18.8 Adverse effects and the unintended seizure

The adverse event that governs how rTMS is regulated is the **unintended seizure**, a different object from the therapeutic seizure of electroconvulsive therapy in every respect that matters: not sought, not dosed, not monitored for adequacy, not the mechanism of any benefit. Until recently it had never been quantified; a large survey now gives standardised risks. Pooled across protocols the risk is **7 seizures per 100,000 sessions**, over more than 300,000 sessions reported for 2012 to 2016, rising to 33 per 100,000 in subjects at elevated risk from medication, brain lesions or epilepsy. Within high-frequency rTMS the split is starker: 67 per 100,000 in those with risk factors against 1 per 100,000 without, while single, paired and low-frequency stimulation together ran at 8 per 100,000. The same document elsewhere puts the risk at under about 0.03 percent, and records that a TMS-induced seizure has never caused permanent damage in current practice and occurs only during stimulation.

One risk factor was new and is directly operational: lack of previous exposure. Over 62 percent of seizures occurred on the first exposure and 75 percent within the first three, and the Indian guideline carries those figures into Indian practice with the instruction to exercise high precaution during the initial sessions. The limitations belong beside the numbers: self-reported survey data, described by their own authors as no more than approximate and possibly biased in reporting, with numbers in low-risk individuals too small for valid comparison.

18.9 The safety limits, and what the most recent update actually published

Here a chapter can print something that does not exist. The original quantitative safety tables of intensity against frequency and train duration are Wassermann's, augmented and improved in later consensus papers. The most recent international update did not replace them: it decided expressly not to provide a formal update of the safety tables and proposed operational guidelines instead, with one hard ceiling. The parameters used to induce a seizure in the seizure-induction modality of this band, taught in this chapter's account of magnetic seizure therapy and the emerging neuromodulation techniques, must not be exceeded. The usual lowest such combination is **100 percent** of maximal stimulator output at 25 Hz in a single train lasting up to 10 seconds, and every combination of intensity, frequency and duration in conventional rTMS must remain well below it. The guidelines tell an investigator who exceeds the earlier limits what to do rather than what number to stop at:

- Balance risk against benefit explicitly, as the responsible investigator.
- Use neurophysiological monitoring, taking motor twitches as a warning of rising cortical excitation.
- Reconsider the protocol if a seizure occurs.

- Alert the scientific community rather than treating the event as local.

One limitation travels with the older tables: they were derived in healthy young subjects, with figure-of-eight coils only, over the primary motor cortex, and were never a universal map of safe parameters for every coil, target and patient.

PITFALL

Printing a quantitative rTMS safety table and attributing it to the most recent international safety update. That update declined to publish new tables, issuing operational guidelines and a single ceiling instead, so a table carrying its name is an artefact the reader cannot find in the source. Attribute the tables to the earlier work, and say plainly that the current position is operational rather than tabular.

18.10 rTMS in India: the suite and the regulatory position

The Indian guideline sets the equipment baseline for an rTMS suite: main unit, coil, cooling unit and control cable, power supply, electromyography machine, coil holder and computer, with provision for emergency seizure management including stored anticonvulsants and immediately available trained physicians. The sample specification is a stimulator of at least 50 Hz capacity with a burst mode, so theta-burst can be delivered. Note what that seizure provision is: an emergency provision, for an event the prescription is designed to avoid.

IN INDIA

The Indian device position is a checked absence and should be stated as one. The national risk-based classification list enumerates 131 devices in the Neurological category, and no entry corresponds to a repetitive transcranial magnetic stimulation system. Searching it for transcranial returns exactly one entry, a transcranial electrical stimulation system at serial 127, Class B, whose device is taught in this chapter's account of transcranial direct current stimulation. Electroconvulsive therapy systems, deep brain stimulators and vagus nerve stimulators are all listed, each taught in its own item; transcranial magnetic stimulation is not. This concerns device classification only. It establishes nothing about Indian product licensing of any named rTMS device, or any indication-specific authorisation, neither of which may be inferred from a foreign clearance.

rTMS induces a current in cortex by electromagnetic induction and is dosed to stay sub-convulsive, so it does not produce the amnestic syndrome of an ECT course, while an unintended seizure remains a rare, separately bounded safety risk; its intensity is a percentage of the motor threshold, a corticospinal measurement that is not the ECT seizure threshold; and its parameters are quoted only as a whole tuple belonging to a named protocol, coil and indication.

19 · Transcranial direct current stimulation (tDCS)

Transcranial direct current stimulation passes a weak, constant current between scalp electrodes and changes how likely cortical neurons are to fire, without ever making them fire.

That is the whole of its mechanism and its separation from the electroconvulsive therapy half of this chapter: no seizure is induced, none is wanted, and nothing is dosed to produce one. The difficulty is that a treatment this simple to deliver has an evidence base that is not simple at all, so a candidate who quotes the milliamps but not the trial result has learned the easy half.

This account owns tDCS and nothing else: the subthreshold mechanism with its qualification, the montage, the milliamps, the session and the course, the evidence and where it is weak, tolerability, and the home-use and regulatory questions. It does not grade tDCS against the other devices of this band; that comparison, across invasiveness, whether a seizure is induced, target, reversibility, evidence and Indian availability, belongs to this chapter's cross-cutting synthesis and its band grid, and every band item teaches its own device. Electromagnetic induction and the motor threshold belong to this chapter's account of repetitive transcranial magnetic stimulation, and the induced therapeutic seizure to this chapter's account of magnetic seizure therapy and the emerging neuromodulation techniques; each is named for contrast, neither re-derived.

2 mA	null	Class B
THE CURRENT OF THE ONE DEPRESSION PROTOCOL CARRIED HERE, NOT A UNIVERSAL SETTING	WHAT THAT TRIAL FOUND FOR ACTIVE STIMULATION AGAINST SHAM ON ITS ANTIDEPRESSANT OUTCOME	THE INDIAN DEVICE CLASSIFICATION, WHICH AUTHORISES NO PSYCHIATRIC INDICATION

19.1 What tDCS is, and the envelope that defines its family

Transcranial direct current stimulation belongs to a family the current safety and application guidelines call **low intensity transcranial electrical stimulation**, defined by a parameter envelope rather than by a mechanism. The envelope is a total intensity of 4 mA or less, for alternating waveforms measured peak to peak, a total stimulation duration of up to 60 minutes per session, electrode sizes of 1 to 100 square centimetres, and frequencies of 0 to 10,000 Hz. Direct current sits at the bottom of that frequency range, which is why it shares an envelope and a safety literature with the alternating and random-noise members.

The envelope carries arithmetic rules that are easy to breach without noticing. With more than one channel, the total intensity is the sum across all electrodes of the same polarity; with more than one session in a day, the total duration is the sum of the sessions. A montage or a schedule can therefore leave the envelope while every reading on the device looks compliant.

RULE **The envelope is a convention, not a safety limit, and its own source says so in terms.** The guideline that defines the family states that its parameter limits rest on convention and do not represent formal safety limits. Printing them as the safe maximum inverts the claim: they mark where the accumulated evidence stops applying, not where injury begins. Quote the envelope with that caveat attached, or do not quote it.

19.2 The subthreshold mechanism, and why polarity is not destiny

Low intensity stimulation modulates brain activity primarily through **subthreshold neuronal polarisation**. The induced electric field shifts membrane potentials without directly causing action potentials, making neurons more or less likely to fire in response to ongoing synaptic input, and through that shift it can influence synaptic efficacy, alter neuronal excitability and shape network-level oscillatory dynamics. Everything the technique does, it does to a cell already

receiving input: there is no step at which the device fires a neuron. That is the structural contrast with electroconvulsive therapy, prescribed precisely to induce a generalised seizure, and with the induction technique of this chapter's account of repetitive transcranial magnetic stimulation, not re-derived here.

The rule every candidate carries, that the anode excites and the cathode inhibits, is a simplification and has to be named as one. The guideline gives the mechanism and its qualification in one passage: tDCS is explained by a sustained polarity-specific change in membrane potential, and the mechanisms of low intensity stimulation vary with the current properties and with electrode placement. tDCS also always has at least one anode and at least one cathode, so every montage is active at each end and inert at neither. Direction and magnitude are therefore modified by montage, current density, duration and the state of the tissue, and the intensity at which the polarity relation stops holding is not carried here.

RULE **Polarity is not destiny: write the anodal and cathodal directions as a first approximation that names its own conditions.** The relation is real, and it is why a montage is described by which pole sits where. But the source states it beside the statement that mechanisms vary with current properties and electrode placement, so a sentence giving the direction without the modifiers has promoted a conditional finding into a law the source does not assert.

19.3 The montage, and the electrode that is not a return

The **montage** is the geometry: which electrode goes where, of what size, and with what current between them. Montage primarily shapes how current flows through the brain, while electrode design primarily affects tolerability, so a change made for comfort is not neutral to physiology. Since the family's electrodes span 1 to 100 square centimetres, and **current density** is current divided by the area it crosses, electrode size is part of the dose and not a detail of the kit: the same milliamps at a smaller electrode is a denser current at the skin and beneath it.

The fully specified montage carried here comes from a named trial, not a textbook default: the anode over F3 and the cathode over F4, a bifrontal arrangement over the prefrontal cortices. Read it as one protocol's geometry, tied to its indication and device, and notice what the **return electrode** is doing. It is not disposing of current at a neutral site; it sits over cortex and it stimulates. That is why the montage rather than the anode gets named, and why moving the second electrode changes the treatment.

19.4 Current, session duration and the course

tDCS is prescribed as a tuple, and the milliamps mean nothing on their own. In the DepressionDC trial, active stimulation was a constant **2 mA** direct current lasting 30 minutes, given as 24 sessions within 6 weeks, in adults with major depressive disorder not responding to a selective serotonin reuptake inhibitor, the stimulation added to that antidepressant rather than replacing it. The trial was triple-blind, randomised and sham-controlled across eight psychiatric centres in Germany, the device a named mobile direct-current stimulator, and the **sham** a ramp-up and ramp-down sequence reproducing the skin sensation without the treatment current.

AXIS	THE DEPRESSIONDC PROTOCOL	THE LOW INTENSITY FAMILY ENVELOPE
CURRENT	Constant 2 mA direct current	Total intensity 4 mA or less
SESSION DURATION	30 minutes	Up to 60 minutes per session
ELECTRODES	Anode F3, cathode F4	Sizes 1 to 100 square centimetres
COURSE	24 sessions within 6 weeks	Not addressed: the envelope bounds a session, never a course
WHAT IT IS	One trial's protocol, one indication, one device	A stated convention, expressly not a formal safety limit

TRAP **Printing one trial's current and session length as the settings for tDCS.** The values in the left column travel together: one protocol, one indication, one device, one montage. Quoted alone they describe a setting rather than the treatment that was tested; quoted beside the right column they invite the reader to treat a convention as a prescribing range. Name the trial, montage, indication and device whenever a milliamp figure is written down.

MNEMONIC

Montage, Milliamps, Minutes, Sessions

The four values that make a tDCS prescription, none meaning anything without the other three and the indication they were tested in: **Montage**, both electrodes named by site; **Milliamps**, with the electrode size that turns current into current density; **Minutes** per session; and **Sessions**, over a stated number of weeks.

19.5 The evidence, and where it is weak

The honest summary is that the evidence for tDCS is heterogeneous, and the trial this account carries in full is a negative one. DepressionDC was a triple-blind, randomised, sham-controlled multicentre trial of tDCS added to a selective serotonin reuptake inhibitor in major depressive disorder, reported in 2023, and its investigators state their own result plainly in a later peer-reviewed report of the same trial: the main trial did not show beneficial antidepressant effects of active tDCS over sham. That is the sentence to carry into an answer: it is the investigators' own and it is not hedged.

The rest of that record matters more than a summary verdict. The same secondary analysis found no group difference in neurocognitive change and no predictive value of baseline cognition, so in this trial the technique bought neither antidepressant benefit nor cognitive cost. That is the actual relation for this parameter in this trial, stated as such, with no general direction imported from elsewhere in this chapter. The blinding problem is structural rather than incidental: electrode designs that produce less sensation blind better, so sham reliability is not comparable across studies using different electrode designs, which means a pooled figure assembled across them pools degrees of blinding as well as montages.

What this account will not do is convert one trial into a verdict on the technique. No pooled estimate and no second trial are carried in the allowed claims, so the wider literature is called heterogeneous rather than summarised with a figure this fragment cannot ground. The primary report is paywalled and was not read at origin, so the quotation above is attributed to the investigators' open-access analysis.

PITFALL

Treating tolerability as evidence of efficacy. tDCS is cheap, portable, painless for most patients and easy to sham, and each is a reason it has been trialled widely rather than a reason it works. An answer that lists the practical advantages and then asserts antidepressant efficacy has skipped the step being tested. Name the negative trial and let the advantages explain the research interest rather than the conclusion.

19.6 Tolerability, and what actually causes a skin lesion

What patients report is local and mild:

- tingling, itching and warmth beneath the electrodes;
- sometimes described as burning or pressure;
- transient, subsiding shortly after stimulation;
- most prominent in the early sessions and habituating with repetition.

Because the sensation is what a patient notices, it is also the main threat to blinding, which is why a sham reproduces the ramp instead of leaving the device off.

The useful claim about skin injury is that it is a technique and equipment problem rather than a current problem. The guideline states that skin lesions are not an expected adverse event when best practices are followed and appropriate equipment is used, and that essentially every case report of a skin lesion during tDCS was correlated with poor technique or poor technology. Framed that way the claim tells a resident what to do, which a bare incidence figure would not.

GOOD TO REMEMBER

The practice points are specific. Prepare the skin by cleaning and drying it, and do not abrade it. Use electrodes verified for the stimulation being delivered, not electroencephalography recording electrodes and not transcutaneous nerve stimulation pads from another trolley. Read impedance as quality control and read it honestly: a low impedance is neither necessary nor sufficient for tolerated stimulation, so it confirms the setup rather than certifying the session.

19.7 Home-based tDCS, and the adjective that carries the safety data

Home use is the first question a patient asks about a portable device, and the answer turns on one adjective. A large-scale tolerability dataset, which the source describes in those terms and not as the largest, is an analysis of **6,779 sessions** of **remotely supervised at-home tDCS** delivered in clinical trial contexts. It reported no serious side effects and a session abort rate of 0.04 percent, the commonest side effect being mild tingling, itching and warmth distributed equally across active and sham. The guideline holds that remotely supervised home-based stimulation is safe

within the standards it sets, under medical prescription or in research settings, and that it buys accessibility and scale rather than any change in effect.

TRAP **Reading the home-use safety data across to an unsupervised consumer device.** Every session in that dataset was remotely supervised and delivered inside a clinical trial, with the equipment, montage, dose and reporting a trial imposes. Direct-to-consumer devices are discussed separately in the same guideline and this dataset is not extended to them. A patient asking whether a headset bought online is safe is not asking a question this evidence answers, and the reply names the supervision condition, not the session count.

19.8 The Indian position: a classification is not an authorisation

India's regulator has classified the device, which is a smaller statement than it appears, so the halves are held apart. The national classification of non-notified medical devices carries an entry for a transcranial electrical stimulation system, continuous current and pulsed current, intended for one or more psychiatric or neurological therapy types, and the intended-use text of that entry names transcranial direct current stimulation and transcranial alternating current stimulation expressly. The tail of the same entry names anxiety, depression, insomnia and addiction among those intended uses and assigns the device a risk class of B.

What that entry establishes is device classification and nothing more. Indication-specific authorisation is recorded separately, and it is recorded as absent: the current international guideline surveyed national regulatory positions and reports that no country in Asia has officially approved transcranial electrical stimulation devices as medical devices, except Singapore and South Korea. In that passage India appears only for its classification system, running from Class A at the lowest risk to Class D at the highest under the Medical Devices Rules of 2017. The absence is stated from a source rather than inferred, and approvals granted elsewhere are never read across to India.

IN INDIA

Write the Indian position as two lines, and never let the first stand in for the second. First: a transcranial electrical stimulation system exists as a classified device category, at a stated risk class, with intended-use text naming direct current stimulation and psychiatric conditions. Second: no indication-specific authorisation for such a device is established in India, and Indian product licensing of any named device is not established by this record either. A classification tells a manufacturer which regulatory pathway a device sits in; it does not tell a psychiatrist that an indication has been authorised.

RULE **A device classification is not an authorisation of an indication, and the two come from different sources.** Classification answers how a device is regulated; authorisation answers whether it may be marketed for a stated clinical use. Print only the classification and the reader supplies the missing half, and the half a reader supplies is always the permissive one.

tDCS shifts membrane potentials below the threshold for firing, so it changes the probability of a response to ongoing input and induces no seizure; its polarity rule is a first approximation conditioned by montage, current density, duration and tissue state, with both electrodes active; its dose is a tuple of montage, milliamps, minutes and sessions belonging to a named trial; its evidence is heterogeneous and the trial carried here is negative; and in India it is a classified device, which is not an authorised indication.

20 · Deep brain stimulation (DBS) in psychiatry

Deep brain stimulation is a permanently implanted electrode left switched on inside the brain, and in psychiatry it is the rung reached only after everything else has failed. The examinable weight sits in three places. The targets have names, and earlier chapters have already promised the reader those names. The sham-controlled depression trials built to settle the depression question did not meet their primary endpoints, which is a fact to be stated rather than managed. And the Indian legal position turns on a question the statute itself leaves open.

This account owns the psychiatric use of deep brain stimulation in full: the implanted system, the circuit rationale, the targets by name, the indications in refractory obsessive-compulsive disorder and refractory depression with the evidence as it reads, the parameters and programming, the adverse effects, and patient selection with the ethical and regulatory frame. It does not grade this device against the others of its band; that comparison belongs to this chapter's cross-cutting synthesis and its band grid. The obsessive-compulsive treatment algorithm that delivers a patient to this rung, and the cortico-striato-thalamo-cortical circuit as obsessive-compulsive neurobiology, are the Anxiety, OCD and trauma-related disorders notes'. The mood, impulse-control and cognitive sequelae of deep brain stimulation given for Parkinson disease are the Neuropsychiatry of systemic and neurological disease notes'. Ablative surgery and its irreversibility belong to this chapter's account of ablative psychosurgery, and the implanted but non-cranial vagus nerve system to its own item. Each is named here; none is re-taught.

VC/VS	8 of 9	130 to 180 Hz
AMONG THE MOST FREQUENTLY INVESTIGATED TARGETS IN OBSESSIVE-COMPULSIVE DISORDER, NAMED JOINTLY WITH THE NUCLEUS ACCUMBENS	GUIDELINES PLACING DBS AFTER ALL ELSE HAS FAILED	STIMULATION FREQUENCY ACROSS THE PSYCHIATRIC LITERATURE

20.1 The implanted system, and why it is no longer called a lesion

Deep brain stimulation is a chain of hardware a candidate should be able to draw. Intracerebral electrodes are placed by stereotactic technique, connected subcutaneously by extension leads, and driven by an **implantable pulse generator** sited in the subclavicular region or the abdomen. Nothing is removed and nothing destroyed: the generator is programmed from outside the skin, its settings revised at any visit, and the intervention ends when the device is switched off.

That is the fact that keeps this item apart from ablation. Stimulation was initially conceptualised as a reversible lesion and is now better described as a **circuit therapy**, and the mechanism as now stated is not inhibition of a target but replacement of a pattern: electrical pulses trigger action

potentials in axons both orthodromically and antidromically, generating new patterns of synaptic activity that overwrite the pathological ones. The history follows the same logic: stimulation entered psychiatry in 1999, when a Belgian group led by Nuttin reported stimulation of the anterior limb of the internal capsule in a patient with refractory obsessive-compulsive disorder, following the 1987 report of thalamic stimulation for parkinsonian tremor.

RULE **Deep brain stimulation and ablative psychosurgery are different kinds of intervention, and the difference is not one of degree.** The published framing of the choice is exactly this trade: the irreversibility and relative simplicity of lesioning against the reversibility, adjustability, and costs associated with stimulation. Ablation destroys tissue, cannot be undone, and carries no device to fail. Stimulation leaves the anatomy intact and can be titrated or stopped, and buys that with a foreign body, a battery, a programming clinic and a failure mode the lesion lacks. Write neither as the more advanced version of the other; the ablative procedures are this chapter's own account of ablative psychosurgery.

20.2 The circuit rationale, and the targets by name

The targets are what earlier chapters have already promised, so they are delivered here in full and split by indication, because the obsessive-compulsive target set and the depression target set are not the same set. For obsessive-compulsive disorder, the ventral capsule and ventral striatum and the nucleus accumbens have emerged as the most frequently investigated loci, with the anterior limb of the internal capsule, the bed nucleus of the stria terminalis and the subthalamic nucleus also receiving substantial attention; less conventional targets include the inferior thalamic peduncle, the caudate nucleus and various thalamic nuclei. For depression, the best studied targets have been the ventral capsule and ventral striatum, the subgenual or subcallosal cingulate cortex (Cg25), and the medial forebrain bundle.

Each target was chosen from a circuit argument, and those arguments explain why one target serves obsessive-compulsive disorder and another depression. The ventral capsule and ventral striatum, including the nucleus accumbens, is a key node of the reward circuit, with afferents from the ventral tegmental area and efferents to multiple limbic structures, and stimulation there was hypothesised to relieve anhedonia. The subcallosal cingulate was proposed as a mood-regulating hub on the basis of functional-imaging hyperactivity in depression. The superolateral medial forebrain bundle connects the ventral tegmental area with ventromedial prefrontal and orbitofrontal cortex, and its fibres course through the anterior limb of the internal capsule. That last detail is why one trajectory recurs under several target names: these are neighbouring parts of one white-matter corridor, not scattered points.

The field has also moved, and the direction is examinable: the preferred stimulation site within the anterior limb of the internal capsule has shifted posteriorly with tractography, and the emphasis has moved from grey-matter nuclei to white-matter convergence zones. A resident who learns a target as a nucleus has learned the older version of the idea.

MNEMONIC

VANS

Ventral capsule and ventral striatum, **A**nterior limb of the internal capsule, **N**ucleus accumbens, **S**ubcallosal cingulate: the psychiatric electrode targets an examiner expects by name. The first three cluster in one ventral corridor; ventral capsule and ventral striatum carries both the obsessive-compulsive work AND one of the two depression trials, and the subcallosal cingulate is the other. Do not let the corridor grouping become an indication grouping: the target sets overlap, which is the point the fragment makes below.

20.3 Refractory obsessive-compulsive disorder: where the guidelines actually put it

The honest answer to whether psychiatric DBS is recommended is a shape, not a yes. A systematic review of the guidelines for obsessive-compulsive disorder found that 9 guidelines were identified, 8 recommended that DBS is used after all other treatment options have failed, and one did not recommend DBS beyond a research setting. The gaps in that literature matter as much as the placement: only one guideline performed a cost-effectiveness analysis, and the other 8 did not provide details on safe or effective DBS protocols. A guideline that endorses a procedure without specifying how to deliver it endorses a direction, not a technique. The neurosurgical consensus is blunter: in its 2021 consensus guidelines the World Society for Stereotactic and Functional Neurosurgery considers DBS an emerging but not yet established treatment, because the current evidence does not meet its standards.

The outcome figures are correspondingly wide, and the width is the teaching point rather than any midpoint a candidate might quote. Response rates for DBS in obsessive-compulsive disorder across studies range from 10 to 61 percent, largely because of differences in electrode placement, electrode type and stimulation. A response rate quoted without its target and its settings therefore tells the reader nothing.

PITFALL

Reading the United States authorisation as evidence of the kind a premarket approval carries, or as an Indian permission. The obsessive-compulsive authorisation is a **Humanitarian Device Exemption, number H050003, decided in 2009**, and a humanitarian exemption is not a premarket approval: it is a small-population route demanding a lower evidentiary showing. Its scope is narrow: bilateral stimulation of the anterior limb of the internal capsule, as an adjunct to medications and as an alternative to anterior capsulotomy, for chronic, severe, treatment-resistant obsessive compulsive disorder in adult patients who have failed at least three selective serotonin reuptake inhibitors. Collapsing that into approved for OCD overstates both the evidentiary standard and the jurisdiction.

20.4 Refractory depression: two pivotal sham-controlled trials, and two different endpoints

Both pivotal sham-controlled trials of deep brain stimulation for depression failed to separate active stimulation from sham on their primary endpoints, and both were stopped for futility. That must be stated plainly: the open-label literature around each is encouraging, and a chapter reporting only the encouraging half is reporting a different field.

The subcallosal cingulate trial, BROADEN, followed encouraging open-label work with reported response rates of 36 to 66 percent. Its endpoint was defined in its own report as frequency of response, defined as a 40 percent or greater reduction in depression severity from baseline, averaged over the fourth to sixth months of the double-blind phase, with a futility analysis performed when approximately half the proposed sample had received implantation and completed the double-blind phase. The result: both groups showed improvement, but there was no statistically significant difference in response during the double-blind, sham-controlled phase, with 12 patients (20 percent) responding in the stimulation group against five patients (17 percent) in the control group. The trial was halted because of a low probability of success on that interim futility analysis.

The ventral capsule and ventral striatum trial, RECLAIM, ran a different design and used a different threshold. Patients were randomised to active versus sham stimulation in a blinded fashion for 16 weeks, followed by an open-label continuation phase, and the primary outcome measure was response, defined as a 50 percent or greater improvement on the Montgomery and Asberg Depression Rating Scale from baseline. The result was again negative: no significant difference in response rates between the active arm (3 of 15 subjects, 20 percent) and the control arm (2 of 14 subjects, 14.3 percent), and no significant difference in the rating-scale change as a continuous measure on completion of the 16-week controlled phase, and the trial was terminated for futility.

RULE **The two trials did not share a primary endpoint, and printing one threshold for both invents a fact.** BROADEN's response threshold was a 40 percent or greater reduction in depression severity, averaged over the fourth to sixth months. RECLAIM's was a 50 percent or greater improvement on the Montgomery and Asberg Depression Rating Scale, assessed at the end of a fixed blinded window. Different thresholds, different scales, different timepoints, different targets. Quote each trial with its own definition, or quote neither.

AXIS	BROADEN	RECLAIM
TARGET	Subcallosal cingulate	Ventral capsule and ventral striatum
RESPONSE DEFINED AS	40 percent or greater reduction in depression severity from baseline	50 percent or greater improvement on the Montgomery and Asberg scale
BLINDED WINDOW	Averaged over the fourth to sixth months of the double-blind phase	16 weeks
RESULT ON THAT ENDPOINT	No significant difference; 12 (20 percent) against five (17 percent)	No significant difference; 3 of 15 (20 percent) against 2 of 14 (14.3 percent)
STOPPED	Halted on interim futility analysis	Terminated for futility

The criticism raised against both is of design rather than of the device, and a candidate should be able to state it without using it to explain the results away. Short blinded phases and limited parameter adjustment likely contributed to the negative findings. Later work is offered against the negative result and should be given as what it is, later and less controlled. Open-label follow-up suggested response rates rising over 1 to 3 years, and tractography work reported response rates above 80 percent when stimulation targeted the convergence zone of forceps minor, cingulum bundle and uncinate fasciculus. And on the same ventral target, another double-blind trial that allowed a one-year optimisation phase before a crossover comparison reported significant differences favouring active stimulation, with response rates of 50 to 60 percent. Two trials on one target reaching opposite conclusions is a live disagreement, not a resolved question, and the difference is largely how long the operator was allowed to programme before the comparison was made.

20.5 Stimulation parameters and programming

Programming does not begin in the operating theatre. Across the psychiatric literature stimulation was mostly bilateral, starting 6 to 8 weeks after surgery, the interval letting the acute surgical effect settle before any setting is judged. The reported settings are **4 to 6 V** of amplitude, 60 to 120 microseconds of pulse width and 130 to 180 Hz of frequency.

What those figures are must travel with them: ranges derived from a systematic review of heterogeneous studies across several targets and electrode types, not a validated protocol and not a manufacturer specification. The same review names variance in target and electrode type as a principal source of the wide response range. Read the trial criticism above against this section and it stops being a statistical complaint: a fixed short blinded window with restricted adjustment means the comparison was made before the operator had finished finding the setting, which is a different objection from an underpowered sample.

20.6 Adverse effects, and the implant effect

The adverse effects divide by source, the division a consent conversation follows. Device-related complications reported across the psychiatric literature included lead damage or malposition, and postoperative infections, some of which necessitated **explantation** or generator replacement. That last clause is the one to hold: a psychiatric implant can end with the hardware coming out. On the surgical side, seizures occurred at a rate consistent with other intracranial procedures, and isolated incidents of intracranial haemorrhage were described. The stimulation-related effects specific to each target and each setting are not carried in this record and are declared as a gap rather than filled from memory.

One phenomenon here explains something about the trials. The reviewers name an **implant effect**, a temporary improvement following electrode placement, possibly linked to microlesioning, and offer it alongside cognitive placebo effects and natural fluctuation as reasons the active and sham arms did not separate. A sham arm in this field is not an untreated arm: it is a patient who has had a craniotomy and an electrode placed, and whose device is off. The mood, impulse-control and cognitive sequelae of stimulation given in a movement-disorder indication

belong to the Neuropsychiatry of systemic and neurological disease notes; they are named here and not taught.

20.7 Patient selection

Selection is where the honest evidence position becomes a clinical rule, and the candidate definitions are strict in both indications.

- Obsessive-compulsive disorder: severe or extreme illness of more than five years' duration, having exhausted first-line and second-line treatments including cognitive behavioural therapy, several selective serotonin reuptake inhibitors, clomipramine and antipsychotic augmentation at adequate doses and durations.
- Depression: severe depression on standardised scales, illness duration beyond two years, marked functional impact, and documented resistance to multiple pharmacological regimens and to electroconvulsive therapy, or a patient for whom electroconvulsive therapy is not appropriate, not acceptable or declined.

Two things follow. Resistance must be documented rather than asserted, so the trials of treatment, their doses and durations are in the record before the question is raised. And electroconvulsive therapy sits upstream of stimulation in the depression pathway, so a referral made without it, or without a stated reason it cannot be used, skips a rung.

20.8 India, the law, and a question the Act does not answer

IN INDIA

The Indian device position is a classification and only a classification. The national risk-based list carries the deep brain electrical stimulation system, designed to apply electrical stimuli to specific areas of the deep brain for the treatment of movement disorders, psychiatric disorders or chronic, severe, intractable pain, in the highest risk class, Class D. Two things follow and neither may be softened. The classification names psychiatric disorders in its own intended-use text, so the category exists in Indian regulatory language. But it establishes nothing about product licensing of any named system in India, and nothing about any indication-specific psychiatric authorisation; neither may be inferred from the classification, and neither from the foreign humanitarian exemption above.

The legal question is unsettled, and this account states it as unsettled rather than answering it. The Mental Healthcare Act restricts psychosurgery, and that restriction, with its dual requirement of informed consent and Board approval, is the Mental health legislation and forensic psychiatry notes' provision; it is named in words here and never renumbered. The question is whether an implanted stimulation system for refractory obsessive-compulsive disorder falls within psychosurgery for the purposes of that restriction, because if it does, the dual requirement attaches. Read against the statute's own text the answer does not arrive: the Act restricts psychosurgery but nowhere defines it, its definitions clause contains no entry for psychosurgery, and the word appears in the Act only in the restricting provision itself. The Act's own definition therefore does not settle the question, and it is recorded here as a declared gap. A

regulation defining the term could settle it; none was located. The practical consequence is caution rather than paralysis: a unit contemplating an implant proceeds as though the stricter reading may apply, and takes the question to its Board and to legal advice. The consent conversation itself, as taken in Indian practice, is this chapter's account of consent for electroconvulsive therapy.

TRAP **Answering the psychosurgery question from memory, in either direction.** Writing that psychiatric deep brain stimulation is psychosurgery under the Act, or that it plainly is not, both assert something the statute does not say. The defensible answer names the restriction in words, says the Act does not define the restricted procedure, and leaves the question open. A second trap sits beside it: quoting the Act's section numbers here. Those belong to the legislation notes, and a chapter that reprints a number it did not itself ground is how a legal fiction enters a syllabus.

Deep brain stimulation is an implanted, adjustable, reversible circuit intervention, not a lesion, and its psychiatric targets are the ventral capsule and ventral striatum, the anterior limb of the internal capsule, the nucleus accumbens and the subcallosal cingulate; most guidelines place it after everything else has failed; both pivotal sham-controlled depression trials, on different targets and with different response thresholds, failed to separate active from sham and were stopped for futility, so the case now rests on later, less controlled work; and whether the Act's psychosurgery restriction reaches an implanted system is a question the statute leaves open.

21 · Vagus nerve stimulation (VNS)

Vagus nerve stimulation treats depression from outside the skull, by driving a peripheral nerve in the neck and letting that nerve carry the signal inward. It is the implanted device of this band whose electrode never enters the brain. Its centre of gravity is not the surgery but the latency: a response, where there is one, emerges over months, and the trial designed to detect it in weeks did not.

This account owns vagus nerve stimulation in full: the implanted left cervical system, the afferent route, the parameters and duty cycle, the regulatory position in both jurisdictions, the evidence with its limits, and the adverse effects. It does not teach the implanted intracranial device, whose surgical placement, psychiatric targets and trial evidence belong to this chapter's account of deep brain stimulation in psychiatry, named here and not restated. Nor does it grade the band's devices against one another: that comparison, across invasiveness, seizure induction, target, reversibility, evidence and Indian availability, belongs to the cross-cutting synthesis and its band grid.

p=0.238	12 months	58.2%
THE ACUTE SHAM-CONTROLLED PRIMARY ENDPOINT, NOT SIGNIFICANT	THE WINDOW OVER WHICH THE EFFECT SUPPORTING APPROVAL WAS MEASURED	VOICE ALTERATION IN THE EARLY MONTHS OF STIMULATION

21.1 The implanted system, and why it is not a cranial implant

The **VNS Therapy System** divides into what is inside the patient and what is not.

- An implanted **pulse generator**, carrying the battery and the programming, sits in a subcutaneous chest pocket.
- A **helical lead** runs from it into the neck and is wound on the cervical vagus nerve, passed between the sites with a tunneler.
- Outside the body are an external **programming wand** and its software, through which every parameter is set without a second operation, and a patient magnet.

The electrode therefore sits on a peripheral nerve, and implantation is a neck and chest procedure carrying the risks of a neck dissection and of a stimulated nerve, not those of an intracranial electrode. Implanted does not mean here what it means for the intracranial device taught elsewhere in this chapter.

21.2 The afferent route, and how far the record goes

Stimulation is delivered to the **left cervical vagus**, and the therapeutic traffic runs centrally rather than out to the viscera. The vagus there is predominantly afferent, so the fibres the electrode recruits carry impulses into the brainstem. The route taught runs from the **nucleus tractus solitarius**, the brainstem terminus of vagal afferents, to the **locus coeruleus** and the raphe nuclei, and on from those monoaminergic nuclei to limbic structures: a peripheral electrode producing a diffuse, slowly accumulating central effect rather than a focal one.

Where the grounding stops must be said. The generator and lead architecture is read from the regulator's own summary of safety and effectiveness data, while the left-sided placement and the brainstem-to-limbic pathway are standard teaching, stated as teaching, not captured verbatim from a primary source by this chapter's grounding, and recorded as a declared gap.

21.3 The stimulation parameters and the duty cycle

Every figure below belongs to one protocol, one indication, one target and one device, and none is a universal setting for vagus nerve stimulation. These are the settings actually reached at 12 months in the pivotal depression cohort, D-02, as printed in the labelling approved for the depression indication on the VNS Therapy System delivered to the left cervical vagus. They are not manufacturer defaults, not a starting prescription, and not transferable to the seizure indication.

PARAMETER	MEDIAN AT 12 MONTHS	RANGE IN THE COHORT
OUTPUT CURRENT (NO UNIT IN THE RECORD)	1.0	0 to 2.25
FREQUENCY	20 Hz	2 to 30 Hz
PULSE WIDTH	500 microseconds	130 to 750 microseconds
ON TIME	30 seconds	7 to 60 seconds
OFF TIME	5 minutes	0.3 to 180 minutes

One row carries no unit in the record it was read from: the labelling table as extracted gives the output current as a bare figure and does not say what it is measured in. No unit is printed here

and none may be supplied from memory, because a plausible unit beside a real number makes the number look grounded when the unit is not.

The **duty cycle** is what the ON and OFF times mean together: the device does not stimulate continuously but delivers current for the programmed ON time, stops for the programmed OFF time, and repeats indefinitely. The duty cycle is therefore not a fixed property of the device but an arithmetic consequence of those two times as programmed, changing the moment either is changed. No duty-cycle percentage is printed here, because computing one is arithmetic rather than a reading from the labelling.

MNEMONIC

SLOW

Subcutaneous generator in the chest. **L**eft cervical vagus carries the lead. **O**n and off, because stimulation is cyclical and never continuous. **W**ait, because the response is measured in months.

21.4 The regulatory position, in its separate parts

The regulatory claims a candidate must keep apart are device **classification**, product **licensing**, **indication-specific authorisation**, and **foreign clearance or approval**. Holding one says nothing about holding another. In the United States the Food and Drug Administration, through its Center for Devices and Radiological Health, approved the VNS Therapy System for depression under premarket approval P970003, supplement S050, decision date 15 July 2005. The authorised indication is precise: adjunctive long-term treatment of chronic or recurrent depression, in patients 18 years of age or older, experiencing a major depressive episode, who have not had an adequate response to four or more adequate antidepressant treatments. Read the wording: adjunctive means added to treatment, and long-term sits in the indication because the evidence is long-term.

IN INDIA

What is established is classification and nothing more. The national risk-based list names the antiseizure and psychiatric-therapy vagus nerve electrical stimulation system in the Neurological category at serial 9, Class D, with its programming system separately at serial 131 in Class C. There the Indian record stops. No Indian product licence for any named device, and no Indian indication-specific authorisation in treatment-resistant depression, was established by this chapter's grounding; both are declared gaps and neither may be inferred. The United States approval above is foreign status: it is not evidence of an Indian one and must never be written so a reader could take it for one. A provenance caution attaches to the list itself, hosted as final while its covering notice circulates the annexed classification for comment.

21.5 The acute randomised trial, which did not separate from sham

The pivotal acute study, **D-02**, is why this modality can be taught honestly at all. Patients with treatment-resistant depression were implanted, then randomised to active stimulation or to sham, the device present in both arms and left off in the sham arm, and the acute phase ran 3

months. The primary endpoint was the proportion of responders, a fall of 50 percent or more in the Hamilton score from baseline to exit.

In the evaluable population 15.3 percent of the active group responded, 17 of 111, against 10.0 percent on sham, 11 of 110. The difference was not statistically significant, p=0.238. Among the secondary measures only the self-rated inventory of depressive symptomatology separated on percent responders, 17.4 against 7.5 percent, p=0.032; the clinical global impression, the observer-rated depression and mania scales and the SF-36 did not.

21.6 The long latency, and what the approval rests on

The device was not approved on that comparison. After the acute analysis was completed, an alternate statistical plan for demonstrating effectiveness was adopted, comparing the 12 month results of the D-02 continuation phase against a separate observational study, D-04. That is the approval basis: a non-randomised comparison of an open-label extension against a different cohort.

The long-term primary analysis was a repeated-measures linear regression on raw Hamilton scores over the first 12 months of stimulation. The slope was minus 0.47 points per month in the completer population, n=177, p less than 0.001, with minus 0.45 in the evaluable population, n=205, and minus 0.40 in the intention-to-treat population, n=231. At 12 months Hamilton response was 29.8 percent and remission 17.1 percent, and sustained response was reached by 27 percent of completers, 47 of 177. Against the observational comparator the average Hamilton change at 12 months was minus 8.2 with the device against minus 4.9 with standard care, p=0.006, with response in 30 against 13 percent, p=0.003.

RULE **The long latency is not a caveat on the evidence; it is the shape of the evidence, and it decides how the device is judged and when.** An effect appearing as a slope over months cannot be detected by a trial reading its endpoint at 3 months, which is why the randomised comparison came out flat and why the authorised indication says long-term. A patient is therefore not a non-responder here at the point at which the same patient would be judged a non-responder to a drug. What is traded is TIME and not cognition; it is this device's own trade, and no direction carries over to any other device in the band.

TRAP **Quoting the long-term response and remission rates as though they came from the randomised sham comparison.** They did not. That comparison failed its primary endpoint; the long-term figures come from an open-label continuation set against a separate observational cohort. An answer giving the second without the first is not partial, it is wrong.

RECOVER is the modern test of the same question, described as the largest neuromodulation study in psychiatry to date: participants randomised to active against sham stimulation for a year, then a prolonged open-label phase. Preliminary reports indicate the primary endpoint was not met, while clinically meaningful improvements were observed in depressive severity, functioning and quality of life. This chapter's grounding read that in a peer-reviewed review and not in the primary report, and the review's own reading, that the device may act as a long-term

progressively acting adjunct whose effect symptom scales do not fully capture, is attributed rather than adopted.

21.7 Adverse effects, and the pattern that matters

The adverse effects divide by cause into what the operation does and what the stimulation does, and the second group carries a pattern worth memorising: the effects involving the voice persist across the first year while most of the rest settle. The frequencies are from the approved labelling for the depression indication.

STIMULATION-RELATED EVENT	0 TO 3 MONTHS (N=232)	9 TO 12 MONTHS (N=209)
VOICE ALTERATION	135 (58.2 percent)	113 (54.1 percent)
INCREASED COUGH	55 (23.7 percent)	13 (6.2 percent)
NECK PAIN	38 (16.4 percent)	27 (12.9 percent)
DYSPNOEA	33 (14.2 percent)	34 (16.3 percent)
DYSPHAGIA	31 (13.4 percent)	9 (4.3 percent)
PARAESTHESIA	26 (11.2 percent)	9 (4.3 percent)
LARYNGISMUS	23 (9.9 percent)	10 (4.8 percent)

The persistent entries are mostly of the voice, the airway and the neck, which is what an electrode wound on a nerve in the neck predicts, and the table above shows why the generalisation cannot be tightened further: dyspnoea persists and rises and is respiratory rather than laryngeal, neck pain persists and is somatic, and laryngismus is laryngeal yet largely settles. and voice alteration is the effect a patient notices and is asked about at every review. Cough, dysphagia and paraesthesia largely settle; dyspnoea does not. Surgery-related events in the acute phase were incision pain in 36 percent, device-site pain in 23 percent, device-site reaction in 14 percent and headache in 8 percent.

The serious events, as the labelling reports them: 30 serious adverse events in 27 subjects in the acute phase, including one death by suicide under active stimulation, with single reports of asystole and of bradycardia in the treatment group; and in the long-term phase worsening depression as 62 events in 31 subjects, 7 suicide attempts in 6 subjects, and one sudden unexplained death. None of that withholds the device where it is indicated; all of it must be described to the patient before implantation.

Vagus nerve stimulation is an implanted but non-cranial system: a generator in the chest, a lead on the left cervical vagus, an afferent signal reaching limbic structures through the brainstem. It stimulates intermittently, so the duty cycle follows from the programmed ON and OFF times. It holds a United States approval for adjunctive long-term treatment after four or more failed adequate antidepressant treatments and, in India, a device classification and nothing further. Its acute randomised comparison against sham did not meet its primary endpoint, the approval resting on a slope across the first year against an observational cohort. Its characteristic adverse effect, voice alteration, is common and does not settle.

22 · Magnetic seizure therapy and emerging neuromodulation

Magnetic seizure therapy uses the induction coil of transcranial magnetic stimulation at parameters chosen to produce a seizure deliberately, under anaesthesia, as an alternative to electroconvulsive therapy. It is the only modality in this group with randomised human comparisons against electroconvulsive therapy, and it is examinable for a reason that is not the hardware: it is this chapter's cleanest example of a claim that must be split in two, one half settled and one open, and a candidate who fuses them writes a sentence the sources do not carry.

This account owns magnetic seizure therapy and the other emerging approaches: low-intensity focused ultrasound, transcranial alternating and random-noise stimulation, and closed-loop or adaptive stimulation. Why an induced seizure helps is taught in this chapter's account of the mechanism of action and neurobiological theories of electroconvulsive therapy, and the cognitive cost of a course, with anterograde and retrograde amnesia held apart, in its account of the cognitive side effects of electroconvulsive therapy; both are named for comparison and neither is re-derived. The ablative form of focused ultrasound belongs with this chapter's account of psychosurgery, and the grid grading the whole band belongs to the cross-cutting synthesis. None of what follows is established psychiatric practice.

100 percent	5.3 percent	animal
OF MAXIMAL STIMULATOR OUTPUT, THE USUAL INTENSITY	REMISSION DIFFERENCE FAVOURING ECT IN THE CONFIRMATORY TRIAL, NON-INFERIORITY MET	THE LEVEL AT WHICH A DIFFERING SEIZURE PHYSIOLOGY IS DEMONSTRATED

22.1 The technique, and how it is dosed

Magnetic seizure therapy is defined by the international safety guideline as the use of transcranial magnetic stimulation to induce seizures deliberately, under anaesthesia, for the treatment of depression or other serious neuropsychiatric conditions. What it demands is electroconvulsive therapy infrastructure, not a transcranial magnetic stimulation clinic: general anaesthesia in a procedure room with a crash cart and an anaesthesia station, a multidisciplinary team, and the standard pre-electroconvulsive-therapy workup. The dose sits at the machine's ceiling rather than a fraction of it. Magnetic seizure therapy is usually given at **100 percent** of maximal stimulator output, at a frequency of 25 to 100 Hz, in a single train lasting up to 10 seconds.

The coil belongs in the prescription. Coils differ in their efficiency at seizure induction, and the larger, less focal designs, the twin coil and the double cone, are more efficient than the focal figure-of-eight; much of the published work has used round or double-cone coils over the vertex, a placement reported to have a lower seizure threshold than midline prefrontal placement. The property that gives the technique its rationale therefore works against the event it must produce, and the operator settles that by coil choice and placement rather than by dose. Threshold is titrated by successively increasing stimuli within a single anaesthesia session, as a seizure threshold is titrated for electroconvulsive therapy; the interval between stimuli is not carried here. Monitoring is two-channel frontomastoid electroencephalography with the motor expression of the seizure, isolated by a leg tourniquet placed before the relaxant. The section ends where the guideline ends: the optimal dose above the seizure threshold for a given coil is not known, and neither is the dosing that would maximise benefit while minimising side effects.

22.2 The rationale, and the two claims that are held apart

The stated rationale is control over where the stimulation acts: increased control over the site of stimulation permits sparing of brain regions related to the adverse effects of electroconvulsive therapy. Two claims sit behind that sentence, they are not equally strong, and separating them is the examinable content here.

What is unambiguous. Studies using realistic head modelling show that, even at maximal stimulator output intensity, the electric field induced in the brain by magnetic seizure therapy is much lower and much more focal than the field induced by electroconvulsive therapy. That follows from the coil geometry, and the site at which the seizure is initiated is correspondingly more restricted. Both statements are about the stimulus, and the modelling is established. Note what is NOT said: no row in this chapter's claim list, and no source quote in it, describes the field or the site as more SUPERFICIAL, so depth is an ungrounded attribute here and is not carried.

What is an evidence question. Whether the seizure that then follows propagates less widely than an electroconvulsive therapy seizure, and how much of the measured cognitive difference such reduced propagation would explain. Here the record is thinner and its level is part of the claim. Animal studies substantiate that seizures induced with magnetic seizure therapy are less robust and differ in their physiological expression from electroconvulsive therapy seizures; in a sensitive non-human primate model, magnetic seizure therapy was significantly safer than electroconvulsive therapy and did not differ from an anaesthesia-alone sham, neither modality showing neuropathological evidence of tissue damage. That is animal evidence, reported as animal evidence. A human demonstration of reduced propagation was not located for this chapter, and the share of the human cognitive difference attributable to propagation is unquantified. The guideline's own bridge from focality to tolerability is a belief, that the field difference is thought to underlie the superior side-effect profile, and prose that hardens it into a finding has changed the evidence while quoting it.

RULE **A focal field is not a confined ictus, and the two claims travel at different evidence strengths.** Say it in one form and keep the two objects straight: the induced electric field is much lower and much more focal than in electroconvulsive therapy, and the site of seizure initiation is correspondingly more restricted. That is settled modelling. Say separately, at the strength the sources carry, that such seizures are less robust and physiologically different in animals, that the human propagation question is open, and that propagation's contribution to the cognitive difference is unquantified. The error in one direction conflates the focal stimulus with the spread of what follows it, which the sources do not show; the error in the other is to deny any difference in propagation, which the animal data contradict.

22.3 The human evidence: two randomised comparisons

Two randomised comparisons against right unilateral ultrabrief electroconvulsive therapy exist, and a candidate should name both: citing the larger alone overstates how settled the position is. Both treated to remission, dropout, or a maximum of 21 treatments, and both paired remission on the 24-item Hamilton scale with worsening of autobiographical memory as co-primary outcomes, worsening defined in the confirmatory trial as a 25 percent reduction in Autobiographical Memory Test score. The confirmatory trial, CREST-MST, used a non-inferiority margin of 15 percent absolute difference in remission and delivered magnetic seizure therapy with a twin coil in a midline frontal position.

AXIS	CONFIRMATORY TRIAL IN MAJOR DEPRESSIVE DISORDER	PILOT TRIAL IN BIPOLAR DEPRESSION
DESIGN	Multisite randomised double-blind parallel-group non-inferiority trial, three academic centres in Canada and the United States	Double-blind randomised parallel-group pilot
NUMBERS	292 enrolled, 239 randomised	55 randomised, 45 given an adequate trial
REMISSION, MAGNETIC SEIZURE THERAPY AGAINST ELECTROCONVULSIVE THERAPY	22.5 percent against 27.8 percent, a difference of 5.3 percent favouring electroconvulsive therapy, non-inferiority established at p = 0.048	5 of 25 (20 percent) against 6 of 20 (30 percent)
MEMORY WORSENING, SAME ORDER	2.7 percent against 17.3 percent, p = 0.0003	2 of 28 (7.1 percent) against 6 of 27 (22.2 percent)
AUTHORS' OWN LIMIT	Enrolment concluded before the intended sample size was reached	Findings to be considered preliminary, given the small pilot sample

The tolerability figures point the same way as the memory outcome: withdrawal for non-serious adverse events ran at 12 participants on electroconvulsive therapy against 3 on magnetic seizure therapy. Its authors read that as supporting magnetic seizure therapy as a first-line convulsive therapy in major depressive disorder, particularly for a patient who refuses right unilateral ultrabrief electroconvulsive therapy. That is an author interpretation of a trial whose enrolment stopped short, in a technique whose optimal dose is acknowledged to be unknown.

TRAP **Reading the memory advantage in these trials as proof that the seizure stayed local.** The trials measured autobiographical memory, not seizure spread. They establish an outcome difference on a named instrument; what produced it, whether the weaker induced field, a difference in how the seizure expresses itself, or something else in the procedure, an outcome trial does not settle. Report the outcome as an outcome and the mechanism as a hypothesis.

22.4 Focused ultrasound, in its neuromodulatory form

Transcranial focused ultrasound delivers acoustic energy through the intact skull to a focus placed at depth, and one name here covers two different interventions. Low-intensity focused ultrasound for neuromodulation is reversible and generally operates at intensities below 100 W per square centimetre. High-intensity focused ultrasound typically employs acoustic intensities greater than 200 W per square centimetre and is an ablation tool; the psychiatric procedure built on it is taught in this chapter's account of psychosurgery. Collapsing the two converts a reversible research technique into a lesion.

One physical trade-off is worth carrying: lower frequencies cross the skull better while higher frequencies give better focal precision, so penetration and precision are bought against each other. The frequency and acoustic pressure bands, and the pulse duration, pulse repetition frequency, duty cycle and train duration, are not carried here. The evidence level is best given in the reviewers' own terms: mechanisms incompletely understood, long-term effects, optimal parameters and safety assessment requiring systematic elucidation, and auditory confounding an unresolved controversy.

22.5 Alternating and random-noise stimulation

The low-intensity transcranial electrical stimulation family is one envelope with several waveforms, defined by the same guideline that defines transcranial direct current stimulation. The current can be of constant intensity and polarity, which is transcranial direct current stimulation and has its own account in this chapter. It can instead be of variable intensity or polarity:

- alternating between polarities at a steady sinusoidal frequency, which is **transcranial alternating current stimulation**;
- alternating at a randomly changing frequency, which is **transcranial random-noise stimulation**;
- varying within a single polarity, as in oscillatory transcranial direct current stimulation.

The examinable point is the shared envelope: these are variants of one low-intensity technique bounded by a maximum current, a maximum session duration, an electrode-area band and a frequency band, rather than separate technologies with limits of their own; the bounds are not carried here. One reading convention travels with them: direct current intensity is reported baseline-to-peak, and for alternating and random-noise stimulation the convention used has to be specified, because the same waveform yields different figures under different conventions. What this record establishes is definitions and a safety envelope, not clinical efficacy for any psychiatric indication, and a tidy definition is not evidence of one.

22.6 Closed-loop and adaptive stimulation

Closed-loop stimulation, also called adaptive stimulation, adjusts its output from a signal recorded in the patient instead of delivering parameters fixed at programming. One regulatory authorisation for the principle exists, and its scope has to be quoted exactly. In 2025 the United States Food and Drug Administration approved, through a premarket approval supplement, an optional programming feature called adaptive deep brain stimulation, for bilateral stimulation of the internal globus pallidus or the subthalamic nucleus, as adjunctive therapy in levodopa-responsive Parkinson disease of at least 4 years duration that is not adequately controlled with medication.

Read the scope rather than the headline. That is a foreign regulatory status, for a neurological indication, at motor targets, on a platform whose psychiatric use is taught in this chapter's own account of deep brain stimulation. It authorises nothing in psychiatry and establishes nothing about the Indian regulatory position for any device. What it does establish is that closed-loop control has crossed from research into an approved product feature in at least one jurisdiction, which is why it appears in a psychiatry chapter at all.

MNEMONIC

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The four emerging approaches, ordered by how much human evidence each carries. **M**agnetic seizure therapy, with two randomised comparisons against right unilateral ultrabrief electroconvulsive therapy. **U**ltrasound, low intensity and focused, with mechanisms still being worked out. **A**lternating and random-noise currents, defined inside the low-intensity electrical stimulation envelope and no further. **C**losed-loop and adaptive stimulation, approved abroad for a motor indication. None of the four is established psychiatric practice.

Magnetic seizure therapy induces a therapeutic seizure with an induced electric field much lower and much more focal than that of electroconvulsive therapy and with a correspondingly more restricted site of initiation, which is settled modelling; whether the resulting seizure spreads less is supported in animals, open in humans, and unquantified as an explanation of the cognitive difference two randomised trials have measured; and low-intensity focused ultrasound, alternating and random-noise stimulation and closed-loop stimulation are each carried at their own evidence level, none of them established psychiatric practice.

23 · Psychosurgery (history, current indications, ethics)

Ablative psychosurgery treats psychiatric illness by destroying a small, deliberately chosen volume of brain tissue, and the tissue does not come back. That one fact governs the rest: the narrow indications, the weight of the consent, and the statutory machinery around it. The topic is examinable from both ends, the documented ethical failure in its history and the technique of a modern stereotactic theatre.

This account owns ablative neurosurgery for psychiatric illness in full: the descent from frontal leucotomy through its abuses to modern stereotactic and image-guided lesioning, the procedures with their targets and how each lesion is placed, the narrow indications, the evidence and the designs it rests on, the irreversibility, and the ethics. It does not draw the band comparison on invasiveness, seizure induction, target, reversibility, evidence and Indian availability; that grid belongs to the cross-cutting synthesis. Deep brain stimulation belongs to this chapter's own account of it, and the history of electroconvulsive therapy to the item owning it. The statutory restriction on psychosurgery belongs to the Mental health legislation and forensic psychiatry notes, named here in words and never renumbered.

four	60,000	50 to 60 percent
ABLATIVE PROCEDURES IN CURRENT USE, EACH WITH ITS OWN TARGET	PROCEDURES AT THE HEIGHT OF THE LEUCOTOMY ERA	RESPONSE IN REFRACTORY ILLNESS, ON LARGELY UNCONTROLLED DESIGNS

23.1 Two groups, not one family

Ablative psychosurgery is not the invasive end of a stimulation scale. Psychosurgical intervention divides into two groups: **lesioning** destroys tissue, stimulation delivers current to tissue that remains intact. Both groups share one principle, to intervene as little as necessary to restore a dysfunctional circuit, and the choice turns on indication, centre experience and patient preference, weighing the irreversibility and relative simplicity of lesioning against the reversibility, adjustability and cost of stimulation.

One qualification travels with the contrast so it is not overdrawn: deep brain stimulation was initially conceptualised as a reversible lesion, and the effects of lesioning are increasingly attributed to circuit reorganisation rather than to tissue destruction alone, so the families may converge in mechanism where they do not converge in reversibility.

RULE **Ablation and stimulation are two families, and the boundary between them is irreversibility, not degree of invasiveness.** Every stimulation modality of this band shares one property no ablative procedure has: switching the device off ends the intervention. Ablation destroys tissue, so it outlives every later decision, including the patient's own change of mind. It therefore appears in the band's grid for contrast, never as the most invasive rung of a stimulation ladder.

23.2 Frontal leucotomy: what was actually done

The named precursors are Gottlieb Burckhardt's cortical resections in psychotic patients and Fulton and Penfield's work on frontal-lobe physiology. In 1936, Egas Moniz, working with the neurosurgeon Almeida Lima, published his first series of 20 patients who underwent prefrontal leucotomy for severe depression, anxiety and aggression. The technique is the detail candidates omit: the lesions were made by free-hand injection of absolute alcohol into the frontal lobes, with **substantial symptom improvement reported in 14 of 20 patients**. Moniz later replaced the alcohol with a hand-held leucotome, making more restricted lesions.

Anatomically, the operation lesioned prefrontal white matter through small frontal burr holes, partially disconnecting the frontal cortex from its thalamic and limbic connections. The

outcomes were not uniform, and that is the point: anxiety and agitation decreased in some patients, while in others apathy, abulia, personality change or cognitive deterioration emerged. A free-hand disconnection produced benefit and injury from the same act.

23.3 The abuses, and the reform they forced

Abuse here means what was done, not disapproval of an era. Walter Freeman and James Watts popularised the procedure in the United States, redefining its access points and lesion strategies, and by 1942, the year their monograph was published, they had performed 200 lobotomies. Freeman then promoted more expedient versions, including the transorbital lobotomy, and advocated wide adoption with lax indications, with interventions performed outside the operating room and sometimes without a neurosurgeon. Volume reached up to 60,000 procedures, against the overcrowding of psychiatric institutions.

Three features make this an abuse rather than a therapeutic error: indications so loose the operation was offered where no case existed, delivery outside the operating theatre, and delivery sometimes without a surgeon. This high-volume, low-supervision phase is what fuelled the ethical and regulatory backlash that continues to stigmatise these procedures. Reform came from within the discipline: cortical undercutting and topectomies were introduced as more selective approaches, and Spiegel and Wycis then introduced the stereotactic frame in humans, lesioning the mediodorsal thalamic nucleus using X-ray ventriculography. Everything modern descends from that instrument: a lesion positioned by calculation and bounded by design.

TRAP **Telling the Freeman story as though it were the whole of psychosurgery, and stopping there.** The leucotomy era is why the field is regulated, and a candidate who cannot narrate it has not answered. But an answer ending in the mid twentieth century treats a living, narrowly indicated, image-guided operation as a curiosity, and says nothing about targets, technique, evidence or present-day consent.

23.4 The current procedures, their targets and their technique

Each has a named target, and the technique of the first two is what the anxiety and obsessive-compulsive disorder material promises the reader here.

PROCEDURE	TARGET	HOW THE LESION IS PLACED	ORIGIN AND MODERN FORM
ANTERIOR CAPSULOTOMY	The anterior limb of the internal capsule	Thermocoagulation, later radioactive yttrium-90 seeds; Leksell independently used parallel bipolar radiofrequency electrodes	Jean Talairach, 1949, for anxiety neuroses and obsessive compulsive disorders
ANTERIOR CINGULOTOMY	The anterior cingulate, lesioned bilaterally	Stereotactic frame, magnetic resonance guidance and intravenous sedation, through a single burr hole per side	Triple-lesion form standardised since 1996
SUBCAUDATE TRACTOTOMY	The posterior orbitofrontal cortex, bilaterally, using the pituitary sella as a landmark	Rod-shaped yttrium seeds creating radiation-necrotic lesions, later replaced by radiofrequency coagulation	Geoffrey Knight, 1965, adapting Scoville's orbitofrontal undercutting
LIMBIC LEUCOTOMY	The cingulate and orbitofrontal targets together	Cingulotomy combined with subcaudate tractotomy	Kelly and colleagues, 1973; now usually reached as a staged procedure

Anterior cingulotomy is best given as an operative sequence, because the sequence is what changed. The historical procedure made a single lesion of about 2 cm by 1 cm per side, under magnetic resonance guidance and intravenous sedation, using a stereotactic frame. Patients who had not responded at 9 to 12 months underwent anterior extension of the lesion, and since 1996 all three lesions per side are made simultaneously, as the triple-lesion or six-pack cingulotomy, through a single burr hole with a 10 mm exposed-tip electrode redirected along the contour of the cingulate gyrus. The staging follows from that: in the mid-1990s at Massachusetts General Hospital, patients who failed the initial six-pack cingulotomy were offered a subcaudate tractotomy, and cingulotomy followed by subcaudate tractotomy is a staged limbic leucotomy.

Anterior capsulotomy aims at white matter rather than cortex, and its history is one of energy sources rather than targets: thermocoagulation first, then radioactive yttrium-90 seeds, with Leksell independently using parallel bipolar radiofrequency electrodes. **Subcaudate tractotomy** and **limbic leucotomy** complete the set, the last being a deliberate combination on the reasoning that if each independently helps, combining them might do better.

MNEMONIC

CATS

Capsulotomy, anterior: anterior limb of the internal capsule. **A**nterior cingulotomy: anterior cingulate. **T**ractotomy, subcaudate: posterior orbitofrontal cortex. **S**taged limbic leucotomy: cingulotomy plus subcaudate tractotomy in one patient.

23.5 How the lesion is actually made

A target is not a technique. Three energy modalities are in use, each with its own working figures.

MODALITY	HOW THE ENERGY REACHES THE TARGET	WHAT IT DOES TO TISSUE
RADIOFREQUENCY THERMAL ABLATION	A stereotactically inserted electrode whose tip delivers a high-frequency alternating current at about 500 kHz	Ionic agitation and microscopic friction raise tissue temperature to around 70 to 85 degrees Celsius for several seconds, causing coagulative necrosis in a sharply delimited volume that depends on electrode geometry, temperature, duration and local microanatomy
STEREOTACTIC RADIOSURGERY, AS IN THE GAMMA KNIFE	Hundreds of collimated gamma-ray beams focused on an isocentre only a few millimetres across, with no intraparenchymal electrode	**High doses of about 140 to 180 Gy at the target, typically the anterior limb of the internal capsule in radiosurgical capsulotomy**
MAGNETIC RESONANCE GUIDED FOCUSED ULTRASOUND	Ultrasound delivered through the skull and focused on a deep target, using acoustic rather than ionising energy	At the focal point, absorption translates into heating to 55 to 60 degrees Celsius, producing thermal necrosis

PITFALL

Carrying a temperature or a dose across from one energy modality to another. The figures belong to the physics of each method: a coagulation temperature is not an ultrasound temperature, and neither is a radiosurgical dose. Quote a figure only with the modality it was measured in.

23.6 The indications, and what the evidence rests on

Ablation is offered for a very short list of conditions, and only after ordinary treatment has genuinely failed. The two current indications are:

- Genuinely refractory obsessive-compulsive disorder. The algorithm leading to surgical referral belongs to the anxiety, obsessive-compulsive and trauma-related disorder material.
- Refractory depression, on the same requirement of exhausted, adequately delivered treatment.

The headline finding is easy to misquote. Ablative approaches are not inferior in efficacy to stimulation techniques, with response rates around 50 to 60 percent, but the evidence base is largely composed of uncontrolled studies and direct comparative trials remain lacking. The caveat is half the finding: ablation has not been shown less effective than stimulation, it has been shown on weaker designs.

Procedure by procedure, the picture is consistent. Radiofrequency and radiosurgical capsulotomy show similar efficacy in several open-label series in refractory obsessive-compulsive disorder, Gamma Knife capsulotomy is now the more commonly used, and one double-blind controlled trial shows significant differences between active and sham; most studies remain single-centre

and non-randomised, and adverse effects including apathy, fatigue and cognitive change are described as not negligible. For cingulotomy, large cohorts show significant improvement, but effect sizes are more modest under modern outcome criteria: in one cohort of 64 patients with refractory obsessive-compulsive disorder, partial response was seen in 47 percent at 11 months, rising to 69 percent at 64 months, with 30 of the 64 undergoing a further procedure. Subcaudate tractotomy may confer a higher response rate than a repeat cingulotomy in cingulotomy non-responders, on a series of 31 patients. Limbic leucotomy shows the staging effect most sharply: it was effective in only 20 percent as the initial procedure but in 50 percent when staged after one or more failed cingulotomies, while the original series of 66 patients reported improvement in 89 percent with obsessive-compulsive disorder and 78 percent with major depression.

Response is a scale threshold, not a clinical judgement: response in obsessive-compulsive disorder is a 35 percent or greater improvement on the Yale-Brown Obsessive Compulsive Scale and remission a score under 8, with the source's own warning that the scale is not strictly linear, so dichotomous responder classification should be interpreted cautiously. The harms are real if uncommon: apathy, seizures, urinary incontinence and memory problems are reported in a minority.

TRAP **Quoting the response rate without the design that produced it.** Set beside a controlled stimulation trial, such a figure invites a comparison of numbers not measured in comparable ways. Carry both halves, and note that the source's own "not inferior" is a failure to show a difference on uncontrolled designs rather than a demonstration of equivalence: efficacy is not SHOWN inferior, and the studies are largely uncontrolled, single-centre and non-randomised, with direct comparative trials lacking.

23.7 The ethics, and the restriction that governs the operation

Ethics here constrains a living procedure; it is not a coda to the Freeman story. Contemporary psychosurgery is only ethically acceptable if it strictly respects the four principles of bioethics, autonomy, beneficence, non-maleficence and justice, in a population that is highly vulnerable and whose capacity to consent may be impaired and should be assessed with specific tools. The evidence problem then becomes an ethical one: limited worldwide experience and the scarcity of class I to II evidence for most procedures complicate the provision of fair, clear and balanced information to patients and families.

The consent failure to guard against has a name. **Therapeutic misconception** is the risk that a patient interprets participation in a clinical trial as individualised care, which becomes likelier when a neurosurgical option is perceived as a last therapeutic intervention. The corrective sits in the consent: it must clearly convey the experimental nature of some of these interventions, the uncertainty of outcomes, and a realistic balance of potential benefits and risks.

Historical controversies and abuses in prisoners and minors led the National Commission for the Protection of Human Subjects, in 1977, to recommend significant restrictions on psychosurgery. That is United States regulatory history and nothing more. In current practice, ethical tension persists at four levels:

- Social: pressure to control aggression or addictions.
- Medical: research enthusiasm.
- Industrial: device-related economic interests.
- Personal: concerns about identity and integrity.

Justice is easily left abstract; the literature makes it concrete through cost: deep brain stimulation is among the most expensive medical therapies and requires rigorous cost-effectiveness and equity analysis when proposed for treatment-resistant psychiatric disorders, named here for that principle only.

GOOD TO REMEMBER

The ethical pressure does not point in one direction. The same literature describes psychosurgery as occupying a narrow corridor between underuse and misuse, with current referral rates strikingly low relative to the burden of treatment-resistant illness. A trainee who has absorbed only the abuses reads every referral as a warning; one who has absorbed only the modern imaging underweights what a permanent lesion costs when refractoriness was assumed.

IN INDIA

The Indian constraint is statutory, not merely professional, and it is double: psychosurgery may not be performed on a person unless that person's informed consent has been obtained and the concerned Board has also approved it. That provision belongs to the Mental health legislation and forensic psychiatry notes' account of psychosurgery under the mental health legislation, is named here in words and never renumbered; go there for the wording and the route to the Board. Whether an implanted deep brain stimulation system falls inside that statutory definition belongs to this chapter's deep brain stimulation account and is a declared gap. The United States restriction above is not an Indian instrument and must never be written as though it were.

Ablative psychosurgery destroys tissue and is therefore not a member of the stimulation family, however invasive that family becomes; the procedures in use are anterior capsulotomy at the anterior limb of the internal capsule, anterior cingulotomy at the anterior cingulate in its triple-lesion form, subcaudate tractotomy at the posterior orbitofrontal cortex, and limbic leucotomy as the staged combination of the last two, made by radiofrequency, radiosurgery or focused ultrasound with parameters specific to each; the indications are genuinely refractory obsessive-compulsive disorder and depression; efficacy is not SHOWN inferior to stimulation and rests on largely uncontrolled designs with no direct comparative trials; and consent must survive impaired capacity and the therapeutic misconception, with India adding a statutory requirement of informed consent and Board approval that this chapter names and does not restate.

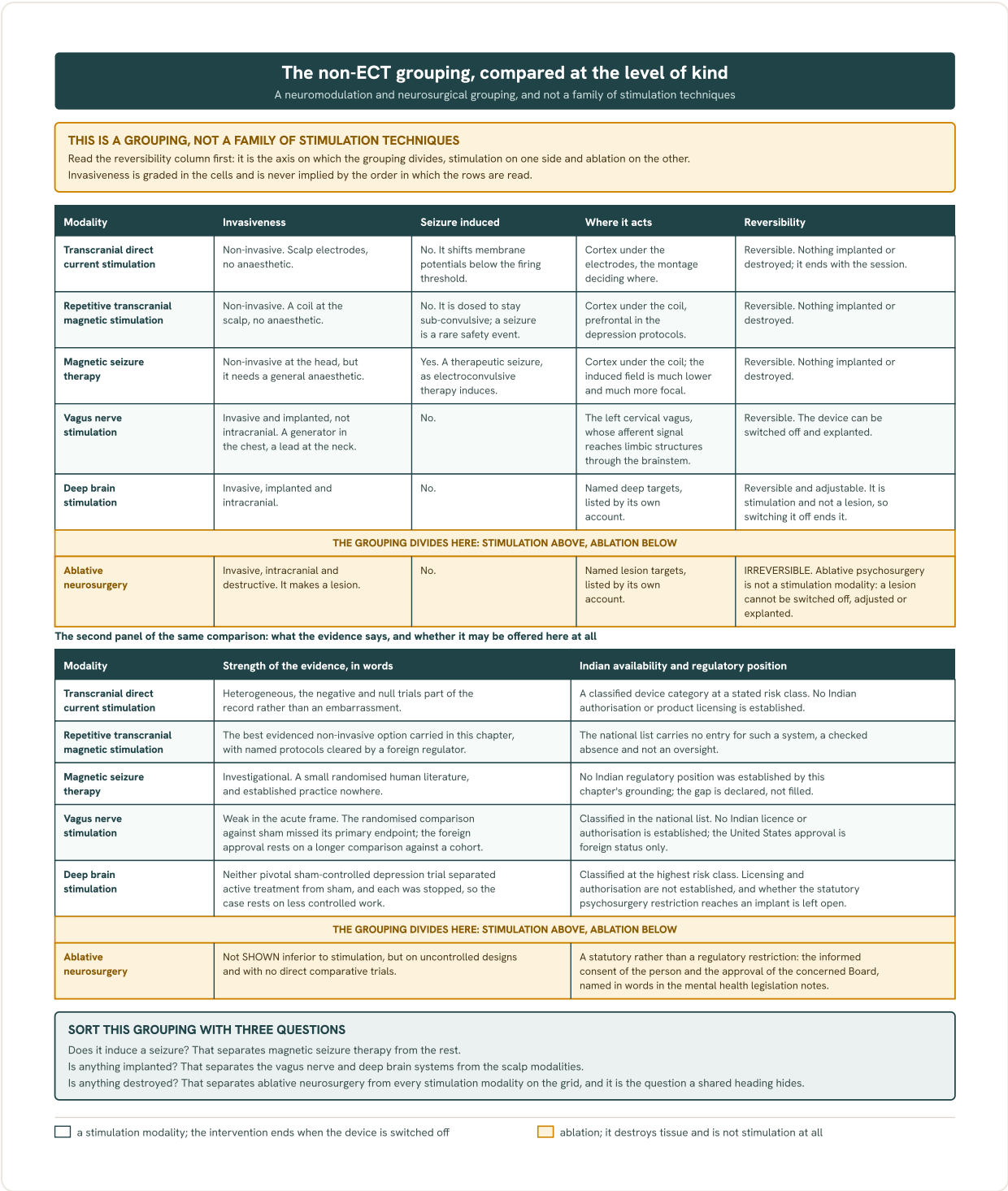
Cross-cutting synthesis

24 · Cross-cutting synthesis

Every other account in this chapter teaches one topic; this one is about how they hold together. An induced seizure is delivered at a measured dose, through a chosen placement, with a chosen shape of stimulus, on a chosen schedule, under an anaesthetic somebody else is giving, to a patient whose agreement has to be lawful. Move any one and something else moves with it: the topics **interlock**. The joint they turn on is the **stimulation dose**: what is delivered, how much, where, and what it costs. One boundary belongs here because it runs across the seam rather than inside any one item: the MOTOR THRESHOLD that bounds repetitive transcranial magnetic stimulation is a different construct from the seizure threshold that bounds this treatment, measured differently and meaning something different, and neither is carried across to the other. Each is taught in full by the item that owns it.

Owned here and nowhere else: the synthesis itself, how the parts move against one another, and the non-ECT comparison at the level of kind. Named in a clause and never re-derived, each with its own account: the mechanism theories, the seizure threshold, the placements and waveform, the placement-by-dose comparison, the cognitive cost, the anaesthetic conduct, the acute course, continuation and maintenance, the interacting drugs, and consent. No dose, multiple, percentage, current or session count is printed here.

Dose	Differs	Kind
THE SEAM THAT ALMOST EVERY OTHER DECISION HERE IS EXPRESSED AGAINST	THE DIRECTION AND THE SIZE OF THE TRADE, BY PARAMETER AND BY PLACEMENT	THE LEVEL THE NON-ECT MODALITIES ARE COMPARED AT, NEVER A SIBLING'S SETTINGS



The non-ECT grouping, compared at the level of kind

A neuromodulation and neurosurgical grouping, and not a family of stimulation techniques

THIS IS A GROUPING, NOT A FAMILY OF STIMULATION TECHNIQUES

Read the reversibility column first: it is the axis on which the grouping divides, stimulation on one side and ablation on the other. Invasiveness is graded in the cells and is never implied by the order in which the rows are read.

Modality	Invasiveness	Seizure induced	Where it acts	Reversibility
Transcranial direct current stimulation	Non-invasive. Scalp electrodes, no anaesthetic.	No. It shifts membrane potentials below the firing threshold.	Cortex under the electrodes, the montage deciding where.	Reversible. Nothing implanted or destroyed; it ends with the session.
Repetitive transcranial magnetic stimulation	Non-invasive. A coil at the scalp, no anaesthetic.	No. It is dosed to stay sub-convulsive; a seizure is a rare safety event.	Cortex under the coil, prefrontal in the depression protocols.	Reversible. Nothing implanted or destroyed.
Magnetic seizure therapy	Non-invasive at the head, but it needs a general anaesthetic.	Yes. A therapeutic seizure, as electroconvulsive therapy induces.	Cortex under the coil; the induced field is much lower and much more focal.	Reversible. Nothing implanted or destroyed.
Vagus nerve stimulation	Invasive and implanted, not intracranial. A generator in the chest, a lead at the neck.	No.	The left cervical vagus, whose afferent signal reaches limbic structures through the brainstem.	Reversible. The device can be switched off and explanted.
Deep brain stimulation	Invasive, implanted and intracranial.	No.	Named deep targets, listed by its own account.	Reversible and adjustable. It is stimulation and not a lesion, so switching it off ends it.
THE GROUPING DIVIDES HERE: STIMULATION ABOVE, ABLATION BELOW				
Ablative neurosurgery	Invasive, intracranial and destructive. It makes a lesion.	No.	Named lesion targets, listed by its own account.	IRREVERSIBLE. Ablative psychosurgery is not a stimulation modality: a lesion cannot be switched off, adjusted or explanted.

The second panel of the same comparison: what the evidence says, and whether it may be offered here at all

Modality	Strength of the evidence, in words	Indian availability and regulatory position
Transcranial direct current stimulation	Heterogeneous, the negative and null trials part of the record rather than an embarrassment.	A classified device category at a stated risk class. No Indian authorisation or product licensing is established.
Repetitive transcranial magnetic stimulation	The best evidenced non-invasive option carried in this chapter, with named protocols cleared by a foreign regulator.	The national list carries no entry for such a system, a checked absence and not an oversight.
Magnetic seizure therapy	Investigational. A small randomised human literature, and established practice nowhere.	No Indian regulatory position was established by this chapter's grounding; the gap is declared, not filled.
Vagus nerve stimulation	Weak in the acute frame. The randomised comparison against sham missed its primary endpoint; the foreign approval rests on a longer comparison against a cohort.	Classified in the national list. No Indian licence or authorisation is established; the United States approval is foreign status only.
Deep brain stimulation	Neither pivotal sham-controlled depression trial separated active treatment from sham, and each was stopped, so the case rests on less controlled work.	Classified at the highest risk class. Licensing and authorisation are not established, and whether the statutory psychosurgery restriction reaches an implant is left open.
THE GROUPING DIVIDES HERE: STIMULATION ABOVE, ABLATION BELOW		
Ablative neurosurgery	Not SHOWN inferior to stimulation, but on uncontrolled designs and with no direct comparative trials.	A statutory rather than a regulatory restriction: the informed consent of the person and the approval of the concerned Board, named in words in the mental health legislation notes.

SORT THIS GROUPING WITH THREE QUESTIONS

Does it induce a seizure? That separates magnetic seizure therapy from the rest.
Is anything implanted? That separates the vagus nerve and deep brain systems from the scalp modalities.
Is anything destroyed? That separates ablative neurosurgery from every stimulation modality on the grid, and it is the question a shared heading hides.

a stimulation modality; the intervention ends when the device is switched off

ablation; it destroys tissue and is not stimulation at all

Fig 27.13. The non-ECT interventions are read as one grouping and not as one family: transcranial direct current stimulation, repetitive transcranial magnetic stimulation, magnetic seizure therapy, vagus nerve stimulation and deep brain stimulation are stimulation modalities whose intervention ends when the device is switched off, while ablative neurosurgery destroys tissue and is irreversible, which is why the reversibility column rather than the order of the rows is what the grid is read on, and the one Indian instrument speaking directly to a modality is statutory, the psychosurgery restriction requiring the informed consent of the person and the approval of the concerned Board.

24.1 One measured quantity, and almost everything expressed against it

No account of how this treatment works is established, and the field says so in its own words, but every candidate account is an account of what an induced seizure does, so the seizure is the therapeutic event and the dose produces it. That dose is not a device setting. It is a multiple of a quantity measured in this patient, the lowest dose at which this brain will seize, which varies enormously and moves across a course. This is why the chapter reads as parameters rather than

protocols: fix the placement and the multiple still has to be chosen; fix the multiple and the placement changes what it buys.

Follow the chain forward and the chapter appears in order. The threshold sets the dose. The dose and placement together settle efficacy and cognitive cost, which is why the comparison between placements has no answer until the multiple is named. The cognitive cost is not one deficit but several on different clocks. The schedule spends the dose over time. Continuation and maintenance settle what happens to the gain once the course stops. Drugs continued across it move the threshold underneath everything. And the law settles, before any of this, whether the treatment may be given.

24.2 The trades differ, and the difference is the finding

Many of the choices along that seam trade among speed of response, efficacy and cognitive cost. Where they do, the direction and size of that trade differ by parameter and by placement, and the chapter asserts no law covering all of them, because several are not that kind of trade at all.

RULE **Read the trade off the parameter in front of you, and never inherit a direction from the parameter beside it.** Every general version of that rule attempted here was contradicted by the parameter next along. State what your parameter trades, at the placement you are standing at. Where a parameter does not behave like its neighbour, that is the finding.

CHOICES THAT DO TRADE AMONG THE THREE	WHAT MOVING IT ACTUALLY DOES	TAUGHT IN FULL BY
STIMULUS DOSE ABOVE THRESHOLD, AT RIGHT UNILATERAL PLACEMENT	The dose-response is steep here, so raising the multiple buys efficacy; the placement's cognitive advantage erodes as that multiple rises, without being abolished.	Stimulus dosing, and the placement comparison.
STIMULUS DOSE ABOVE THRESHOLD, AT BITEMPORAL PLACEMENT	Efficacy is already near maximal at a low multiple, so a higher dose here largely buys cognitive cost alone. The same knob, turned the same way, makes a different purchase.	The placement comparison.
THE PLACEMENT ITSELF	Not a fixed ranking, and never usable as one. Right unilateral treatment is markedly inferior near threshold and converges toward bitemporal efficacy at a high multiple without established superiority over it; the comparison narrows and does not reverse.	The placement comparison.
PULSE WIDTH	A narrower pulse is associated with a cognitive advantage at right unilateral placement in depressive illness, with antidepressant efficacy possibly compromised. The relation is bounded to pulse width inside a placement.	Technique and electrode placement.
TREATMENT FREQUENCY	A faster schedule buys speed of response at a higher cognitive price; end-of-course efficacy is equivalent between the schedules. Frequency is not an efficacy lever, and writing it as one imposes cognitive injury for a gain that does not exist.	The acute course and its schedules.

The second table stops the first from hardening into a law. These choices sit on the same seam and are not purchases among speed, efficacy and cognitive cost at all.

CHOICES THAT ARE NOT THAT KIND OF TRADE	WHAT MOVING IT ACTUALLY DOES	TAUGHT IN FULL BY
THE INDUCTION AGENT AND THE CONDUCT OF THE ANAESTHETIC	A different currency altogether. The agent shapes the seizure the psychiatrist then has to read, and is chosen against separate rankings for its effect on the threshold, the cardiovascular response and emergence, at no cognitive price.	The pre-ECT workup and anaesthesia.
THE AIRWAY, THE MONITORING AND THE TOURNIQUET	Not trades among speed, efficacy and cognitive cost in any form. The airway and monitoring buy safety and information; the tourniquet buys a limb on which the motor seizure can still be seen.	The pre-ECT workup and anaesthesia.
DRUGS CONTINUED ACROSS THE COURSE	A hazard rather than a purchase. They move the threshold underneath everything above, in either direction, each with a management step, and the direction belongs to the drug.	Drug interactions and concurrent medications.

24.3 Buying the right thing at the least price

A map with no single direction still yields a task. Decide first what this patient needs, efficacy or speed, because those are different purchases not made with the same parameter. Then buy it at the least cognitive price the illness and the law allow: the placement and multiple chosen together, the pulse width with them, the schedule for what it genuinely delivers. Where speed itself is the requirement, the schedule that answers it is the accelerated one, assembled only in this chapter's account of the course, frequency and number of sessions.

The cognitive price is not a fixed toll: the same efficacy can often be bought at different prices depending on how the parameters are combined.

> **PITFALL**
>
> The real-world error is not getting a parameter wrong. It is getting one right and then carrying its direction to the next: a clinician who has learned that a higher multiple earns a response at right unilateral placement raises it at bitemporal placement too, where efficacy was already near maximal, buying cognitive cost with nothing on the other side.

24.4 The handoffs a real course crosses

A single patient can walk a resident through most of this chapter. The difficulty is rarely inside a topic but at the joints, where the question changes shape and the governing account with it.

- **An indication becomes a consent question.** The presentation earns the treatment clinically, and the next question is not the dose but the authority: who may agree, and whether the route

is complete. Urgency strengthens the clinical case and completes no route.

- **A threshold titration becomes a placement decision.** The threshold is only part of an answer, because the multiple worth using depends on where the electrodes sit. They are chosen together, or the dose is chosen wrongly with great precision.
- **A cognitive complaint becomes a dosing change.** A patient reporting memory loss is a finding, not a nuisance, and the response is a change in the parameters that move it: placement, multiple, pulse width, schedule, drugs.
- **An acute response becomes a maintenance question.** A course that worked does not end the decision: relapse is the rule when nothing active follows.
- **A failed medication ladder becomes a modality question.** When the drugs have not worked, the question stops being which drug and becomes which intervention.

24.5 The law bounds the seam rather than sitting on it

The last element in the chain behaves unlike the others, and treating it as one more parameter is the commonest structural error. Consent, capacity and the statutory provisions do not tune the treatment; they settle whether it may be given at all, and on whose authority. Clinical urgency does not convert a missing authority into a present one: a lawful route has to be established separately, the emergency-treatment provision of the Act cannot supply it, and that is a point about treatment authority and not about admission, because a capacitous adult can consent to this treatment with no admission at all. The routes, an advance directive refusing treatment, the nominated representative and the minor's gate belong to this chapter's account of consent.

Statutory bars sit at the edges of the chapter, not inside its parameters. Unmodified, or direct, electroconvulsive therapy is unlawful in India rather than merely inadvisable, as this chapter's modified-against-unmodified contrast states with the history behind it. And ablative psychosurgery may not be performed without the person's informed consent and the approval of the concerned Board. Each provision belongs to the Mental health legislation and forensic psychiatry notes, named here in words and renumbered nowhere.

24.6 The non-ECT grouping, compared at the level of kind

The second part of the chapter meets the other interventions that act on the brain directly. They are read in the bank's own sequence, which ranks nothing: the grading of **invasiveness** is taught here, never implied by which item comes first. Each modality's own settings belong to its own account, and the accompanying plate carries this comparison as one grid.

Before the grid can be read honestly, the grouping needs its right name. This is a **neuromodulation and neurosurgical grouping**, not a family of stimulation techniques. The stimulation members share a property mattering more than their differences: switching the device off ends the intervention. Ablative neurosurgery does not share it. It destroys tissue, it is not stimulation at all, and it sits on the grid for contrast rather than as the invasive end of one gradient. That is why **reversibility** is the column to read first. It is the axis on which the grouping divides, stimulation on one side and ablation on the other, and the ablative psychosurgery account owns that irreversibility in full.

MODALITY	INVASIVENESS	SEIZURE INDUCED	WHERE IT ACTS	REVERSIBILITY
TRANSCRANIAL DIRECT CURRENT STIMULATION	Non-invasive. Scalp electrodes, no anaesthetic.	No. It shifts membrane potentials below the firing threshold.	Cortex under the electrodes, the montage deciding where.	Reversible. Nothing implanted or destroyed; it ends with the session.
REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION	Non-invasive. A coil at the scalp, no anaesthetic.	No. It is dosed to stay sub-convulsive; a seizure is a rare safety event.	Cortex under the coil, prefrontal in the depression protocols.	Reversible. Nothing implanted or destroyed.
MAGNETIC SEIZURE THERAPY	Non-invasive at the head, but needs a general anaesthetic.	Yes. A therapeutic seizure, as electroconvulsive therapy induces.	Cortex under the coil; the induced field is much lower and much more focal.	Reversible. Nothing implanted or destroyed.
VAGUS NERVE STIMULATION	Invasive and implanted, not intracranial. A generator in the chest, a lead at the neck.	No.	The left cervical vagus, whose afferent signal reaches limbic structures through the brainstem.	Reversible. The device can be switched off and explanted.
DEEP BRAIN STIMULATION	Invasive, implanted and intracranial.	No.	Named deep targets, listed by its own account.	Reversible and adjustable. It is stimulation and not a lesion, so switching it off ends it.
ABLATIVE NEUROSURGERY	Invasive, intracranial and destructive. It makes a lesion.	No.	Named lesion targets, listed by its own account.	Irreversible. Ablative psychosurgery is not a stimulation modality: a lesion cannot be switched off, adjusted or explanted, and this cell is why the grouping is not one family.

The remaining axes are the second panel of the same comparison: what a modality is settles what it could do, while its evidence and regulatory position settle whether it may be offered at all.

MODALITY	STRENGTH OF THE EVIDENCE, IN WORDS	INDIAN AVAILABILITY AND REGULATORY POSITION
TRANSCRANIAL DIRECT CURRENT STIMULATION	Heterogeneous, the negative and null trials part of the record rather than an embarrassment.	A classified device category at a stated risk class. No Indian authorisation or product licensing is established.
REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION	The best evidenced non-invasive option carried in this chapter, with named protocols cleared by a foreign regulator.	The national list carries no entry for such a system, a checked absence and not an oversight.
MAGNETIC SEIZURE THERAPY	Investigational. A small randomised human literature, and established practice nowhere.	No Indian regulatory position was established by this chapter's grounding; the gap is declared, not filled.
VAGUS NERVE STIMULATION	Weak in the acute frame. The randomised comparison against sham missed its primary endpoint; the foreign approval rests on a longer comparison against an observational cohort.	Classified in the national list. No Indian licence or authorisation is established; the United States approval is foreign status only.
DEEP BRAIN STIMULATION	Neither pivotal sham-controlled depression trial separated active treatment from sham, and each was stopped, so the case rests on less controlled work.	Classified at the highest risk class. Licensing and authorisation are not established, and whether the statutory psychosurgery restriction reaches an implanted system is left open.
ABLATIVE NEUROSURGERY	Not SHOWN inferior to stimulation, but on uncontrolled designs and with no direct comparative trials.	A statutory rather than a regulatory restriction: informed consent of the person and approval of the concerned Board, named in the Mental health legislation and forensic psychiatry notes.

GOOD TO REMEMBER

Sort this grouping with three questions. Does it induce a seizure? That separates magnetic seizure therapy from the rest. Is anything implanted? That separates the vagus nerve and deep brain systems from the scalp modalities. Is anything destroyed? That separates ablative neurosurgery from every stimulation modality on the grid, and it is the question a shared heading hides.

IN INDIA

Read the Indian column as four claims and never as one. A device classification says which regulatory pathway a device sits in; a product licence says a named device may be sold here; an indication-specific authorisation says it may be sold for a stated psychiatric use; a foreign clearance speaks to another jurisdiction, not this one. On this grid the classification claim is usually the only one available: Indian licensing and authorisation are not established for any modality, written as not established rather than left for a reader to infer. The one Indian instrument speaking directly to a modality is statutory, the psychosurgery restriction named above.

MNEMONIC

ONE KNOB AT A TIME

Before stating any trade, name the knob exactly: the dose, and at which placement; the pulse width, and at which placement; the schedule; the anaesthetic. Then read that knob's trade and stop. Do not carry the direction to the next, which has its own. And some controls here, the airway, the monitoring and the tourniquet, are not on this trade at all.

The stimulation dose is the seam: mechanism proposes it, the threshold measures it, placement conditions what it buys, the cognitive cost prices it, and the law bounds who may receive it. Many of the choices along that seam trade among speed of response, efficacy and cognitive cost, and where they do the direction and size of the trade differ by parameter and by placement; several, the airway, the monitoring and the tourniquet among them, are not that kind of trade in any form. The non-ECT grouping is not one family: its stimulation members end when the device is switched off, while ablation destroys tissue and cannot be undone.

TRAP **Answering a synthesis question with a single general rule.** The question invites it, because an examiner asking what the trade-off is sounds like one wanting a single sentence, and one sentence sounds like mastery. It cannot be right here: the relation at right unilateral placement is not the one at bitemporal placement, and the schedule's is different again. Name the parameter, give its relation with its condition, then say the others run differently.

Apply and consolidate

25 · Applying the chapter

A vignette in this territory almost never asks whether electroconvulsive therapy works; it asks whether this patient may lawfully be given it, with what, and at what price. Those are separate findings reached by separate reasoning, and the candidate who learned the chapter as a list of facts answers the question nobody asked. Name the kind of question before reaching for what you know.

These vignettes assert nothing of their own. Every threshold, multiple, interval, effect size and statutory provision they deploy is taught, and cited to its source, by the account that owns it, and is named here rather than restated. Cover each answer, decide what you would do, then read on.

Earned	Authorised	Priced
WHETHER THE PRESENTATION INDICATES THE TREATMENT	WHETHER A LAWFUL ROUTE EXISTS TO GIVE IT	WHAT THE CHOSEN PARAMETER ACTUALLY BUYS

25.1 How to work a vignette in this chapter

Sort the case before you answer it.

- An **indication question** asks whether this presentation earns the treatment.
- An **authority question** asks on what lawful basis it may be given, answered from the Act and never from severity.
- A **parameter question** asks what a change to placement, dose, pulse width, schedule or anaesthetic conduct buys and costs.
- A **modality question** asks whether a different device is the better answer, a family whose terms are not the terms of electroconvulsive therapy.

Each parameter has its own relation to efficacy and its own to cognition, so a relation established for one is never inherited by another, and some decisions here are not trades of that kind at all.

RULE **An indication and a lawful route are separate findings, and neither supplies the other.** Deciding that a presentation earns this treatment settles the clinical question completely and the legal question not at all. Answer both, in that order, wherever treatment is proposed, and say which of the two your reasoning has discharged.

25.2 Vignette: the emergency the emergency provision cannot authorise

Presentation. A woman in her thirties is in the third week of a severe depressive episode. She has taken almost nothing by mouth for days, is at times mute and immobile, refuses oral medication, and is dry, tachycardic and deteriorating. The consultant says she needs electroconvulsive therapy tonight. The resident proposes to treat under the Act's emergency-treatment provision and asks the family to sign an admission form.

Decision point. On what authority may this be given tonight, and does the urgency change the answer.

Reasoning to show. Split the case at once. The clinical half is uncontentious: food and fluid refusal, immobility and a deteriorating physical state secondary to a psychiatric condition are what the indications account carries as first-line where a rapid response is needed to avert harm. That finding is complete, and it authorises nothing. The legal half is where the resident errs: this treatment can be clinically indicated in an emergency, and the Act's emergency-treatment provision cannot authorise it, because that provision expressly excludes it. A lawful route must be established separately, and urgency does not cure an incomplete one.

The limb candidates lose: treatment authority is not admission authority. A capacitous adult can consent with no admission at all, so the emergency route closing never converts the question into whether she must first be admitted, and a family signature on an admission form is nobody's consent to this treatment. Assess her **capacity**, now and for this decision, the Act presuming every person to have it. If she retains it, the route is her own informed consent, intervention-specific and covering risks, benefits and alternatives; if not, the supported-admission route runs in its fixed order, the directive first, then her own consent with her representative's support, then temporary substituted consent.

Answer. Say the indication is clear and that it is not the authority. Do not treat under the emergency provision, which excludes this treatment by name. Assess capacity tonight, because that is what urgency buys: speed in establishing a route, never a shorter one. With capacity, take her own informed consent; without it, look for a directive first, then work the supported route. Record which route was used, not only that a form was signed, and rehydrate her now.

PITFALL

Writing the emergency in as though it were a source of authority. It is a clinical urgency and nothing more, and the Act's emergency-treatment provision excludes this treatment by name. The paired error costs the same marks: assuming that because that route is closed, an admission must be arranged first. It need not be, if the adult has capacity and consents.

25.3 Vignette: the directive that says no

Presentation. A man in his forties with recurrent severe depression had electroconvulsive therapy in an earlier episode. While well, he made a written **advance directive** refusing it in future. He is now in severe relapse, has lost capacity, is refusing food and is at high risk. His wife, his nominated representative, wants it given. The senior registrar says the directive cannot have been meant to cover a picture like this, and that the team should proceed.

Decision point. Does the directive bind the team, and if it does, what is the route out of it.

Reasoning to show. Name the instrument first, because a resident who has met it only as a way of saying yes reads refusal as obstruction. It runs in either direction, is invoked only when the maker ceases to have capacity, lapses when capacity returns, and is overridden by a later capacitous decision. A refusal is the instrument working, not a defect in it. The duty to treat in accordance with a valid directive falls on the medical officer in charge of the establishment and on the psychiatrist in charge of treatment, subject only to Board review. What that duty lacks is the examinable part: no bedside-override limb, no urgency limb, no senior-clinician limb.

The route out is an application. Where a professional, a relative or a care-giver desires not to follow a directive, the Act directs an application to the concerned Board, which hears all parties and may uphold, modify, alter or cancel it against the considerations the provision lists: voluntariness, whether he intended it to apply to circumstances such as these, whether he was sufficiently informed, whether he had capacity, and whether its content is contrary to other law.

That intention limb is what the registrar is arguing, and it is argued to the Board, never settled at the bedside.

Answer. The directive binds the team. Do not give the treatment. File the application to the concerned Board today, framed on the intention limb the registrar has already argued, and state the clinical urgency in it, urgency being a reason for the Board to move rather than to be bypassed. Meanwhile treat the relapse by every lawful means that remains. If capacity returns the directive lapses. Record the decision not to override it and the date of the application.

TRAP **Treating a refusing directive as a clinical problem to be solved.** A resident who has met only the authorising face of the instrument reads a refusal as an obstacle to good care, then solves it the way clinical obstacles are solved, at the bedside and under time pressure. That is the unlawful act. The only lawful exit is the application, and urgency creates no exception to it.

25.4 Vignette: the hemiplegic arm and the wrong clock

Presentation. A man in his sixties has a dense right hemiplegia following a stroke some months ago, and has since developed a severe depressive episode with poor oral intake. Electroconvulsive therapy is planned. The registrar reasons that the stroke is no longer recent, that the risk has settled, and tells the anaesthetist that the usual depolarising relaxant may be used.

Decision point. Is the recency of the stroke the right marker for the blockade decision, and what emergency is being risked.

Reasoning to show. Two risks run here on opposite clocks, which is why one word carried from one to the other is dangerous. The word recent, as it attaches to a cerebrovascular or cardiac event in the risk-profile account, concerns the cardiovascular and cerebral risk of the induced seizure: highest close to the event and falling with time, which is why that account recommends postponement. The registrar has read that direction correctly and applied it to a question it does not govern. The blockade question has its own mechanism: after denervation or disuse, extrajunctional acetylcholine receptors up-regulate, so a depolarising agent depolarises a greatly enlarged receptor population and releases potassium from it.

The receptors must change first, so the danger RISES as the up-regulation proceeds, peaking at the interval the workup and anaesthesia account states, and the label's own contraindication applies after the acute phase. The onset and duration of that risk period are expressly unknown, so no date of safety is printed here. Reading recency across therefore inverts the window: it refuses the relaxant before the receptors have up-regulated, where the label still requires great caution and prints no interval of safety, and hands it to the established hemiplegic in whom danger has built for weeks. It clears exactly the wrong patient, and the emergency it clears him into is severe hyperkalaemia which may result in cardiac arrest.

Answer. The stroke being old is a reason for concern about the relaxant, not reassurance about it, and saying so explicitly is the mark. Nor is this a decision for the anaesthetic room: the relaxant question belongs to the pre-treatment assessment, before the patient is fasted and listed. Ask what denervating or disuse lesion exists and how long ago the insult was, remembering that the

risk rises toward the stated peak rather than falling away from the insult, and ask about the emergencies that do not share this mechanism, lowered plasma cholinesterase ending in prolonged apnoea and the ryanodine route in malignant hyperthermia. The choice and dose of relaxant remain the anaesthetist's decision.

25.5 Vignette: which placement, and at what multiple

Presentation. A schoolteacher in her fifties with a severe first depressive episode has consented to electroconvulsive therapy and is frightened, specifically and articulately, of losing her memory. She was started on right unilateral placement at a dose just above her measured seizure threshold, on the stated ground that this is the gentle option. After several treatments she is no better, and the team is discussing a switch to a bilateral placement.

Decision point. Was the near-threshold unilateral course the gentle choice, and what does the switch change.

Reasoning to show. Refuse the question as posed: whether right unilateral placement is as good as a bilateral one has no answer until the dose is named, because the placements have different dose-response relations. Near the threshold, right unilateral treatment is markedly inferior while bilateral efficacy is already near its maximum, so the near-threshold unilateral course is not a gentle version of the treatment but an under-treated one. As the multiple rises, right unilateral treatment converges toward bitemporal efficacy without establishing superiority over it, and the cognitive advantage it buys erodes as that same multiple rises; state both halves or neither, since erosion is not abolition and a real advantage survives at the top of the range, domain-specific rather than broad.

Then the relation the chapter exists to protect. Stimulus dose above the threshold buys efficacy in right unilateral placement, where the dose-response is steep; in bitemporal placement, where efficacy is already near-maximal at a low multiple, a higher dose largely buys cognitive cost alone. That is one relation for one parameter and its mirror for another, and it is not a direction to be carried anywhere else. The threshold is measured in this patient rather than looked up and rises across a course, so the multiple she receives today is not the one she received in the first week unless somebody has checked.

Answer. Name the multiple before answering anything. The failure so far is a dosing failure rather than a placement failure, so the first correction is to dose the unilateral placement adequately against a re-measured threshold rather than abandon the placement carrying the advantage she asked for. Tell her what that advantage is and is not: it survives in named domains rather than across the board, and the same rising dose that buys the efficacy partly spends it. If an adequate course still fails, a switch is legitimate on efficacy grounds, with the cognitive cost stated.

25.6 Vignette: the memory complaint, and the family who want it faster

Presentation. A man in his forties is midway through an acute course for a severe depressive episode and is improving, slowly. His wife says he cannot recall the week of his admission at all and has patchy gaps for the months before it, including a family wedding. He scores normally on

the bedside screen the unit uses. The family, impatient with the pace, ask that treatments be given more often so that the treatment works better.

Decision point. What to do about the memory complaint, and whether to raise the frequency to improve the outcome.

Reasoning to show. Take the frequency request first, because it rests on a false premise. Treatment frequency buys speed of response; it is not an efficacy lever. The acute-course account established that the thrice-weekly and twice-weekly schedules reach equivalent antidepressant outcome at the end of the course, that the faster schedule reaches response sooner, and that it costs more in memory impairment even where the total number of treatments does not differ. The cost belongs to the spacing, not the number of treatments. The family are asking, without knowing it, to pay a cognitive price for a gain that does not exist; the malignant presentations measured in days earn speed, and this man does not.

Then the memory complaint, separating report from measurement. The cognitive cost is not one deficit but separate phenomena on separate clocks. Postictal confusion belongs to the minutes after each treatment. **Anterograde amnesia** is the difficulty laying down new memories while the course runs, which is why the week of admission is patchy, and it is the limb that recovers after the course. **Retrograde amnesia** is the loss of what was already laid down, with a gradient toward events near the treatment, which is what the missing wedding is; the Indian guideline calls it among the most distressing adverse effects and difficult to measure using objective tests. The normal bedside screen therefore excludes nothing.

Where his wife's account and the ward's testing diverge, the divergence is the finding. The Indian guideline directs that subjective memory impairment be given due importance alongside objective assessment, the reason report exceeds measurement being a caution about the instruments, not the patient. Its menu is what can be done: space the sessions, switch to unilateral placement, switch to a briefer pulse width, reduce the stimulus dose, reduce or stop drugs affecting cognition, reduce a high anaesthetic dose, and terminate the course where risks outweigh benefits, each step balanced against the effectiveness it may cost.

Answer. Decline the frequency increase on the right ground: not that it is unsafe, but that it does not buy what is being asked for, the end-of-course outcome being equivalent and only the speed and the cognitive price differing. On the memory, ask about life memories rather than orientation and word lists, because the instrument that finds retrograde loss is a conversation about his own past; record the wife's account as a finding; and space the sessions if anything, the opposite of what was requested. The encoding gap recovers; the loss around the wedding is contested.

RULE **Name the parameter before you name its price, because each has its own relation and none lends its direction to another.** The stimulus dose, the placement, the pulse width, the schedule and the anaesthetic conduct each stand in a different relation to efficacy and to cognition. A candidate who has learned one direction as the law of the chapter will apply it to the parameter it does not fit.

25.7 Vignette: the patient for whom the answer may not be electroconvulsive therapy

Presentation. A software engineer in his thirties has a moderate depressive episode that has not responded to successive adequate antidepressant trials. He is working, eating, sleeping badly, and denies suicidal intent. He is frightened of the memory loss he has read about, and asks instead about the magnetic treatment he has seen advertised; his family have read about a home device and about an implanted stimulator a relative received.

Decision point. Is a non-electroconvulsive device the right answer, and on what axes is that choice made.

Reasoning to show. Establish first that the question is genuinely open, because this case is mishandled by letting a device stand in for an urgently indicated treatment. He carries none of the features that move electroconvulsive therapy to a first-line position: no food or fluid refusal, no catatonia, no psychotic features, no acute suicidal risk. His treatment resistance is a second-line indication, so there is time to choose, and his fear is a reason to explain the cognitive cost rather than to steer him elsewhere. Then refuse the shape of his question: these devices are not a ladder with a single gradient. They differ on whether a seizure is induced at all, on invasiveness, on target, on reversibility, on the evidence for the indication, and on the Indian regulatory position, and those axes do not move together.

Then take each device on its own account. Repetitive transcranial magnetic stimulation induces no seizure, is referenced to a motor threshold measured in this patient, and needs weeks of daily attendance, a real question for a man with a job; its Indian position is a checked absence establishing nothing about licensing. Transcranial direct current stimulation induces no seizure, is authorised for no psychiatric indication in the Indian classification, and did not separate from sham in the depression trial carried here, which answers the home-device question. Deep brain stimulation is a permanently implanted electrode reached only after everything else has failed, and its sham-controlled depression trials missed their primary endpoints. Vagus nerve stimulation drives a peripheral nerve in the neck, its acute sham-controlled endpoint was not significant, and its approval rested on an effect measured over a long window. Carry nothing across: those relations belong inside electroconvulsive therapy.

Answer. The honest reply is a conversation rather than a device. Tell him his presentation does not make electroconvulsive therapy urgent, so there is room to choose; correct what he fears in the separated terms the cognitive account supplies; and if he then refuses it, record that as the valid refusal of a capacitous adult rather than an obstacle. Choose among the devices on the axes that differ, naming for each the evidence for this indication and what the Indian record establishes.

IN INDIA

Three Indian facts decide these cases. The Act supplies the routes and closes the emergency route to this treatment by name. The Indian guideline gives patient-reported memory impairment due importance alongside objective testing. And the Indian device-classification record governs the non-electroconvulsive family, a foreign clearance never being readable across.

25.8 The cases on one grid, and the thread through them

Set side by side, the cases are one discipline in different clothes, and the right-hand column is a single family of mistakes.

VIGNETTE	THE QUESTION IT REALLY ASKS	WHERE THE ANSWER COMES FROM	THE CLASSIC WRONG ANSWER
THE EMERGENCY AT NIGHT	Indication, then authority, as separate findings	The indications account, then the Act's routes	Treating under the emergency provision, or assuming admission comes first
THE DIRECTIVE THAT SAYS NO	Whether a valid refusal binds the team	The duty to follow a valid directive, and Board review	Deciding the maker's intention at the bedside instead of applying to the Board
THE HEMIPLEGIC ARM	Which clock the blockade risk runs on	The workup and anaesthesia account, which owns the window	Reading recency across from the seizure risk, clearing the wrong patient
THE FRIGHTENED TEACHER	What the dose does at this placement	The placement comparison and the stimulus-dosing account	Calling a near-threshold unilateral course the gentle option
THE IMPATIENT FAMILY	What a faster schedule actually buys	The acute-course account and the cognitive account	Raising the frequency to improve the end-of-course outcome
THE ENGINEER AND THE DEVICES	Whether another modality fits, and on what axes	Each device's own account, and the cross-cutting grid	Ranking the family on one gradient, or carrying the electroconvulsive relations across

The thread, stated once. Every case turns on refusing to let one finding answer for another: a clinical indication does not answer an authority question, a risk on one clock does not answer a risk on another, a relation established for one parameter does not answer for a second, and nothing established inside electroconvulsive therapy answers for devices whose terms differ.

MNEMONIC

ROUTE, RELAXANT, RELATION, REMAINDER

Rebuild the closer from these when a vignette empties your head. **Route**: an indication says the treatment is earned, never that it may be given, and urgency does not cure an incomplete route. **Relaxant**: the safety question runs on its own clock, recency is the wrong marker, and it is asked before the patient is fasted. **Relation**: name the parameter before you name its price, because none inherits a direction from another. **Remainder**: everything outside electroconvulsive therapy is a different family on different terms, compared on the chapter's grid rather than ranked.

Every vignette here separates findings that residents merge: the indication from the lawful route, one risk's clock from another's, and each parameter's own relation from a general direction that does not exist.

26 · Consolidation

The last useful thing to do with this chapter is not to read it again but to produce it from memory, with no answer in sight. Everything below is a question, and nothing is answered. That is the design: **active recall**, forcing an answer out of memory before checking it, fixes material for an examination, while an answer printed beside its question converts the exercise back into rereading. Answer each prompt in full, then turn back to the topic that owns it.

This section owns the device alone: the prompt list, a map of the errors that decide marks, and one frame for an unseen question. No multiple, threshold, rate, interval, dose or session count is printed, because an answer beside its question destroys the exercise. Where a prompt reaches a doctrine this chapter does not teach, it names the owner: the statutory provisions to the Mental health legislation and forensic psychiatry notes, the catatonia entity to the Other psychotic disorders, delusional syndromes and catatonia notes, and the algorithms and resistance ladder to the Mood disorders and Schizophrenia notes.

Retrieve	Route	Parameter
THE DEVICE THIS SECTION RUNS ON, NEVER REREAD	WHAT AN INDICATION NEVER SUPPLIES	NAMED BEFORE ANY TRADE IS STATED

26.1 How to use this list

Work the four groups in order; they follow the chapter's sequence: decide whether to treat, how to deliver it, live with what it does, then step outside the induced seizure. Answer aloud or on paper before opening anything.

RULE **Retrieve first, check second.** An answer-free list loses its value the moment you read an answer before producing one. **Retrieval practice** strengthens a memory trace in a way recognising a stated answer does not, and the two feel identical from the inside, which is why the candidate who revises by rereading empties out on a blank page.

26.2 Two habits that answer most of the list

Two moves produce most of the answers below. The first splits the clinical question from the legal one: whether this presentation earns the treatment is settled clinically, whether it may be given by establishing a **lawful route**, and a strong answer to the first is no answer to the second. The second names the parameter before any trade.

RULE **Name the parameter, then state its own relation.** Many choices in this chapter trade among speed of response, efficacy and cognitive cost, and where they do, the direction and the size of that trade differ by parameter and by placement. Some are not trades among those three at all: the airway, the monitoring and the tourniquet buy safety and information at no cognitive price. The chapter therefore asserts no law covering all of them. Stimulus dose above threshold behaves one way in right unilateral treatment and another in bitemporal; treatment frequency is a different trade again. State the relation for the parameter in front of you and inherit no direction from any other.

26.3 Group one: foundations and indications

Where the treatment came from, how it works, which presentations earn it, and what raises its risk.

1. Narrate the arc from a false premise to a modern procedure: whose hypothesis began it, what produced the first therapeutic convulsions, what ended the chemical era, and who achieved the first electrical induction.
2. State the field's own position on how the treatment works, then give the successive accounts in order, each with the observation it rests on and the residue it leaves.
3. List the presentations that earn the treatment and grade each by its evidence. Say where the Indian and United Kingdom positions on schizophrenia diverge, and what an indication never settles.
4. Give both positions on contraindication with the tradition attached to each, what stands in place of a contraindication list today, and why pregnancy belongs on the risk list.

26.4 Group two: technique and dose

Here the answers are parameters, and a parameter is correct only with its document.

1. Say what drives investigation before a course. Then take the depolarising relaxant: name the mechanisms that bar it, and which way the hyperkalaemic danger moves with time after a denervating insult.
2. Name the members of the bilateral and unilateral classes with each placement's landmark. Then name the stimulus parameters in the order of the charge equation, and why a charge figure alone specifies no dose.
3. Answer the placement comparison properly: what the evidence shows near threshold, what happens to the efficacy difference and separately to the cognitive advantage as the multiple rises, and the qualifier that stops convergence being read as overtaking.
4. Define the seizure threshold as a measured quantity rather than a machine setting, and why the therapeutic multiple is not one number across placements. Then judge a seizure: the criteria in order of weight.
5. State what modification modifies and what it leaves untouched, and name the injuries the unmodified technique produced. Then give the Indian position in the correct register: a statutory bar and not clinical advice, the modified form being the only lawful one, the

provision belonging to the Mental health legislation and forensic psychiatry notes and named there in words.

26.5 Group three: effects, consent and course

The longest group, and the one deciding most marks: where the treatment meets the patient, the law and the calendar at once.

1. Separate the three cognitive phenomena and give the clock each runs on. Say which recovers, which stays contested, and why a recovery finding from a corpus with no instrument for the second is not reassurance.
2. Give the cardiovascular sequence in its fixed order, and what a candidate naming only the second phase has dropped. Then explain why the two mortality estimates differ without either being wrong.
3. Name the lawful routes to giving this treatment in India, with the limit that travels with each, and say what urgency changes and what it never changes. Then state why the Act's emergency-treatment provision cannot authorise this treatment even where the presentation plainly earns it, why **treatment authority** is not **admission authority**, and what gate applies to a minor.
4. For pregnancy, state the comparative safety claim exactly as its source bounds it and what it does not say. For the elderly, what leads. For the adolescent, what comes first.
5. Say what the acute schedule is, what a faster schedule buys, what it costs and where both schedules end up. Then separate the point at which technique is changed from the point at which failure may be declared.
6. State what happens when nothing active follows a successful course, and what is therefore started in every case. Give the taper in the order it is asked for.
7. Give the three statements any drug interaction across a course requires, then sort the common agents into those that raise the threshold, those that lower it and those that do neither.

> **GOOD TO REMEMBER**
> Do not run this list once, the night before. Retrieval strengthens memory most when spaced, so sweep the four groups now, mark the prompts you missed, and return to those after some days.

26.6 Group four: the other neurostimulation therapies

Every modality here is defined by contrast with the induced seizure, so each prompt asks what the device does before what the evidence says.

1. Explain how current reaches cortex without touching the skin, and why the treatment is dosed to stay below a seizure. Then say why parameters quoted without their protocol and indication describe nothing ever trialled.
2. State what a weak constant current does to cortical neurons and what it never does. Give the polarity rule as a first approximation, then why a device classification is not an authorisation.

3. Name the psychiatric targets, and what separates this intervention from an ablative one. Then state what the two pivotal sham-controlled depression trials found.
4. Describe the implanted system and say why it is not a cranial implant, then why an effect appearing as a slope over months cannot be detected by a trial reading its endpoint early.
5. For magnetic seizure therapy, separate what the modelling settles about the induced field and the site of initiation from what remains open in humans about spread.
6. State the single property separating ablation from every stimulation modality, and why the two therefore do not form one family however the syllabus groups them. Name the current procedures with their targets, and give the double Indian statutory constraint in words.

26.7 The five answers this chapter punishes

More marks are lost on this chapter to five wrong answers than to genuine ignorance, because each is a compact, confident sentence that sounds like clinical sense. If anything you produced matches the middle column, reopen that topic first.

AXIS	THE ANSWER THAT LOSES THE MARK	THE ANSWER THAT EARNS IT	WHERE TO REOPEN
UNMODIFIED, THAT IS DIRECT, TREATMENT	Filing a statutory bar under clinical advice, as though the question were which technique is safer	In India it is unlawful, not merely inadvisable, and the modified form is the only lawful one; what remains teachable about the older technique is historical	modified against unmodified treatment, and the Mental health legislation and forensic psychiatry notes
THE EMERGENCY	Reaching for the Act's emergency-treatment provision because the presentation is desperate	The presentation can genuinely earn the treatment while that provision cannot authorise it, because it excludes this treatment by name; a lawful route is established even so, and urgency changes the timetable, never the route	indications, and consent
AUTHORITY	Assuming that because the emergency route is closed, the patient must be admitted first	Treatment authority is not admission authority: a capacitous adult can consent to this treatment with no admission at all	consent and the legal aspects
EFFICACY AND COGNITIVE COST	Carrying one parameter's relation across to another as though the chapter held a single law of stimulation	There is no such law; many choices trade among speed, efficacy and cognitive cost, the direction and size differing by parameter and by placement, and several are not trades among those three at all	the cross-cutting synthesis, and the item owning each parameter
TREATMENT FREQUENCY	Writing the faster schedule as the stronger one	What the faster schedule buys is speed of response; end-of-course efficacy is equivalent between the schedules, and the faster one reaches response sooner at a higher cognitive price	course, frequency and number of sessions

PITFALL

A sixth error runs underneath all five: quoting a figure away from the document stating it. A device's specification is that device's and not the field's; a guideline's threshold is that guideline's; a formula holds only inside the parameter set it was derived in; and a rate quoted without its comparator reports a hazard the study never established.

IN INDIA

Many answers here are Indian, and several differ from the Western default. The technique is settled by statute rather than preference; the minor's gate is statutory and comes first; the emergency route is closed by name; the national guideline, not a foreign one, governs the parameter answers where the two diverge; and for every device in the final group the Indian record is a risk classification and nothing more.

26.8 The master frame to run on any question

The whole chapter collapses into one procedure, its own spine gathered into five moves, so an unfamiliar question becomes a sequence of decisions rather than a scramble for the nearest rule.

MNEMONIC

SPINE

Settle the indication: does this presentation earn the treatment, and on what evidence? That is answered clinically, and first. **P**rove the route: an indication is never an authority, so establish a lawful route, remembering that urgency changes the timetable and not the route, and that treatment authority is not admission authority. **I**dentify the parameter: before stating any trade, say which is in front of you, because placement, stimulus dose, treatment frequency, pulse width and anaesthetic conduct each carry their own relation. **N**ame the source beside the figure: the device, guideline, trial or formula that produced it. **E**very provision in words: the Act's provisions touching this treatment are named, never renumbered, and belong to the Mental health legislation and forensic psychiatry notes.

TRAP **Answering a question that has not been fully asked.** Which placement is better, does memory loss persist, which schedule is stronger: each is under-specified, and the examiner knows it. The first has no answer until the multiple of threshold is named, the second none until you say which memory and by which instrument, the third none until you say what is bought.

Settle whether the presentation earns it, prove a lawful route before anything is given, name the parameter before you state its trade and inherit no direction from another, keep every figure beside the document that produced it, and name the Act's provisions in words: the rest is detail hanging off those five.

Previously asked

There is no indexed past-question bank for this chapter, so nothing in the table below is a catalogued past question and no board or year is claimed for any of them. Attributing a paper the index does not hold would be a fabrication, so in place of a board of origin each row is marked Representative, and the questions are written in the register an examiner uses. Electroconvulsive therapy is examined heavily and in every form the paper allows, as a long answer on indications, technique and dose, as a short note on a single population or a single

complication, and in the viva on the seizure the candidate has just been asked to describe, while the other neurostimulation therapies are examined mostly as short notes and as the second half of a compare-and-contrast. The list therefore maps the examined spine of this chapter rather than one board's recent record. Read it as a high-yield revision map, not as a set of questions on record.

QUESTION	MARKS	ASKED
Enumerate the indications for electroconvulsive therapy and discuss the strength of the evidence behind each, including its place in the psychiatric emergency.	10	Representative
Describe the pre-electroconvulsive-therapy workup and the anaesthetic conduct of a modified treatment, including the muscle relaxant and the situations in which the usual agent must not be used.	10	Representative
Electrode placement in electroconvulsive therapy. Compare bilateral with right unilateral placement on efficacy and on cognitive cost, stating the dose at which each comparison holds.	10	Representative
Define the seizure threshold, describe how it is measured, and explain how the treatment dose is set against it and judged adequate.	10	Representative
Modified against unmodified, that is direct, electroconvulsive therapy, and the Indian legal position on the direct technique. Short note.	*5*	Representative
Cognitive adverse effects of electroconvulsive therapy. Distinguish anterograde from retrograde amnesia, give the course of each, and discuss whether the retrograde deficit persists.	10	Representative
Complications of electroconvulsive therapy other than the cognitive ones, and their management in the suite and in the recovery room.	10	Representative
Consent for electroconvulsive therapy under the Mental Healthcare Act: the lawful routes, the advance directive, and the position of a minor.	10	Representative

QUESTION	MARKS	ASKED
Electroconvulsive therapy in pregnancy. Short note.	*5*	Representative
Electroconvulsive therapy in the elderly patient. Short note.	*5*	Representative
Discuss the frequency and number of electroconvulsive therapy sessions in an acute course, how response is judged, and what ends the course.	10	Representative
Continuation and maintenance electroconvulsive therapy. Short note.	*5*	Representative
Drug interactions and concurrent medication during a course of electroconvulsive therapy. Short note.	*5*	Representative
Mechanism of action of electroconvulsive therapy. State the principal neurobiological hypotheses, the observations each rests on, and what each fails to explain.	10	Representative
Repetitive transcranial magnetic stimulation: principle, the motor threshold, stimulation parameters, indication and adverse effects.	10	Representative
Transcranial direct current stimulation. Short note.	*5*	Representative
Vagus nerve stimulation in treatment-resistant depression. Short note.	*5*	Representative
Deep brain stimulation in psychiatry: the targets by indication, the evidence from the sham-controlled trials, and the Indian regulatory and legal position.	10	Representative
Psychosurgery: history, the current procedures and their indications, and the ethical and statutory constraints on the operation today.	10	Representative
Magnetic seizure therapy. Short note.	*5*	Representative

The shape of these questions is worth reading before their content. A ten-mark question that opens with enumerate, describe or compare wants a structured map rather than a definition, and the marks are won on the discriminations this chapter turns on: the difference between an indication and a lawful route, the difference between a definition and a permission, the difference between speed of response and efficacy, and the difference between a device classification and an indication-specific authorisation. A short note carries fewer marks and the same demand for the exact figure with the document that states it, because a device specification is that device's, a guideline threshold is that guideline's, a formula holds only inside the parameter set it was derived in, and a trial's parameters travel as a tuple with their protocol and their indication. Two habits earn marks across the whole list. Say which parameter is in front of you before stating any trade, since placement, stimulus dose, treatment frequency, pulse width and anaesthetic conduct each carry their own relation and none inherits another's. And name the Act's provisions in words, because a candidate who reprints a section number he has not read is doing the one thing this chapter is examined to prevent.

The quick review

One table, read down the left column and cover the right. Every line is taught in full somewhere above and nothing here is new: each is that topic's single must-hold line, so a line you cannot recover is a topic to reread rather than a fact to memorise here. Four things are load-bearing across the chapter. Every figure travels with the document that produced it: a specification, a threshold, a formula and a trial's parameters hold only inside the protocol they came from. There is no chapter-wide law about efficacy and cognitive cost: the direction and the size of any such trade differ by parameter and by placement, and several choices are not trades among those three at all, airway management and monitoring being done because they are correct. An indication is never an authority, so a lawful route is established separately and urgency changes the timetable, never the route. The Mental Healthcare Act's provisions are named in words throughout and never renumbered here. Where the Indian guideline and a foreign college guideline differ, both are printed with their body and their year.

ASK	HOLD
ELECTROCONVULSIVE THERAPY: FOUNDATIONS AND INDICATIONS	
MEDUNA, AND THE CHEMICAL ERA	An inverse relationship between seizures and schizophrenia, from a lack of glial cells in schizophrenia against an overgrowth in epilepsy: the founding premise, and it did not survive. Camphor in oil, then cardiazol; the era ended not on efficacy but on the unpredictable interval between injection and seizure.

ASK	HOLD
CERLETTI AND BINI, AND THE DECLINE	First electrical induction in a psychotic patient, Rome, April 1938, reported August 1939 at Copenhagen; the Central Institute of Psychiatry, Ranchi, followed, cardiazol in 1938 and electroconvulsive therapy in 1943. The mid-century fall was part earned, by regressive treatment to a deliberate acute brain syndrome, and part not, running well past those abuses.
THE MECHANISM: REGISTER AND HYPOTHESIS	Nobody has established how it works and no single mechanism should be assumed, so naming the anticonvulsant hypothesis as the mechanism contradicts the literature; low-dose right unilateral seizures lacked antidepressant efficacy, so seizure induction may be necessary but insufficient. That hypothesis is a postictal prefrontal inhibitory surge which terminates the seizure and enhances GABAergic function, and it does not cover efficacy outside depression.
THE TWO BIOMARKER ACCOUNTS	Neuroendocrine: a transient adrenocorticotrophic hormone, cortisol and prolactin rise, back to baseline in hours, so evidence of delivery rather than mechanism. Neurotrophic: hippocampal volume rises with session number, but greater enlargement went with worse outcome and volumes returned by six months, so not a biomarker of response.
DEPRESSION: INDICATION, EFFECT SIZES, SPEED	First line for a severe episode with psychotic features, catatonia, high suicide risk, or food or fluid refusal; second line where it has not responded to psychotherapy or medication. Effect sizes minus 0.91 against simulated treatment and minus 0.80 against pharmacotherapy, the negative sign being the direction of benefit. Suicidality fell to zero in 38.2 per cent after three treatments and 80.9 per cent by the end, so consider it earlier than its last-resort position.
CATATONIA, MANIA, SCHIZOPHRENIA: TRUE STRENGTH	Catatonia: response 80 to 100 per cent, including after benzodiazepines have failed, but on retrospective observational studies, the strongest indication on the weakest design. Mania: remission or marked improvement in 80 per cent. Schizophrenia: moderate-quality Cochrane evidence added to standard care, risk ratio 2.06; clozapine-resistant response 53.6 against 25.4 per cent, remission 13.3 against 3.7, so response is common and remission is not.
THE EMERGENCY, AND THE AUTHORITY WITHHELD	The treatment can be clinically indicated in an emergency, and the Act's emergency-treatment provision cannot authorise it, because that provision expressly excludes electroconvulsive therapy from the treatment it permits. Both are true: a lawful route is established separately, and no emergency doctrine supplies the authority the Act withholds.

ASK	HOLD
CONTRAINDICATION: TWO POSITIONS WITH THEIR DATES	Position one, the modern task-force position: no absolute contraindications, reaching the page through an anaesthesia review of 2022 citing the consensus statement of 2001. Position two, standard in Indian teaching: raised intracranial pressure with a space-occupying lesion, Maltbie 1980, on Carter's chain of rising cerebral blood flow, oedema and pressure. Both printed, neither graded above the other; routine neuroimaging is not mandatory, bedside fundoscopy is.
ELECTROCONVULSIVE THERAPY: TECHNIQUE AND DOSE	
THE EVALUATION, THE FAST AND THE MORNING LIST	As close to the course as possible, because a workup done weeks earlier certifies a patient who no longer exists; examination-led, the blood panel not mandatory and imaging indication driven. Fasting 2 hours from clear liquids, 6 from milk and light meals, over 8 from fried or fatty food. Cerebral oxygen consumption rises almost 200 per cent, so 100 per cent oxygen from 1 minute before induction until breathing resumes. Antihypertensives, thyroxine, antianginals and bronchodilators are not withheld.
SUCCINYLCHOLINE, WHAT BARS IT, AND RESTIMULATION	Blockade in about 1 minute, MAXIMUM blockade about 2, recovery in 4 to 6; the dose is the anaesthetist's. The under-dosing warning belongs to MIVACURIUM, where trimming to shorten its longer block is the temptation, and a dose trimmed there buys an unmodified convulsion under a patient who looks paralysed. Three mechanisms bar it: potassium efflux from abnormal muscle, deficient plasma cholinesterase, malignant hyperthermia. Prophylactic anticholinergics are not routine, and bradycardia is commoner after a second dose of relaxant, so a restimulation is a cardiac event.
BILATERAL IS A CLASS, AND THE LANDMARKS	Bilateral has three members, bitemporal, bifrontal and left anterior right temporal; bitemporal is one member, not a synonym for the class. Bitemporal: one inch above the outer canthus to external auditory meatus line. Right unilateral, d'Elia: right frontotemporal and 1 inch right of the vertex. Bifrontal: 2 inches above the outer canthus.
WAVEFORM, THE DISPUTED BAND, AND COGNITION	A brief or ultrabrief pulse with a constant current device is strongly recommended. The two GUIDELINE brief-pulse bands agree at 0.5 to 2 ms, and that agreement is bounded to them, a meta-analytic band of 0.5 to 1.5 ms also appearing in the chapter; ultrabrief does not agree at all, 0.2 to 0.4 ms in the Indian guideline of 2023 against 0.25 to 0.3 in the college guideline of 2019. Broader widths carry worse cognitive effects, and 0.3 ms has a cognitive advantage with right unilateral placement though efficacy may be compromised.

ASK	HOLD
THE FOUR PARAMETERS, AND WHY CHARGE IS NOT THE DOSE	Charge is current intensity multiplied by pulse width, frequency and train duration, but charge as the chief measure of dosing is faulty: equal charge from different parameters is a different stimulus. Intensity is held constant during incrementation, train duration is what moves, and lower frequencies are the more efficient.
IMPEDANCE, AND MONITORING THE SEIZURE	Static impedance is read before stimulation, dynamic during it; on one named device static should be above 100 and below 3000 ohms, too low meaning the current found a path that is not the patient, too high that it will struggle to find one. Monitoring is three records of one event, cortical, muscular and cardiac, with the Hamilton cuff isolating a limb from the relaxant.
THE SEIZURE THRESHOLD, AND THE RANGE	The lowest electrical dose eliciting seizure activity, electroencephalographic and motor. Found only by producing a response, not transferable across pulse widths, and a floor rather than a treatment, which is why the prescription is a multiple of it. A 12-fold range across 52 titrated patients, 40-fold across the wider literature: neither is the number.
FOUR DOSING METHODS, AND THE FORMULA'S ERROR	Stimulus titration in regular practice; formula-based methods guide its first dose rather than substitute for it; fixed high dosing for serious medical comorbidity. Half-age formula: half the chronological age as the percentage of charge on one device family, the device clause being part of the formula. Estimates averaged 18 per cent above the empirical THRESHOLD, which is the authors' own summary figure and sits outside the quoted passage, and matched the titrated TREATMENT level in only 14.7 per cent. Two benchmarks, not two directions of one error.
THE MULTIPLE DIFFERS BY PLACEMENT, AND THE THRESHOLD RISES	Right unilateral dose-response is steep, needing markedly suprathreshold dosing, while bilateral efficacy arrives marginally above threshold. The right unilateral brief-pulse cell is disputed, 4 to 6 times threshold in the Indian guideline of 2023 against five to six in the college guideline of 2019, and averaging invents a figure neither states. The threshold rises across a course, about 47 per cent on average but in only 56 per cent of patients.
RESTIMULATION BY KIND, AND THE ADEQUATE SEIZURE	A missed seizure is no seizure at all: nothing motor or electroencephalographic 20 seconds after the stimulus, restimulate at an increased dose. An inadequate seizure happened but was not good enough, and the delay is disputed, 45 seconds in the Indian guideline of 2023 against 60 to 90 in the college guideline of 2019. Quality matters more than duration: the earlier 15 and 25 second definition is of little prognostic benefit, so the question is demoted, not re-answered.

ASK	HOLD
BILATERAL AGAINST RIGHT UNILATERAL, BY MULTIPLE	As a ranking the comparison is memorable and clinically false; as a function of the multiple of threshold it is correct. Right unilateral 17 per cent at a low dose against 43 at 2.5 times threshold, while bilateral was 65 against 63; at a high multiple both reached 65 per cent. They converge toward one another, with no superiority of right unilateral established anywhere.
WHAT THE HIGHER MULTIPLE COSTS, AND ITS LIMIT	Some, but not all, of the cognitive advantage is lost when right unilateral is dosed to equal bitemporal efficacy: erosion, not abolition. Two domains survive, reorientation time and retrograde autobiographical memory. The unilateral efficacy evidence exists only for depression, so carrying the argument to schizophrenia or mania exceeds it.
UNMODIFIED, THAT IS DIRECT, TREATMENT: THE INDIAN POSITION	The statute prohibits electroconvulsive therapy given without muscle relaxants and without anaesthesia, so the modified form is the only lawful form and the direct technique is unlawful, not merely inadvisable. No degree of urgency turns it into something a clinician is entitled to weigh. The provision is named in words and never renumbered. Filing that statutory bar under clinical advice, as though the question were which technique is safer, is one of the five answers this chapter punishes.
WHAT MODIFICATION MODIFIES, AND ITS ONE GAP	Three steps: the motor seizure injures muscles, joints, teeth and bones; it is irrelevant to the therapeutic action; so a relaxant given after the anaesthesia abolishes it. The middle step carries the argument, and the cerebral seizure is untouched. The masseter is stimulated directly rather than through the junction the relaxant blocks, which is why bite blocks and jaw immobilisation still matter.
ELECTROCONVULSIVE THERAPY: EFFECTS, CONSENT AND COURSE	
THREE PHENOMENA ON THREE CLOCKS	Minutes for postictal confusion, orientation back within 5 to 45 minutes; days to weeks for anterograde amnesia; months, and contested, for retrograde. One clock never tells the time on another. The anterograde deficit is significant at 0 to 3 days, recovered by 15, and domain-specific rather than global.
RETROGRADE AMNESIA, AND WHAT STAYS CONTESTED	Hard to measure objectively, so a normal bedside screen does not exclude it; a temporal gradient, personal events within about 6 months rather than the distant past. Brief pulse, unilateral placement and titration each reduce autobiographical loss. Persistence stays contested: standardised mean difference 0.55 against controls, unchanged at 6 to 12 months, while the recovery meta-analysis pooled no standardised retrograde tests. At least one third of patients report persistent loss, so subjective assessment counts alongside objective.

ASK	HOLD
THE CARDIOVASCULAR SEQUENCE, AND THE PROLONGED SEIZURE	Parasympathetic first, 10 to 15 seconds of vagal outflow in the tonic phase with bradycardia and occasional asystole, then the sympathetic surge in the clonic phase, peaking at 1 minute. About 2 per cent of patients have a major adverse cardiac event, roughly 1 per 200 treatments. Prolonged means beyond 180 seconds while termination can be attempted beyond 120: a definition and a permission, and collapsing them loses the mark.
POSTICTAL AGITATION, THE TARDIVE SEIZURE AND THE JAW	Agitation: 13.9 per cent at patient level, 18.0 once studies at high risk of bias are removed, which is the authors' recommended figure, with no validated predictor among 7 factors. A tardive seizure comes within hours, after recovery, and may be non-motor. Temporomandibular dislocation happens under modification because those muscles are stimulated directly.
WHAT THE ACT MEANS BY INFORMED CONSENT	Consent for a specific intervention, without force, undue influence, fraud, threat, mistake or misrepresentation, after adequate information including risks, benefits and alternatives, in a language and manner the person understands. It is intervention-specific, so a general admission consent is not consent to this, and the alternatives limb is the one most often dropped.
TREATMENT AUTHORITY IS NOT ADMISSION AUTHORITY	The second half of the emergency error, and the more often lost. Assuming that because the emergency-treatment provision is closed the patient must first be admitted inverts the position: a capacitous adult can consent to this treatment with no admission at all. Urgency changes the timetable, never the route.
THE LAWFUL ROUTES, AND THE ADVANCE DIRECTIVE	His own consent first, on a presumption of capacity that a decision others think wrong does not rebut. Where capacity is absent: the advance directive first, then his own consent supported by his nominated representative, and only where he needs nearly total support may that representative temporarily consent. A valid directive is a duty on the treating psychiatrist, with no bedside-override, urgency or senior-clinician limb, so the route out of a refusal is an application to the Board.
THE MINOR'S GATE, AND RE-CONSENT	Below eighteen there is no capacity to consent, the legal guardian being the nominated representative unless the Board orders otherwise. Two limbs bind, the guardian's informed consent and prior permission of the concerned Board, with no clinical discretion; assent and two independent psychiatrists are professional additions, not statutory. Re-consent runs on triggers, not intervals: capacity returning, a minor attaining eighteen, and before continuation or maintenance. Refusal and withdrawal carry the best available alternative treatments without prejudice.

ASK	HOLD
PREGNANCY AND THE ELDERLY	Pregnancy: most applicable in the second and third trimesters, with left lateral tilt, routine anticholinergic premedication avoided and cardiotocography around each session. Causation is unsettled, and in the Swedish cohort the comparator decides the answer, premature delivery significant against one control group and not the other. The elderly run the other way: older age predicted remission and response, so preferentially good candidates rather than merely tolerable ones.
TREATMENT FREQUENCY BUYS SPEED, NOT EFFICACY	The acute course runs 2 to 3 sessions per week, spaced evenly. Two double-blind trials and their joint synthesis settle it: end-of-course antidepressant effect was equal, while the thrice-weekly schedule induced more severe memory impairment. The cost belongs to the spacing, not to receiving more treatments. Where rapid improvement is warranted the faster schedule may be preferred, both being equally efficacious, the slower one priced at roughly 4.8 to 6.5 days longer. Writing the faster schedule as the stronger one is one of the five answers this chapter punishes.
THE ACCELERATED SCHEDULE, AND WHAT BUYS IT	In malignant catatonia, bilateral treatments daily or twice daily for 3 to 5 days, then conventional frequencies until resolution, 5 to 20 treatments at expert-consensus grade. What buys the extra cognitive cost is mortality: 51 of 54 treated patients survived against 6 of 14 given antipsychotics and supportive care.
HOW MANY TREATMENTS, AND THE MID-COURSE THRESHOLDS	Not predetermined but based on individual need; the task force gives 6 to 12 sessions for depression. Two thresholds must not be merged: technique changes first, unilateral to bilateral or ultrabrief to brief pulse after four to eight sessions without improvement, while failure is declared later, at a minimum of 8 to 12. The United Kingdom handbook is stricter; both are printed. The endpoint is stable remission, not response.
CONTINUATION, MAINTENANCE AND THE INTERVAL PRINCIPLE	Continuation consolidates the index course, maintenance prevents a new episode, the line drawn at 6 months. Over 24 weeks relapse was 84 per cent on placebo, 60 on nortriptyline and 39 on the combination. The taper runs twice weekly to weekly, fortnightly, monthly, never prefixed. What is managed is cumulative exposure and the interval is how: extend it and minimise the cumulative number of treatments.

ASK	HOLD
CONCURRENT MEDICATION, AND THE THREE MOST EXAMINED	Anticonvulsants raise the threshold; chlorpromazine and clozapine are pro-convulsant; lithium raises the risk of postictal delirium; tricyclics raise cardiac risk. An interaction is never one fact: a direction on the seizure, a consequence, a management step. Benzodiazepines raise the threshold, shorten the seizure and decrease potential efficacy, the third mattering most. Theophylline is stopped 24 hours before in the Indian guideline while a second source gives no interval at all.
OTHER NEUROSTIMULATION THERAPIES	
RTMS: SUB-CONVULSIVE BY DESIGN	A high-voltage discharge drives a coil, producing a time-varying magnetic field of 1 to 2.5 Tesla under about 1 millisecond; parameters are chosen to minimise seizure risk, so a seizure here is an adverse event, not the mechanism. At therapeutic intensity it does not produce the amnestic syndrome that follows an induced generalised seizure, because it induces none, while an unintended seizure can still occur: the absence of the first neither abolishes nor excuses the second.
THE MOTOR THRESHOLD, FREQUENCY, COILS AND TARGETING	Rossini criterion: the lowest intensity, as a percentage of maximum stimulator output, inducing a motor evoked potential in 5 of 10 trials; resting and active thresholds differ, and a threshold read by eye comes out higher, inflating everything derived from it. Protocols divide at 1 Hz, low frequencies reducing excitability and faster ones raising it; the figure-of-eight coil is the most focal, and F3 by head measurement is the most practical targeting.
THE COURSE, THE SEIZURE RISK, AND THE CEILING	20 to 30 sessions over 6 weeks are very likely needed for results consistent with the regulatory trials. Seizure risk 7 per 100,000 sessions pooled and 33 at elevated risk. The most recent international update declined to update the safety tables, keeping one ceiling: the parameters used to induce a seizure deliberately must not be exceeded, usually 100 per cent of output at 25 Hz for up to 10 seconds.
TDCS: ENVELOPE, MECHANISM, POLARITY	A family defined by a parameter envelope rather than a mechanism: 4 mA or less, up to 60 minutes, electrodes 1 to 100 square centimetres, 0 to 10,000 Hz. It works by subthreshold polarisation, shifting membrane potentials without causing action potentials, so no step fires a neuron. Anode excites and cathode inhibits is a simplification: every montage is active at both ends, and electrode size is part of the dose.
THE TUPLE, AND A NEGATIVE TRIAL	In DepressionDC, a constant 2 mA for 30 minutes, 24 sessions within 6 weeks, added to a selective serotonin reuptake inhibitor, anode F3 and cathode F4. The investigators state their result plainly: no antidepressant benefit over sham and no difference in neurocognitive change, so the technique bought neither benefit nor cognitive cost.

ASK	HOLD
INDIA: A CLASSIFICATION IS NOT AN AUTHORISATION	The national risk-based list enumerates 131 devices in the Neurological category with no entry for a repetitive transcranial magnetic stimulation system, while electroconvulsive therapy systems, deep brain stimulators and vagus nerve stimulators are listed. That is classification and nothing more, establishing nothing about product licensing or indication-specific authorisation. The Act restricts psychosurgery but nowhere defines it, so whether an implanted system falls inside that restriction does not arrive from the statute's text.
VNS: THE SYSTEM, THE ROUTE, THE TRIAL	The implanted device whose electrode never enters the brain: a pulse generator in a subcutaneous chest pocket, a helical lead on the left cervical vagus. The vagus there is predominantly afferent, running nucleus tractus solitarius to locus coeruleus and raphe and on to limbic structures. In the acute trial 15.3 per cent responded against 10.0 on sham, not significant; approval rested instead on 12 month continuation results compared against a separate observational study.
DBS: THE TARGETS, AND THE WIDTH OF THE FIGURES	Not a reversible lesion but a circuit therapy that replaces a pattern. Obsessive-compulsive disorder: ventral capsule and ventral striatum and nucleus accumbens; depression: ventral capsule and ventral striatum, subgenual cingulate, medial forebrain bundle. Not the same set. Both sham-controlled depression trials failed their primary endpoints, 20 against 17 and 20 against 14.3 per cent, while obsessive-compulsive response ranges from 10 to 61 per cent, so a rate without its target and settings says nothing.
MAGNETIC SEIZURE THERAPY: SETTLED AND OPEN	Magnetic stimulation at parameters chosen to produce a seizure deliberately, under anaesthesia, demanding electroconvulsive therapy infrastructure. Settled: the induced electric field is much lower and much more focal, the site of initiation more restricted. Open: whether the ictus that follows propagates less widely. The guideline's bridge from focality to tolerability is a belief, not a finding.
PSYCHOSURGERY: THE GROUPS, HISTORY AND ABUSE	Lesioning destroys tissue, stimulation delivers current to tissue that remains intact. Moniz with Almeida Lima, 1936, 20 prefrontal leucotomies by free-hand injection of absolute alcohol, substantial improvement in 14 of 20 and apathy, abulia or personality change in others. Three features made it an abuse: indications so loose it was offered where no case existed, delivery outside the operating theatre, and sometimes without a neurosurgeon. Reform ended in Spiegel and Wycis's stereotactic frame.

ASK	HOLD
PSYCHOSURGERY: CURRENT SET, EVIDENCE, ETHICS	Anterior cingulotomy, anterior capsulotomy, subcaudate tractotomy, limbic leucotomy; since 1996 all three cingulotomy lesions per side are made simultaneously. The caveat is half the headline: ablative approaches are not SHOWN inferior to stimulation, response 50 to 60 per cent, but on largely uncontrolled studies with no direct comparative trials: not shown less effective, shown on weaker designs. Ethically acceptable only with strict respect for autonomy, beneficence, non-maleficence and justice; the named consent failure is therapeutic misconception.

References

Every specific in this chapter is bound to one of the sources below, and the count is the number of claim rows each carried. This chapter was grounded from PRIMARY sources read at origin rather than from any textbook or from the repo corpus, and the reason is specific to this chapter: the corpus carries no current guideline for the technique, no device manual and no regulator label, while this chapter's numbers are electrical parameters, anaesthetic doses, device authorisations and statutory provisions, where a textbook paraphrase is not good enough and a stale or summarised figure changes what a clinician does at the machine. Each of the 436 rows carries the verbatim quote it was read from, together with a receipt naming the issuer, the document, the version or year, the jurisdiction and the retrieval date. Four classes of primary source carry the chapter. Current clinical practice guidelines were read at the guideline text, the Indian Psychiatric Society guideline of 2023 controlling Indian practice questions and the Australian, South Australian, United Kingdom and international bodies printed beside it with their own bodies and years wherever they diverge, the divergences being recorded and not averaged. Regulator records were read at the regulator, meaning device approval and classification records and product labelling, and a classification is reported as a classification, never as an indication-specific authorisation, and never read across from one jurisdiction to another. Trial reports, meta-analyses and reviews were read at the published article rather than at a summary of it, so that a population, a comparator and a confidence interval travel with every effect size. And the statutory rows were read at the bare Act, on India Code and at the Legislative Department text, because a provision is what decides whether a lawful route exists; the Act's provisions touching this treatment are named in words throughout the chapter and never renumbered, their numbering belonging to the Mental health legislation and forensic psychiatry notes. Of the 436 claim rows, 319 are recorded at verified confidence and 117 at partial, the latter authored from established clinical knowledge or from a source read at abstract or at second reporting and checked by the adversarial content pass rather than bound to a single primary quote at origin; 4 rows are carried forward from the Mental health legislation & forensic psychiatry notes with their reuse declared on the row. Where a specific could not be grounded it was declared as a gap in the prose and taught around rather than supplied from memory, which is why several passages state plainly that no figure exists. The must-have-papers cross-check was NOT performed for this Paper III chapter,

because the paper lists do not yet exist in the intel index; for Paper III the topic bank plus the syllabus scaffolding, together with the inbound-promise sweep of the built corpus, is the completeness authority. This table records provenance, not proof: it says where each specific came from, not that the chapter's prose uses it correctly, which the content pass and the ship review test.

SOURCE	CLAIMS CARRIED
Peer-reviewed trial reports, meta-analyses and reviews (read at the published article; verbatim quote and URL on file for each row)	204
Indian Psychiatric Society, Clinical Practice Guidelines for the Use of Electroconvulsive Therapy (Indian Journal of Psychiatry, 2023)	121
SA Health, Government of South Australia, Electroconvulsive Therapy Policy Guideline (read at the numbered policy sections)	23
United States Food and Drug Administration: device approval and exemption records and product labelling (Center for Devices and Radiological Health; Structured Product Labels)	21
The Mental Healthcare Act, 2017 (Act 10 of 2017), bare Act text read at India Code and at the Legislative Department, Ministry of Law and Justice	17
International Federation of Clinical Neurophysiology, with the European Society for Brain Stimulation: safety and application guidelines for magnetic and low-intensity electrical stimulation	15
National Institute for Health and Care Excellence (technology appraisal and depression guidance)	7
Royal Australian and New Zealand College of Psychiatrists, professional practice guidelines for the administration of electroconvulsive therapy (2019)	7
Somatics LLC, Thymatron System IV instruction manual and instructions for use (manufacturer device documentation, not a regulatory statement)	7
British Association for Psychopharmacology, evidence-based consensus guidelines for the management of catatonia (2023)	6
Central Drugs Standard Control Organisation, classification of non-notified medical devices under the Medical Devices Rules 2017	5

SOURCE	CLAIMS CARRIED
National Network of Depression Centers rTMS Task Group with the American Psychiatric Association Council on Research task force (2018)	3

PART IX

IX

Perinatal and Emergency Psychiatry

Prescribing and treating for two, the postpartum period and women's mental health, and the psychiatric emergencies.

01 Orientation: two doors, one patient

02 Prescribing and treating in pregnancy and lactation

03 The postpartum period

04 Women's mental health across the lifespan

05 The behavioural emergency

06 The rigid, hyperthermic and toxidromic emergencies

07 The medical emergency and the perinatal overlay

08 Cross-cutting synthesis

09 Apply and consolidate

PAPER III

Perinatal and women's mental health, and emergency psychiatry

Eight bands . one complete notes document

Orientation: two doors, one patient

1 · Orientation: two doors, one patient

This chapter has two doors, and one patient walks through both. The first is the door of the antenatal clinic, the labour room and the postnatal ward, where the question is rarely whether a woman is unwell and almost always what may safely be done about it while she is carrying or feeding a child. The second is the casualty door at two in the morning, through which a patient arrives rigid, or confused, or fighting the people holding him, and through which no diagnosis has yet arrived. The chapter is built on the fact that the same woman can come through the second door weeks after leaving the first, and that nothing about the first door's caution is suspended when she does.

What follows is an **advance organizer** rather than a summary. It asserts no figure of its own, because every figure in this chapter belongs to the section that owns it, and it describes no syndrome, because not describing syndromes is the whole design. What it owns is the shape: the decision the chapter is organised around, the two seams that run through its halves, the order in which it runs, and the map of what it deliberately does not carry. The accompanying figure sets out the same architecture visually.

The act	The setting	The first hour	Two patients
WHAT EVERY SECTION HERE TEACHES, FROM THE FIRST MINUTE TO THE HANDOVER	WHERE IT IS DONE, ON WHOSE AUTHORITY, AND WHERE THE PATIENT GOES NEXT	THE SEAM RUNNING THE LENGTH OF THE EMERGENCY HALF OF THIS CHAPTER	THE SEAM RUNNING THE LENGTH OF THE PERINATAL HALF OF THIS CHAPTER

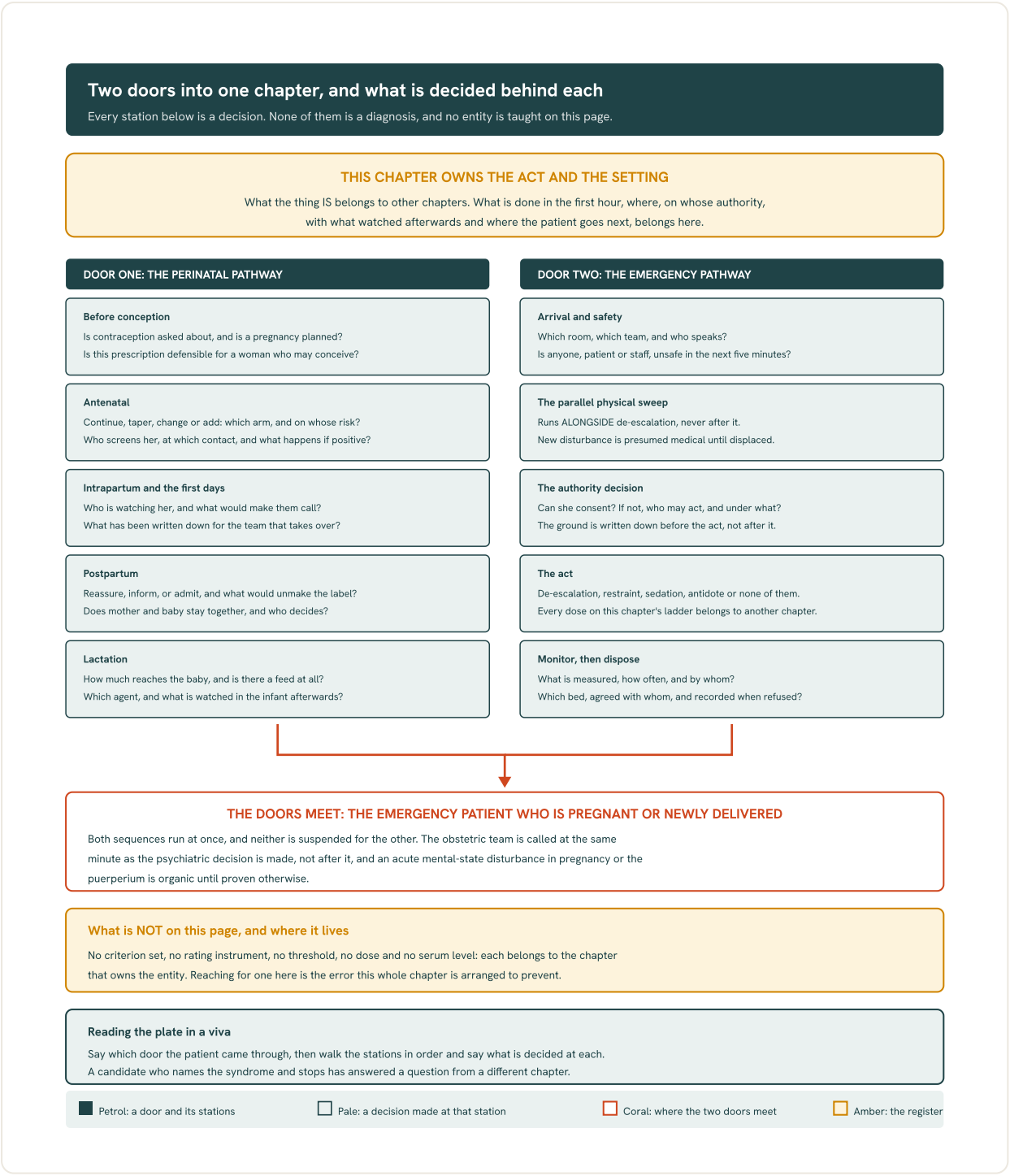


Fig 28.1. The chapter drawn as two doors the same patient may come through, the perinatal pathway from before conception to lactation set against the emergency pathway from arrival to disposition, with every station stated as a decision rather than as an entity, the point at which the two sequences run together in the pregnant or newly delivered emergency patient marked, and the criteria, instruments, thresholds and doses that belong to other chapters named as absent.

1.1 The decision this chapter is organised around

Almost everything named in this chapter has already been taught elsewhere, and taught properly: with its clinical features, its differential, its pathophysiology, its drug treatments and their doses. That body of work is the **entity**. What a syndrome is, what it looks like at the bedside, how it is told apart from the things it resembles, and which agent shifts it, all of that belongs to the chapters that own each disorder, and none of it is repeated here.

This chapter owns the other half, which nothing has yet carried. It is the **act** and the **setting**: what is done in the first hour, where it is done, on whose authority it is done when the patient cannot agree or will not, and where the patient goes afterwards. Reduced to a single contrast, the other chapters answer the question *what is this?* and this one answers *what do I do about it, here, tonight, and who allows me to?*

That division is not a compromise and it is not a shortage of material. It is the harder half of the question, and it is the half that is examined badly and practised badly. A registrar who names a hyperthermic drug reaction correctly and then leaves the patient on an open psychiatric ward has the entity right and the setting wrong, and it is the second error the patient carries. A woman whose antidepressant is stopped for exactly the right reason and in exactly the wrong manner is harmed by the manner. The **disposition** decision, the monitoring cadence, the authority question and the handover are where emergency and perinatal psychiatry are actually won or lost, and they are the content of this chapter.

RULE **Every section here answers what is done, where, on whose authority and where the patient goes next. None of them answers what the thing is.** Hold that while you read, because it decides what counts as a complete answer in this material. A section that says little about a disorder you already know is not thin; it has been written on the assumption that you know it, and everything it does say is content its owning chapter does not carry. The corollary is the one that costs marks. If you can describe a syndrome in this chapter but cannot say who you would call, what you would check before sedating, how often it would be checked afterwards and which bed the patient would be in at dawn, you have read the wrong half of the material.

1.2 The first hour, and how the emergency half is held together

Every emergency in this chapter is entered through one sequence. Recognise that something is wrong, make the patient and the room safe, establish who has the authority to act on someone who cannot consent, act, monitor what the act has done, and decide where the patient goes. That sequence is **the first hour**, and it is the seam that runs the length of the emergency half.

It is set out in full by the section on the assessment and management of the acutely agitated and aggressive patient, which owns it. Every other emergency section names it and enters it at a different point rather than restating it, and knowing where your section enters is most of what makes this half quick to read. The rigid, hyperthermic and toxidromic sections enter at the act, because recognition has happened elsewhere and their question is what the recognition selects. The sections on observation, monitoring and restraint occupy the stretch after the act, which is the stretch most often skipped. Triage and disposition own the two ends.

Two properties of the seam are worth carrying from the start. The first is that it is not a checklist to be worked through and ticked; the sections that own its steps will show you where two of them are meant to be running at the same time. The second is that establishing authority is a clinical step and not paperwork appended afterwards. It has a statutory frame, that frame is Indian, and it is taught in full by the Mental health legislation and forensic psychiatry notes and by the Forensic ethics, consent and legal procedure notes. What this chapter teaches is the decision itself: who is asked, what is recorded, and what is done when there is nobody available to ask.

1.3 The two-patient problem, and how the perinatal half is held together

The perinatal half has a seam of its own, and it is easier to state than to apply. Every decision in it is made for two people at once. That is **the two-patient problem**, and the framework for reasoning through it is set out by the section on prescribing psychotropics in pregnancy, which owns it; the remaining perinatal sections state which two patients their own decision is for and then get on with the decision.

Two things about the frame are worth fixing before you meet it. The first is that the second patient changes identity as the chapter moves: a fetus while she is pregnant, an infant at the breast while she is feeding, a relationship while that relationship is still forming, and, on the night she is acutely unwell, a baby who needs a named adult holding him. The second is that doing nothing is not the neutral option against which the others are scored. Untreated illness is itself one of the exposures being weighed, and the section that owns the framework builds that in from the first line rather than adding it as a caveat at the end.

GOOD TO REMEMBER

The four questions above are the ones this chapter answers, and they are worth carrying as questions rather than as an acronym: what is done now, where it is done, on whose authority, and where the patient goes next. A fifth runs the length of the perinatal half and is asked of every one of the other four, which is who else is the patient. The chapter's own memorable spine is cashed in at the close, built from what the sections actually taught, and it is not seeded here.

That is also why the sections ahead spend their space on sequence, cadence, authority and destination: those are the things rarely written down anywhere, and asked for every time. Four habits make the chapter read as one argument rather than as thirty-one:

- read every section for what it INSTRUCTS, and take the entity it names on trust from the chapter that owns it;
- where a section names another account by description, go and read that account before answering on the point it hands over;
- treat a declared gap as a finding rather than as an omission, because a stated absence is what stops a remembered number being written in;
- and hold the fifth question, who else is the patient, open across the whole perinatal half rather than asking it once.

Every section in this chapter answers four questions and leaves the fifth to the chapter that owns the disorder: what is done now, where it is done, on whose authority, and where the patient goes next. In the perinatal half all four are answered twice over, because two patients are in front of you; in the emergency half they are answered as one sequence, from the door to the handover.

Prescribing and treating in pregnancy and lactation

2 · Prescribing psychotropics in pregnancy (risk categories, teratogenicity)

Every prescription written in pregnancy is written for two patients, and only one of them can be asked what she wants. That asymmetry is the whole of the difficulty, and it is why this decision behaves unlike any other prescribing decision in psychiatry. Candidates prepare the topic as a list of safe and unsafe drugs and then answer the wrong question, because what is actually being examined is not a list. It is a method for reasoning about an exposure whose harm is uncommon, delayed, hard to attribute to any one cause, and measured against a background that was never zero. Get the method right and the agent-level figures become usable. Get it wrong and no quantity of memorised percentages will rescue you, because you will not know what any of them are percentages of.

The topic also carries a piece of currency that Indian teaching has been slow to absorb. The pregnancy risk categories that a generation of candidates learned as a five-rung ladder are no longer the labelling scheme they were drawn from, and a chapter written now has to say so with a date attached rather than quietly reprint the grid. Presenting the withdrawn system as current practice is the commonest way this topic is got wrong in print, and it is worth understanding why the regulator abandoned it, because the reasons are themselves the teaching.

Owned here in full: the two-patient frame that governs every perinatal decision in these notes; the withdrawn letter system and the labelling rule that replaced it; the general teratogenicity framework, meaning critical periods, background risk, and absolute against relative risk; kinetic change across the trimesters and its postpartum reversal; the pre-conception conversation; and the record a shared decision leaves behind. Named once and not re-derived: the agent-level malformation figures for individual mood stabilisers and antiepileptics, which belong with the agents in the Mood disorders: pharmacotherapy notes; electroconvulsive therapy in pregnancy, which belongs to the ECT and neurostimulation notes; and the milk-side exposure metric, defined in the Neurochemistry, Neuroendocrinology, Neuroimaging and Basic Psychopharmacology notes and applied in the breastfeeding topic of these notes.

2 to 4 per cent
BACKGROUND MAJOR BIRTH DEFECT RATE THE REGULATOR CALLS A REASONABLE REPRESENTATION, IN DRAFT GUIDANCE

15 to 20 per cent
BACKGROUND MISCARRIAGE RATE REPORTED IN CLINICALLY RECOGNISED PREGNANCIES, SAME DRAFT GUIDANCE

3 to 16 weeks
POST-CONCEPTION, THE MOST CRITICAL PERIOD FOR BRAIN DEVELOPMENT, LONGER THAN ANY OTHER ORGAN

up to 330 per cent
RISE IN LAMOTRIGINE CLEARANCE IN PREGNANCY, THE CLEAREST WORKED EXAMPLE OF TRIMESTER KINETICS

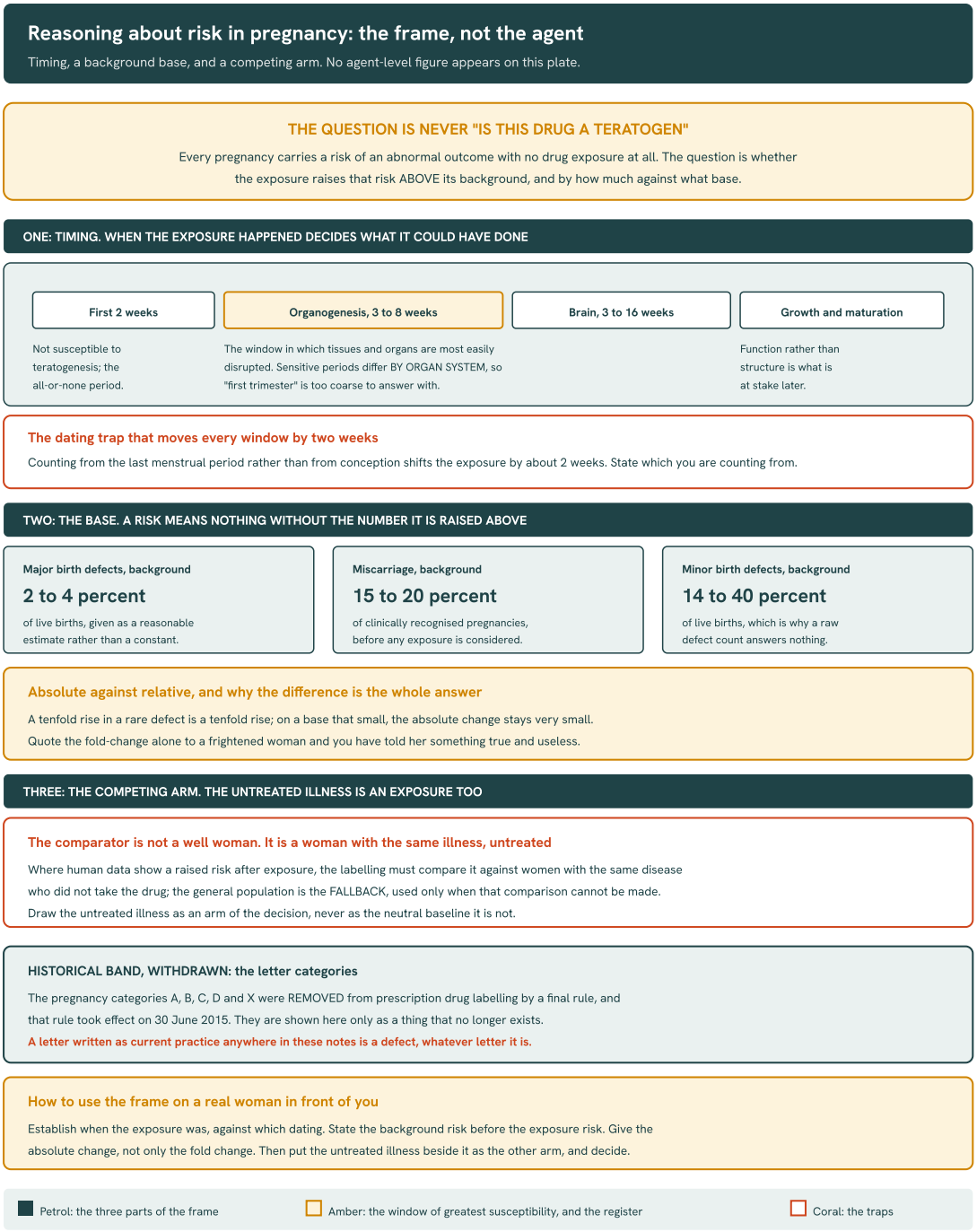


Fig 28.2. The general frame for reasoning about drug risk in pregnancy, drawn in three parts: the critical periods set against gestational age with the dating offset that moves all of them, the background rates of major and minor birth defects and of miscarriage that any exposure risk must be read against, and the untreated illness drawn as a competing arm rather than as a neutral baseline, with the withdrawn letter categories shown only in a dated historical band and labelled as removed.

2.1 Two patients, and the arm that has no drug in it

Start where the arithmetic starts. A woman with a serious mental illness who stops her medication has not moved into an unexposed condition. She has moved from one exposure to a different one, and the second is no better characterised than the first. The American College of

Obstetricians and Gynecologists states this as a recommendation rather than a sentiment in its clinical practice guideline on the treatment and management of mental health conditions during pregnancy and postpartum, issued in 2023: consider untreated or inadequately treated mental health disorders **an exposure**, and recognise the risks associated with inadequate treatment alongside the perinatal risks of any psychopharmacologic agent. Read that twice, because it inverts the way the question is usually asked in an outpatient department. The default framing puts the drug on trial and treats no-drug as the neutral condition. The guideline puts both arms on trial.

This is not a soft principle, and that surprises people. It is written into the labelling regulation itself. Where human data indicate an increased risk of a specific adverse developmental outcome after exposure in pregnancy, the United States regulation on labelling for use in specific populations requires that risk to be quantitatively compared with the risk of the same outcome in infants born to women who were not exposed to the drug but who have the disease or condition the drug is indicated to treat. The comparator the regulator mandates is the untreated ill woman, not the healthy population. Only when risk information for women with that condition is unavailable does the regulation permit the fallback of comparing with the rate at which the outcome occurs in the general population, and that fallback is explicitly second best, used because the better data are missing rather than because the healthy population is the right yardstick.

The same regulation carries the untreated illness onto the label as a required element rather than leaving it to the prescriber's conscience. Under clinical considerations, labelling must describe **any serious known or potential risk to the pregnant woman or to the embryo or fetus associated with the disease or condition for which the drug is indicated**. So when you open a current label to answer a woman's question about her medication, the document is built to tell you two things, not one: what the drug may do, and what her illness may do if it is left to run. Most clinicians read only the first half, which is precisely how a counselling conversation ends up numerically lopsided while feeling scrupulously cautious.

RULE **There is no unexposed arm in this decision, only two exposures.** The woman in front of you will carry either drug exposure or illness exposure, and usually some of each. Any counselling that quantifies one arm and leaves the other qualitative is not balanced counselling, however carefully the drug numbers are quoted. When you cannot quantify the illness arm, say so out loud rather than letting silence stand in for safety, because a number beside a blank always wins the argument.

2.2 The pregnancy risk categories, dated at both ends

Now the historical instrument, taught as history and dated on the page. The United States Food and Drug Administration adopted a pregnancy category system in **1979** to convey risk and benefit information about potential or documented human teratogenic risk and the potential maternal and fetal benefits of drug treatment in pregnancy. Under those regulations each drug product was identified with a pregnancy category: A, B, C, D or X. That is the grid Indian question banks still test, and it is the grid that no longer exists in current labelling.

It was dismantled deliberately. A final rule on the content and format of labelling for human prescription drug and biological products, referred to by the agency as the **Pregnancy and Lactation Labeling Rule**, requires the removal of the pregnancy categories A, B, C, D and X from all human prescription drug and biological product labelling. Removal is mandatory and it reaches all such labelling rather than only newly submitted products. The rule is effective **30 June 2015**, and that is the date from which the letter system ceased to be the applicable labelling scheme going forward. A system born in 1979 and struck out with effect from 2015 is a historical object, and it should appear in your answer with both of those dates attached or not at all.

What replaced it is a change of form, not a change of stringency. The agency's stated position is that **a narrative structure** for pregnancy labelling, rather than a category system, is best able to capture and convey the potential risks of drug exposure based on animal or human data or both. Concretely, the rule replaces the old subsections on pregnancy, nursing mothers, and labor and delivery with three subsections entitled Pregnancy, Lactation, and Females and Males of Reproductive Potential. A letter has become a description of the evidence, which is harder to memorise and far harder to misuse.

Two boundaries are worth holding, because both are commonly misstated. First, the letters never covered breastfeeding: the agency records plainly that the categories were not used to characterise the risks and benefits of drug treatment by lactating women. Anyone who quotes a lactation letter category is quoting something that never existed. Second, the instrument governs prescription products only. Labelling for over-the-counter medicines does not change, and over-the-counter drug products are not affected by the final rule, which matters in a country where a great deal of what a pregnant woman actually swallows was never prescribed to her.

The disappearance was staggered rather than instant, and this is where a confident single date would be an invention. Products submitted after the effective date use the new format immediately, while labelling for prescription drugs approved on or after 30 June 2001 is phased in gradually. For an application not subject to the earlier physician labelling rule, and therefore not required to adopt the new narrative content at all, the holder must still remove the pregnancy category from its labelling within 3 years after the rule's effective date. For an application that is subject to that earlier rule, the category is not removed until the product's labelling is revised into the new format, which may fall more than 3 years after the effective date. The letters therefore left product by product on a staggered schedule. No single calendar day on which every letter vanished can be quoted from the rule, and this account does not supply one.

TRAP **Answering a pregnancy prescribing question by reciting a letter.** Candidates do it because the grid is compact, memorable and still printed in old question banks, and because a single character feels like an answer. It is not an answer now and it was not a good one then. If a question asks for the category of an agent, the mark is in naming the system, dating its withdrawal, naming the narrative labelling rule that replaced it, and then reasoning about the actual evidence. A bare letter offered as current practice is a factual error, not a shortcut.

2.3 Why a letter could not carry the information

The reasons the regulator gave are the most efficient teaching in this whole topic, because each one is a general lesson about risk communication wearing regulatory clothes. The agency records that the system had long been criticised as confusing and overly simplistic, and then sets out what went wrong in specific terms.

- It was read as a grade. Through experience and stakeholder feedback the agency learned that the categories were heavily relied upon by clinicians but misinterpreted, misunderstood and erroneously used as a grading system in which fetal risk increased from A to X. The letters looked ordinal, so they were read as ordinal, and the underlying data never supported a single ranked axis of harm.
- It implied equivalence that did not exist. The categories gave the incorrect impression that drugs in the same category carried the same risk or potential for human adverse developmental outcomes. Two agents sharing a letter were never thereby comparable.
- It collapsed incommensurable evidence. The categories did not discriminate between risk information from non-clinical animal studies and from post-marketing human studies, and did not discriminate between drugs associated with adverse outcomes of differing severity or incidence. One character concealed both what kind of evidence existed and how bad the outcome was.
- It saw only structural harm. Stakeholders pointed out that the categories focused on structural abnormalities and so did not adequately address the full range of potential developmental toxicities. For psychotropics this is the decisive objection, since the harms that most concern a psychiatrist are functional and neurodevelopmental and a letter had no way to express them.
- No category system worked, including the alternatives. The agency explored a range of models to see whether the former system or a different one could communicate differences in degrees of fetal risk, and reports that when the criteria were applied to actual animal and human findings for drugs with known risk profiles, none of the models produced clinically informative and reliable differentiations of risk.

That last point is the one to carry into an answer, because it is the strongest and the least quoted. The failure was not that the wrong five letters were chosen. It was that the categorical form itself cannot hold the information, since a single ordered label has to compress evidence type, outcome severity, outcome frequency and gestational timing into one dimension, and those four dimensions do not lie on one line. Every subsequent element of a current label is an attempt to keep them apart.

2.4 What a current label must state, and how to read one in clinic

If the answer is no longer a letter, you have to know what the answer now looks like, otherwise the replacement is an abstraction. The regulation specifies required content, and reading a label for this decision means going after those elements deliberately rather than skimming the pregnancy paragraph for a reassuring adjective.

The single most useful requirement is the mandated comparator statement. The labelling must state the percentage range of live births in the United States with a major birth defect and the percentage range of pregnancies in the United States that end in miscarriage, regardless of drug exposure. Absolute against relative risk, which most clinicians treat as a matter of good communication style, is here a legal requirement of the document: the background sits on the page beside the drug figure so that the reader cannot see one without the other. The second is the required anatomy of the risk statement itself. Where human data establish the presence or absence of an adverse developmental outcome, the risk summary must summarise the specific outcome, its incidence, and the effects of dose, duration of exposure and gestational timing of exposure. Gestational timing is a required dimension, which is the critical-period principle written into law.

WHAT THE LABEL MUST CARRY	THE QUESTION IT ANSWERS BEFORE YOU PRESCRIBE
BACKGROUND RATES, STATED REGARDLESS OF EXPOSURE	The percentage range of live births with a major birth defect and of pregnancies ending in miscarriage, so the drug figure has a denominator on the same page
COMPARATOR FOR A HUMAN-DATA RISK	Unexposed women who have the same disease, with the general population only when data for diseased women are unavailable
DIMENSIONS OF THE RISK STATEMENT	Which outcome, how often, and how it varies with dose, duration and gestational timing
DISEASE-ASSOCIATED RISK, UNDER CLINICAL CONSIDERATIONS	Serious known or potential risk of the untreated condition to the woman or the embryo or fetus
DOSE ADJUSTMENT, UNDER CLINICAL CONSIDERATIONS	A summary of pharmacokinetic data supporting dose adjustment during pregnancy and the postpartum period
THE THREE NARRATIVE SUBSECTIONS	Pregnancy, Lactation, and Females and Males of Reproductive Potential, so pregnancy, feeding and contraception are answered from separate text rather than one letter

The practical consequence is a change in what you extract. The old act was to find a character and act on it, which took seconds and told you almost nothing. The new act takes minutes and gives you material for the actual conversation: the background rate you will quote first, the comparator the evidence used, whether the human data are informative or absent, the timing dependence, and whether the kinetics oblige you to plan a dose change. That is also why a label is no longer a substitute for judgement. It furnishes the arguments; it does not close them.

2.5 The denominator, before any drug is involved

Nothing in this topic can be interpreted without a background rate, and the first thing to establish with a frightened woman is that the alternative to her tablet is not a guaranteed normal baby. The framework begins from the premise that every pregnancy has a risk of an abnormal outcome regardless of drug exposure, and that reproductive toxicologists treat the major

manifestations of abnormal fetal development as growth alteration, functional deficit, structural malformation and death. Malformation is one member of that set and not the whole of teratogenicity, which is why a drug with a clean malformation record is not thereby a drug with a clean developmental record.

The regulator's own draft guidance on pregnancy, lactation and reproductive potential labelling, issued for comment in 2020 and non-binding, states that because various factors may affect the overall rate, a range of 2 to 4 per cent is a reasonable representation of the background major birth defect rate, and that miscarriage has been reported to occur in 15 to 20 per cent of clinically recognised pregnancies. Note the status carefully, because it is examinable in its own right: the requirement to print a background range is binding regulation, while these particular figures are a draft recommendation and must be quoted as such.

A rate means nothing until the numerator is defined. Most case reports and studies concern **major birth defects**, meaning those incompatible with life or requiring medical or surgical intervention, as against **minor birth defects**, the minor physical anomalies of less clinical importance that deviate from normal without obvious medical or surgical consequence. The minor category is enormous and elastic: minor defects occur in 14 to 40 per cent of live births, and the width of that range is itself the lesson, since what counts as a minor defect is substantially subjective. A study that widens its numerator definition can manufacture an apparent excess without a single extra child being harmed.

Two cautions travel with any background figure, and both come from the regulator rather than from commentary. All-inclusive background rates of major birth defects may include infants with genetic syndromes and chromosomal abnormalities not caused by a medication or other toxic exposure, so at best such rates constitute very crude comparisons. And population estimates can vary considerably by maternal age, race, geographic region, socioeconomic status and time period, including because the availability of diagnostic tools changes across eras. A background rate is a property of a named population, so carrying one across populations is a substantive assumption, not a neutral convenience.

IN INDIA

Three service realities change how this is used here. The letter categories were a United States labelling instrument and were never Indian law, yet they persist in Indian teaching, in older printed inserts and in question banks, which is why dating them matters more in an Indian answer than in an American one; no Indian labelling instrument governing pregnancy risk communication was available for this account, so nothing here should be read as a statement of Indian regulatory requirement. The background figures quoted above are United States estimates, and no Indian background malformation or miscarriage rate was retrievable for this account, so the denominator you quote to a woman in a district clinic is imported into a population with a different maternal age structure, different consanguinity, different nutrition and different ascertainment. Say that it is imported. Third, most women here present already pregnant rather than planning, and serum monitoring for the agents where it would help is often not obtainable outside a teaching hospital, so the follow-up plan has to be built out of clinical review at intervals a family can actually attend rather than out of assays.

2.6 Absolute against relative, and the study that reassures nobody

Here is the inferential target, stated by the regulator in one sentence: the purpose of collecting and evaluating data on drug exposure during pregnancy is to address whether a particular exposure increases the risk of abnormal fetal development above the background rate. The question is never whether a bad outcome occurred in exposed pregnancies. Bad outcomes occur in unexposed pregnancies at a rate that is not small. The question is whether they occurred more often than they would have anyway.

The worked illustration is the most useful arithmetic in the topic. A population experiencing a tenfold increase in a specific rare birth defect, **from 0.04 per cent to 0.4 per cent**, may still have a total birth defect rate across all malformations that is not measurably different from a reference population. Two conclusions follow and they point in opposite directions, which is why this example earns its place. A large relative increase on a tiny absolute base can be real and still invisible in aggregate data, so a reassuring study of total malformation rates does not exclude it. Equally, a tenfold relative risk quoted to a woman without its base sounds like a catastrophe when the absolute change may be a fraction of one per cent. The number that belongs in the consultation is the absolute one, with the background beside it; the relative figure belongs in the appraisal of the study.

Negative studies need reading with the same suspicion as positive ones. The regulator's appraisal rule is blunt: any study reporting no increase in the background rate of birth defects in exposed pregnancies can be viewed with scepticism unless the power of the study to detect or rule out a stated level of risk is also included. Pregnancy exposure cohorts are small, outcomes are rare, and a study with a hundred exposed pregnancies can exclude almost nothing while reading, in an abstract, as clean. When a colleague tells you an agent has been shown to be safe in pregnancy, the follow-up question is not which study, it is safe against what level of risk, with what power to exclude it.

GOOD TO REMEMBER

Write the background figures down before the consultation starts, not during it. The moment you are working out arithmetic in front of a frightened woman, you will quote whichever number you can retrieve, and the retrievable number is almost always the relative one. Two numbers spoken in the same breath, the background rate and the exposed rate, in the same units, do more counselling work than any amount of reassurance, and they are also what you will be able to defend later if the outcome is poor.

2.7 Timing: which clock, which window, which harm

The first thing to fix is the clock, because getting it wrong silently moves a drug into or out of the window that matters. The regulator warns that determining the gestational week of exposure from the date of the last menstrual period rather than the date of conception can produce a 2 week time difference that can be critical when evaluating an association between a birth defect and drug exposure, and states that in its own guidance gestational age means time since conception. Every window quoted below is post-conception. Obstetric practice in the clinic next door usually dates from the last menstrual period. If you carry a figure across without converting, you will be systematically out by a fortnight in the direction that makes exposure look earlier and safer than it was.

The organising principle is that sensitivity belongs to the organ rather than to the drug. Agents producing adverse fetal effects typically do so during discrete sensitive periods that vary with the particular teratogenic process and the target organ, and each part, tissue and organ of an embryo has a **critical period** during which its development may be disrupted. There is therefore no such thing as a safe trimester in general; there is only a window that is or is not critical for the structure you are worried about.

WINDOW, COUNTED FROM CONCEPTION	WHAT IS HAPPENING	WHAT EXPOSURE CAN PRODUCE THERE
FIRST 2 WEEKS	Cleavage of the zygote and implantation of the blastocyst, before differentiation	Not susceptible to teratogenesis, and exposures are not known to cause congenital anomalies in human embryos; interference with cleavage or implantation, or early death and spontaneous abortion
3 TO 8 WEEKS	Organogenesis, when the tissues and organs are forming, and when the embryo is most easily disrupted	Gross structural abnormalities readily seen at birth
3 TO 16 WEEKS	The most critical period for brain development, with susceptibility continuing beyond it as the brain differentiates and grows rapidly	Disruption of the organ with the longest window of any, which is why a first-trimester rule alone cannot govern psychotropic exposure
LATER GESTATION	Rapid fetal growth and maturation, with active cell growth, differentiation and migration, particularly in the central nervous system	A different class of harm rather than a smaller quantity of the same harm: growth and function rather than gross structure

Two clinical consequences follow, and both are commonly missed. The first is that the pre-differentiation window is also the window in which a woman is least likely to know she is pregnant, so an exposure that ENDED inside it is incapable of causing a malformation, though it is not incapable of causing a loss. That is a genuinely reassuring thing to be able to say, and it is worth saying precisely rather than vaguely, because the precision is what makes it true. Establish first which case you are in. A woman who stopped when the test turned positive has usually gone on dosing past this window and into organogenesis, since the window closes around the missed period, and the reassurance does not reach her exposure. Naming the clock is how you tell the two apart, and telling them apart is the whole point of naming it. The second is that the psychiatric agents we worry about act on a developing central nervous system whose critical period is the longest in the table and does not close when organogenesis does. A woman told she is past the dangerous phase at the end of the first trimester has been told something that is true of the palate and false of the brain.

MNEMONIC

Clock, window, harm

Three questions of any exposure, in order. **Clock:** is this week count measured from conception or from the last menstrual period, and have I converted. **Window:** which structures were in their critical period during the exposure, remembering that the brain's runs longest. **Harm:** which class of outcome that window can produce, since the same drug at a different point buys loss, malformation, or growth and functional harm rather than more or less of one thing.

2.8 Dose across the trimesters, and the reversal nobody owns

Once the decision to treat is made, the prescribing task changes character. The dose that was right at booking will frequently not be right at term, and this is a pharmacokinetic fact rather than a matter of the illness worsening. The obstetric guideline states that up-titration in pregnancy may be required with advancing gestation secondary to expected physiologic changes such as increased renal clearance and distribution volume, as well as changes in the activity of drug-metabolising enzymes. A woman whose symptoms creep back in the second half of pregnancy on a dose that held her for a year is not necessarily relapsing in the ordinary sense; she may simply be underdosed by her own physiology.

The direction of the change is broadly predictable from the elimination route, which is what makes this teachable rather than merely cautionary. A mechanistic pharmacokinetic review published in 2005 reports that renal excretion of unchanged drug is increased in pregnancy, and that metabolism catalysed by CYP3A4, CYP2D6, CYP2C9, UGT1A4 and UGT2B7 is increased, so that doses of drugs handled by those routes may need to rise to avoid loss of efficacy, whereas CYP1A2 and CYP2C19 activity is decreased, suggesting that reductions may be needed for their substrates. It is a narrative review rather than a primary study and no magnitude for an individual psychotropic should be taken from it, but the direction of travel is a usable heuristic when you are deciding which agents to watch hardest.

The magnitude, where it has been measured, can be startling. Lamotrigine is metabolised by **UGT1A4**, which is upregulated in pregnancy, increasing clearance of the drug by up to 330 per cent. That is the mechanism-to-magnitude chain the general principle needs in order to become real, and it is quoted here purely as kinetics. The malformation figures for this and every other agent, and the antiepileptic prescribing route, belong to their own chapters and are not extended here; the mood stabiliser numbers sit in the Mood disorders: pharmacotherapy notes.

Where there is no level to chase, the monitoring has to be clinical. Some psychiatric medications have therapeutic drug ranges requiring monitoring, whereas others such as the selective serotonin reuptake inhibitors have no established therapeutic concentration but do have **concentration-to-dose ratios** known to be dynamic across pregnancy and the postpartum. So the absence of an assay does not mean the absence of kinetic change; it means the change is invisible unless somebody is looking at the patient at planned intervals. No monitoring interval is asserted here, because none of the sources consulted for this account gives one, and an invented review cadence would be worse than an honest blank.

The step that gets forgotten is the reversal. The guideline is explicit that the dose needs to be carefully down-titrated again postpartum to avoid toxicity, with close clinical monitoring of the patient. Pregnancy kinetics unwind quickly after delivery, so a dose raised across gestation becomes a toxic dose within days of birth if nobody owns the review. This is a systems failure waiting to happen, because the antenatal dose rise is made by whoever is following the pregnancy and the postnatal fall belongs to nobody in particular. Name the person and the date before the woman delivers, and write it where the postnatal team will see it, not only in the psychiatric notes.

2.9 The pre-conception conversation, and the record a shared decision leaves

Almost everything above is more useful before conception than after it, which is why the conversation is owed early and broadly rather than at the first positive test. The United Kingdom guideline on antenatal and postnatal mental health directs that all women of childbearing potential with a new, existing or past mental health problem be asked about contraception and any plans for a pregnancy, and told how pregnancy and childbirth might affect the mental health problem including the risk of relapse, and how the problem and its treatment might affect the woman, the fetus and baby, and parenting.

- Contraception and any plans for a pregnancy, asked about rather than waited for, which is what converts this from a perinatal topic into a general adult prescribing habit.
- How pregnancy and childbirth might affect the mental health problem, including the risk of relapse, which is the illness arm of the two-exposure comparison made concrete for this woman.
- How the problem and its treatment might affect the woman, the fetus and the baby, kept as three separate questions because the answers differ.
- How the problem and its treatment might affect parenting, which is the element most often dropped and the one families ask about most.

The timing argument for holding this conversation early is the pre-differentiation window discussed above. By the time a woman with an unplanned pregnancy reaches you, organogenesis has usually begun, the exposure has already happened, and the only decisions left are downstream ones. Nothing about the framework changes, but the menu shrinks. A conversation at the point of prescribing, repeated when contraception or plans change, is the only version of this that is genuinely preventive.

The record is part of the clinical act, not an administrative afterthought. Shared decisions in this area are revisited, sometimes years later and sometimes by people who were not in the room, and the woman herself will not retain the arithmetic. What protects the decision is a note showing the reasoning rather than the conclusion. No documentation proforma from a professional body was available for this account, so what follows is derived from what the labelling regulation itself obliges a label to contain, and should be read as a structure rather than as a standard.

- Both arms named: the risks discussed for the agent, and the risks discussed for the untreated or inadequately treated illness in this particular woman, including her own relapse history.
- The comparator used, and whether it was other women with the same condition or the general population, since the two support different conclusions.
- The absolute figures actually quoted, with the background rate beside them, and the population those figures come from.
- The dating frame used for any gestational window discussed, since a note that says nine weeks without saying from what is not interpretable later.

- The kinetic plan: which direction the dose is expected to move with advancing gestation, who reviews it, and who is responsible for the postpartum down-titration and by when.
- What the woman decided, in her words, and what would change the decision, so that a future clinician can tell a settled choice from an unresolved one.

One boundary before leaving the topic. This framework tells you how to reason about an agent; it does not tell you which agent. The individual malformation and adverse-outcome figures for particular mood stabilisers are in live disagreement across published sources, and they are taught with their agents in the Mood disorders: pharmacotherapy notes rather than restated here. What travels from this topic to every other perinatal decision, including the feeding decision in the breastfeeding topic of these notes and the emergency decisions later on, is the frame: two patients, two exposures, an absolute number with its background beside it, and a clock you have named out loud.

> Every figure you quote in this conversation is an increase above a background that is not zero, on a clock you must name, for a woman whose untreated illness is itself an exposure.

3 · Drugs safe in breastfeeding (relative infant dose, agent selection)

Two people receive this prescription and only one of them is dosed. The mother's milligrams are chosen, titrated and written down. The infant's are inferred from a milk assay and a body weight, arrive at intervals nobody controls, and appear on no chart at all. That asymmetry is what this topic is about, and why the question asked is never "which drug is safe" but "which drug, for which infant, watched how, and what would make you stop".

The temptation is to memorise a ranked list of agents, and a ranked list is precisely what the published figures do not support. Several of the agents a candidate is most likely to name have no published figure at all. In two of the four classes the headline figure means something quite different from what it appears to mean, because it omits an active metabolite carrying most of the exposure. And the highest figure in the table belongs to a drug women take through lactation, under monitoring, every day. What is examined is whether a candidate can read a percentage, see what it excludes, and make a decision the percentage was never capable of making. The two-patient frame that governs this band, mother and infant weighed together, is developed in the pregnancy-prescribing topic of these notes.

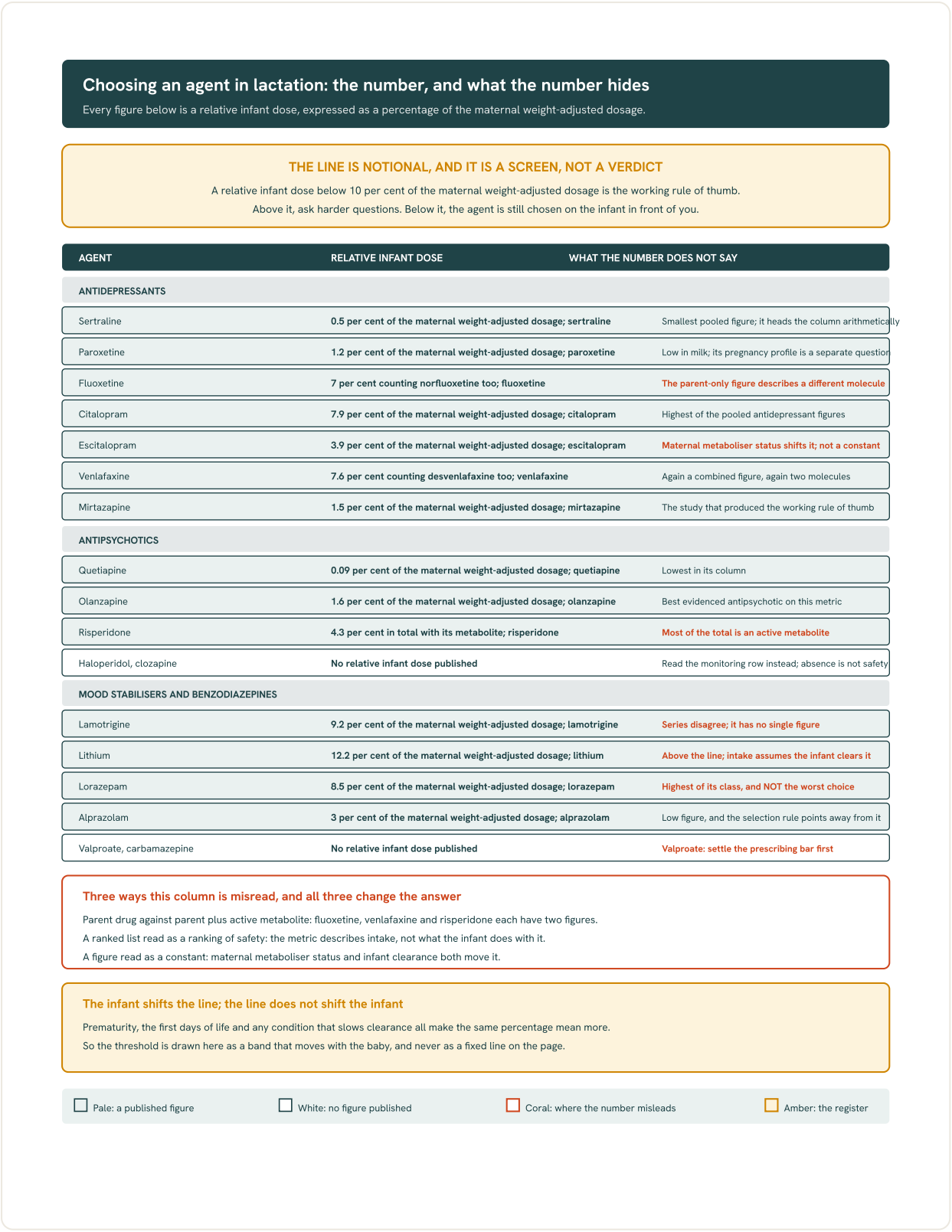


Fig 28.3. Agent selection in lactation, with the relative infant dose for each antidepressant, antipsychotic, mood stabiliser and benzodiazepine that has one, each figure naming in the same line what it is a dose of, set against the notional ten per cent working threshold, the agents for which no figure is published shown as such rather than omitted, and the three misreadings that change the answer named alongside the infant factors that move the threshold rather than the number.

3.1 The number you quote, and the half of the exposure it leaves out

The **relative infant dose** expresses what the breastfed infant takes in as a percentage of the mother's own weight-adjusted dose, and a value **below 10 per cent** of that maternal weight-

adjusted dose is conventionally taken as the notional level of acceptability. The derivation, the arithmetic and the worked exemplars are printed in the Neurochemistry, Neuroendocrinology, Neuroimaging and Basic Psychopharmacology notes and are not repeated here. What belongs here is what the metric cannot do, and the primary sentence supplying the threshold supplies the caveat alongside it: the feeding decision remains an individual risk and benefit analysis rather than a threshold test.

Read literally, the metric is a statement about intake, and says nothing about what happens after the milk is swallowed. Two infants taking identical relative infant doses of the same agent can reach entirely different serum concentrations, because absorption, hepatic conjugation and renal clearance are all maturational and all slower in the first weeks of life than the adult pharmacokinetics behind the calculation assume. The exposure that matters clinically is intake set against clearance, and only the first of those is inside the number.

RULE **A relative infant dose is an intake figure, not an exposure figure.** It is calculated from what enters the infant and it assumes he can clear it. Every caveat in this topic, prematurity, the first postnatal days, dehydration, intercurrent illness and maternal genotype, is a statement about a clearance term the metric does not carry. A figure comfortably acceptable in a thriving infant of a few months can be the wrong figure in a jaundiced newborn on the same milk, and nothing on the page changes to tell you so.

3.2 The agent table, and how to read a blank cell

The figures that follow come from the Drugs and Lactation Database, a compilation of maternal serum and milk assays, together with the primary pharmacokinetic study of mirtazapine that supplies the working threshold. They are laboratory calculations on small samples of healthy, term, exclusively breastfed infants, not outcome data. A blank in the percentage column is neither reassurance nor warning: it means the calculation was not made, and the reason differs by agent. For the anticonvulsant mood stabilisers the database gives its own reason and it is methodological, which is worth teaching in itself.

0.09%
QUETIAPINE, LOWEST PUBLISHED RELATIVE INFANT DOSE HERE

0.5%
SERTRALINE, LOWEST ANTIDEPRESSANT FIGURE

12.2%
LITHIUM, ONLY CENTRAL ESTIMATE ABOVE THE NOTIONAL LEVEL

17.85%
INFANT SIDE EFFECTS ON ATYPICALS, INDIAN MOTHER AND BABY UNIT

AGENT	RELATIVE INFANT DOSE, AS PERCENTAGE OF THE MATERNAL WEIGHT-ADJUSTED DOSE	WHAT THE FIGURE DOES NOT CONTAIN
SERTRALINE	0.5%, pooled dataset	Nothing material; this is the arithmetic reason it sits where it does
PAROXETINE	1.2%, pooled dataset	Discontinuation effects in the mother if it is stopped abruptly to permit feeding
FLUOXETINE	2.4% for the parent drug alone	The active metabolite; measured with it, about 7%, range 3 to 12%

AGENT	RELATIVE INFANT DOSE, AS PERCENTAGE OF THE MATERNAL WEIGHT-ADJUSTED DOSE	WHAT THE FIGURE DOES NOT CONTAIN
CITALOPRAM	7.9%, pooled dataset	Individual studies in the same record running both below and above this
ESCITALOPRAM	3.9%, with 1.7% more as desmethylcitalopram	Maternal genotype; modelled median 3.3%, range 0.8% to 11.3%
VENLAFAXINE	7.6% for drug plus metabolite, range 4.7 to 9.2%	Nothing; but it must be quoted as the combined figure, never as the parent alone
MIRTAZAPINE	1.5%, range 0.6 to 2.8%, plus 0.4% as the desmethyl metabolite	Maternal sedation, which is a feeding-safety issue in its own right
QUETIAPINE	0.09% on average; modelled worst case 0.43%	Nothing; the worst case already assumes every feed at the peak milk level
OLANZAPINE	1.6% on average, range 0 to 2.66%	Nothing material; the best-evidenced antipsychotic on this metric
RISPERIDONE	4.3% in total	Four fifths of it is 9-hydroxyrisperidone, itself a marketed antipsychotic
HALOPERIDOL	No figure published	A maternal oral ceiling statement instead: up to 10 mg daily gives low milk levels
CLOZAPINE	No figure published	The only agent here for which an infant blood count is the named action
LITHIUM	12.2%, range 0 to 30%, in the better-technique series	Infant clearance, which is the variable that actually decides the case
LAMOTRIGINE	9.2%, range 3.1 to 21.1%, in one series	A second series averaging 11.6%, range 5 to 31%
VALPROATE	No figure published	The calculation is held to be less meaningful for this class.

AGENT	RELATIVE INFANT DOSE, AS PERCENTAGE OF THE MATERNAL WEIGHT-ADJUSTED DOSE	WHAT THE FIGURE DOES NOT CONTAIN
VALPROATE, BEFORE THE LACTATION QUESTION ARISES AT ALL	Not a relative infant dose question	A woman who is breastfeeding is by definition of childbearing potential, so the bar on offering valproate to this group absent the conditions set out with contraception counselling in these notes applies to her before any milk calculation is reached. Settle that question first; it is not answered by this table.
CARBAMAZEPINE	No figure published	The same methodological reason as valproate
LORAZEPAM	About 8.5%, counting conjugated as well as free drug	Nothing; the conjugate is why this figure is the highest of its class, and the figure is not a verdict on the agent. It is short-acting and free of active metabolites, which is precisely what the selection rule in the row below asks for
ALPRAZOLAM	About 3%	Reported infant sedation, which drives the caution against repeated use in nursing and points instead to a shorter-acting benzodiazepine without active metabolites, especially with a neonate or a preterm infant
CLONAZEPAM	Maximum 2.5%, from a single mother and infant pair	Any population estimate; this is one report, not a mean
DIAZEPAM	No figure published	Accumulation of drug and metabolite in infant serum on repeated dosing

3.3 Antidepressants: the metabolite is the decision

Sertraline heads the antidepressant column for an arithmetic reason rather than a pharmacological one: its pooled figure is simply the smallest, and it carries no long-lived active metabolite to be added to it. Paroxetine follows closely, and mirtazapine is comparably low where sleep and appetite dominate the presentation.

Fluoxetine is where a single number misleads most reliably. The parent compound's pooled figure looks unremarkable, and the database flags in the same breath that the figure omits **norfluoxetine**, an active metabolite of equivalent antidepressant activity. Where both were measured together, in 14 mothers, the combined figure rose to about **7 per cent** of the maternal weight-adjusted dose, with the upper end of the range crossing the notional level. Long half-lives also mean the infant has no trough to be fed in. That is the whole clinical argument for choosing a

shorter-acting agent when treatment is started fresh in a breastfeeding mother, and emphatically not an argument for switching a woman already well on fluoxetine.

Citalopram gives the highest single-agent figure among the plain serotonin reuptake inhibitors, close enough to the notional level to matter when the infant is young or unwell. Escitalopram demonstrates why the column cannot be read as a table of constants at all. In a modelled analysis the median figure came with a range spanning more than an order of magnitude, and it split by maternal genotype: a **CYP2C19 poor metaboliser** mother produced a modelled relative infant dose of 5.5 per cent of her weight-adjusted dose against 3 per cent in other phenotypes. One agent therefore spans much of the column on its own, which should permanently discourage comparing two drugs on the second decimal place. Venlafaxine must always be quoted as drug plus **desvenlafaxine**, because the active metabolite carries most of it.

3.4 Antipsychotics: what is actually prescribed, and what is actually watched

Quetiapine gives the lowest published relative infant dose of any agent here, and the figure survives its own worst case: a model assuming that every single feed occurred at the peak milk concentration still returned a figure far below the notional level. That is a useful shape to recognise, because most published figures are averages across a dosing interval and a worst case is rarely offered. Olanzapine is the best-evidenced of the class and its published range extends down to zero. Risperidone is the trap.

TRAP **Quoting risperidone by its parent drug alone.** The parent contributes 0.84 per cent of the maternal weight-adjusted dose and **9-hydroxyrisperidone** a further 3.46 per cent, giving **4.3 per cent** in total. Candidates quote the first of those because it is the figure attached to the drug name they recognise, and thereby understate the infant's exposure roughly fivefold. A small series gives a mean of 3.3 per cent, range 2.2 to 4.7 per cent, which is consistent with the combined total and not with the parent figure. The general form of the error is the one that also catches fluoxetine and venlafaxine: where an agent has an active metabolite, the drug name and the number in front of you are describing different molecules.

Haloperidol has no relative infant dose in the database at all. What exists instead is a statement about the mother: doses of up to 10 mg daily by mouth during lactation produce low levels in milk and usually do not affect the breastfed infant, with very limited long-term follow-up showing no adverse developmental effect where haloperidol is used alone. That is a ceiling on the mother's oral daily dose offered in place of a figure for the infant, and it must be taught as exactly that. Clozapine likewise has no published figure, and the same database records that other agents are preferred and that some sources advise a woman taking it should not breastfeed at all.

IN INDIA

The most usable cadence available comes from an Indian tertiary-centre mother and baby inpatient psychiatry unit, published in the Indian Journal of Psychiatry in 2021, in which infants of 28 postpartum women taking atypical antipsychotics had medication side effects checked every alternate day for 1 to 2 weeks against a prepared checklist. Side effects including sedation and constipation attributable to the antipsychotic occurred in 17.85 per cent of that single-centre, uncontrolled, short-window sample. The exposure profile is Indian too: 15 of the 28 infants were exposed to olanzapine at maternal oral doses of 2.5 to 30 mg daily, 11 to risperidone at maternal oral doses of 4 to 8 mg daily, and 2 to quetiapine. The service point matters more than the percentage. An alternate-day check by the nurse at the cot is deliverable in a district hospital anywhere in the country. Serial infant serum levels and repeat white cell counts are not, and where the blood test cannot realistically be obtained, the agent choice itself must carry the safety the monitoring was supposed to provide.

3.5 Mood stabilisers: where the metric runs out

Lithium carries the highest central relative infant dose of any agent here, and the only central estimate sitting above the notional level. It also carries the widest disagreement between datasets. The better-technique series gives one figure; an older estimate from 6 infants, in reports published up to the start of the nineteen-nineties, gives about **26 per cent** of the maternal weight-adjusted dose, range 11 to 42 per cent, with the database noting that many of those case reports were of poor quality and that the reason for the gap between the two estimates is not apparent. Both have to be stated. Quietly choosing the lower because it supports a decision already made is the error, and so is quoting the higher to close a conversation down. Whether lithium prohibits feeding outright or permits it under monitoring is a separate argument with a substantial cohort literature behind it, and it is developed in the Mood disorders: pharmacotherapy notes rather than restated here.

Lamotrigine straddles the line rather than sitting on one side of it. One series gives a central figure just under the notional level with an upper bound at twice it; a second series averages above the line entirely. The honest teaching is that lamotrigine has no single relative infant dose, and that a mother asking for one is asking for a certainty the published data does not contain.

Valproate and carbamazepine have no figure at all, and here the database states its own reason rather than leaving the cell mysteriously empty. In the published lactation reports most women were taking **combination anticonvulsant therapy**, and because some of these agents induce and others inhibit the metabolism of the rest, the relationship between the mother's dose and the concentration in her milk becomes variable enough that the weight-adjusted percentage is less meaningful for this class than for other drugs in that database. That is a statement about the method rather than the drug, and it is why those two cells must stay blank rather than be filled from memory in a viva.

3.6 Anxiolytics: the agent for which timing the feed is useless

The benzodiazepine column contains the topic's most counter-intuitive result. Lorazepam has the practice reputation of being the most benign of the group and carries the highest published

relative infant dose of them, **about 8.5 per cent** of the maternal weight-adjusted dose. The reason is both methodological and clinically real: the figure counts **conjugated as well as free drug**, because infants can deconjugate and absorb glucuronides, so a metabolite an adult would have safely inactivated becomes available to the baby again. Alprazolam and clonazepam give lower figures, the clonazepam one from a single mother and infant pair rather than a population, which is the kind of provenance difference that disappears once figures are tabulated side by side.

Diazepam is the exception that governs the practical advice given later in this topic. Diazepam and nordiazepam accumulate in the serum of breastfed infants with repeated doses, and because both half-lives are long, timing breastfeeding with respect to the maternal dose is of little or no benefit in reducing infant exposure. Every timing manoeuvre a mother might be offered assumes a peak and a trough she can feed between. Diazepam on repeated dosing does not provide one.

Two further rules attach to this class, both population rules rather than agent rules. Because of reported infant effects including sedation, alprazolam is probably not the best benzodiazepine for repeated use during nursing, particularly with a neonate or premature infant, and a **shorter-acting benzodiazepine without active metabolites** is preferred. And the class as a whole has to be read against guidance that would rather it were not being prescribed to this population at all: the National Institute for Health and Care Excellence guidance on antenatal and postnatal mental health, which applies in England and Wales, advises considering gradually stopping benzodiazepines in women who are planning a pregnancy, pregnant or considering breastfeeding.

3.7 The infant who is not in the data

Every figure in the table was derived in a healthy, term, exclusively breastfed baby. The Indian cohort states this explicitly by way of its exclusions: preterm delivery, birth weight below 2 kilograms, major neonatal complications needing intensive care, major congenital anomaly and major medical or surgical illness were all excluded before a single infant was observed. Whatever reassurance that study offers, therefore, it does not offer it about the preterm infant, the small infant or the sick infant, and those are precisely the infants in whom clearance is worst. The reassurance and the risk have been separated by the study design, and a reader who does not check the exclusions will carry the reassurance across the gap.

The database makes the mechanism explicit for lithium and the shape generalises. Lithium in milk can harm the infant acutely where **elimination is impaired**, as in dehydration or in the newborn or premature infant, and a neonate may in addition be carrying transplacentally acquired serum lithium from before delivery. Consider what that does to the arithmetic. A baby with gastroenteritis and reduced feeding has an unchanged relative infant dose on paper and a rising serum concentration in reality, because the number describes what goes in and the illness has changed what comes out. The clinical habit follows directly: treat acute illness in the infant of a mother on a narrow-margin agent as a reason to reassess feeding that day, not at the next appointment.

MNEMONIC

Metabolite, Maturity, Malady, Mother

The four things a relative infant dose does not contain. **M**etabolite: the active metabolite frequently excluded from the headline figure. **M**aturity: prematurity and the first postnatal weeks, when clearance is immature. **M**alady: intercurrent infant illness or dehydration, which changes elimination without changing the number. **M**other: her metaboliser phenotype, which can move the figure several-fold on the same prescription.

3.8 What is watched in the infant, and who does the watching

Monitoring here is overwhelmingly clinical rather than laboratory, and where a blood test is named it is named for a reason a candidate should be able to give. The residual duty, covering every agent for which no panel and no figure exists, is a single line from the same English and Welsh guidance: where a woman is taking psychotropic medication while breastfeeding, the baby is monitored for adverse effects. No panel, no interval and no duration is specified there, so none should be invented to fill the silence.

AGENT	INFANT CLINICAL WATCH	INFANT BLOOD TEST NAMED BY THE SOURCE
LITHIUM	Dehydration, feeding, any acute illness	Serum lithium, creatinine, blood urea nitrogen and thyroid stimulating hormone, at intervals variously recommended from periodic to every 4 to 12 weeks, attributed to some investigators rather than to a guideline
LAMOTRIGINE	Apnoea, rash, drowsiness, poor sucking; stop feeding if a rash appears, until the cause is established	Infant serum level where there is concern; platelet count and liver function; levels before and after any increase in the maternal dose. Less extensive monitoring where the mother takes 150 mg daily or less
CARBAMAZEPINE	Jaundice, drowsiness, adequate weight gain, milestones; more closely in younger exclusively breastfed infants and on polytherapy	Serum carbamazepine, liver enzymes and a complete blood count, attributed by the source to one author rather than a guideline; no interval given
VALPROATE	Jaundice, unusual bruising or bleeding; sedation or withdrawal reactions where sedating agents are combined	None specified
CLOZAPINE	Close monitoring for excessive sedation	Periodic infant white blood cell count; the source gives no interval
HALOPERIDOL	Drowsiness and developmental milestones, more closely with concurrent antipsychotics; on the decanoate also excessive sedation, irritability, poor feeding and extrapyramidal signs	None specified
ANY OTHER PSYCHOTROPIC	Adverse effects, unspecified	None; the residual duty carries no panel

Three things are worth drawing out. Clozapine is the only agent for which a blood count on the infant is the named action, for the reason the reader already knows from the mother's own monitoring. Lamotrigine carries the most specific panel and the only monitoring-intensity threshold expressed as a maternal dose, on the stated logic that beneath it the infant is unlikely to have measurable serum drug at all. And the lithium panel is the only one with a named interval, attributed by the source to investigators rather than to a guideline and arriving with no target value and no action threshold: the reader is told what to send, not what to do with the result. An interval with no owner reads as universal, and none of these are.

3.9 Timing, expressing, and the decision the table cannot make

Mothers do not ask about relative infant dose. They ask whether to feed before the tablet or after it, whether expressing and discarding the milk helps, and whether to stop feeding altogether. The first two have arithmetic answers; the third does not. For sertraline the manoeuvre has actually been quantified: in one series the relative infant dose was 0.54 per cent of the maternal weight-adjusted dose, and **pumping and discarding** milk 8 to 9 hours after the mother's dose was calculated to reduce the infant's daily dosage by 17 per cent. A proportional reduction of that size, applied to an intake already among the smallest in the table, buys almost nothing at the cost of a discarded feed, a pump the family may not own, and a mother's sleep. Timing is not useless; its value must be computed against the figure it is applied to.

Timing is worth more where the peak is sharp and the baseline higher, nothing at all for diazepam on repeated dosing, and something quite specific after a single dose. After one dose of diazepam, for sedation before a procedure or for a seizure, there is usually no need to wait before resuming breastfeeding; with a newborn or preterm infant a cautious approach is to wait 6 to 8 hours before resuming nursing, and for that population other agents are preferred in the first place. That is one of the few genuinely timed acts here and it is worth carrying precisely.

The last question is the one no percentage answers. The English and Welsh guidance sets a default of encouraging breastfeeding in women with a mental health problem, and names its exceptions: carbamazepine, clozapine and lithium. Notice what that list is and is not. It is a service-level decision rule rather than a pharmacokinetic ranking, and most of the named agents have no published relative infant dose at all, so they appear on it because of the absence of a number rather than because of a high one. The same recommendation closes by requiring that each woman be supported in the choice of feeding method that best suits her and her family, which is what stops an exception list becoming a prohibition. It constrains what is encouraged; it does not decide for the woman.

The genuinely hard case is the woman already well on the agent with the worst milk data. The guidance names both sides without resolving them: the limited safety data on these drugs in milk, and the risk associated with switching from a previously effective medication, with specialist perinatal advice sought for specific drugs. Nothing in the percentage column tells you the second of those. A relapse in the early postnatal weeks costs the infant his mother's availability, frequently costs the feeding relationship anyway, and sometimes costs an admission, none of which appears in a milk assay. That is why the agent table is a set of inputs rather than a ranking of answers. One caution on jurisdiction: that guidance is English and Welsh, Indian guidance controls for Indian practice where it exists, and no Indian equivalent of the exception list was retrievable, so it structures the conversation rather than governing an Indian unit.

GOOD TO REMEMBER

Before the first dose, write down which infant this is: gestation at birth, current weight, age in weeks, whether feeding is exclusive, and whether the baby is well today. Then write down what will be watched and who will watch it. Every figure here assumes a term, healthy, exclusively breastfed baby, and the moment yours is not one, the number has stopped describing him and the plan is built from the infant instead.

- Name the metabolite before quoting the number: fluoxetine, venlafaxine and risperidone are each understated by their parent-drug figures.
- Read a blank cell as an absent calculation, never as reassurance, and be able to say why it is missing.
- Reassess feeding on the day an infant becomes acutely unwell, not at the next review, wherever the mother is on a narrow-margin agent.
- State whose an interval is. Where a source attributes a schedule to investigators rather than a guideline, say so out loud.

Quote no relative infant dose without naming the metabolite it excludes and the infant it assumes: a term, healthy, exclusively breastfed baby who can clear what he takes in.

4 · Mood and anxiety disorders in pregnancy

The commonest question about mood and anxiety disorders in pregnancy is not which drug is safe but what to do about the drug she is already taking. A woman maintained on treatment for depression, bipolar disorder or an anxiety disorder arrives either pregnant or planning to be, and something has to be decided in that consultation, on that afternoon, by whoever is sitting opposite her. Candidates prepare this as a teratogenicity table and then find that no table answers it, because the question on the table is not what an agent does to a fetus. It is what to do about a person who is currently well because of it. The two-patient frame is set out where these notes deal with prescribing psychotropics in pregnancy; what is added here is that the exposure being weighed on one side has a competitor on the other, and the competitor is her illness.

Owned here in full: the antenatal decision itself and the four arms it actually has, which are to continue, to switch, to reduce or to stop, each priced with what it costs; the relapse and recurrence evidence that turns stopping from a neutral act into a decision with a bill attached; the manner of stopping, where stopping is what she chooses; the detection of perinatal anxiety and perinatal obsessive-compulsive disorder, both of which are systematically under-recognised; and the narrow set of situations in which a non-pharmacological route is genuinely first-line rather than a way of postponing the decision. Named once and not re-taught here: the depressive, bipolar and anxiety syndromes themselves, which belong to the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes; and agent selection, comparative teratogenicity and dosing, which belong to the Mood disorders: pharmacotherapy notes.

68 per cent	26 per cent	71 per cent	22.2 per cent
RELAPSED IN PREGNANCY AFTER STOPPING THE ANTIDEPRESSANT	RELAPSED IN PREGNANCY ON THE ANTIDEPRESSANT MAINTAINED	HAD AT LEAST ONE RECURRENCE IN PREGNANCY IN A BIPOLAR COHORT	PERINATAL GENERALISED ANXIETY DISORDER, POOLED ACROSS LOW- AND MIDDLE-INCOME COUNTRIES

4.1 Who is in front of you, and what is actually being decided

Three consultations hide behind this heading and they are not the same problem. The first is the woman who is planning a pregnancy and has come to ask about it: the only version of this decision made with time in hand, where every arm is still open and nothing has been done that cannot be undone. The second, and by a distance the commonest, is the woman who is already several weeks pregnant when she finds out, whose exposure decision was made for her by biology before anyone was consulted. The third is the woman with no psychiatric history who becomes unwell during the antenatal period, where the question is whether to start rather than whether to continue, and where the reference point is a woman who has never been treated at all.

The decision itself has four arms, not two. She can continue what she is on; she can be switched to a different agent; the dose can be reduced; or the drug can be stopped. Examination answers and, more damagingly, real consultations collapse this into a binary of drug or no drug, and every collapse of that kind moves the conversation to the arm that feels safest rather than the arm that is safest. Each of the four is a positive act with a specific price, and a candidate who can name the price of each has understood the topic. The prices are not symmetrical and they are not all pharmacological: two of them are paid by the fetus, one is paid by the woman's mental state, and one is paid by both at once.

THE ARM	WHAT IT IS MEANT TO BUY	WHAT IT ACTUALLY COSTS
CONTINUE	Maintained control of an illness that is currently in remission on this agent	Steady exposure of the fetus to one drug for the whole of the antenatal period, and the review burden that goes with it
SWITCH	Exchange of an agent with worse evidence for one with better evidence	Exposure to two drugs across the changeover instead of one, plus destabilisation of a woman who was well
REDUCE	Less exposure while keeping some treatment	Possible loss of efficacy without a matching loss of exposure, which is the worst ratio of the four
STOP	Zero further drug exposure from the day it is stopped	Relapse or recurrence risk that is quantified, large, and largely borne in the antenatal period itself

MNEMONIC

Continue, Switch, Reduce, Stop - and name the bill for each

Four arms, four bills. Say all four aloud in the consultation, price each one in her hearing, and the conversation stops being a request for permission to stop and becomes a choice between four named positions.

4.2 Building the conversation the guidance actually requires

Before any arm is chosen there is a discussion, and the guidance specifies its contents rather than leaving them to the clinician's instinct. The National Institute for Health and Care Excellence, in guidance published in 2014 and last updated in 2020, requires that detailed advice about the risks of mental health problems and the benefits and harms of treatment in the antenatal and postnatal periods cover three things that clinicians routinely leave out.

- The **background risk of harm** to the woman and to the fetus or baby that comes from the mental health problem itself, and the risk to her mental health and to her parenting if she is not treated at all.
- The risks and harms attached to stopping or changing a treatment, which is a separate question from the risks attached to being on it.
- The need for prompt treatment, because of what an untreated mental health problem can do to the fetus or baby.

Notice what that list does to the arithmetic. The framework behind it, that the untreated illness is itself an exposure and that a relative risk must be read against its base rate, is set out where these notes deal with prescribing psychotropics in pregnancy, and is not re-derived here. What belongs to this decision is the direction it points. The American College of Obstetricians and Gynecologists, in its clinical practice guideline of 2023, directs that the **absolute risk** of adverse obstetric, perinatal and infant developmental outcomes, which for almost all psychiatric medications appears to be low, be set against the high risk of illness recurrence, and states that in general this balance favours continuing pharmacotherapy.

RULE **The default is not neutrality, and the burden of argument sits on stopping.** The same American guideline states that although pharmacotherapy is an exposure, for most individuals and most medications the risk of that exposure is lower than the risk of symptom exacerbation or relapse. Continuation is therefore the position that stands unless a case is made against it, and a clinician who stops a psychotropic in pregnancy is the one who owes the argument, not the one who keeps it going.

4.3 Pricing the stop option in unipolar depression

The counterweight to teratogenic risk is relapse risk, and unless it is quantified in the consultation it does not weigh anything at all. The best-known evidence comes from a prospective multicentre cohort of women with a history of major depression who were euthymic at conception and followed across the antenatal period. Of 201 women, 86, or 43 per cent, relapsed during pregnancy. That headline figure conceals the finding that matters. Among the 82

women who maintained medication throughout, 21, or 26 per cent, relapsed, against 44 of the 65 who discontinued, which is **68 per cent**. Expressed as an effect size across the whole of pregnancy, discontinuation carried a hazard ratio for relapse of **5.0**, with a 95 per cent confidence interval of 2.8 to 9.1.

The authors' conclusion is the sentence to carry into the consultation: pregnancy is not **protective** against relapse of major depression, and a woman with a depressive history who is euthymic on an antidepressant should be told that stopping it in pregnancy is associated with relapse. Many women and a fair number of clinicians hold the opposite belief, usually without ever having examined it, and the belief does real work: it makes stopping feel like a return to a natural, safer state rather than the removal of an active treatment from a person who has an illness.

Two honest qualifications travel with these numbers and a good candidate offers them before being asked. The design is naturalistic rather than randomised, so the women who discontinued were not allocated to do so; they chose, and the reasons a woman chooses to stop may themselves predict how she will fare. The direction of that bias is not obvious, because a woman with milder illness may feel safer stopping while a woman with more severe illness may be the one most frightened by exposure. What survives the qualification is the size of the gap and the fact that both arms were followed prospectively by the same investigators to the same endpoint.

4.4 Pricing the stop option in bipolar disorder

The bipolar figures are larger and the decision is correspondingly less balanced. In a prospective cohort of women with bipolar disorder who were euthymic at conception, the overall risk of at least one recurrence during pregnancy was **71 per cent**. Comparing those who discontinued a mood stabiliser with those who continued it, the discontinuers carried twofold the recurrence risk, a median time to first recurrence more than fourfold shorter, and a proportion of weeks spent ill during pregnancy that was five times greater. That last measure is the one to quote to a woman who is thinking in terms of a single feared event, because it describes not whether she becomes unwell but how much of her pregnancy she spends unwell.

An independent guideline summary of two cohort studies reaches the same place by a different route. Compared with continued use, discontinuing a mood-stabilising medication in pregnancy was associated with an increased risk of recurrence at an adjusted hazard ratio of 2.2 with a 95 per cent interval of 1.2 to 4.2, and with a reduced time to recurrence of 2 weeks against 28 weeks, at an adjusted hazard ratio of 12.1 with an interval of 1.6 to 91. Print the second interval whenever the point estimate is printed. An interval that wide says the direction is secure and the magnitude is not, and a candidate who quotes the point estimate alone has misrepresented the evidence in the direction of confidence.

Two further features of that cohort change what you do rather than what you think. Most recurrences were depressive or mixed, at 74 per cent, so the surveillance a clinician sets up should not be built around watching for mania; and 47 per cent of recurrences fell in the first trimester, which is exactly the window in which a woman who has just stopped is least likely to be under

psychiatric review and most likely to be attributing her symptoms to being pregnant. The investigators' own framing closes the argument: treatment planning here has to consider not only the relative risk of fetal exposure to a mood stabiliser but also the high risk of recurrence and morbidity that comes from stopping maintenance treatment.

4.5 Continue: the default, and the clock that governs any later stop

The American guideline sets two defaults that are worth memorising as a pair, because they are not the same default. In severe mental health conditions such as bipolar disorder and the psychotic disorders, pregnant and postpartum individuals should in general continue medication management. In depression or an anxiety disorder diagnosed in the antenatal or postnatal period, continued pharmacotherapy should be recommended for at least **6 to 12 months** of symptom remission before discontinuation is even considered. Note what that second default is a clock on. It runs from remission, not from delivery, not from the end of breastfeeding, and not from any gestational milestone. A woman who becomes well at some point in the antenatal period and delivers three months later has not finished the clock, and the postnatal request to come off is therefore usually a request made early rather than a request made at a natural end point.

The same guideline states plainly that discontinuing effective pharmacotherapy in pregnancy or the postpartum period increases relapse risk and is not recommended, and that where discontinuation is being considered it requires careful consideration of the risk of recurrence. For major depressive disorder it names two predictors of recurrence that a clinician can check in the room: **discontinuation before remission**, meaning before symptoms have completely resolved rather than merely improved, and an increasing number of lifetime depressive episodes. Both are answerable from the history in under a minute, and both convert an abstract worry into a statement about this woman.

Continuing is itself an act and not the absence of one. It commits the clinician to review, to a plan for what happens if she becomes unwell anyway, and to a decision about whether the dose that is right in the first trimester is still the right dose later, since the handling of a drug changes across pregnancy for reasons that belong to the Neurochemistry, Neuroendocrinology, Neuroimaging and Basic Psychopharmacology notes. No review interval is asserted here, because none is carried in the sources used for this topic; what is asserted is that a decision to continue with no review date written next to it has not been fully made.

4.6 Switch: paying for one exposure with two

Switching is the arm that most often gets proposed by a clinician rather than requested by a woman, usually with the intention of moving her from an agent with worse reproductive evidence to one with better. Its cost is structural and easy to miss. A switch is executed as a **cross-taper**, the initial medication down-titrated while the newer agent is started and up-titrated, and the American guideline notes that this results in increased exposure, which is best avoided if a therapeutic effect can be reached with a single agent. For a period that may run into weeks the fetus sees two drugs where it previously saw one, and the woman spends that period on a subtherapeutic amount of the drug that was working and a not-yet-effective amount of the drug that might.

Two sequencing rules follow from that, and both are stated in the guideline rather than inferred. First, because a switch is expensive, careful assessment of what medication has actually been effective for this woman in the past is of particular importance; the agent with the best published reproductive data is of no use to a woman it has never worked for, and switching away from the one agent that has ever produced remission in her is the most consequential version of this error. Second, assuming that side effects are not prohibitive, dose optimisation should be considered before switching. Optimising is cheap in exposure terms and reversible; switching is neither.

4.7 Reduce: buying the exposure without buying the benefit

Reduction is the arm that feels like a compromise and has the worst ratio of the four. The British guidance directs use of the lowest effective dose, and adds in the same breath that this matters particularly where the risks of adverse effects to the woman, fetus and baby may be dose related. But it then states the cost explicitly: a **sub-therapeutic dose** may also expose the fetus to risks and not treat the mental health problem effectively.

The word carrying the weight in that recommendation is effective. Lowest effective dose is not the same instruction as lowest dose, and the two get conflated whenever a clinician halves a dose in the first trimester as a gesture towards caution. Exposure does not fall to nothing when a dose is halved; the drug is still crossing, still being metabolised, still detectable in the pregnancy. What may fall to nothing is the therapeutic effect that justified the exposure in the first place. A woman on a reduced dose who then relapses has ended up with both costs and neither benefit, and she has also lost the argument that the drug does not work for her, since it was never given a fair test at the dose that worked.

4.8 Stop: the taper is the instruction, not the decision

Stopping is two decisions wearing one word, and only the second is fully inside the clinician's control. The first is whether to stop, which is largely hers. The second is how, which is a technical act with evidence behind it. In the bipolar cohort described above, the median recurrence latency was 11 times shorter after abrupt or rapid discontinuation of a mood stabiliser than after gradual discontinuation. Same decision to stop, same drug, and an order-of-magnitude difference in how long she stayed well, determined by a variable the prescriber sets.

For the antidepressants the American guideline names the method directly: to avoid the discontinuation syndrome, a person who has been on a serotonin reuptake inhibitor or a serotonin and noradrenaline reuptake inhibitor should undergo a **progressive taper** over **2 to 4 weeks**. Two clinical consequences follow. An entry in the notes that reads only that the drug was stopped, with no taper written beside it, is half an instruction, and the missing half is the half that predicts the outcome. And because a discontinuation syndrome in a pregnant woman produces sleep disturbance, agitation, nausea and dysphoria, it is routinely misread as either an early relapse or as the pregnancy itself, which sends the consultation in the wrong direction at the worst moment.

Stopping is never the cautious option and never one decision: whether to stop belongs largely to her, how to stop belongs entirely to you, and the manner of stopping changes the outcome as much as the choice to stop.

4.9 When she has already decided to stop

Some women will decide to come off medication whatever is said, and the clinical task then changes from persuasion to damage limitation. The British guidance sets out what the conversation should contain when a woman with a severe mental illness decides to stop a psychotropic in the antenatal or postnatal period: discuss her reasons, and discuss the possibility of each of the following, then make sure she knows the risks to herself and to the fetus or baby of stopping.

- Restarting the medication, offered here without any precondition attached.
- Switching to a different medication, if the objection is to this agent rather than to treatment.
- A psychological intervention, which is a treatment and not a placeholder.
- Increasing the level of monitoring and support, which is the arm that stays available when every other one has been refused.

The parallel recommendation for a woman with depression or an anxiety disorder is worth putting side by side with that one, because it differs in exactly one place and the difference is examinable. There, the restarting option is conditioned: it applies if the depression or anxiety disorder is or has been severe and there has been a **previous good response to treatment**. No such condition appears in the severe mental illness recommendation. The threshold for pressing a restart is therefore explicitly higher in depression and anxiety than in severe mental illness, which is a proportionality judgement written into the guidance rather than a clinical preference, and it tells you where the guidance thinks the greater danger of undertreatment lies.

GOOD TO REMEMBER

Write the four arms and their costs into the notes, name which one was chosen, name who chose it, and write a date next to it. A decision recorded as "patient wishes to stop, medication stopped" cannot be defended, cannot be reviewed and cannot be handed over. A decision recorded as four options offered, relapse risk quantified in her hearing, her choice, taper plan, review date, is the same clinical act with the evidence of care attached to it.

4.10 When the pregnancy is already confirmed

This is the presentation that walks into most clinics, and it carries a correction that changes the first thing a clinician says. Where a pregnant woman has taken a psychotropic with a known teratogenic risk at any point in the first trimester, the British guidance directs that the pregnancy be confirmed as quickly as possible and that she be told, explicitly, that stopping or switching the medication after the pregnancy is confirmed may not remove the risk of fetal malformations.

The logic is uncomfortable and it is the point. By the time a routine test is positive, the exposure that would have mattered has usually already happened. Stopping today therefore buys much less

than it appears to on the risk that is being feared, while buying, in full and immediately, the relapse risk quantified earlier in this topic. That does not make stopping wrong; it makes stopping a decision that has to be justified on its own forward-looking terms rather than as a retrospective repair. The practical acts that follow are to confirm and date the pregnancy rather than assume it, to record what she actually took and when rather than what she was prescribed, and to route the exposure question to the people who can actually assess it obstetrically, instead of resolving it by withdrawing the treatment.

TRAP **Stopping the drug the day the test comes back positive, in the belief that this undoes the exposure.** It is made in good faith and it feels like the responsible act, which is why it is so durable. It usually cannot reverse a first-trimester exposure that has already occurred, and it adds a discontinuation to a woman in the very trimester in which recurrences cluster. The reflex substitutes an act that is visible for one that is useful.

4.11 Asking about antenatal anxiety, and why the number depends on how you ask

Perinatal services are built around depression, and the arithmetic does not support that design. In a Canadian cohort assessed by structured diagnostic interview, the prevalence of anxiety and related disorders was 15.8 per cent during pregnancy and 17.1 per cent in the early postpartum, against depression at 3.9 per cent and 4.8 per cent in the same sample. That is a single regional cohort, and only participants who screened positive went on to interview, so the authors describe their own estimates as conservative. Even discounted for both, a service whose only routine perinatal enquiry is about low mood is aimed at the smaller of the two problems.

The second thing to understand about these figures is that the number you find is partly a property of the method you used. Within one meta-analysis, generalised anxiety prevalence came out at 24.4 per cent when estimated from screening tools and 11.5 per cent when estimated from **diagnostic interview**, for the same construct in the same review. Roughly half the apparent prevalence of perinatal anxiety is instrument. That is not an argument against screening, which is doing what a screen is meant to do; it is an argument for never quoting a prevalence figure in an answer without saying how it was ascertained, and for never treating a positive screen as a diagnosis in the clinic.

WHAT WAS COUNTED	HOW IT WAS ASCERTAINED	STUDY BASE	THE FIGURE
ANTENATAL ANXIETY SYMPTOMS	Self-report	102 studies, 221 974 women, 34 countries	Self-reported anxiety symptoms in 18.2 per cent in the first trimester, 19.1 per cent in the second and 24.6 per cent in the third
ANY ANTENATAL ANXIETY DISORDER	Clinical diagnosis	The same global review	Any anxiety disorder in 15.2 per cent
ANTENATAL GENERALISED ANXIETY DISORDER	Clinical diagnosis	The same global review	Generalised anxiety disorder in 4.1 per cent

WHAT WAS COUNTED	HOW IT WAS ASCERTAINED	STUDY BASE	THE FIGURE
PERINATAL GENERALISED ANXIETY DISORDER	Pooled across all ascertainment methods	203 studies, 212 318 women, 33 low- and middle-income countries	Generalised anxiety disorder in 22.2 per cent, the most prevalent disorder in that review
THE SAME, SPLIT BY COUNTRY INCOME BAND	Pooled, subgrouped	The same low- and middle-income review	Generalised anxiety in 27.6 per cent in lower-middle-income countries, 24.0 per cent in low-income countries and 19.1 per cent in upper-middle-income countries

For an Indian answer, the pooled low- and middle-income figure is the more defensible comparator than a global pooled figure, because the studies behind it were done in economies that resemble the one the reader works in. One caution belongs with it and is stated rather than glossed: that review reports prevalence by World Bank income band, but it does not itself state which band India falls into, so no Indian figure is being asserted here by implication.

4.12 Asking about perinatal obsessive-compulsive disorder

Obsessive-compulsive disorder in the perinatal period is the clearest example in this topic of a diagnosis whose apparent frequency is determined by whether anyone asked. The older pooled estimates, drawn from studies using structured interviews, put prevalence at 1.08 per cent in the general female population, 2.07 per cent in pregnancy and 2.43 per cent postpartum, with regionally matched risk ratios of 1.45 in pregnancy and 2.38 postpartum and an aggregate risk ratio of 1.79. That much was established years ago: the perinatal period raises the risk, and it raises it more after delivery than before.

A later province-wide cohort of unselected women, interviewed directly and asked about perinatal-specific content, returned figures several times higher. Weighted **period prevalence** was 7.8 per cent prenatally and 16.9 per cent postpartum, with average point prevalence of 2.9 per cent prenatally and 7.0 per cent postpartum. Keep the two quantities apart when quoting them, since a period prevalence spanning months and a point prevalence at a single assessment are different measurements and the higher pair is not the more alarming version of the lower pair. The two estimates disagree substantially and the disagreement is unresolved; the honest position for a candidate is to quote both and to name the methodological reason they differ rather than to pick the more striking one.

The timing tells you when to ask. Point prevalence rose across pregnancy and the early postpartum to a peak of close to 9 per cent at approximately 8 weeks postpartum before declining, and the cumulative incidence of new diagnoses was estimated at 9 per cent by 6 months postpartum. Two things follow for the clinic. The peak sits in the early postnatal weeks, when most contact is obstetric or paediatric rather than psychiatric, so the enquiry has to be built

into whatever contact exists rather than into a psychiatric follow-up that has not been arranged. And a large share of it is new onset rather than pre-existing illness carried into the pregnancy, which means a negative psychiatric history is not a reason to skip the question.

The authors state the mechanism of under-recognition as a measurement fact rather than a clinical impression: when women are encouraged to report their **perinatal-specific symptoms** and current diagnostic criteria are applied, estimates come out higher than previously believed. Under-recognition here is a failure to ask about content, not a failure of the disorder to occur. The general enquiries most clinicians make do not reach obsessions whose content is about the infant, and a woman rarely volunteers them, for reasons that are obvious the moment you consider what she believes will happen if she says them aloud in an antenatal clinic.

PITFALL

Acting on the content of an intrusive thought about harm to the infant instead of on its form. The reflex is an emergency referral, a safeguarding entry, or a decision to keep mother and baby apart, and it punishes a woman for disclosing. What you ask about is the form. The discrimination itself, and the risk formulation that follows from it, are made in the section of these notes on mother-infant bonding and infanticide risk; the urgent-risk pathway belongs to the section on psychiatric emergencies in the perinatal period.

4.13 Choosing a non-pharmacological route where it is genuinely first-line

A psychological intervention appears in the guidance as one of the named options when a woman decides to stop medication, alongside restarting, switching and increased monitoring. It is a treatment arm in its own right, and there are three situations in which it is genuinely first-line rather than a way of deferring the decision.

- The woman not currently on medication whose symptoms are of low or moderate severity with no history of severe illness, where the comparison is between a psychological treatment and starting a drug rather than between a psychological treatment and continuing one.
- The woman who has firmly declined medication, where the real comparison is between a psychological intervention and nothing at all, and where the arm that is available beats the arm that is optimal.
- The woman who has stopped and accepted increased monitoring, where a psychological intervention is what turns a surveillance plan into an active one.

What makes any of these real is availability inside a clinically useful interval. A referral to a service that will assess her after delivery is not first-line treatment for antenatal illness; it is a deferral wearing a treatment's name, and the pregnancy will be over before the intervention begins. The honest test to apply before writing it in the plan is whether she will actually be seen while the problem is still the problem. Where the answer is no, saying so and choosing among the remaining arms is better practice than recording an intervention that will not arrive, because the record then reflects the decision that was actually made. No severity threshold, no named therapy and no efficacy estimate for psychological treatment in the antenatal period is asserted here;

none is carried in the sources used for this topic, and the principle is offered without a number rather than with an invented one. Where the illness is severe enough that no pharmacological arm is acceptable to her and psychological treatment is not sufficient, electroconvulsive therapy becomes the next question, and it belongs in full to the ECT and neurostimulation notes.

IN INDIA

A peer-reviewed analysis of Indian maternal mental health policy records that the National Mental Health Policy launched in 2014, directed at vulnerable populations and at de-stigmatisation, does not include women in the perinatal period among the populations it names as susceptible to psychiatric problems. That is a policy analysis rather than a government instrument, and it is cited as analysis. Its practical consequence is the one every reader will recognise: there is no funded pathway that puts a psychiatrist inside the antenatal clinic, so almost every contact this woman has during pregnancy is obstetric, and almost every opportunity to ask about anxiety or intrusive thoughts belongs to someone who has not been asked to ask. The arms of the decision above are all deliverable in that setting except one. Continuing, tapering properly, optimising a dose and increasing the frequency of review can all be done in a district clinic with a telephone number that works. A timely psychological intervention usually cannot. Where that is the local reality, it should change which arm is chosen, not be recorded as though it had been offered.

A closing note on jurisdiction, because it governs how the material above should be used. The four-arm structure, the required contents of the risk-and-benefit discussion, the remission clock, the taper interval and the option sets are British and American guidance. No Indian national guideline on the antenatal psychotropic decision was retrievable for this topic, and where an Indian instrument exists it controls for Indian practice. The relapse and recurrence figures come from North American cohorts of women who were in specialist follow-up and euthymic at conception, which is a more closely observed population than most Indian services can offer; the direction of that difference is that relapse in a less closely followed population is likely to be detected later rather than to occur less often. Use the structure as a way of organising the consultation, and the figures as the order of magnitude of what stopping costs, which is the part a woman needs in her hearing before she decides.

The postpartum period

5 · Postpartum blues (features, course)

Why the marks sit in the act and not in the description. **Postpartum blues** is judged quickly, usually by somebody who is not a psychiatrist, and then rarely revisited. What the state is, how it runs, and how it stands against a postnatal depressive episode and against a puerperal psychosis belong to the three-way treatment carried by the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes, and none of it is restated here. What belongs at the front door is different: the act performed in the room, the person into whose hands the judgment is given, and the condition under which it must be reopened.



Fig 28.4 The front-door distinction among postpartum blues, depression and psychosis is a disposition decision: reassure with a named review threshold, begin treatment, or arrange urgent admission and coordinated mother–infant safety.

The label is the easy part; the harm sits in how it is closed. A woman correctly judged to have blues may be depressed some weeks later: the first judgment was not wrong, the way it was ended can be. Every decision in this band is taken for **two patients** at once, the mother and the infant who depends on her, a frame belonging with prescribing in pregnancy and holding even though nothing is prescribed.

Reassure, inform, return	Reassurance and a named threshold	Mother and infant
THE THREE THINGS DONE WITH HER, AND ALL THAT IS DONE	THE TWO LIMBS OF THE TRIGGER, EACH INERT WITHOUT THE OTHER	WHO EVERY DECISION IN THIS BAND IS TAKEN FOR

5.1 The discrimination the front door actually makes

There are not three descriptions to choose between at the door so much as three **dispositions**, and the choice turns on what is safe to do next rather than on which picture fits best.

- **Reassure and review.** She is coping with the support she has, nothing needs treating tonight, and she can safely be seen again. That is the blues judgment: a disposition, not a description.
- **Treat now.** The state is deepening, or simply failing to lift, and function is going rather than holding. It has become a treatment question and enters the screening and referral pathway taught where postnatal depression is handled in this chapter.
- **Do not discharge.** Disorganisation, fluctuating awareness, perceptual disturbance, or any thought of harm to herself or to the infant takes her out of this category altogether and calls for same-day assessment and an admission decision. The branches then separate by destination, and getting them the wrong way round is the error. Fluctuating awareness or disorganisation is an organic question first, and goes to the emergency triage of the confused patient in these notes. A thought of harm goes to the risk assessment taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. The presentation as a whole goes to this chapter's account of postpartum psychosis, which owns the same-day assessment and the admission decision it triggers.

Blues is therefore a **provisional judgment** by construction: it says treatment is not needed now, not that it never will be. And because the third branch is settled at the moment of contact rather than by watching, the examination that excludes it belongs to the first visit, not to the review.

5.2 The act in the room, and why each part fails alone

The response to blues has been set out as an act rather than as a description by the **IGEDEPP** prospective multicentre cohort, the cleanest available statement of the front-door task. **Three** things are done with the woman: her awareness of what she is living through is raised, so it has a name she recognises; she is reassured; and she is given information about postpartum depression and the symptoms by which it declares itself.

Take one away and the other two stop working. Awareness without reassurance medicalises an experience that does not need treating. Reassurance without information is heard as an instruction to disregard whatever comes next, so a woman whose state deepens reads that as her own failure. The information is what actually gets dropped, out of kindness: a woman never told a postpartum depressive episode exists cannot recognise she has crossed into one.

MNEMONIC

Reassure, Inform, Return

Reassure, with her awareness raised rather than her experience dismissed; **I**nform, about postpartum depression and the symptoms that announce it; **R**eturn, on a stated trigger held by a named person.

5.3 The trigger that reopens the judgment

RULE **Blues is managed by reassurance plus a named return threshold, and it ceases to be blues the moment the threshold is crossed.** Each half is inert without the other. Reassurance alone closes the encounter; a threshold alone, handed over flat, converts a settling experience into vigilance. Together they turn a judgment nobody can check today into one that checks itself later.

The condition attached is that the blues **worsens or is prolonged**, either of which requires management, so the trigger has **two** limbs and no third. That is what spares the clinician from having to predict: you have to be right about the trigger, not about the future. It stays coarse because it will be applied by an exhausted woman and by relatives with no clinical training.

How long counts as prolonged is fixed by no figure this section can assert, and inventing one would hand the family a false permission to wait. What the clinician can do instead is fix the review and let that date carry the meaning of prolonged: if the state has not lifted by the contact already arranged, the judgment is reopened there.

5.4 Handing the threshold to somebody who will still be there

Safety-netting is an allocation, not a sentence. A threshold given to the woman alone lands on the person least placed to act on it: the judgment about whether a state is worsening is being asked of the person whose state it is. **Safety-netting** means deciding, before she leaves the room, who else holds the trigger, and fixing a contact rather than issuing an invitation to return.

WHO HOLDS THE THRESHOLD	WHAT THEY ARE ASKED TO NOTICE	WHAT THEY DO WITH IT
The woman herself	That the state is deepening, or has not lifted	Present again, without waiting for the review
The relative in the room	The same change, which she may minimise	Bring her, having been told where and to whom
Whoever sees her at the next routine contact	Whether the judgment still holds	Escalate rather than reassure a second time

IN INDIA

The threshold assumes a clinician who stays reachable, and that is where this pathway breaks. The postnatal contact is commonly obstetric, or the frontline home visit by the auxiliary nurse midwife or the accredited social health activist, rather than anything psychiatric. Many women move to the natal home after delivery, often in another district, so whoever set the threshold is not whoever sees her next. Two adjustments cost nothing: give the trigger to the relative travelling with her, and name a destination where she is going.

TRAP **Writing postpartum blues into the record as a diagnosis instead of as a judgment with a trigger attached.** The label is correct when written, and correctness feels like a finished act, so it travels forward as a conclusion and the next clinician reassures a second time without ever seeing the condition the first reassurance depended on. In a viva the discriminating answer is what was said, to whom, and what was arranged.

GOOD TO REMEMBER

If the consultation is cut short, protect the trigger and the review before the reassurance. Warmth is remembered but not inherited; a threshold never stated is the part nobody downstream can reconstruct.

You are entitled to record postpartum blues only if you also state, out loud and in the notes, what would make you unmake it.

6 · Postpartum depression (assessment, EPDS, management)

Why the marks are here. Depression after childbirth is one of the few psychiatric conditions in which the diagnostic work is easy and the detection work is hard. A woman has more scheduled contact with health services in the perinatal year than at almost any other time in adult life, and she is still routinely missed, because being seen is not being asked. What this section teaches is not the illness but the machinery around it: who asks, at which contacts, with what, and what happens to the woman who answers yes. The entity itself, its specifier, epidemiology, recurrence risk and first-line treatment, belongs to the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes.

Two features make this a service question rather than a bedside one. Every decision in the perinatal band is taken for two patients at once, the mother and the fetus or infant, which is the frame these notes set out for prescribing in pregnancy: a missed diagnosis here is transmitted rather than contained. And screening is itself an intervention with a cost. It manufactures positives, and a positive that goes nowhere is worse than no screen, because it teaches a woman that disclosure achieves nothing.

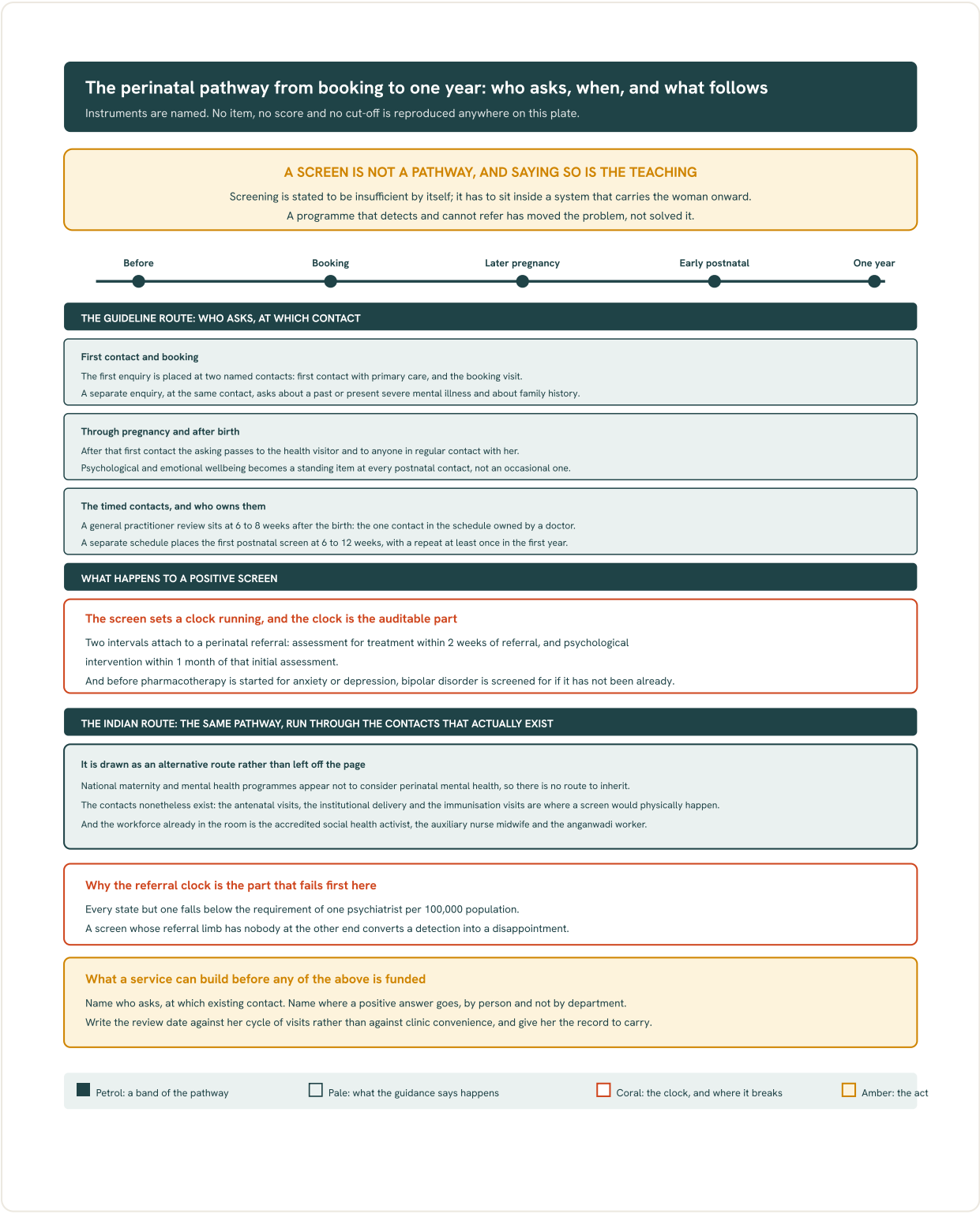


Fig 28.5. The perinatal screening and service pathway on a timeline from before conception to one year after birth, showing who asks at each contact, the timed reviews and the intervals a positive screen sets running, with the Indian route drawn as the alternative it has to be, through the antenatal, delivery and immunisation contacts that already exist and the workforce already in the room, and with the referral limb marked as the place the pathway fails first.

6.1 A screen is not a service

The governing principle comes from the American College of Obstetricians and Gynecologists, in its 2023 clinical practice guideline: screening is valuable but by itself insufficient, and earns its place only inside a system that carries a woman through the whole mental health pathway. That guideline names the stages in order: detection, assessment, triage and referral, treatment access

and initiation, symptom monitoring, and **measurement-guided treatment adjustments** continued until symptoms remit.

Read that as a chain of joins, not a list of activities, because the weakest join is almost never detection. Detection is cheap and easy to audit, which is why services install it first and why the unaccompanied screening programme is so common. Assessment costs clinician time; triage needs a destination with capacity; initiation needs it to accept and start; monitoring needs somebody to own the case after the referral letter leaves. Naming the stage at which a described service breaks answers the question; naming an instrument does not.

MNEMONIC

Who, When, With what, What next

The four questions a perinatal screening pathway must answer before it is worth running. **Who** is screened, and by which worker. **When** in the perinatal timeline the contacts fall. **With what** enquiry or instrument. **What next** when the answer is positive. Services specify the first three and improvise the fourth at the point of need, which is where the pathway fails.

RULE **Do not put a screening instrument into a service until the destination of a positive result has been named, and named as a person or a clinic rather than a category.** It is the easiest part of the pathway to install and the least useful alone. Where a service cannot say who assesses the positives, within what interval, and who follows the woman if treatment starts, a questionnaire increases documented distress without increasing treated distress.

6.2 Who is screened: a population defined by the care episode, not by risk

The first design decision is whom to ask, and the guidelines that have thought hardest about it define the population by the care a person is receiving rather than by risk stratification. ACOG makes screening for depression and anxiety universal across well-woman, prepregnancy, prenatal and postpartum care, using standardised and validated instruments. That is the difference between a programme and case-finding: a programme asks everyone inside a defined care episode.

The reasoning matters more than the rule. Risk-based screening sounds efficient and fails structurally: risk factors are unevenly documented, so the woman with the thinnest record is least likely to be flagged and often most exposed, and risk assessment inserts a judgement between the woman and the question, at which point bias and social distance select who is asked. A universal rule keeps judgement for the assessment rather than the front door.

The Australian clinical practice guideline of 2023 widens the population further than any other, offering screening to **non-birthing parents** early in pregnancy and again from 3 to 6 months after the birth, repeated when clinically indicated. That limb is missing from most teaching and almost every service, yet a depressed partner is both a risk to the infant and a determinant of whether the mother's treatment succeeds.

6.3 Which contacts carry the enquiry

The second decision is when, and every serious guideline answers with named contacts rather than a frequency, because a contact already exists in a schedule and a frequency has to be remembered. The NICE guideline on antenatal and postnatal mental health, published in 2014 and last updated in 2020, places the first enquiry at the woman's first contact with primary care or her booking visit, and again in the early postnatal period. Its form matters: the **depression identification questions** are asked inside a general discussion about mental health and wellbeing, not bolted on as a separate screening event, because an enquiry that arrives as a form feels like an audit.

NICE postnatal care guidance, issued in 2021 and updated in 2026, makes assessment of psychological and emotional wellbeing a standing item at every postnatal contact, routes the clinician to the mental health guidance for recognition and referral, and requires concerns to be followed by further assessment and follow-up. Screening thereby becomes part of routine postnatal care, the only form in which it survives a busy service.

ISSUER AND YEAR	WHO ASKS	ANTENATAL CONTACTS	POSTNATAL CONTACTS
NICE, antenatal and postnatal mental health, 2014, updated 2020	Primary care first; then the health visitor and any professional in regular contact	First contact with primary care or the booking visit, then later contacts	The early postnatal period, and contacts through the first year after birth
NICE, postnatal care, 2021, updated 2026	The postnatal care provider; the GP at the timed review	Outside scope	Wellbeing assessed at each postnatal contact; GP assessment 6 to 8 weeks after the birth
ACOG, 2023	The obstetric or well-woman provider	Initial prenatal visit, and again later in pregnancy	Postpartum visits
Australian clinical practice guideline, 2023	The perinatal care provider	As early as practical in pregnancy, repeated at least once later in pregnancy	First postnatal screen 6 to 12 weeks after birth, repeated at least once in the first postnatal year
American Academy of Pediatrics, 2019	The paediatric medical home	Coordination with prenatal providers where depression was diagnosed before birth	The 1-, 2-, 4- and 6-month well-child visits
India	No national requirement to screen; community health workers hold the contacts	Four incentivised antenatal care visits	Two incentivised postnatal care visits, plus institutional delivery

One point in the accompanying comparison is easily missed. These postnatal schedules are timed rather than merely repeated: the Australian schedule sets its first postnatal screen beyond the earliest weeks after delivery, when transient emotional change is expected and a screen would

largely detect that instead, so the timetable itself carries a discrimination the front door would otherwise make unaided.

6.4 Who does the screening, and for how long

The third decision is whose job this is, and the answer is uncomfortable for psychiatry: mostly not ours. NICE names the **health visitor**, with every other professional in regular contact during pregnancy and the postnatal period, defined as the first year after birth, as those who should ask the depression identification questions and the GAD-2 at contacts after the first, and use a rating instrument as part of monitoring. Screening is a repeated act distributed across a workforce, and the psychiatrist sits downstream of it.

The American Academy of Pediatrics gives the answer residents almost never do. Its 2019 policy statement puts postpartum depression screening inside the **paediatric medical home** at the early well-child visits, with three duties attached: coordinating with the prenatal provider where depression was diagnosed before birth, using community resources for the mother's treatment and referral, and supporting the mother-infant relationship including breastfeeding. The logic is attendance: after delivery the appointment reliably kept is the baby's, so the clinician who reliably sees the mother is the baby's doctor.

> **GOOD TO REMEMBER**
>
> A positive screen must be owned by a named person until it is closed, and the guidance builds that in rather than leaving it to goodwill: NICE requires the woman's GP to be told about a referral, and makes wellbeing a standing item at every postnatal contact so the finding is revisited by whoever sees her next. Your equivalent act is to record which contact the enquiry happened at, what the answer was, and who owns the next step.

6.5 The enquiry that no instrument performs

Alongside the depression questions, and frequently omitted, runs a second enquiry that is historical rather than symptomatic. NICE directs that at a woman's first contact with services in pregnancy and the postnatal period the clinician asks about three things:

- any past or present severe mental illness;
- any past or present treatment by a specialist mental health service, including inpatient care;
- any severe perinatal mental illness in a first-degree relative, named as mother, sister or daughter.

Note the strength of the instruction: the depression enquiry is framed as something to consider, this one as something to do. Note also what it is for. A symptom questionnaire describes today, and the women at highest risk here are frequently well when asked. No rating instrument detects a lifetime course or a family history, so this is the only route by which the highest-risk group is identified, and it runs through history-taking rather than screening in the technical sense.

What follows from a positive history does not wait for symptoms. NICE directs referral to a secondary mental health service, preferably a **specialist perinatal mental health service**, for

assessment and treatment of every woman who has or is suspected to have severe mental illness, and every woman with any history of one, whether from pregnancy, the postnatal period or any other time in her life. History alone triggers it, and the GP is told. This period compresses the interval between the first sign of relapse and a dangerous outcome, so the assessment must be in place before the sign appears.

6.6 What actually happens to a positive screen

The fourth decision is the one services skip, and NICE specifies it precisely. A positive answer to either depression identification question, a woman judged at risk, or clinical concern opens two branches, and the clinician chooses:

- use the **Edinburgh Postnatal Depression Scale** or the **Patient Health Questionnaire** as part of a full assessment; or
- refer to her GP, and to a mental health professional if a severe mental health problem is suspected.

Two structural points follow and they are the heart of this topic. The instrument is the second step of the pathway, not the first: the screening act is the conversational enquiry, and the rating scale enters afterwards, inside a full assessment, in a woman who has already said something. A service that inverts this hands the questionnaire out at a desk and scores it without a conversation. Referral is also an alternative to using the instrument rather than a consequence of it, which matters wherever the person who detects the problem is not the person who will assess it.

These notes name the instruments and stop there. What an examination can fairly ask is where an instrument sits in the pathway, who administers it, and what its result may decide.

TRAP **Starting an antidepressant on the strength of a positive depression screen.** ACOG requires screening for **bipolar disorder** before pharmacotherapy for depression or anxiety is initiated, if it has not already been done. This is a sequencing rule inside the pathway rather than a fact about either illness, and it is the front door's most consequential ordering decision: a depression screen is cross-sectional and knows nothing of lifetime course, so a pathway beginning with a positive screen can end in a precipitated episode of a different kind.

6.7 The intervals that make a positive screen mean something

A pathway with no clock is an aspiration. NICE attaches two intervals to a perinatal mental health referral: assessment for treatment within **2 weeks** of referral, and psychological interventions within **1 month** of the initial assessment. Both sit in the same guidance as the screening recommendations: the body that tells you to ask also tells you how fast you must answer for the reply.

They are short for a reason. The perinatal year is a moving target: the infant's developmental window does not pause while a waiting list clears, the mother's capacity to attend falls as the illness progresses, and the contact through which she was detected expires on its own schedule. A

wait unremarkable in general adult practice is useless here, because by the time it is reached she is no longer attending the service that found her.

4	6 to 8 weeks	0.05	1.2
MINIMUM SCREENING EVENTS ACROSS THE PERINATAL YEAR, AUSTRALIAN GUIDELINE	AFTER THE BIRTH, THE GP POSTNATAL ASSESSMENT, NICE	PSYCHIATRISTS PER 100,000 POPULATION, MADHYA PRADESH, LOWEST REPORTED	PSYCHIATRISTS PER 100,000 POPULATION, KERALA, HIGHEST REPORTED

6.8 The Indian position: the contacts exist, the instruction does not

Everything above describes systems that have decided to screen. India has not, and the absence is documented rather than assumed. A systematic review of Indian national maternity and mental health policies and programmes concludes that they appear not to consider perinatal mental health at all; its search yielded **11** relevant documents and no peer-reviewed publications, and identified no specific national policy or programme on maternal mental health. A policy analysis records that the **National Mental Health Policy**, launched in 2014 with a stated focus on vulnerable populations and de-stigmatisation, still fails to include perinatal women among the populations named as susceptible. Promising initiatives exist at state level; where they do not, need goes unrecognised and unmet.

Why the referral limb is the harder problem. Citing the national mental health survey of 2015 to 2016, the same analysis reports that every state except Kerala fell below the benchmark of **one psychiatrist per 100,000 population**, the reported figures spanning more than an order of magnitude between lowest and highest. Those figures are quoted in a policy analysis rather than read from the survey report, and are best taught as reported rather than settled. The conclusion does not turn on the decimal place: the referral limb every Western pathway assumes cannot exist at scale across most Indian states. That argues for a pathway built on task-shifted first-line management and brief psychological intervention by trained non-specialists, with specialist referral reserved for severe illness and for the history-based enquiry above. It is not an argument against screening; it is a decisive argument against installing an instrument and calling it a service.

IN INDIA

The contacts exist and are already funded. Cash benefits attached to four antenatal care visits, two postnatal care visits and institutional delivery create windows in which a woman is present, expected and identifiable, and the authors propose them as the natural sites at which healthcare workers could screen for perinatal mental illness. The workforce exists too: **accredited social health activists**, auxiliary nurse midwives and staff of primary and community health centres, credited by the same authors with the country's falling maternal and infant mortality. What is missing is the instruction to ask, and a named destination for the answer.

A perinatal screening pathway is judged by what happens in the fortnight after a positive answer, never by the instrument that produced it.

7 · Postpartum psychosis (presentation, emergency management)

Why it matters clinically. Nearly every other perinatal presentation is answered with an appointment. This one is answered with a clock, and the second patient in the room cannot report anything. What the service owes her is a same-day assessment by somebody with the authority to admit, a decision about where she sleeps tonight, and a written answer to who is holding the baby meanwhile. What postpartum psychosis is, how it declares itself and how its phenomenology separates from its neighbours belong to the Other psychotic disorders, delusional syndromes and catatonia notes, which own it as a psychotic disorder.

The examination question has the same shape: what you do, in what order, on whose authority, and where she and the baby go next. Candidates lose the marks by preparing it as a description and meeting it as a disposition. Every decision below is made for two patients at once, the frame set out where prescribing in pregnancy is taken up in these notes.

7.1 The classification that removes the discretion

The 2023 ACOG clinical practice guideline on mental health conditions during pregnancy and the postpartum classifies this presentation as an **obstetric and psychiatric emergency**, and as a severe mental health illness. The dual assignment is the operative part: it belongs to two services at once, so neither can hold it as a referral to the other and wait. It also sets a default for the time when you are still uncertain, since the trigger for everything that follows is a patient with possible or probable postpartum psychosis, not a confirmed one, which puts the threshold for acting below the threshold for diagnosing.

TRAP **Each service assumes the other owns her.** The obstetric team sees a psychiatric problem in an obstetric bed; the psychiatric team sees a recently delivered woman with a wound, a fundus and a feeding infant. The referral moves sideways while the clock runs, and both sets of notes honestly record that they referred on. Begin the act, then call the other team.

7.2 What "immediate" means once somebody writes it down

NICE guideline CG192 on antenatal and postnatal mental health, published in 2014 and last updated in 2020, is where the word acquires a number. A woman with sudden onset of symptoms suggesting postpartum psychosis is referred to a secondary mental health service, preferably a **specialist perinatal mental health service**, for immediate assessment **within 4 hours of referral**. No other perinatal presentation in that guideline carries a response time counted in hours. An emergency nobody has timed cannot be audited.

Three details are worth holding apart. The trigger is sudden onset of symptoms, so the referrer need not have made the diagnosis. The destination is a service, not a named individual, which puts the problem of finding somebody free on the receiving end. And the interval is a time to assessment, not to admission: it promises a competent pair of eyes, not a bed.

Assessed within 4 h	A psychiatric emergency	Staffed round the clock, all week
NICE CG192 STANDARD AFTER REFERRAL OF SYMPTOMS SUGGESTING THIS PRESENTATION	THE CLASSIFICATION THAT REMOVES THE DISCRETION, AND WITH IT THE OPTION OF A ROUTINE APPOINTMENT	DEDICATED MULTIDISCIPLINARY STAFF ABLE TO CARE FOR MOTHERS AND BABIES

Two honesties belong with that number. It and the postnatal window below are English NHS guidance, quoted with their owner attached rather than as a domestic obligation; no Indian national counterpart was available for the four-hour standard, and none requiring that the destination be a specialist mother and baby unit. The joint-admission default itself is a different matter and is NOT a gap: it is Indian statute, restated in Indian guidance, and it is taught with psychiatric emergencies in pregnancy and the postpartum period in these notes. And no source here states an observation cadence for the stretch between referral and assessment, so that gap is left open rather than filled with a plausible frequency.

7.3 The act at the point of contact, and the two rules about the infant

ACOG sets out the immediate act in one passage, written for whoever is standing there. The clinician encountering possible or probable postpartum psychosis obtains an **emergent psychiatric consultation**, or otherwise connects the patient with emergency medical or emergency mental health services; the condition then requires immediate emergent evaluation, admission and treatment, to assure the safety of the patient and the infant together. **Intensive monitoring** is required, and the guideline names what it is for: the risk of suicide and the risk of infanticide. No source available here attaches an interval or content to that monitoring, so it is left unstated rather than invented. Risk assessment as a framework belongs to the Somatic-symptom, sexual, impulse-control disorders and suicide notes; infanticide is a risk to ask about here, its classification belonging to the Mental health legislation and forensic psychiatry notes.

Two supervision rules close the passage: the patient should not be left alone, and she should not be left unattended with the infant. They are separate rules, and the second is not a separation order. It says the pair are not to be by themselves together, which a third person in the room satisfies, and it is compatible with feeding, holding and ordinary contact.

MNEMONIC

Never alone, never alone with the baby

The first covers the mother's safety, the second the infant's, and the second is about who else is present rather than where the baby is. Both bite from the moment the presentation is suspected: before the assessment, before the bed, before anyone has agreed a diagnosis.

7.4 What the admission actually buys

An admission is justified by what it delivers, and here that is a medical evaluation which cannot be completed in a corridor. Read the list below as an EXCLUSION SET rather than as a benefit of the bed: the question it answers is whether this presentation is organic, and that question is opened at the door and merely finished on the ward. The bedside acts that come first, and the order they come in, are set out with psychiatric emergencies in pregnancy and the postpartum

period in these notes. The **psychiatric inpatient evaluation** is described as one that may include:

- physical examination, and head imaging;
- complete blood count, and a complete metabolic panel;
- thyroid-stimulating hormone level, and ammonia level;
- lumbar puncture and electroencephalogram, which some clinicians add and others do not.

The strength is permissive: it may include these things, not must, and converting it into a compulsory battery invents a standard. No sequence, turnaround time or action threshold is given, and none is supplied here from memory. Each item needs a patient who stays put and a team that will chase the result, so an emergency department can start this work and only an admission finishes it. Treat the workup and the sedation decision as one plan with one owner: an evaluation abandoned because the patient was too disturbed, and never diarised again, has excluded nothing.

7.5 The risk formulation that has two subjects

At the first Indian mother and baby unit the admission decision is a formal step: every mother-infant dyad is assessed by the team for suitability, and that assessment has named limbs.

- a structured risk assessment covering self-harm and harm to the infant, carried out with a structured instrument, the **Formal Initial Risk Assessment for Mothers And Babies**, named here and not reproduced;
- infant health details;
- ruling out medical conditions in the mother;
- assessment of problems related to breastfeeding.

The shape of that list is the teaching: two limbs are about the baby and a third about the pair. A formulation that speaks only of the mother is not an abbreviated version of the right one but a different one, and it cannot answer what the team must close before admission, which is whether these two can safely be in a room together and on what conditions.

The 2023 Australian clinical practice guideline gives the test in usable form. Co-admission may not be appropriate for women who are severely unwell and incapable of caring for the infant, or where the safety of the infant may be compromised. Those are two independent gates, capability and danger, and they recover on different timescales, so collapsing them into one impression of how unwell she looks loses the decision. Against them sits the benefit the same guideline names, since co-admission assists the development of **mothercraft skills** and of a positive relationship with the infant.

GOOD TO REMEMBER

A supervision plan that names nobody is not a plan. Record who is with the mother now, who is with the infant now, who takes over at the next handover, and what would change the arrangement. The rules being absolute, the only variable is which named adult discharges them at any hour, and that is what goes missing between shifts.

7.6 Where she goes, and where the burden of proof sits

The destination is a decision, not a vacancy. The default is that mother and infant are admitted together, and separation is the deviation that has to be argued for, authored, dated and reviewed rather than arrived at because no cot was free. That is the whole of what this topic needs from the destination question, and it is the part a candidate is examined on: not what a specialist unit contains, but who carries the burden when one is not available.

What such a unit is, what its presence changes, the service specification behind it, the Indian answer to who cares for the infant while its mother cannot, and the availability position in this country are all set out with lactation and mother-baby unit care in these notes. This topic does not restate them, because a destination described twice in one chapter drifts, and the two accounts then disagree about the thing a reader most needs to be sure of.

The Indian statutory position on rooming-in and on the review clock that governs any separation is a different matter again, and it is not guidance but law. It is taught with psychiatric emergencies in pregnancy and the postpartum period in these notes. A clinician who separates a mother from her infant in India is working inside a statutory framework with an interval and a ceiling that are not the team's to set.

RULE **Joint admission is the default and separation is the deviation.** The clinical question is never whether to justify keeping them together; it is whether the reasons for parting them are good enough to be written down and reviewed.

7.7 The handover, and what this section hands on

What the receiving team needs is not the mental state examination, which they will repeat, but what is hard to reconstruct: when the clock started, what the risk assessment covered on both sides, who has been supervising each of them and under what instruction, and the reason for the destination chosen. A handover carrying the diagnosis but not the supervision plan has passed on the label and dropped the safety.

Three boundaries are worth naming. What changes about every other emergency when the patient is pregnant or newly delivered is taken up in the section of these notes on psychiatric emergencies in pregnancy and the postpartum period, which is built around this presentation. What the unit does across the rest of the admission sits with the section on lactation and mother-baby unit care, and agent selection in a breastfeeding woman with the section on drugs in breastfeeding, a decision that follows the destination rather than preceding it.

Postpartum psychosis is acted on before it is confirmed: same-day assessment by a service that can admit, an admission that buys the medical evaluation, and a supervision plan naming an adult for the mother and an adult for the infant, written before either is left alone.

8 · Mother-infant bonding and infanticide risk

Why the marks are here. A woman can be profoundly depressed after childbirth and remain warmly, competently attached to her baby. Another can pass every mood enquiry you put to her and feel nothing at all for hers. Almost every clinical error made in this area comes from assuming that one of those two sentences is impossible. The depressive syndrome itself, its specifier, its epidemiology and its first-line treatment belong to the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes. What is owned here is the relationship: how the bond is elicited and observed at the bedside rather than inferred from the mood, how far along the rejection and hostility gradient a given mother has travelled, and what the resulting formulation obliges you to arrange for the infant before she leaves your care. Every decision here is made for two patients at once, as the sections on prescribing in pregnancy set out, and the infant is the patient who cannot be interviewed.

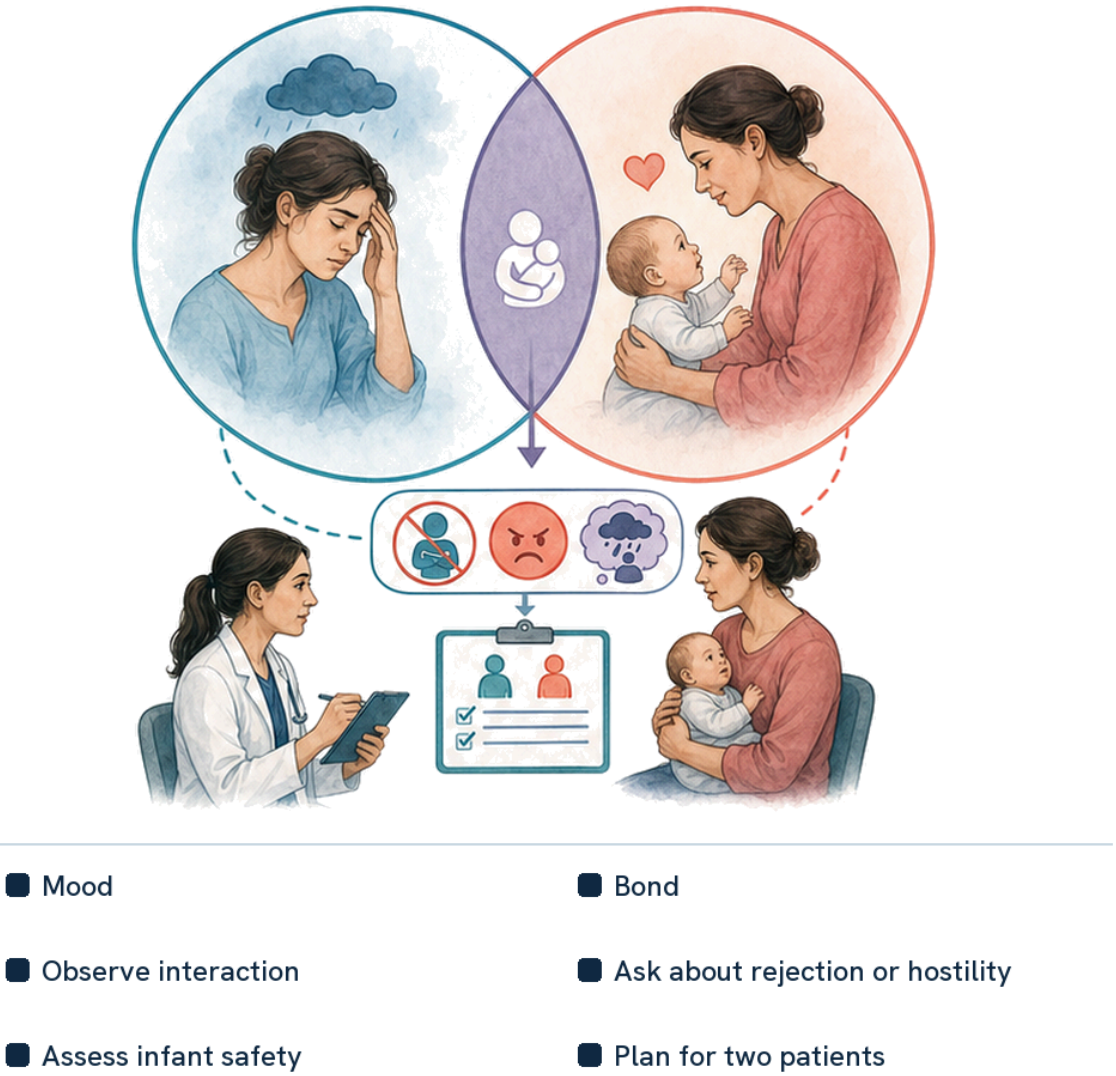


Fig 28.6 Maternal mood and the mother–infant bond are related but not interchangeable. Assessment elicits and observes the relationship directly, asks about rejection, hostility and thoughts of harm, and makes a safety plan for both mother and infant.

Infanticide enters this topic in one form only: as a risk to be asked about and acted on. The classification of filicide and neonaticide, and its forensic frame, belong to the Mental health legislation and forensic psychiatry notes, which also carry postpartum psychosis as the illness context in which infanticide is conventionally taught. That taxonomy is named here and not reproduced, for a clinical reason: a classification of completed acts is a retrospective instrument built for courts, and it does not tell you what to ask the woman in front of you on a postnatal ward.

8.1 Separate the bond from the mood before you ask anything else

The argument for treating a disturbed mother-infant relationship as an entity in its own right, rather than as a symptom of postnatal depression, opens with a claim about where the feeling points. A disturbed relationship is a distinct phenomenon whose **affective focus** differs from that of depression. That word carries the whole argument. Depressive affect is diffuse and self-

referred: everything is grey, and the woman herself is the worthless object. The affect of a bonding disorder is aimed, and it is aimed at one specific person who is in the room.

The claim is then supported in both directions, which is what makes it a dissociation rather than a preference. In one direction, maternal aversion to the infant is often disproportionate to depression and can occur without it. That half obliges you to ask about the bond in a woman whose mood enquiry is entirely negative, and it is why a depression instrument can never serve as a bonding instrument: it is not measuring the thing. In the other direction, only a minority of depressed mothers have a relationship problem with their infants, and what follows is both a clinical instruction and an ethical one. Select that minority for special treatment. Do not stigmatise the rest. Assuming that a depressed mother is a poorly bonded mother is wrong most of the time and harmful every time it is wrong, because the assumption reaches the woman, her family and often her notes.

The figure that makes the argument operational comes from women already diagnosed with postnatal depression, among whom a bonding disorder was present in **29%** of those depressed mothers. It sits in the right place to be useful: high enough that the bond must be asked about in every depressed mother, and low enough that it cannot be assumed in any of them. Two caveats travel with it: it is reported in a later paper citing an earlier study rather than generated by the paper that carries it, and it describes women referred for psychiatric help rather than a community.

RULE **Mood and bond are separate endpoints, so they are enquired about separately, recorded separately, and recovered from separately.** A mood enquiry that comes back negative has excluded a mood disorder and nothing else. A mood enquiry that comes back positive has raised the prior probability of a bonding disorder and settled nothing. In practice this means two passes at the same interview: one about how she feels in herself, one about how she feels towards this baby, in that order, because the second is harder to disclose and comes more readily once the first has shown that you are not there to judge her.

There is a genuine counter-position, and an examiner may know it. In the founding series, postnatal mental illness and recalled severe pain during labour were both significantly associated with these disorders, which in their severe forms did not occur in the absence of postnatal mental illness. Taken at face value that makes severe bonding disorder a complication of illness rather than an independent entity. The sampling caveat is load-bearing: the cohort was recruited among women who had suffered postnatal mental illness, so it was structurally incapable of demonstrating severe bonding disorder without it. The safe answer states both positions and says why they cannot be compared directly.

8.2 Establish that the disturbance belongs to one child

The clinical description that founded the field came from a series of self-selected women who reported absent affection, sometimes frank hate, rejection, neglect or impulses to harm, in relation to at least one of their children. Two features of it do the diagnostic work. The feelings often began immediately or very shortly after the birth, so this is not the slow erosion of a relationship across months of exhausted parenting. And, with a single exception in the whole

series, they were **specific to one child**, which is what produced the term maternal bonding disorder rather than any language about parenting capacity or personality.

Child-specificity is the most useful discrimination available at the bedside and the one a candidate most often misses. A woman who is affectionate with her older child and cannot bear to hold her newborn does not have a parenting problem or a failure of character. She has a disorder of one relationship, and the intact relationship sitting beside the disordered one is the evidence. It also reframes the conversation, because a mother who believes she is being assessed as a mother will conceal, while a mother who understands that you are asking about one particular bond will often tell you. So ask it plainly: whether she felt like this with her other children, and what is different about this one.

What the disorder contains has been described consistently across the literature: a distressing lack of maternal feeling, irritability, hostility and aggressive impulses, pathological ideas, and outright rejection. The list runs from an absence to an action. The absence, that flat and frightening nothing where the mother expected to find love, is the least likely to be volunteered without a direct question, because it carries more shame than any symptom in perinatal psychiatry. Its distressing quality matters diagnostically: these women are not indifferent to their indifference, and a mother who reports the absence with no distress about it is describing something else.

8.3 Place it in the classification, and know why it is missing from yours

A construct with a substantial clinical literature, a structured interview and inpatient admissions attached to it is nonetheless absent from most residents' differentials, and the reason given by the field's own originator generalises. Writing in 2004, he attributed the neglect of these disorders principally to their absence from ICD-10 and DSM-IV. That is a dated statement, since both classifications named in it have since been superseded. The mechanism it describes is not dated at all: a phenomenon with no code is not counted, so it is not audited, so it is not commissioned for, so it is not taught, so it is not looked for.

The current classificatory position is a partial answer at best. The nearest available category is **caregiver-child relationship problem**, defined as substantial and sustained dissatisfaction within a caregiver-child relationship, including a parental relationship, associated with significant disturbance in functioning. Read that against the clinical picture and the gap is obvious. Dissatisfaction and functional disturbance are captured; rejection of the infant is not, and pathological anger directed at the infant is not. The old complaint has been answered in form rather than in substance, and a candidate who says so, having quoted the definition accurately, is showing the judgement these questions are set to find. One limit is declared rather than hidden: that definition came from a coding reference mirroring the classification rather than from the classification's own browser, so the alphanumeric code is not printed here and should be verified at source.

The practical consequence is that nothing in the record will prompt you: no box to tick, no code that triggers a review. The enquiry has to be made deliberately, in free text, and a unit that wants

it done reliably must build the prompt into its own postnatal proforma.

8.4 Ask about rejection and about anger, in the words the literature uses

The gradient is useful only if it is expressed as behaviour a clinician can ask about by name, and it is. At the severe level of rejection the mother may try to escape; may seek permanent transfer of infant care within or outside the family; may express the wish that the baby be stolen, or succumb to cot death. Those last two are what candidates most often fail to ask about, because they sound too extreme to raise, and they are exactly what a woman will confirm if asked plainly and never volunteer. The question is not whether she wants to harm the baby. It is whether she has found herself wishing the baby were simply gone, by any route, including one that would not be her doing.

Presented separately in the same account, and the separation matters, is **pathological anger**: shouting, cursing or screaming at the infant, accompanied by impulses to strike, shake or smother the child. It is tempting to read them as two points on one severity scale, with anger further along. They are not described that way. **Emotional rejection**, the core concept of a bonding disorder, and pathological anger, which may harm the baby, can coexist, but they have different clinical features and require different intervention strategies. They are elicited by different questions, and the inference each supports differs: rejection points towards neglect, deprivation and relinquishment of care, anger towards an assault that could happen tonight. That last reading is clinical inference from the two descriptions rather than a sourced finding, and should be offered as such.

The category ladder and its proportions come from over 200 mothers referred to services in Birmingham and Christchurch, all interviewed with a semi-structured interview. **Established rejection** was present in **10.6%** of those referred mothers and threatened rejection in a further **14.6%** of them, while pathological anger of some degree was present in **28.6%** of the same referred mothers and was severe in 8.3% of them. Quote these with their denominator attached every time: they describe women already referred to specialist perinatal services, and an answer offering them as population prevalences has misread the study rather than merely rounded it.

CATEGORY ON THE GRADIENT	WHAT THE MOTHER DESCRIBES OR IS SEEN TO DO	WHAT IT SHOULD MAKE YOU ASK NEXT	WHAT IT CHANGES TODAY
Threatened rejection	Rejection voiced or approached rather than settled into. The source separates it from established rejection but does not describe its behaviours, and none are supplied here	What would have to happen for the threat to become a request, and whom she has already told	Frequency of contact, and whether the family have begun arranging a transfer of care
Established rejection	Attempts to escape; seeking permanent transfer of infant care within or outside the family; expressing the wish that the baby be stolen, or succumb to cot death	Who is physically caring for the baby now, and what happens when she is alone with the infant	Whether the infant's daily care can rest on her at all, and who else is named to provide it
Pathological anger	Shouting, cursing or screaming at the infant, accompanied by impulses to strike, shake or smother the child	Whether an impulse has ever come close to an act, what stopped it, and whether that brake still holds	Whether the infant can be unsupervised with her tonight, which is a disposition question rather than a formulation question

The two antenatal openings. The same referred series found rejection strongly associated with unwanted pregnancy and lack of interaction with the foetus. Both are askable before delivery, in an ordinary antenatal consultation, in ordinary language: whether this pregnancy was wanted, and whether she talks to, thinks about or has any sense of the baby she is carrying. That converts a postnatal problem into an antenatal enquiry, which is the only point in the pathway where anything can be arranged before the relationship starts badly.

8.5 Assess the relationship at every postnatal contact, and decide who supplies the information

The guideline-level bedside method is short enough to memorise and worth memorising. NICE guidance on antenatal and postnatal mental health, published in 2014 and last updated in 2020, requires clinicians to recognise that some women with a mental health problem experience difficulties with the mother-baby relationship, and to assess the nature of that relationship at all postnatal contacts along three named axes: verbal interaction, **emotional sensitivity** and physical care. It further requires that the woman's own concerns about her relationship with her baby are discussed, and that information and treatment for the mental health problem are provided. Read those last two duties as concurrent rather than sequential: the relationship is not parked until the illness is treated.

Its economy is the point. Verbal interaction is whether she talks to the baby at all, and in what register. Emotional sensitivity is whether she reads and answers the infant's signals, or handles a distressed baby as an object to be managed. Physical care is whether feeding, changing and

holding are done, and how. None of it needs an instrument, a room or an appointment, and all of it can be recorded in a line.

MNEMONIC

Ask her, watch them, ask them

The three sources of a bonding picture. **Ask her**: her own account of how she feels towards this baby, taken separately from the mood enquiry and after it. **Watch them**: the dyad observed directly, across the named axes, including what happens at separation. **Ask them**: the relatives and nursing staff who have watched the pair across a whole day and night. No single source is sufficient, and disagreement between them is data rather than noise.

Where a structured route is wanted, a semistructured interview containing a specific section for assessing perinatal bonding disorders exists in the form of **the Stafford Interview**, developed by the same author who advanced the construct. Where a self-report route is wanted, **the Postpartum Bonding Questionnaire** is the named instrument in this literature. Both are named here and nothing is reproduced from either: no item, no probe, no scoring rule, no threshold. An instrument reproduced piecemeal in a revision note gets used piecemeal in a clinic, and a bonding measure administered without its scoring yields a number that feels like a finding.

The important design question is not which instrument but who supplies the information. At the mother and baby unit at NIMHANS, Bengaluru, described in 2015, an objective bonding instrument was used to assess maternal infant safety, psychotic ideas about the baby, maternal care toward the baby and other aspects of maternal behaviour toward the infant, based on family and nurses observations rather than on what the mother said about herself. That is the only workable method in a woman too unwell to give an account, or too frightened of losing her baby to give an honest one, and those groups include most of the mothers about whom the question matters.

What that observation consists of was set out concretely by the same unit in a later outcome series, reported in 2021. Each mother-infant dyad was observed for:

- care for the baby's basic needs;
- affectionate behaviour;
- significant incidents;
- an overall assessment of safety;
- how the mother handles separation from the baby;
- whether the mother has been separated from the baby in recent days, and the reasons for it.

The last two are what a Western checklist usually omits and what carries most information in an Indian ward, where separation is often arranged informally by relatives long before a clinician has been asked. A mother relieved by separation, a mother distressed by it and a mother who does not register it are not the same formulation, and eliciting the difference costs nothing beyond a nurse who writes down what she saw.

ROUTE	WHO SUPPLIES THE INFORMATION	WHAT IT CAPTURES WELL	WHERE IT FAILS
The woman's own concerns, raised at every postnatal contact	The mother	The distressing absence of feeling, which nothing else detects, and her own reading of the relationship	Shame, and fear of losing the baby, both of which suppress disclosure
Direct observation of the dyad along the named axes	The clinician at the contact	Verbal interaction, emotional sensitivity and physical care, in minutes and with no equipment	A single brief window, and a mother who knows she is being watched
Structured clinical interview with a bonding section	The mother, with a trained interviewer	Category assignment on the rejection and anger gradient	Training and time; unavailable in most general settings
Third-party observational rating	Relatives and ward nurses across a whole day	Infant safety, care actually delivered, incidents, and behaviour at separation	Observer variability; needs a ward and a habit of recording

PITFALL

A reassuring self-report bonding questionnaire in a floridly unwell or a frightened mother is not reassurance, and filing it as such is the commonest way this assessment passes on paper while failing the infant in fact. Self-report assumes a respondent who can introspect and who believes that answering honestly is safe. A woman with active psychotic illness may satisfy neither condition, and a woman who has worked out that her answers decide whether she keeps her baby will satisfy the second only if you have told her, credibly, what happens next. Where self-report and observation disagree, the observation is the safer document, and the disagreement itself belongs in the notes.

8.6 Formulate the risk, and make the intrusive-thought discrimination first

Guideline risk assessment in the perinatal period is carried out with the woman and, if she agrees, her partner, family or carer, and is focused on self-neglect, self-harm, suicidal thoughts and intent, risks to others including the baby, smoking, drug or alcohol misuse, and domestic violence and abuse. The baby is written inside the risks to others limb, in a parenthesis, rather than given a heading of its own. That drafting is exactly how an infant gets missed by a clinician working down a proforma at speed, and it is why a bonding formulation has to be conducted as its own act rather than trusted to appear inside a general risk assessment.

What the formulation must consider is set out probabilistically and should be repeated in that register. The risks are higher in mothers with a disorder of the mother-infant relationship, and emotional deprivation, impaired cognitive and personality development, child abuse, child neglect and infanticide are probably commoner in this group. That is probability rather than established fact, and reproducing the hedge is what allows infanticide to sit among the outcomes to be asked about and acted on, rather than becoming the headline that turns every disclosure of

maternal ambivalence into a child protection emergency. The slow outcomes on that list happen far more often, and a formulation attending only to the dramatic one will miss the ones already under way.

The discrimination on which the whole formulation turns is between an intrusive thought and a psychotic idea. In its clinical practice guideline on screening and diagnosis of mental health conditions during pregnancy and postpartum, issued in 2023, the American College of Obstetricians and Gynecologists states that **intrusive thoughts** not associated with psychosis are common, that they can indicate severe distress and severe illness associated with depression, anxiety and obsessive-compulsive disorder, and that they most often do not indicate risk of actual harm to the infant, although they do merit further inquiry and evaluation. The discriminator is whether the thought is ego dystonic and distressing to her: an unwanted image of the baby being dropped, which horrifies her and which she manages by avoiding the stairs, marks illness severity rather than danger. Note the clause that survives the reassurance: common and non-predictive is not the same as ignorable.

TRAP **Reading a disclosed ego-dystonic intrusive thought of harm as evidence that the baby is in danger, and separating them on it.** The error is costly in both directions. The mother who has just described the most frightening thing in her head, having been told it was safe to speak, watches her infant removed, and she will not disclose again. Meanwhile the presentation that genuinely warrants urgency, an idea about the baby held with conviction and without distress, is quieter, is not offered spontaneously, and is missed by a clinician whose alarm has already been spent. Distress about the thought is reassuring; conviction is not; the enquiry continues either way.

8.7 Convert the formulation into supervision, surrogate care and a discharge plan

A bonding assessment that does not alter a plan has not been done, and there is Indian inpatient evidence for both of the ways it alters one. First, the disorder can stand alone as a reason for admission. In the Indian mother and baby unit series, three mothers were admitted for a primary mother-infant bonding disorder that was independent of the psychiatric problem. That is a small absolute number, offered as a demonstration that the category exists in practice rather than as a frequency estimate. Its force is that the bonding disorder was severe enough to justify an inpatient bed in its own right, in an Indian setting, without a mood or psychotic illness driving it.

Second, and more useful for everyday work, the bonding rating generates the discharge plan. Among 98 dyads in that unit who needed mother-infant bonding interventions, bonding was rated as normal at discharge in 88 of those mothers, while ten of those dyads needed close supervision or **surrogate infant care** even at discharge. Most dyads who need bonding work respond to it, which is the reason to do the work rather than plan around the relationship failing. A minority do not, and for them the discharge summary must name a person: who is supervising, when, and what specifically they are supervising against. A plan that says the family will help is not a plan. What a joint mother-and-baby admission is for, and how available such a facility is, is a separate question not taught here.

IN INDIA

Most of the assessment table assumes a service the average Indian unit does not have. A dedicated joint admission facility exists in very few centres, which leaves the method needing nothing but a ward, a nurse and the habit of writing down what was seen. In most Indian wards the person continuously with the mother and baby is a relative rather than a nurse, which makes third-party observation unusually available and unusually unreliable at once, since the relative may be the one who wants the baby transferred, or the one who will be blamed if anything goes wrong. Ask them separately, and record who said it. The same reality shapes the discharge decision: where close supervision or surrogate infant care is needed, the surrogate will almost always be a family member, so the plan names the individual, confirms that they have agreed, and sets a review date, rather than assuming a joint family absorbs the problem.

8.8 Re-examine the bond after the mood has recovered

The last act is the one most often skipped, and it is a timing rule rather than a technique. Where bonding difficulties are prominent, the instruction is to attend to the relationship problems in their own right and to assess whether they are still present beyond the recovery from depression. The timing is the whole of it: the re-assessment comes after mood recovery and not at the same sitting, because before recovery you cannot tell how much of the flatness towards the baby is the depression speaking. Treat the illness, look again at the bond, and treat what is left as a target in its own right. No interval is given in the source used here, so this is taught as a sequence and not as a number of weeks.

Indian prospective inpatient data make the same point as a null result. In dyads admitted to a mother and baby unit and assessed at admission, at discharge and again at follow-up, there was no correlation between maternal psychopathology and mother-infant bonding. The translation should be said plainly to teams: the woman whose psychosis has resolved is not thereby a woman whose bond has recovered. Symptomatic recovery and bonding recovery are separate endpoints, they move independently, and discharging on the first without measuring the second is a decision taken on the wrong variable.

GOOD TO REMEMBER

Book the second look before you need it. At the moment the mood is treated and discharge is being discussed, write two things into the plan: when the bond will be re-examined after recovery, and the named person who will do it. Both are trivial to record on the spot and impossible to reconstruct afterwards; without them the re-assessment becomes a good intention nobody owns. If the mother is going home to a district where nobody will see her again for months, make the re-assessment the stated reason for the follow-up appointment rather than bolting it onto a medication review.

29%	10.6%	14.6%	28.6%
OF MOTHERS DIAGNOSED WITH POSTNATAL DEPRESSION HAVE A MOTHER-INFANT BONDING DISORDER	ESTABLISHED REJECTION, AMONG OVER 200 MOTHERS REFERRED TO SPECIALIST SERVICES	THREATENED REJECTION, AMONG THE SAME REFERRED MOTHERS	PATHOLOGICAL ANGER OF ANY DEGREE, AMONG THE SAME REFERRED MOTHERS

A depression screen is not a bonding enquiry: ask about the mood and the bond separately, ask about the bond again after the mood has recovered, and let the answer to that second question, not the first, decide who is watching the baby at discharge.

9 · Lactation and mother-baby unit care

Why the marks are here. Ask a candidate what to do for a severely ill woman three weeks after her delivery and the answer arrives as a drug. Ask where she is to be nursed, who holds the baby while she is sedated, who decides whether the baby stays with her, and who picks up the telephone six weeks after she goes home, and the answer usually stops. That second set of questions is what this section owns: what a mother-baby unit is, what it is asked to do, how the joint admission and separation decisions are made and remade, what is physically done for a feed during acute treatment, and what an Indian team assembles when no such unit is within reach. Which drug to choose for a lactating woman is a different question with its own metric, and it belongs to the topic on drugs safe in breastfeeding in these notes.

Carry one idea through the section. A mother-baby unit is not a psychiatric ward that tolerates an infant on the premises. It is a service with a written specification, and every clause of it exists because something predictable goes wrong when it is missing.

9.1 The specification, and why each clause earns its place

The structural definition used by the Indian group that built the country's first such service is deliberately spare, and it teaches better than any description of the atmosphere on the unit. A mother-baby unit is an inpatient psychiatry service with at least **four** beds, physically separate from the other wards, configured for **joint admission** of the mother along with her baby, and staffed round the clock, every day of the week, by dedicated multidisciplinary staff who look after both of them.

Each clause earns its place. A minimum bed number exists because a smaller service cannot hold a rota, and one or two cots on an acute open ward is a gesture that collapses the first time the ward is full. Round-the-clock staffing matters because the hours in which an acutely unwell newly delivered mother is least able to care for her baby are the night hours, exactly when a general ward runs thinnest. And staff who care for both is what separates the model from every imitation of it: without someone competent and rostered to notice the baby is unwell, the service has an infant on the premises and nobody accountable for that infant.

What the unit is *for* is a separate specification from what it *is*, and the functional one is what candidates omit. Such a unit is expected to encourage breastfeeding, deliver specific interventions for parenting, provide psychotherapy, work on the mother's relationship with her infant, and educate her about the current illness and about preventing the next one; it must also support the spouse and caregivers and involve social services where the infant is at risk. Treating the mother's illness does not appear on that list, because treatment is the assumption rather than the purpose. The purpose is that a functioning dyad leaves the hospital, and a unit discharging a well mother and a relationship nobody has worked on has done the ward's job and not the unit's.

The English service guidance adds the limbs that make the specification auditable rather than aspirational. Specialist perinatal inpatient services should provide facilities designed specifically for mothers and babies, be staffed by specialist perinatal mental health staff and staffed to care appropriately for the babies, liaise effectively with general medical and mental health services, have the full range of therapeutic services available, and be closely integrated with community services so that continuity is preserved and the stay kept short. The last two limbs are what a new service forgets: without a therapeutic programme a unit is an admission ward with cots, and without community integration it produces long stays because there is nowhere safe to discharge into.

RULE **Joint admission is the default and separation is the deviation that has to be justified, recorded and reviewed.** Almost every ward runs the opposite assumption without ever having decided to, because the infant is not the ward's patient. The English guidance inverts it explicitly: a woman needing inpatient care for a mental health problem within 12 months of childbirth should normally be admitted to a **specialist mother and baby unit**, unless there are specific reasons for not doing so. Read that for its grammar: the burden of argument sits on whoever proposes to separate the pair, and that direction is worth more in an answer than the recommendation itself.

9.2 The arithmetic that decides whether such a unit can exist near you

Residents in India are routinely taught that mother-baby units are scarce here, in a tone implying the scarcity is a national failing. The service-planning parameter behind the model explains most of it. The same English guidance specifies that each **managed perinatal mental health network** should have designated specialist inpatient services covering a population in which there are between **25,000 and 50,000** live births a year, varying with the local rate of psychiatric morbidity.

The catchment for one unit is therefore defined by births rather than headcount or distance, and it is a large number of births. A service with that denominator is by construction regional or tertiary, never a district service, and it will sit in a handful of centres in any health system that builds it at all. So most severely ill postnatal women anywhere, and the overwhelming majority in India, will be treated by clinicians who have no mother-baby unit and never will. The model is therefore taught not as an ideal but as a specification you can partially reproduce, and the defensible answer to a district planning question names the unit as the regional referral destination and spends its words on what the district builds instead.

9.3 Who comes through the door, and what the case-mix demands of the design

The published series from India's first unit gives the denominator a resident actually needs. There were 237 admissions across a little over four years from July 2009; the mothers had a mean age of 24.25 years and a mean of 6.50 years of education, and most came from lower socio-economic status and rural backgrounds. Most of them, 80 per cent, stayed for three to four weeks, and the mean length of stay was 17.23 days.

That profile should change how the unit is run rather than merely being recited. Women admitted for weeks from rural homes with minimal schooling cannot be handed written

psychoeducation and a follow-up card and be expected to return: the family that travelled with them is part of the treatment and of the discharge plan. A stay of weeks is also long enough for a feed to be established or lost, which is why lactation here is an active programme and not a courtesy.

The risk case-mix dictates the physical design. In the same service, suicide risk was present in 36 mothers, 17 per cent of the series, and risk to the infant from the mother in 32 mothers, 16 per cent; problems in the mother's relationship with her infant affected 98 mothers, 41 per cent. Two of those percentages are the series' own and do not recompute against the series' own denominator: the first two work out nearer fifteen and thirteen and a half per cent. They are reproduced as printed rather than silently corrected, and the design argument is made from the counts, which are not in doubt. A unit admitting mothers together with their babies is therefore admitting, at any time, roughly one mother in seven who poses some risk to the baby sleeping beside her, and it must be built and staffed on that assumption rather than on the hope of filtering such women out at the door. Everything downstream follows: the sightlines, the observation arrangements, who may take the infant out of the bay, and the requirement that a member of staff rather than a relative is accountable overnight. The taxonomy of harm to infants by parents belongs to the Mental health legislation and forensic psychiatry notes; the design consequence belongs here.

The feed is in trouble at the door as often as the relationship is. Breastfeeding had stopped completely because of the maternal illness in 87 mothers, 36 per cent of that series, while 150 were still feeding at least partially on arrival. More than a third of the lactation work is therefore restoration, not maintenance, and a service that can only support a continuing feed will fail the sicker half of its intake.

237	17.23 days	11 weeks	86%
ADMISSIONS IN THE INDIAN MOTHER-BABY UNIT SERIES	MEAN STAY, INDIAN MOTHER-BABY UNIT SERIES	MEAN STAY, FRENCH AND BELGIAN MOTHER-BABY UNITS	LACTATION RESTORED AMONG INDIAN MOTHERS WHO HAD STOPPED

9.4 How the unit is staffed, and the two posts an Indian service borrows

The first mother-baby unit in India opened in July 2009 at the National Institute of Mental Health and Neurosciences in Bengaluru, as a five bedded facility for mother-infant dyads. Naming the place and the date teaches better than a vague statement that such units are rare: it says where the Indian evidence comes from and gives the referral a destination.

Its staffing model is the transferable part. The unit is run by a multidisciplinary team of psychiatrists, psychiatric social workers and nurses; one psychiatry trainee is posted to it round the clock, and social work and psychology trainees provide part-time input. Two posts are not resident but available: a **lactation expert** is on call to respond to breastfeeding difficulties, and paediatric support is obtained from a neighbouring paediatric hospital rather than from an in-house paediatrician.

The design lesson in that sentence. An Indian unit does not solve the two-patient problem by employing two full establishments. It borrows the two competencies it cannot generate and

makes the borrowing formal rather than ad hoc. Telephoning the paediatric registrar when somebody happens to worry about the baby is not the same arrangement, because it depends on a psychiatric nurse recognising an unwell neonate. A named service, a route of referral and an expectation that the infant is reviewed as part of the admission converts a hope into a pathway.

IN INDIA

Those two on-call posts are exactly the two an ordinary Indian psychiatric ward lacks. Most district and many teaching hospitals have no identified lactation counsellor, and where one exists she is attached to the obstetric service and never comes to the psychiatry ward because nobody has asked her to. That is administrative rather than financial: one written arrangement with the obstetric or paediatric department buys the most useful non-psychiatric competency on the ward. If you cannot build a unit, build the two referral routes it borrows, because they are the cheap half of the specification.

9.5 The separation decision: safety, not diagnosis, and never final

This is the hard call in perinatal inpatient practice, because it is made about someone who is not your patient, on incomplete evidence, with consequences outlasting the admission. Two things must be held together: joint admission is the default, and a proportion of dyads cannot safely be admitted together on arrival.

The Indian series shows the decision being made and then unmade, which is the shape to reproduce. Ten mothers were refused admission to the unit initially because there was **serious risk to the infant** from the mother, and were cared for on a different ward away from the baby; they were moved into the unit with their infants once the high-risk status had improved. Three features of that practice are what to take. The criterion is the infant's safety as it stands now, not the mother's diagnostic label. The separation is an interim arrangement with an expected end rather than a disposal. And somebody must own the review, because a separation nobody is scheduled to reconsider becomes permanent by default.

Joint admission is not, however, a promise that the pair goes home together, and teaching it as one is dishonest. In a French mother-baby unit series, separation at discharge occurred in **23 per cent** of joint admissions; women admitted with acute postpartum psychoses and with major depressive disorders had better outcomes than those with chronic psychoses, and the latter were more often separated from their children at discharge. The authors make the point any good answer should: where separation occurred, the admission had bought the time in which to arrange the best available placement for the child. An admission ending in separation is therefore not a failed admission but one in which a considered decision replaced an emergency one.

The gradient replicates in a multi-unit national dataset from France and Belgium: women with schizophrenia or chronic delusional disorders, and women with personality disorders or intellectual disability, stayed longer, improved less, and were more often separated from their babies or discharged with supervision than women with other diagnoses. It is a robust finding and the most misused one in this topic.

TRAP **Converting the diagnostic gradient into a decision rule.** Candidates read that chronic psychosis predicts separation and then write that a mother with chronic schizophrenia should be separated from her infant. That inverts an observed association into a policy, and it fails both ways: it separates dyads that were manageable, and it reassures the team about a benign-sounding diagnosis attached to a frankly unsafe home. Diagnosis is not the criterion. What it legitimately does is tell you where to look hardest, how long to plan for, and when to open the placement conversation early, so the option is prepared and not forced.

When separation happens the infant goes somewhere, and the routes differ by jurisdiction. In the French series the separated children fell into two groups: those removed by judicial order into foster care, and those placed in the **unofficial custody of another family member**, an arrangement the children's court judge usually confirmed afterwards. The second route is the one that matters for Indian practice, where family placement is the norm and a court order the exception. That machinery is French, however, and the Indian legal route for a child in need of care and protection belongs to the Mental health legislation and forensic psychiatry notes rather than being asserted from a European series.

AXIS	SEPARATION DECIDED AT ADMISSION	SEPARATION DECIDED AT DISCHARGE
What triggers it	Serious risk to the infant from the mother, assessed on arrival	Persistent inability to care safely for the infant once the acute episode is treated
Expected course	Interim and reversible; the Indian series moved such mothers in once the risk state improved	May be durable; in a French series it occurred in 23 per cent of joint admissions
What the admission buys	A safe place to treat while the risk is reassessed	Time to arrange the best placement rather than an emergency one
Commonest error	Making it once and never scheduling the review	Reading it off the diagnosis instead of the observed caregiving

9.6 Managing lactation during acute treatment: the package, not the principle

Everyone agrees breastfeeding should be supported during psychiatric treatment. Almost nobody can say what supporting it consists of, which is why the itemised package from an Indian unit is the most useful content here. The interventions delivered were: dispelling myths about feeding during treatment; helping with positioning at the feed; educating the mother on timing the feed against the peak level of the psychotropic in her milk; encouraging electric breast pumps and **expressed breast milk** where sedation, agitation or a treatment session stopped her feeding; and seeking a lactation expert's advice for severe difficulties. Of the 87 mothers who had stopped breastfeeding because of mental illness, lactation was restored in 75, **86 per cent**.

Read that outcome twice. A feed stopped by maternal mental illness is in the great majority of cases recoverable, and it is recovered by unglamorous physical and educational work rather than by any decision about the drug. So "has stopped breastfeeding" at admission is a problem to be

worked on, not a fact to be recorded and left. The pump keeps the option open while she is too unwell to feed, and its absence in the first days makes the loss permanent.

MNEMONIC

Myths, Position, Timing, Pump, Expert

The five moves of the lactation package, in the order usually needed: dispel the **myths** that treatment forbids feeding; correct the **position** at the breast; teach the **timing** of the feed against the peak drug level in milk; use the **pump** and expressed milk when sedation, agitation or a treatment session stops her feeding; call the lactation **expert** for severe difficulties. The first two need no equipment and no prescription, and are the two most often skipped.

THE OBSTACLE AT THE BEDSIDE	WHAT IS ACTUALLY DONE	WHO DOES IT
The family believes any psychotropic makes the milk unsafe and has stopped the feed	The myth is addressed directly, with the family present, before anything else	Treating team, at admission
She is willing but the infant is not latching and the feed is failing mechanically	Hands-on correction of positioning and attachment at the feed	Nursing staff, repeatedly, not once
She is feeding but anxious about drug in the milk at every feed	Education on timing the feed against the peak psychotropic level in milk	Treating team, with agent-specific information
She is too sedated or agitated to feed, or is off the ward for a treatment session	Electric pump and expressed breast milk, preserving supply and option	Nursing staff, on a schedule not on request
Severe or persistent difficulty that ward measures have not solved	Formal referral for specialist lactation advice	Lactation expert, on call
Nobody has decided whether her drug is compatible with the feed at all	An explicit agent-level decision, written down rather than assumed	Treating psychiatrist; the agent table sits outside this section

Two boundaries around that last row keep the answer clean. Which drug is acceptable in lactation, judged by how much of the maternal dose reaches the infant, belongs to the topic on drugs safe in breastfeeding in these notes, and the metric behind that judgement is defined in the Neurochemistry, Neuroendocrinology, Neuroimaging and Basic Psychopharmacology notes. And where the reason she is off the ward is a course of electroconvulsive treatment, that licenses no teaching here about the treatment in the perinatal period, which sits in the ECT and neurostimulation notes.

9.7 The milk supply question the ward actually asks

A second lactation question, quite separate from infant exposure, is the one asked out loud on ward rounds: will this antipsychotic wreck her supply? It is about the mother's prolactin axis rather than the baby's blood, and confusing the two is the commonest muddle here.

The mechanism is straightforward. The rise in prolactin on haloperidol follows from blockade of dopamine in the **tuberoinfundibular pathway**, dopamine being the tonic inhibitor of prolactin release. The answer, stated plainly by the lactation database, is that a raised maternal prolactin level in a mother whose lactation is already established may not affect her ability to breastfeed. That is narrower than it first appears, and the narrowness is the teaching point: the source says it of established lactation and does not extend it further. In a woman admitted in the first days after delivery, before the feed is running, the same reassurance is not available and the question is unsettled.

The axis is also not loaded equally by every agent, which gives the ward a real selection axis when the feed itself is under threat. **Olanzapine**, unlike the phenothiazines, has a minimal effect on serum prolactin levels. That is a group tendency and not an absolute, since the same record notes hyperprolactinaemia and galactorrhoea have been reported with it. Note what this axis does not do: it says nothing about how much drug the infant receives, and an agent chosen on it must still clear the exposure question in the topic on drugs safe in breastfeeding in these notes.

> The two lactation questions are separate and both must be answered explicitly: how much drug reaches the baby, which decides whether the feed is safe, and what the drug does to the mother's prolactin axis, which affects whether there is a feed at all.

9.8 What joint admission changes, and how strong the evidence actually is

The argument usually offered for the model is a chain of consequences following from separation of a mother from her infant: mothers refuse admission, the feed fails, the diagnostic picture is harder to read, dyadic psychotherapy becomes impossible, stays run longer, relapse after discharge rises, and infant care falls on the husband and extended family. Its own source states that chain as what the absence of a unit *may* produce. It is a mechanism argument, not a measured effect, and presenting it as measured is overclaiming.

The measured evidence is narrower than the enthusiasm around it. In an Australian cohort assessed at admission and at discharge, joint admission was highly beneficial in the short term across clinical, functional and parenting outcomes, with the authors noting that follow-up studies are needed before longer-term benefit to the dyad can be claimed. Within that cohort 73.3 per cent recovered symptomatically, and recovery was associated with increasing maternal age and with lower psychosocial risk at admission. Both are observational, and the second is the interesting one: psychosocial risk, not diagnosis, does the predictive work, which is the lesson the separation literature teaches from the other end.

Length of stay is where the international and Indian pictures diverge most sharply. Across the French and Belgian units the mean duration of hospitalisation was 11 weeks, and units also offering day-care admission in the same or a nearby unit had shorter mean admissions. The Indian mean quoted earlier is measured in days rather than months. Some of that gap is case-mix and some is what the receiving community can hold; the reproducible lever is the day-care arm.

Finally, the honest statement about the evidence base, which a good answer includes rather than avoids. A systematic review of research in psychiatric mother-baby units found that most studies of the impact of admission showed favourable results, but that few follow-up studies had been done and few had compared outcomes on such units against other clinical settings; it also reports a shortage of research on infant outcomes. The model rests on before-and-after data and a strong mechanism argument, not on comparative data, and saying so defends it better than implying a trial that does not exist.

9.9 Where there is no unit: the alternate model, and the variants that scale down

The plainest statement of the Indian position comes from the group that runs the country's first unit: in many low-resource settings the absence of specialised mother-baby units necessitates **alternate models of care**. The unit is the standard; the alternate model is the norm, and teaching only the standard teaches most Indian readers about a facility they will never work in.

The components named in its place by the same group are:

- family engagement, which in Indian practice means an admitted attendant rather than a visiting relative;
- telepsychosocial support and caregiver education, which are how expertise reaches a district where none is resident;
- safety planning, and community-based care that continues after the ward has finished.

The same source names multidisciplinary team working and a medication plan compatible with breastfeeding as further elements. Two of these are notably cheap and notably omitted: caregiver education and safety planning need time and a written record and nothing else.

There is also a documented intermediate between a full unit and nothing. The French unit had capacity for four families day and night through the week, and additionally treated a limited number of mother-baby pairs in day or even **half-day hospitalisation** from Monday through Friday. Partial admission of a dyad is therefore an established configuration rather than an improvisation; it maps onto Indian day-care infrastructure far better than a residential unit does, and it needs no night establishment, the most expensive part of the specification.

One indication for joint admission is worth knowing precisely because nobody expects it. The French unit's fourth category of situation in which mother-baby hospitalisation may be proposed is child-led: children with functional symptoms such as sleeping or eating disorders, or with developmental delay, admitted for short-term inpatient treatment in a mother-child setting, where the parents are normally not mentally ill and it is the child who has the disorder. Held alongside the maternal indications, that makes the point that what is admitted and treated here is a relationship, which is why the unit needs staff competent in both halves of it.

9.10 Where the patient goes next: discharge is not the end of the episode

A service model is only as good as its disposition, and this one is demanding: two people go home, one of them cannot report her own condition, and the mother's illness carries a relapse

risk in the months ahead. The community integration clause exists for exactly this, and where it is absent the gains of the admission are lost within weeks.

An Indian unit's answer is instructive because it is affordable. Mothers discharged were given a mobile telephone helpline number answered by a social worker. Of 113 mothers, 51, 45 per cent, made 248 calls between them. What they called about lists everything a discharge plan should have anticipated and usually has not:

- medication, sleep problems and symptom exacerbation;
- appointments, and planning future pregnancies;
- suicidal ideation, with separate calls about domestic violence and about infant health and breastfeeding.

Three things follow. Nearly half of discharged mothers used a channel costing one social worker's time, so this tail is real and cheap to catch. The content spans psychiatry, obstetrics, paediatrics and safeguarding, so whoever answers must be able to route and not merely reassure. And the reported limitation is what an Indian service must design around: some women could not use it for want of a telephone, so a helpline supplements a follow-up appointment and never replaces it.

GOOD TO REMEMBER

Four things to put in the notes of any acutely ill postnatal woman you admit, unit or no unit. Write the separation decision as a decision, with the reason, the person who made it and the date it will be reviewed, because an unreviewed separation becomes permanent. Write the feeding status as a plan and not a fact, since more than a third arrive having already stopped and most of those feeds can be brought back. Book the infant's paediatric review at admission, not when somebody becomes worried. And name, before she leaves, whom she or her family will telephone and what will happen when they do.

Women's mental health across the lifespan

10 · Premenstrual dysphoric disorder (criteria, management)

The disorder the classification hides. A woman describes a week of irritability, hopelessness and conflict at home that lifts within a day or two of her period starting. The first question is not which drug. It is which clinic she belongs to, what must be documented before anyone commits to a label, and who holds her meanwhile. **Premenstrual dysphoric disorder** earns its place here for reasons unrelated to its symptom list: the classification does not file it where a psychiatrist would look, most of these women are already in another specialty's clinic when the question is asked, and the step that settles it is a service step, not a bedside one.

10.1 Filed under gynaecology: what the code tree does to your pathway

In the World Health Organization's current international classification the disorder carries the code **GA34.41**. It sits under a parent grouping of **premenstrual disturbances**, coded **GA34.4**, and its immediate neighbour there is **premenstrual tension syndrome**, coded **GA34.40**. That

grouping resides in the **genitourinary chapter**, among the diseases of the female genital system, in the same company as endometriosis and the menopausal disorders. It is not filed there and forgotten. The classification's own clinical manual for the mental, behavioural and neurodevelopmental disorders cross-lists the disorder into its depressive disorders grouping as a secondary-parented category, and prints the reason: the prominence of mood symptoms in its clinical presentation, and to assist in differential diagnosis. One code, two homes, and the two do different work.

GA34.41	GA34.4	GA34.40
PREMENSTRUAL DYSPHORIC DISORDER	PARENT GROUPING	SIBLING CODE

Where a disorder is coded decides who meets it, who counts it and who is expected to treat it, and each consequence lands on the psychiatric service rather than on the coder:

- the record leaves the hospital tagged to a gynaecological chapter, so an audit or a registry built from the mental disorders codes never retrieves these women;
- the specialty that sees her first is the one the code sits with, so the psychiatric opinion arrives as a referral, not as a first contact;
- a service planning clinics from mental-chapter workload data cannot see the demand, and will not staff for it.

TRAP **Finding the disorder in the mental-disorders manual and assuming the coded record will therefore be found among the mental disorders.** The manual does carry it, deliberately, with its reason printed. The code does not move. What leaves the hospital is a genitourinary code, so a registry, an audit or a workload return assembled from mental-disorder code ranges retrieves none of these women however the manual is arranged. Read the manual for the diagnosis and the code for the count, and never let one stand in for the other.

10.2 The front door: which clinic she is in when the question reaches you

The referral route changes the first act. These complaints reach psychiatry along four paths, and running the same interview on each produces a treatment discussion in a patient whose complaint has not been shown to be cycle-bound at all.

WHERE THE QUESTION REACHES YOU	THE FIRST ACT	WHERE SHE GOES NEXT
Obstetrics and gynaecology outpatient, referred for mood symptoms before menses	Establish whether the complaint is confined to the premenstrual window; issue the record and fix the review	Joint review with the referring clinic once the record exists
Primary care or general outpatient, presenting as irritability and conflict at home	Ask directly whether the complaint tracks the cycle	Full psychiatric assessment if symptoms cross the whole cycle; forward-looking record if not
Already under psychiatric follow-up, worse premenstrually	Do not relabel on the timing alone; record where in the cycle each review falls	Stays with the treating team; the discrimination from **premenstrual exacerbation** is taught by the Endocrine and metabolic psychiatry notes
Crisis contact with distress the family attributes to the cycle	Risk assessment first and on its own terms, timing question second	Disposition on the risk, never on the presumed cycle attribution

RULE **A premenstrual complaint is a routing decision before it is a diagnosis, and a diagnosis before it is a prescription.** What decides the routing is information about time, which cannot be had in the consultation where the question is first asked. The service must build around that: a record collected across cycles, a named reviewer, a plan for the interval. Compressing those steps into one sitting substitutes recall for observation.

10.3 The act this section owns: documenting the timing forward, not backwards

Confirmation rests on **prospective charting**: the patient records symptoms as the cycle runs rather than reconstructing them at the clinic. The instrument, the number of cycles it must cover and the rules for reading it belong to the Endocrine and metabolic psychiatry notes. What a service chapter owns is what that requirement costs and how a clinic delivers it. Before she leaves the room:

- the review appointment is fixed and written down, its date chosen against her cycle rather than clinic convenience;
- she is told what she is bringing back and what will be decided when she does, so the second visit has a purpose she can weigh against its cost;
- a named plan covers deterioration before review, including whom she contacts if the worst part of the cycle brings a safety concern, assessed on the principles set out in the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

IN INDIA

The prospective record assumes a second visit, and that is where this pathway breaks. She is often attending a district or teaching hospital far from home, with a relative whose permission and lost wages the trip costs, for a complaint the family has already filed as a normal period problem rather than illness. The visit for charting alone is the one that gets dropped. Two adjustments cost nothing: fix the review to a date she can keep, and give the record in a form she can carry, in her own language. Where psychiatric opinion sits inside the obstetrics and gynaecology clinic rather than behind a referral, charting is likelier to be completed.

10.4 Handing on: who holds this patient, and where the rest is taught

Two chapters carry premenstrual dysphoric disorder in full between them, and this section adds no third account. Its nosological position, meaning how it stands in relation to the depressive disorders, belongs to the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes. The working clinical material, meaning the criteria set, the rating record and how it is read, the discrimination from premenstrual worsening of an existing disorder, the epidemiology and the treatment ladder with its starting doses, belongs to the Endocrine and metabolic psychiatry notes. No criterion and no dose is printed here.

What remains is the **disposition** decision, and it is usually shared rather than transferred. Once the diagnosis is established most of these women are managed in the clinic that first saw them, with psychiatric input reserved for comorbid mood or anxiety disorder, for failure of first-line treatment, or where risk rather than distress leads. Psychiatry retains her outright when the cycle-linked worsening proves to sit on a disorder running through the month.

GOOD TO REMEMBER

Write the cycle position into the note at every review, for any woman of reproductive age under follow-up for a mood or anxiety disorder, whether or not premenstrual symptoms have been raised. Without it, a year of notes cannot answer the timing question later.

Premenstrual dysphoric disorder is coded in the genitourinary chapter and cross-listed into the depressive disorders: the manual will hand it to a psychiatrist and the code will not, so the service has to go and collect it, and the diagnosis is settled by a record kept forward across cycles.

11 · Menopause and perimenopausal mental health

Why a transition filed outside psychiatry gets a psychiatric section. A woman in midlife presents with low mood, broken nights and flushing, and the explanation is agreed before she arrives: it is the change. Almost none of the work that follows is endocrinology. Staging, the endocrine markers, the size of any risk the transition carries, the oestradiol evidence and endometrial protection belong to the Endocrine and metabolic psychiatry notes, and the hypothalamic-pituitary-gonadal axis beneath them to the Neurochemistry, Neuroendocrinology,

Neuroimaging and Basic Psychopharmacology notes. What is left over is a consultation, and that is what gets examined.

11.1 Where the transition sits, and what its placement instructs you to do

The World Health Organization's current international classification carries the transition as one grouping, **GA30 Menopausal or perimenopausal disorders**, filed among the diseases of the female genital system in the genitourinary chapter rather than among the mental disorders. What that placement does to a psychiatric pathway is worked out with premenstrual dysphoric disorder elsewhere in these notes and is not re-derived here. Its neighbours are the other reproductive events of adult life: **GA31** female infertility, **GA32** complications associated with medically assisted reproduction and **GA33** recurrent pregnancy loss, whose psychiatric side is taken up in the section of these notes on infertility, abortion and contraception. The transition has a nosological home, and it is not psychiatry's.

Read that as a clinical instruction, not a filing detail. There is no label called menopausal depression to reach for: you identify the mental disorder that is present, diagnose it on its own terms, and record the **menopausal transition** as the setting in which it appeared. Where the complaint genuinely is a symptom of the transition, the clinician who treats it sits outside psychiatry and the correct act is a referral, not a prescription.

RULE **The perimenopause is a context, not a diagnosis.** A context tells you what else to ask about and whom to involve, not what to treat. Collapse it into the diagnosis and two opposite errors open at once: a depressive episode goes untreated because it has been explained away, and a transition needing a gynaecological opinion is absorbed into a psychiatric formulation.

11.2 Establishing the episode before attributing it

Identification is the whole of the psychiatric task here. An expert panel convened by the North American Menopause Society and the National Network of Depression Centers Women and Mood Disorders Task Group framed the perimenopause as a **window of vulnerability** for depressive symptoms and for major depressive episodes, and recorded that clinical recommendations on identifying and treating depression in that window were lacking. Both halves are usable: raise the index of suspicion where nobody screens, and do not wait for a bespoke pathway, because what you have is the ordinary assessment done early.

The difficulty the panel names is **overlap**. Symptoms of the transition complicate the presentation of depression, run alongside it and overlap it, so the same broken sleep and fatigue read either way. Establish the episode on its own core features and course, not on the symptoms the two conditions share, since a shared symptom cannot arbitrate between them. How far the risk of depression rises across the transition is a question this section does not answer; it sits with the entity in the Endocrine and metabolic psychiatry notes. The framing above is North American expert-panel guidance, not Indian practice.

TRAP **Waiting for the transition to finish.** It is the most comfortable error available, because the patient offers it herself: review is set a long way out, and a woman with recurrent depressive illness goes untreated on an explanation her history does not support. An episode diagnosed in the perimenopause is treated on the same terms as one diagnosed at any other point: the timing changes what else you look for and whom you involve, never whether you treat.

11.3 The history that decides the formulation

The decisive fact about this window is historical rather than endocrine. The same panel concluded that most midlife women who have a major depressive episode during the perimenopause have had a **prior episode of depression**, and that they present with a classic depressive picture combined with menopause symptoms, **vasomotor symptoms** and sleep disturbance among them, plus the psychosocial pressures of midlife. The lay picture, of a fresh illness with a purely hormonal cause, is what the family arrives holding; correcting it is this section's work. So the **lifetime mood history** comes before the flushes. What the answer changes:

- if there were earlier episodes, this one is a recurrence, and her own record is the most useful thing in the room: what she was given, whether it worked, why it stopped;
- if there were none, a first episode in later life earns a physical review and a look at what she already takes before anything is attributed to the transition;
- ask separately about mood at earlier reproductive events, because many women do not file those episodes under depression and answer no to the general question, yes to the specific one.

11.4 Dividing the decision, and working where there is nobody to divide it with

This is a two-clinic presentation, and saying which decision belongs where is most of what a psychiatric opinion adds; the handoff fails quietly when each clinician assumes the other is deciding.

THE QUESTION	WHOSE DECISION	WHERE IT IS TAUGHT
Is she in the transition, and does a hormonal measurement help?	Gynaecology or the physician	the Endocrine and metabolic psychiatry notes
Is hormonal treatment indicated, and what protects the endometrium?	Gynaecology	the Endocrine and metabolic psychiatry notes
Is a depressive episode present, and is it a recurrence?	Yours, in this consultation	the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes
Which antidepressant, and for how long?	Yours	the Mood disorders: pharmacotherapy notes

Notice what the table does not contain: a second patient. Every other decision in this band is made for a mother and a fetus or infant at once, a calculus set out with prescribing in pregnancy

earlier in these notes; here the risk is hers alone. Three things must be explicit when you write:

- which symptoms you have assigned to the mood episode and which you have left with the transition, so two clinicians do not treat one complaint;
- whether an episode is established, suspected or excluded, in those words, because menopausal symptoms with low mood commits nobody to anything;
- the single decision you want made, and who reviews her next, so that a woman who improves on hormonal treatment alone is not discharged by both clinics.

IN INDIA

Plan the consultation on the assumption that you cannot refer. The perinatal period has scheduled contacts and this transition has none, so no appointment obliges anyone to ask about her mood: these episodes are missed for structural rather than clinical reasons. Dedicated menopause services are gynaecology-led where they exist and cannot be assumed at district or taluk level, so outside a teaching hospital, whoever sees her first asks the mood questions.

GA30	Genitourinary	Overlap	Prior episode
GROUPING FOR THE TRANSITION	CHAPTER IT IS FILED IN	WHY IDENTIFICATION IS ACTIVE	THE USUAL HISTORY

Most depressive episodes in the perimenopause occur in women who have been depressed before: the transition is where the episode happened, not what it is.

12 · Gender and mental health, intimate partner violence

Why this earns a section of its own. Two facts about who becomes unwell, and who is reached, are stable enough to plan a service around: common mental disorders are commoner in women, and a substantial minority of those women are being hurt at home by the person they live with. Neither is a diagnosis; both change what is done in the room. Whom you ask, what has to be in place before you are entitled to ask, what you say in the first minutes after the answer is yes, and who in the Indian system is legally supposed to do the rest: that is this section. The syndromes themselves are taught in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes and in the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

It is examined because an epidemiological finding, a guideline recommendation with a stated strength and an Indian statute bear on the same five minutes of consultation. A candidate who can quote a prevalence but cannot say who may be asked, on what trigger and with what arranged beforehand, has learned the wrong half.

12.1 The size of the sex difference, and the shape that constrains its explanation

The reference estimate comes from meta-analyses restricted to nationally representative samples, which matters because clinic samples are shaped by who reaches a clinic. Pooled, the female-to-male odds ratio for depression is **1.95**, with a confidence interval of 1.88 to 2.03, and the

standardised mean difference for depressive symptoms is 0.27. Hold both. The odds ratio says a woman is roughly twice as likely to carry the diagnosis; the standardised mean difference says the symptom-score distributions overlap heavily. Those are compatible, and quoting only the first teaches a difference between two kinds of person rather than a shift in one population.

The shape across the lifespan is where the teaching sits, and it is not a constant. It is detectable in late childhood, with an odds ratio of 2.37 at age 12, reaches its maximum in adolescence at 3.02 for ages 13 to 15, then falls back and stays broadly stable through adult life. A difference that switches on around puberty, peaks and partially resolves fits neither a fixed constitutional account nor a pure ascertainment account. The pooled base spans over 90 nations, which is why it is carried in preference to any single survey.

12.2 Testing the explanations, and the mirror error that follows them

Dispose of the reporting-artefact account first. Its logic is familiar: women consult, disclose and are labelled more readily, so the excess is partly manufactured at measurement. That makes a checkable prediction: if the excess were mainly men under-reporting, it should shrink where disclosure is least constrained. The cross-national moderator analysis in the same meta-analytic programme found the opposite: larger female-to-male differences in major depression in nations with greater gender equity, though not for depression symptoms. Measurement bias is not abolished by that, but the simplest artefact story runs the wrong way, and a candidate who offers it as the whole explanation can be asked why the difference is largest where women are freest to speak.

The social-role account has been tested directly. Across cohorts and countries in the World Health Organization's World Mental Health Survey Initiative, the directions were consistent: women carried more anxiety and mood disorders, men more externalizing and substance use disorders. What moved was the size: in more recent cohorts the difference narrowed for major depressive disorder and for substance use disorders, tracking variation in **gender role traditionality**, indexed by aggregate patterns of female education, employment, marital timing and use of birth control. A difference that moves when social roles move is, to that extent, made rather than found.

Then the mirror error, which those authors named themselves: the magnitude of the difference does not license overlooking depression in men. The male excess of externalizing and substance presentations is how a male depressive episode gets rerouted away from a mood assessment, so the difference becomes partly self-fulfilling at the clinic door.

12.3 The Indian figures, and the half of the disparity that is about who is reached

An Indian chapter cannot run on cross-national odds ratios. National survey data give a weighted current prevalence of common mental disorders in adults of 5.1 per cent, and a higher prevalence in women at 5.79 per cent. Check what the label covers first: common mental disorders here means depressive and anxiety disorders, the anxiety group including generalized anxiety disorder, social phobia, agoraphobia, panic disorder, obsessive-compulsive disorder and post-traumatic stress disorder, ascertained by structured interview. On multiple logistic regression,

with age, education, occupation, marital status and residence in the model, the risk in women was **1.53** times that in men.

Set a second adjusted figure from the same model beside it: people in metro urban cities carried 1.86 times the risk of those in rural areas. Sex is one structural driver among several, and treating it as the only one misses the urban, displaced, low-income patient in front of you.

The service half is left out of most answers. The **treatment gap** for common mental disorders in the same data was about 80.4 per cent overall and slightly greater in women, at **81.5 per cent**. Teach the female excess in prevalence and stop, and you have taught half a disparity: it sits inside a population that is overwhelmingly untreated. That is the argument for asking well when contact happens, because for many of these women it will not be repeated.

12.4 Reading a violence prevalence figure: the denominator is part of the number

Global estimates from the World Health Organization put lifetime exposure to physical or sexual intimate partner violence, or non-partner sexual violence, at about one in three women worldwide. It is also the most misquoted, because a second sits beside it on a different denominator: among women ever in a relationship, 25.8 per cent of those aged 15 to 49 years and 24.7 per cent of those aged 15 years and older have been subjected to physical or sexual violence by a current or former husband or male intimate partner. The first denominator is all women and includes non-partner violence; the second is ever-partnered women only.

The highest lifetime prevalence of intimate partner violence is reported in Oceania at 37 per cent, Sub-Saharan Africa at 32 per cent and Southern Asia at 31 per cent. Southern Asia is a regional aggregate, not an Indian figure. Over twenty years the average annual decline has been 0.2 per cent, and the one-in-three figure has stayed effectively stagnant.

22.3%	2.7%	31.6%	0.2%
EVER-MARRIED INDIAN WOMEN 18 TO 49 WHO HAVE EVER EXPERIENCED SPOUSAL VIOLENCE	THE SAME WOMEN, PHYSICAL VIOLENCE DURING ANY PREGNANCY	WOMEN WORLDWIDE, LIFETIME PHYSICAL OR SEXUAL PARTNER VIOLENCE, OR NON-PARTNER SEXUAL VIOLENCE	AVERAGE ANNUAL FALL IN PARTNER VIOLENCE OVER TWENTY YEARS

The Indian figure comes from the key-indicator table of the National Family Health Survey, whose latest round has fieldwork in 2023-24 and gives urban, rural and total columns beside a single total for the previous round, 2019-21. Ever-married women aged 18 to 49 ever experiencing spousal violence run at 22.3 per cent nationally, against 29.2 per cent nationally in the previous round; the same women reported physical violence during any pregnancy at 2.7 per cent nationally, against 3.1 per cent nationally in the previous round. Both comparisons are national against national, which is what makes them comparisons; the disaggregation is a separate reading, and the rural column runs higher than the urban on both indicators, at 24.4 per cent against 17.5 per cent for spousal violence ever. Two cautions travel with the fall: the issuing institute states these fact-sheet results to be provisional, and a fall in a disclosure-dependent indicator is not by itself a fall in the behaviour.

PITFALL

Quoting the Indian national figure as a measure of domestic abuse in general. The survey's own footnote defines **spousal violence** as physical and sexual violence, so emotional abuse, economic abuse and controlling behaviour sit outside the headline number. A woman who is not hit, not sexually coerced and comprehensively controlled therefore falls outside the indicator altogether, and a resident who learned the number as a measure of abuse will hear her account as something lesser than what the statistics describe.

12.5 Intimate partner violence as a risk factor, and as the presentation itself

The World Health Organization's statement of consequences is the bridge from a social fact to a psychiatric one. Violence against women is listed as leading to depression, post-traumatic stress and anxiety disorders, sleep difficulties, alcohol use disorders and suicide attempts, and to increased smoking, substance use and risky sexual behaviours. In women subjected to intimate partner violence during pregnancy it is listed as increasing the likelihood of miscarriage, stillbirth, pre-term delivery and low birth weight, which ties this material to the antenatal and postnatal decisions taken elsewhere.

Two quantitative anchors answer different questions. The first is direction. A systematic review of longitudinal studies found, in women, a pooled odds ratio of **1.97** for intimate partner violence predicting incident depressive symptoms, with a confidence interval of 1.56 to 2.48 across six studies, and 12 of 13 studies pointing the same way. It found the reverse path too, depressive symptoms predicting incident violence, at 1.93 across four studies, and violence was also associated with incident suicide attempts. The relationship is bidirectional, so a depressive episode in a woman being abused is neither purely reactive nor safely treated as though the exposure had stopped.

The second anchor justifies enquiry in a psychiatric clinic specifically. Compared with women without mental disorders, the odds of adult lifetime partner violence were 2.77 in women with depressive disorders, 4.08 in women with anxiety disorders and **7.34** in women with post-traumatic stress disorder, with individual studies reporting raised odds across all diagnostic categories including the psychoses. Those authors could not investigate causal direction, having too few longitudinal studies to pool. The operational point survives that, because it is about base rates: a psychiatric outpatient population is enriched for exposure, so asking only when it is volunteered misses most of it.

12.6 The enquiry decision: not everyone, and not by accident

Instinct gets this backwards. The World Health Organization's clinical and policy guidelines recommend that **universal screening**, also called routine enquiry and meaning asking women in all health-care encounters, should not be implemented; the quality of evidence was graded low to moderate and the recommendation is conditional. The reasoning is examinable. Screening increases identification but has not been shown to reduce violence or improve health outcomes; where referral options are limited the burden is real, women find repeated asking difficult when nothing follows, and the question degrades into a tick-box.

The positive half is stronger. The same guidelines make a strong recommendation, on indirect evidence, that providers undertake **clinical enquiry** about exposure to intimate partner violence when assessing conditions that violence may cause or complicate, to improve identification and subsequent care. The example conditions listed are psychiatric: symptoms of depression, anxiety, post-traumatic stress disorder and sleep disorders, and suicidality or self-harm. Read the two together and the rule for a psychiatrist is not conditional. Routine, for us, means routine within the presentations that trigger it.

THE SITUATION	WHAT THE GUIDELINE SAYS TO DO	HOW STRONGLY
Every woman attending any health-care encounter	Do not implement universal screening or routine enquiry	Conditional; evidence low to moderate
A woman assessed for a condition violence may cause or complicate	Ask about exposure, to improve identification and subsequent care	Strong, on indirect evidence
A woman presenting with depression, anxiety, post-traumatic stress disorder, self-harm or a suicide attempt	She could be asked as good clinical practice, since exposure may change her care	A remark, not a graded recommendation
Antenatal care	An opportunity to enquire routinely, given the vulnerability of pregnancy and the possibility of follow-up	A remark, conditional on minimum requirements; evidence limited and from high-income settings

The antenatal exception is the seam to every perinatal decision. Routine enquiry is permitted there because pregnancy creates a **dual vulnerability**, because interventions following identification may improve outcomes, and because the antenatal schedule uniquely offers repeated contact. It is conditional on the guideline's minimum requirements for a health sector response, and a clinic that asks without them takes the risk of asking and none of the benefit.

TRAP **Answering "screen every woman" because it sounds like the caring answer.** It is the answer the guideline explicitly rejects, and rejecting it is not a counsel of neglect. The distinction tested is between asking everybody once and asking the right patients properly: enquiry is targeted by presentation, unconditional inside those presentations, and routine in antenatal care alone. A candidate who cannot state the negative recommendation cannot explain why the positive one is graded strong while the negative one is only conditional.

12.7 The preconditions, and the manner of asking

Before the question is asked at all, conditions have to hold. The guideline states them as a minimum, not as good form:

- it is safe to ask, which the guideline operationalises as the partner not being present;
- the provider is trained in the correct way to ask, and in how to respond to a woman who discloses, at least to first-line support;
- the provider is aware of and knowledgeable about the resources she can be referred to, before the question is put.

The companion clinical handbook sharpens the first into an absolute: never raise the issue of partner violence unless a woman is alone, and note the reason: even if she is with another woman, that woman could be the mother or sister of an abuser. This is the rule most often broken in an Indian outpatient department, where the accompanying relative is a fixture and separating a patient from her attendant reads as rude. Build it into clinic routine, because improvising it in front of the family announces the question you were trying to ask privately.

The manner is specified too. Ask in an empathic, non-judgmental way, in language appropriate to the culture and community you work in, and use the words the woman herself uses rather than the words violence and abuse, which many women do not accept for what is happening to them. The question is therefore built out of her own account: what happens at home when he is angry, whether she is ever frightened, whether anyone stops her going out. The construct is coercion and injury; the vocabulary is hers.

MNEMONIC

Alone, trained, and somewhere to send her

Alone: no partner present, and no accompanying person at all before the topic is raised. **Trained**: to ask, and to respond to a disclosure at least to the level of first-line support. **Somewhere to send her**: referral resources known before the question, not after the answer.

RULE **Asking is a commitment, not a question.** Every element of the minimum condition is about the capacity to answer the answer, which is why a service can be criticised for asking as readily as for not asking. Enquiry with nowhere to refer, no privacy and no trained response converts a disclosure into new risk the woman carries home, and that is the mechanism behind the guideline's objection to universal screening where referral options are limited.

12.8 First-line support, and what changes when the room is an emergency department

What follows a disclosure has a name and a fixed content. The guideline makes a strong recommendation, on indirect evidence, that women who disclose any form of violence by an intimate partner or other family member, or sexual assault by any perpetrator, are offered immediate support, and that providers offer **first-line support** as a minimum. Learn the components as acts rather than attitudes.

COMPONENT OF FIRST-LINE SUPPORT	WHAT IT REQUIRES OF YOU
Consultation conducted in private	Arranged before the topic is raised, not once she has started
Confidentiality ensured, and its limits stated	She is told what would have to be passed on, for example where reporting is mandatory, before deciding how much to say
Non-judgmental, supportive, validating	Her account is treated as an account of events, not a symptom to interpret
Practical care responding to her concerns without intruding	Her stated priority sets the agenda, not the one you would choose
Asking about her history of violence, listening without pressure	Silence is allowed; with an interpreter, care over sensitive material
Helping her access information about resources	Named legal and other services, not an assurance that help exists
Assisting her to increase safety for herself and her children	The children sit inside the safety question, not a separate referral
Providing or mobilising social support	Someone in her own network, identified with her

Two structural points sit around that table. First, a fallback: a provider who cannot give first-line support must ensure someone else, in that setting or an easily accessible one, is immediately available. It is not permission to defer. Second, the setting rule that makes this an emergency topic. In settings such as emergency care departments, as much as possible is done at first contact because the woman may not return, and safe, accessible means of follow-up are negotiated with her. Three principles run underneath: do no harm, the safety of the woman and her children is uppermost, and the woman always decides.

12.9 The safety assessment as a repeated act

It is a process, not a form. The clinical handbook frames safety assessment as ongoing rather than a single conversation, revisited each time she is seen because her situation changes, and instructs the clinician to say plainly that partner violence is not likely to stop on its own. That sentence does work: a woman who expects the violence to resolve will decline planning she would otherwise accept, and the family urging her to be patient shares the expectation.

The judgement is narrow, and should be stated narrowly: whether there is an immediate and likely risk of serious injury. If she is worried about her safety she is taken seriously, her appraisal being evidence rather than anxiety to be reassured away. Where immediate high risk is apparent, the handbook names the concern to her in plain words and puts concrete options on the table:

- contacting the police;
- arranging for her to stay that night away from home;
- where it is not safe to return home at all, referral for shelter or safe housing, or identifying a safe place with her.

One omission is declared rather than left silent. The handbook's job aid for assessing immediate risk carries a fixed list of questions and a numeric answer threshold, adapted from a published violence-risk instrument. Neither items nor threshold is reproduced here, and no violence-risk instrument appears in item or score form anywhere in these notes. What transfers is the judgement, the options and the revisiting.

GOOD TO REMEMBER

Four things should exist before she leaves that did not exist when she arrived: a record of what she disclosed, kept where her partner cannot request it; a named person or service she can contact, written somewhere she can safely carry; a plan for tonight if tonight is the risk; and a next appointment she has agreed is safe to attend. In an emergency department all four are done at that contact.

12.10 The Indian legal and service frame, named and not renumbered

The governing instrument is the Protection of Women from Domestic Violence Act, 2005, whose long title describes it as an Act to provide for more effective protection of the rights of women guaranteed under the Constitution who are victims of violence of any kind occurring within the family. Two features matter clinically. It is a civil protective statute, so its purpose is protection and relief rather than conviction, and a woman can want the first without the second. And it builds a service architecture: it creates the **Protection Officer**, recognises registered service providers, provides for notified shelter homes and places duties on medical facilities. Its reliefs are a **protection order**, monetary relief, a custody order, a residence order and a compensation order.

The provision a psychiatrist is personally bound by is short. If an **aggrieved person**, or a Protection Officer or service provider on her behalf, requests the person in charge of a medical facility to provide medical aid, that person shall provide it in the facility. The duty is triggered by a request. It is not conditional on a police complaint, and a refusal on the ground that the police are not involved has no basis in the Act.

The information duty sits on a police officer, Protection Officer, service provider or Magistrate who receives a complaint of domestic violence, is present at the place of an incident, or has an incident reported to them. They are to inform her of her right to apply for those reliefs, of the availability of service providers and Protection Officers, and of her right to free legal services. Note that a treating clinician is not among the named duty holders unless the facility is registered as a service provider. It is still the referral information a psychiatrist should be able to give from memory, but an answer saying a doctor must inform her under the statute is an over-claim.

IN INDIA

The statute creates the roles; it does not staff them for you. Three local facts have to be known by name before this material is usable in your department, and none is in any book: who your district's Protection Officer is and how they are actually reached, which organisations near you are registered service providers rather than merely helpful, and where the nearest notified shelter is and whether it admits at night. The guideline precondition that a provider know the referral resources before asking is, in an Indian district hospital, an administrative task somebody does once for the whole unit. A service that has not done it cannot yet run enquiry, however willing its residents are.

12.11 Obligations on disclosure, and where the settled ground ends

The reporting question is most often answered from memory and answered wrongly, so state exactly what is sourced. Government of India guidance for medical practitioners on medico-legal care in cases of sexual violence, issued through the Ministry of Home Affairs, records that the examining registered medical practitioner or hospital is required to inform the police about a sexual offence. It records in the same breath that if the survivor does not wish to lodge a first information report or take part in a police investigation, the practitioner is bound to provide medical treatment, and that **informed refusal** is documented in such cases. It further records that every hospital and doctor is bound to provide free first aid or medical treatment to victims of rape and to intimate the police, and that the victim, or the person in whom she reposes trust, may refuse medico-legal examination or evidence collection or both, with that refusal never taken as denial of treatment.

Two limits travel with that paragraph. The first is scope: the guidance addresses sexual offences. It does not settle what a clinician must report when an adult woman discloses non-sexual intimate partner violence and asks that nothing be done, which is the commoner situation by a wide margin. That position is not sourced here and is not asserted. The practical course is to state the limits of confidentiality to her before she decides how much to say, as first-line support requires, and to take the doctrine of confidentiality and its exceptions from the Forensic ethics, consent and legal procedure notes. The second limit is currency: the guidance cites a code of criminal procedure and a penal code since replaced, and the successor provisions are not carried here. Name the duty, and do not translate an old section number into a new one from memory.

12.12 Sexual and gender minority patients at the same doors

The same logic extends to a group the epidemiology reaches less reliably. Pooling population-based studies, lesbian and gay people carried odds ratios for common mental disorders between 1.97 and 2.89 compared with heterosexual people, across every diagnostic category investigated, and bisexual people higher odds still, between 2.70 and 4.81, their excess over lesbian and gay people concentrated in depression and suicidality. Exploratory analysis found no narrowing in recent years except for alcohol use disorders. One limitation governs Indian use of these figures: the evidence base is predominantly Western, so the direction transfers more safely than the magnitude.

In India the obligation is statutory as well as clinical. The Transgender Persons (Protection of Rights) Act provides that no person or establishment shall discriminate against a transgender person on grounds that include the denial or discontinuation of, or unfair treatment in, healthcare services, and bars the same in access to any facility available to the general public. Read that against what an emergency department does. A refusal of registration, a refusal to admit, a ward placement made on documents rather than the patient's stated gender, or unequal treatment at triage is a statutory matter in India, not only an ethical one. The Act also requires the appropriate Government to provide medical care including sex reassignment surgery and hormonal therapy, counselling before and after both, a health manual in accordance with the **World Professional Association for Transgender Health** guidelines, review of the medical curriculum, and access in hospitals. The counselling obligation is directly psychiatry's.

The Indian professional position has a date, and dating it teaches better than presenting it as timeless. A peer-reviewed account records that in 2018, a day before the Supreme Court of India began hearing the curative petition on the penal provision then criminalising carnal intercourse against the order of nature, the Indian Psychiatric Society issued an official statement that homosexuality is not a mental pathology, and that in 2014 the then President had termed it a pathology requiring treatment. That is a secondary account rather than the Society's own instrument and should be quoted as such, and the penal provision it refers to has itself been replaced, with no successor number given here. The profession's position in India was therefore contested within living professional memory, which is why a patient may arrive expecting to be pathologised and will read your first questions as a test of whether she is safe with you.

> Do not raise intimate partner violence unless she is alone, you are trained to respond and you already know where she can be referred; and in an emergency department, do everything at that contact, because there may not be another.

13 · Psychiatric aspects of infertility, abortion and contraception

Why the marks are here. Reproductive medicine hands psychiatry three separate tasks, and candidates lose marks treating them as one. In infertility the psychiatrist is asked to keep two people functioning through a long, expensive, invasive treatment that may not work. In abortion the psychiatrist may be asked for an opinion a statute names as a precondition of a lawful procedure. In contraception the psychiatrist is the prescriber whose own drug is why the conversation cannot be left to the gynaecologist. Three acts, three sources of authority, three destinations.

The characteristic error is to arrive with a view about whether fertility treatment, or termination, or a contraceptive decision is psychologically good or bad for women. None of the three settings asks that. Each asks a procedural question with a defined answer: what must be discussed and by whom, what opinion the law requires and on what ground, and what must be in place before a prescription is defensible. Get it wrong and a careful formulation answers a question nobody asked, while the real question goes back unanswered to a clinic working against a clock. The

disorders that present inside these settings are taught in the chapters that own them and are named here rather than restated.

13.1 Taking the referral: what infertility is, whose it is, and who is asking

Infertility is defined by the World Health Organization as a disease of the male or female reproductive system, established by failure to achieve a pregnancy after **twelve months or more** of regular unprotected sexual intercourse, and it may arise from male, female or unexplained factors. Two things in that definition matter at the point of referral: it is framed as a disease of a reproductive system rather than as a failure of a person, and it is explicitly not assumed to be the woman's. Estimates on the same authority suggest approximately **one in every six** people of reproductive age worldwide experience infertility in their lifetime. This is not a niche referral.

The classification reinforces this. The international classification of diseases carries female infertility at GA31 and, as a separate entry, **complications associated with medically assisted reproduction** at **GA32**, both filed among the diseases of the female genital system in the genitourinary chapter alongside recurrent pregnancy loss. A treatment given its own morbidity entry, distinct from the condition it treats, is one whose burden the classification has already conceded. Much of what you are asked to manage is generated by the treatment, not by the infertility.

The first act on receiving the referral is therefore to establish which question is being asked, because the letter will rarely say. Is this couple in a state to start or continue a cycle. Is a mental disorder present that needs treatment in its own right, irrespective of the fertility work. Does an existing illness or its medication change what the service can safely offer. Each has a different output and destination, and answering the wrong one is how this consultation is wasted. Note too that the referral will almost always name the woman even where the factor is the man's or unexplained, and correcting that framing is part of the first consultation.

IN INDIA

The World Health Organization records in the same fact sheet that equal and equitable access to fertility care remains a challenge in most countries, particularly in low and middle-income countries, and that fertility care is rarely prioritized in national universal health coverage benefit packages. Read that as a clinical fact, not a policy one. Where treatment is paid for privately and cycle by cycle, continuing is also a household financial decision, often with in-laws holding the money, and the distress you are asked to treat is partly a debt and partly a loss of standing. Who is paying, and what happens in the family if the next cycle fails, is material the formulation is built from, and the question most reliably omitted.

13.2 Mapping the cycle: what to ask before, during and after treatment

The most useful structure for this work is not a psychiatric one. **Routine psychosocial care**, as the European Society of Human Reproduction and Embryology guideline for fertility staff sets it out, organises the emotional course of treatment as needs experienced across the treatment pathway, before, during and after treatment, and sorts those needs into four kinds: behavioural, relational, emotional and cognitive. The table below carries what the guideline places in each.

Learn it as a grid rather than a list, because the grid turns a vague enquiry about coping into a structured interview. The same four domains carry different content at each phase. Before treatment the cognitive domain is dominated by what the couple has understood about their chances; during treatment by what each injection, scan and result means; afterwards by whether to go again. The relational domain moves the same way, from disclosure and whom to tell, through the erosion of a sexual relationship that has become scheduled, to the anniversary of a failed cycle.

MNEMONIC

Be Real Every Cycle

Behavioural, **R**elational, **E**motional, **C**ognitive: the four psychosocial need domains, asked at each of the three phases of the pathway. Four questions, three times, and the interview is covered.

NEED DOMAIN	WHAT THE GUIDELINE PLACES IN IT	WHAT THAT TURNS INTO AT THE BEDSIDE
Behavioural	Lifestyle, exercise, nutrition, compliance	Whether the regimen is actually being taken as prescribed, and what has been given up to take it
Relational	The relationship with the partner where there is one, family, friends and the wider network, and work	Who knows, who is asking, who is paying, what leave has been used
Emotional	Wellbeing, including anxiety, depression and quality of life	The screen for a treatable disorder, and whether this is distress or illness
Cognitive	Treatment concerns and knowledge	What the couple believes the odds are, and whether that matches what the clinic has told them

The guideline's other structural instruction is about who does this. It directs that fertility clinic staff detect and address these needs, making routine psychosocial care a responsibility distributed across the team rather than a referral generated when someone cries in the waiting area. The durable act is therefore to teach the four domains to the nursing and embryology staff who see the couple far more often than you do, and to keep the psychiatric consultation for the questions that need one.

13.3 Why the burden is a treatment outcome and not a side issue

The argument that psychological care in a fertility unit is a luxury collapses against the discontinuation data. A systematic review of why patients stop fertility treatment, pooling studies across several countries, found that **discontinuation** is not driven mainly by treatment failure or by cost alone. The reasons selected most often were postponement of treatment, then physical and psychological burden, then relational and personal problems, then rejection of the treatment itself, with organizational and clinic problems behind.

39.18%	19.07%	16.67%	13.23%
STOPPING FERTILITY TREATMENT: POSTPONEMENT	STOPPING FERTILITY TREATMENT: BURDEN	STOPPING FERTILITY TREATMENT: RELATIONAL	STOPPING FERTILITY TREATMENT: REJECTION

The split within that burden category is instructive: the psychological component accounted for 14 per cent of reasons selected for discontinuing fertility treatment and the physical component for 6.32 per cent. The mind is carrying more than twice the load of the body in the decision to stop, and adding the relational and personal figures makes the psychosocial share the largest identifiable block after simple postponement. The same authors report that none of the predictors they examined was consistently associated with discontinuation, and that finding has the sharpest operational consequence: you cannot select in advance who will drop out and support only them. Support has to be routine, which is exactly what the guideline above calls it.

GOOD TO REMEMBER

Ask directly, at every review, whether the couple has considered stopping, and treat the answer as clinical data rather than as a failure of morale. People who stop treatment that might still have worked usually stop after a period in which nobody asked. The question does not push them towards stopping; it converts an unspoken drift into a decision made deliberately, with the psychological burden named as one of the things being weighed.

13.4 The counselling duty Indian law places on the fertility clinic

India answers the European guideline with a statute rather than guidance. The Assisted Reproductive Technology (Regulation) Act places on assisted reproductive technology clinics a duty to counsel, and specifies its content. The clinics must:

- provide **professional counselling** to the commissioning couple and woman about all the implications and chances of success of assisted reproductive technology procedures in the clinic;
- inform them of the advantages, disadvantages and cost of the procedures, their medical side effects and risks including the risk of multiple pregnancy;
- help them arrive at an informed decision on the matters most likely to be best for them.

The Act further requires that they be made aware of the rights of a child born through assisted reproductive technology, and a companion provision requires the written informed consent of all the parties seeking it before treatment. Counselling in Indian assisted reproduction is therefore an obligation with a statutory duty holder, and the duty holder is the clinic. It is not an extra a busy unit may drop, and it is not, by default, the psychiatrist's.

Hold that distinction: the two get conflated in practice and the conflation harms both. The clinic's statutory counselling is informational and decisional, covering implications, success rates, costs, side effects, risks and support to a decision. A psychiatric consultation is diagnostic and therapeutic, triggered by a question about mental state, capacity, medication or risk. When a unit sends a couple to you and calls it counselling, clarify in writing which is being requested, because the record must show whether the clinic has discharged its statutory duty and, separately, what

psychiatric opinion was given. A note that blurs them leaves the clinic exposed and leaves you carrying a duty that is not yours.

13.5 Saying honestly what psychosocial care can and cannot deliver

Residents oversell this work in vivas, and the guideline itself does not. Its own summary is that the evidence presented shows that providing routine psychosocial care is associated with, or has the potential to, reduce stress and concerns about medical procedures and to improve lifestyle outcomes, fertility-related knowledge, patient wellbeing and compliance with treatment. Read the verbs: association, or potential, is not demonstrated causation. It then quantifies its own foundations: only 45 of the 125 recommendations in that guideline, 36.0 per cent of them, were based on high-quality evidence, and the guideline group wrote recommendations aimed at generating the research the rest of them need.

Two consequences follow. First, the outcomes on that list are stress, procedural concern, lifestyle, knowledge, wellbeing and compliance. A pregnancy outcome is not among them, and you should not imply one. A couple told that counselling improves their chance of a baby has been given a false reason to attend, and will read the next failed cycle as a failure of their own psychological effort, which is the attribution this work exists to prevent. Second, compliance and treatment concerns are on the list, and compliance is what the discontinuation data says is at stake. The defensible claim is that psychosocial care makes an arduous treatment tolerable enough to complete, and that distress is worth treating in its own right, not that it is fertility treatment by another route.

13.6 The termination request: which statutory question you are being asked

The Indian frame is the Medical Termination of Pregnancy Act, 1971, as amended by the Medical Termination of Pregnancy (Amendment) Act, 2021, which defines termination of pregnancy as a procedure to terminate a pregnancy by medical or surgical methods and introduces the Medical Board as a statutory body. Name the Acts; do not carry their section numbers into an answer, because a wrong number reads worse than none.

Under the statute as amended, a pregnancy may be terminated by a registered medical practitioner on the opinion, formed in good faith, that continuance would involve a risk to the life of the pregnant woman or of **grave injury to her physical or mental health**, or that there is a substantial risk that the child, if born, would suffer from any serious physical or mental abnormality. How many practitioners must hold that opinion depends on the length of the pregnancy, and that two-tier structure is the part most often mangled in written answers.

LENGTH OF PREGNANCY	OPINION THE STATUTE REQUIRES	WHERE THE PSYCHIATRIST ENTERS
Not exceeding twenty weeks of pregnancy	The opinion of one registered medical practitioner, formed in good faith	As the practitioner forming that opinion where the ground is mental health, or as the source of the evidence the treating practitioner relies on
Exceeding twenty weeks but not exceeding twenty-four weeks of pregnancy, for a prescribed category of woman	The opinion of not less than two registered medical practitioners, formed in good faith	Commonly as one of the two, since one of the prescribed categories is itself psychiatric
Where termination is necessitated by substantial foetal abnormalities	Diagnosis by a Medical Board, on which the length-of-pregnancy limits do not apply	Not the psychiatric route; recognise it so a case is not misrouted through a psychiatric opinion

RULE **The statutory question is prospective, and it is about continuance.** The Act asks whether continuance of the pregnancy would involve grave injury to mental health. It does not ask whether termination will damage mental health, and it does not ask you to predict outcome after the procedure. An opinion that discusses post-abortion regret, or weighs whether she will cope afterwards, answers a question the statute does not pose and can defeat a lawful request while appearing thorough. Write about continuance.

13.7 The two presumptions, and the categories that open the extended window

The statute does not leave grave injury to mental health entirely to case-by-case judgment. Two explanations attach to it, and the difference between them is the most examinable psychiatric content in the Indian abortion frame. Where a pregnancy results from failure of any device or method used by any woman or her partner to limit the number of children or prevent pregnancy, the anguish caused by such pregnancy may be presumed to constitute grave injury to the mental health of the pregnant woman. Where a pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by the pregnancy shall be presumed to constitute grave injury to her mental health.

Three things follow. The verbs differ, and permissive is not mandatory. The reach differs: the contraceptive-failure explanation is expressed for the first gestational clause, the rape explanation for both. And the trigger for the second is the woman's own allegation, not a police finding, corroboration or a conviction; requiring proof first is a misreading with real consequences for a woman against a deadline. Note also that the amendment replaced the older married-woman-and-her-husband framing of the device-failure explanation with any woman or her partner, removing marital status from that route entirely.

> Grave injury to mental health is a statutory ground for termination in India, and where the woman alleges the pregnancy was caused by rape the anguish shall be presumed to constitute it.

The extended window depends on being within a **prescribed category of vulnerable women**. Answering in Parliament, the Government of India stated that the amendment rules define these categories, eligible for termination beyond twenty weeks till twenty-four weeks of gestation with the permission of two doctors, as survivors of sexual assault or rape or incest; minors; change of marital status during the ongoing pregnancy, namely widowhood and divorce; women with physical disabilities meeting the major disability criteria laid down under the Rights of Persons with Disabilities Act, 2016; mentally ill women, the Government's own wording adding the phrase including mental retardation; foetal malformation carrying a substantial risk of being incompatible with life or of the child being seriously handicapped; and women with pregnancy in humanitarian settings or disaster or emergency situations as declared by the Government. Two caveats belong with that list. The wording quoted for the fifth category is the Government's and reflects superseded terminology. And the categories come from an official parliamentary answer restating the rules rather than from the rules as separately retrieved, so name the categories and the rules and do not cite a rule number.

Mentally ill women being a named category is what most often brings an Indian psychiatrist into this decision, and it carries a trap. Membership of the category opens the extended window; it does not establish the ground, and it does not answer whether this woman can consent. Capacity and consent are set out in the Forensic ethics, consent and legal procedure notes, and where the woman is a minor, or a reporting obligation may bite, protective legislation belongs with the Mental health legislation and forensic psychiatry notes. Establish category, ground and capacity as three separate findings and record them separately.

13.8 Answering on the evidence, not on the politics

Whether abortion damages mental health is treated in public debate as an open scientific controversy. It is better understood as a methodological artefact, which is the most useful thing to carry out of this topic. A systematic review of studies of abortion and long-term mental health outcomes rated each study on the methodological features needed to answer the question, and found **a clear quality gradient**: the highest quality studies had findings that were mostly neutral, suggesting few if any differences between women who had abortions and their comparison groups in terms of mental health sequelae, while the studies with the most flawed methodology were the ones that found negative mental health sequelae of abortion. No study in that review reached the top rating.

TRAP **Reading the abortion literature as a genuine disagreement between equally good studies.** Candidates write that the evidence is conflicting and leave it there, which sounds balanced and is wrong. The direction of a finding in this literature tracks methodological quality, and the weakest designs generate the strongest claims of harm. The comparison group is where most fail: women who have an abortion are compared with women never pregnant, or who carried to term by choice, leaving the unwanted pregnancy itself, the exposure that predicts distress, uncontrolled.

The design that solves the comparison-group problem compares women who obtained an abortion just under a facility's gestational limit with women turned away because they had passed it. In that prospective longitudinal cohort, being denied an abortion was associated with greater

risk of initially experiencing adverse psychological outcomes compared with having one: at the first assessment after seeking the abortion the women who had been denied it reported more anxiety symptoms, lower self-esteem and lower life satisfaction, with similar levels of depression in the two groups. Over the follow-up, psychological wellbeing improved and the two groups eventually converged. The authors state that their findings do not support policies restricting access to abortion on the basis that abortion harms women's mental health.

Handle the transfer honestly. That cohort was recruited in a jurisdiction whose statutory and service model is not India's, so the psychiatric finding transfers and the service model does not. What it gives an Indian psychiatrist is a defensible answer to the question a family, a colleague or an examiner will put: the mental-health case against access is not supported by the strongest available design, and the acute psychological cost in these data sits with denial rather than with the procedure. It is not licence to promise any woman a particular emotional outcome. Where a woman denied a termination presents with active suicidal ideation, assessment and disposition are those in the Somatic-symptom, sexual, impulse-control disorders and suicide notes; a legal refusal as the stressor changes the urgency, not the method.

13.9 Writing the opinion, and protecting it

The output of this consultation is a document, and its quality is what gets examined and, occasionally, litigated. Four features distinguish a usable opinion from an essay. It states the ground in the statute's own terms rather than in diagnostic shorthand, because a diagnosis is evidence for the ground and is not the ground itself. It addresses continuance rather than outcome after the procedure. It records capacity and voluntariness as separate findings with reasons for each, since coercion runs both ways and a woman pressed towards termination and one prevented from it both present as ambivalence. And it is dated against the gestational age at the time of writing, because the window it opens is closing while the note is being typed.

Speed is therefore part of the standard of care here in a way it is not in most psychiatric opinions. A request left in an outpatient queue for a fortnight can convert a first-tier decision requiring one practitioner into a second-tier decision requiring two, or take the case outside the window entirely; where the service cannot see the woman quickly, saying so in writing and escalating is itself the clinical act.

The last element is confidentiality, and here the statute is unusually direct. **The confidentiality provision** of the Act as amended states that no registered medical practitioner shall reveal the name and other particulars of a woman whose pregnancy has been terminated under the Act except to a person authorised by any law for the time being in force, and that contravention is punishable with imprisonment which may extend to **one year**, or with fine, or with both. Note what that means for a consulting psychiatrist: the duty is on the registered medical practitioner, not only on the operating gynaecologist, and it attaches to the woman's identity rather than to the clinical detail.

PITFALL

The breach in this area is almost never a deliberate disclosure. It is a case discussed by name in an open ward round, a shared register carrying the woman's name against the indication, a case sheet photographed and sent to a colleague for advice, or a relative told at the door what the appointment was for. Each discloses name and particulars, and the sanction here runs to imprisonment. Decide how a termination case will be recorded, presented and handed over in your unit before the first such case, not after.

13.10 Contraception counselling as a psychiatric responsibility

Why it matters clinically. The commonest way psychiatry harms a pregnancy is not by mismanaging one. It is by never having the conversation that would have made the pregnancy a planned event. The four-limb pre-conception recommendation itself, its wording and the record it leaves behind, is set out with prescribing psychotropics in pregnancy elsewhere in these notes and is not restated here. What this topic owns is the contraceptive limb of it, which is the one a general psychiatric clinic acts on every week and the one that has a prescribing bar attached.

Read the population before the content, because it is not the population the topic's name suggests. Not pregnant women. Not women already on a teratogen. All **women of childbearing potential** with a new, existing or past mental health problem, which in a general psychiatric clinic is most of the women on the list. Contraception is placed first of the four limbs, ahead of relapse risk and parenting, making it the entry point to the conversation rather than an afterthought once a pregnancy is announced. That conversation is a decision made for two patients at once, one of whom does not yet exist; the framework for weighing treatment risk against the risk of the untreated illness belongs with prescribing in pregnancy and is not re-derived here.

The prescribing rule that pairs with it is deliberately not a number. The same guideline recommends that, when prescribing psychotropic medication or anti-epileptics for women or girls of childbearing potential, including young girls likely to need treatment into their childbearing years, the prescriber takes account of the latest data on the risks to the fetus and baby and follows **the medicines regulator's current safety advice** on anti-epileptic drugs in pregnancy. That is an instruction to consult the live regulatory position rather than a remembered figure, which is the right discipline: agent-level teratogenicity figures move, disagree between sources, and belong with the chapters that own each agent.

One prescribing bar makes contraception a formal precondition rather than advice. The same guideline recommends not offering valproate for acute or long-term treatment of a mental health problem in women or girls of childbearing potential, including young girls likely to need treatment into their childbearing years, unless other options are ineffective or not tolerated and the **pregnancy prevention programme** is in place. Both limbs are required, not either. Contraception here is not a conversation the prescriber ought to have; it is a condition of the prescription being defensible at all, whatever the indication. The regulator's current requirements

under such a programme were not retrievable for this section and are not stated; check the live position.

Finally, name the pharmacology and do not re-derive it. Enzyme-inducing psychotropics can reduce the effectiveness of hormonal contraception; the mechanism, the agents involved and the hormonal thresholds at stake are taught in the Mood disorders: pharmacotherapy notes and in the Neurochemistry, Neuroendocrinology, Neuroimaging and Basic Psychopharmacology notes. What belongs here is the act the mechanism obliges: when you start or change such a drug in a woman of childbearing potential, the contraceptive method is reviewed in the same consultation and the review is documented. The failure in practice is never ignorance of the interaction. It is that the psychiatrist knew it and treated contraception as somebody else's department.

No Indian recommendation equivalent to that discussion duty was located for this section, so it is cited as United Kingdom guidance and the Indian reader substitutes the current advice of the national medicines regulator on the anti-epileptic limb. The practical Indian gap is not knowledge but access: the conversation names a method the woman must then obtain, often from a different service, sometimes without her family knowing, and usually at her own cost. A referral that ends at the door of a clinic she cannot reach unaccompanied has discharged nothing. Ask how she will get the method, and where follow-up will happen, before the consultation ends.

The behavioural emergency

14 · Assessment and management of the acutely agitated and aggressive patient

Why the marks are here. Asked how to manage an acutely agitated and aggressive patient, most candidates produce a ladder: talk to the patient, offer oral medication, tranquillise, restrain. The ladder is correct, it is taught in full by the Mental health legislation and forensic psychiatry notes and by the Schizophrenia: management, antipsychotics and adverse effects notes, and it is not restated here. The trouble is that it answers only the second half of the question. It begins once the clinician has decided this is an agitated psychiatric patient who needs calming, and says nothing about the minutes before that decision: which room the patient is in, how many people are in it, who may speak, how far away they stand, what is measured while the talking happens, and which physical causes are excluded at the same moment. That is the assessment half, and where the examinable difficulty sits.

What follows is act and setting rather than entity. The sequence it belongs to is the one every other emergency invokes: recognise, make safe, decide who has authority to act, act, monitor, dispose. This section owns the front of that sequence, from arrival to the moment a treatment decision is taken, and owns it for the undifferentiated patient, whose diagnosis is not yet known and may never turn out to be psychiatric. The organising commitment is that assessment and calming are not consecutive. They run at the same time, in the same room, performed by different members of the same team, and a candidate who describes them sequentially has described something that does not happen.

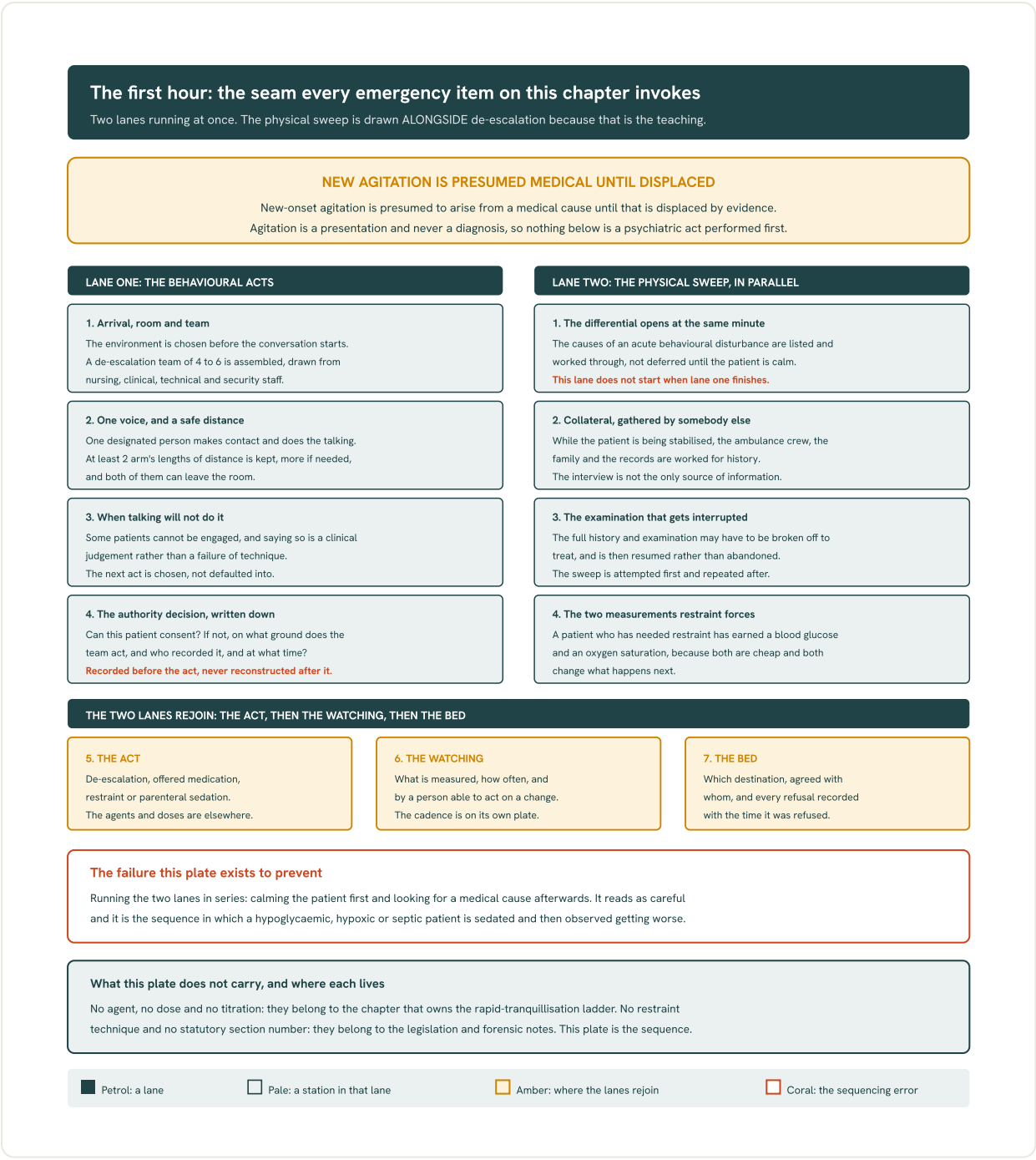


Fig 28.7. The first hour drawn as two lanes running at once, the behavioural acts of environment, one designated voice, safe distance and the authority decision set beside the physical sweep of differential, collateral, the interrupted examination and the two measurements that restraint compels, with the lanes rejoining at the act, the watching and the bed, and the sequencing error of running them one after the other named as the failure the arrangement exists to prevent.

14.1 Agitation is a presentation, and never a diagnosis

The most consequential error in this area is to treat agitation as though it were itself the thing to be treated. It is a final common pathway. The consensus statement of the American Association for Emergency Psychiatry, produced by its **Project BETA** medical evaluation workgroup, puts this as a formal consensus position rather than as advice: agitation that is **new in onset** is to be presumed to arise from a general medical condition. The presumption runs that way deliberately, and it does not wait for a positive finding to activate it. The clinician who wants to conclude that this is psychiatric carries the burden of excluding the medical cause first.

Two riders come with it. The first is about testing: the same consensus states that routine laboratory testing is not indicated, and that **directed testing** chosen from the most likely diagnosis is what is indicated instead. The reflex in a busy casualty runs the other way, and a standard panel sent from the trolley is expensive, slow, frequently uninterpretable, and above all a substitute for thinking. A directed test follows a hypothesis; a routine panel replaces one.

The second rider names when to hold the presumption most tightly. Suspicion rises where the past medical history is concerning, with immunosuppression given as the example, and where onset falls outside the normal age ranges of psychiatric disease. The second is the more useful at the bedside, because it is available before any test result and often before any history: first-onset agitation in a man in his seventies, or in a child, is a medical presentation until proved otherwise, whatever the referral letter says.

TRAP **Reading a known psychiatric history as the explanation for new agitation.** The patient with an established diagnosis is the exact patient in whom the medical cause is missed, because the history supplies a ready-made account that closes the question before it is asked, and the presumption rule carries no exemption for people already known to services. Candidates make this error because the vignette gives the diagnosis in its first line and they read it as the answer rather than the distractor. The discipline is to notice that the history explains why this patient might become agitated, which is a different question from why they are agitated today.

14.2 Reading risk at the door, with what the first minutes actually give you

Prediction at the front door is where the honest answer is uncomfortable and should be given anyway. The available evidence-based recommendation is not about the emergency room. The National Institute for Health and Care Excellence guideline on the short-term management of violence and aggression recommends considering an **actuarial prediction instrument** rather than unstructured clinical judgement alone, to monitor and reduce incidents of violence and aggression and to help develop a risk management plan, and it names two: the **Broset Violence Checklist** and the **Dynamic Appraisal of Situational Aggression, Inpatient Version**. Neither is reproduced here, and no item, anchor or threshold from either belongs in an answer; they are named, and naming them is the whole of what a candidate should do with them.

The recommendation carries a scope restriction that is routinely dropped when it is quoted, and dropping it is a real error. It is written for inpatient psychiatric settings, where a known patient is observed continuously by staff who saw them yesterday and can score a change. The emergency door is a different problem: a stranger, no baseline, no serial observation, minutes rather than shifts. No instrument validated for that position is quoted here because none was available to quote, and the correct answer says so rather than transplanting an inpatient tool to the door and calling the transplant evidence.

What remains is what the first minutes genuinely supply: behaviour observed in real time, and an account from whoever brought the patient. What makes a prediction from that defensible is not a score but a stated basis. What specifically is being predicted, over what period, from which observed features, and what would change the answer. That formulation is transferable at handover and survives the question an incident review actually asks, which is never what the risk

level was but always what it rested on. The framework for assessing risk to self, and the instruments used for it, belong to the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

14.3 The room: exits, doors, stimulus and ligature points

The environment is the only part of this problem that can be fixed before the patient arrives, and the part candidates never mention. The Royal College of Emergency Medicine best practice guideline on **acute behavioural disturbance** in emergency departments specifies the ideal space for verbal and environmental de-escalation. It is a United Kingdom emergency department specification and should be attributed as one; no equivalent Indian specification is quoted here because none was found. Read its features as events they are designed to prevent, because each removes something that has actually gone wrong somewhere.

WHAT THE SPECIFICATION ASKS FOR	WHAT ITS ABSENCE PRODUCES
Adequate and appropriately located exits, so staff can leave without being trapped by the patient	A clinician cornered between the patient and the curtain, whose attention is on their own escape and who is read accurately as afraid
Doors which open outwards	A door wedged shut from inside, so that entry becomes forced entry with no intermediate step
A quiet, low-stimulus space that is not too warm	De-escalation attempted against a continuing provocation, so its failure is misattributed to the patient
No equipment, furniture or moveable object usable as a weapon or to barricade an exit	Injury and a barricaded room, and a threshold for restraint that falls because waiting has been made costlier
No potential ligature points	Self-harm in the interval when nobody is in the room, so staffing rather than fabric becomes rate-limiting
Constant observability, and staff able to signal for additional support easily	An incident found late, and help that arrives after the event rather than in time

Where the department cannot supply the room, the specification becomes a checklist for choosing the least bad space and stating what has been accepted. Observability and the ability to signal are the two that must be met somehow, because both are about the arrival of help, and both can be met with people when they cannot be met with architecture.

14.4 Where you stand: distance, positioning and your own way out

Personal safety at this stage is a matter of geometry, and the geometry is specified. The Project BETA de-escalation consensus directs the clinician approaching an agitated patient to keep a minimum of **2 arm's lengths** between themselves and that patient. The unit is deliberate and should not be converted into metres: an arm's length scales with the two people in the room, and what is specified is the distance at which a strike cannot land. The stated reasoning is double: it gives the patient the space they need, and gives the clinician room to move out of the way if the patient kicks out or otherwise strikes.

Three refinements follow, each examinable. The clinician may take more distance in order to feel safe, which makes the parameter a floor rather than a prescription and legitimises the clinician's own discomfort as data. If the patient tells the clinician to get out of the way, the clinician does so immediately, because complying with a request that costs nothing is itself de-escalation, and refusing converts the clinician into the obstacle. And both people must be able to leave the room without feeling that the other is blocking the way, which is the sentence that decides where everybody stands: neither party is between the other and the door. In a cubicle with one exit this cannot be perfectly satisfied, and the practical resolution is to stand off the direct line to the door rather than on it, so neither has to move the other to leave.

MNEMONIC

Room, Team, Voice, Sweep

Room: the space and its exits, settled before the patient is in it. **Team**: enough people, and the right ones, present before the approach. **Voice**: one designated person makes and keeps verbal contact. **Sweep**: the physical differential runs in parallel with the talking, not after it. Everything the escalation ladder teaches begins only once these four are settled, which is why an answer that starts at the ladder has skipped the examinable half.

14.5 The team: how many, who, and who is allowed to speak

Working with an agitated patient is a team activity, and the Project BETA de-escalation consensus is specific about size: in a busy emergency service the **de-escalation team** should consist of **4 to 6 team members**, made up of nurses, clinicians, technicians, and police and security officers if available. The stated purpose explains why the figure is not arbitrary: enough people to provide verbal de-escalation, to offer the possibility of voluntary medication, and to maintain safety if agitation escalates to violence. Sufficient numbers also communicate non-verbally that violence will not be acceptable, and this is easy to get wrong in both directions. Too few, and the patient correctly perceives that the room can be dominated. Too many, or too close, and the same presence reads as a threat and drives the escalation it was assembled to prevent.

The rule about who speaks is one sentence and it is the most useful sentence here. The **first person to make contact** should be the person designated to de-escalate the patient, and if that person is not trained or is otherwise unable to take the role, another should be designated immediately. Two things are fixed at once. Only one person interacts verbally, because an agitated person receiving instructions from several directions has been given a task they cannot perform and will experience the room as an assault. And the designation is a live decision rather than an accident of who reached the trolley first: if the nearest person cannot do it, the role moves, at once and out loud, so everyone else knows to stop talking.

The rest of the team therefore have jobs which are not talking. Someone obtains the bedside physiology, someone interviews the people who brought the patient, someone is positioned so help can be signalled and reached. In a well-run department this is choreographed and almost silent, and the loudest failure mode is a room full of staff all reasoning with the patient at once.

IN INDIA

None of the numbers above describes a district hospital casualty at two in the morning, where the available team may be one postgraduate resident, one nursing officer with a whole department to run, and one security guard whose training is in guarding rather than de-escalation. The honest position is not to pretend the specification is met but to state what is substituted and what that costs. The designated-de-escalator rule becomes easier rather than harder to keep when there are only two staff: one talks, one does everything else. But the missing team members are exactly the people who would have run the parallel physical sweep, so where numbers are short the sweep is the first thing silently dropped and the last thing that should be. Accompanying relatives are almost always present, and they are at once the collateral source, a calming influence in some cases and an inflaming one in others, and people whose own safety the team is responsible for. Which relative stays in the room is a clinical decision taken by the person leading.

14.6 The parallel sweep: what is measured while somebody else is talking

The rule that organises the whole hour. The Project BETA medical evaluation consensus states that the complete history and physical examination may have to be interrupted to treat the patient's agitation, and resumed once the patient is less agitated. Two clauses make this coherent: the patient may need treatment to reduce agitation without a definitive diagnosis, and the goal of medication is to calm the patient enough to allow a thorough evaluation. Read the last one carefully, because it inverts the usual framing. Sedation is not the end of the assessment; it is an instrument of it. A patient who has been calmed and then left alone has received half a treatment, and the half omitted is the reason the other half was given.

What is swept is set out most usefully for a resource-realistic setting by the World Health Organization mhGAP Intervention Guide, written for non-specialised health settings, whose table on the person with agitated or aggressive behaviour directs the clinician to attempt to communicate with the person and, in the same breath, to evaluate for an underlying cause:

- check blood glucose, and give glucose if it is low;
- check vital signs including temperature and oxygen saturation, and give oxygen if needed;
- rule out delirium and medical causes including poisoning;
- rule out drug and alcohol use, considering stimulant intoxication and alcohol or sedative withdrawal specifically;
- rule out agitation due to psychosis or a manic episode.

The order of that list is the teaching. The psychiatric attribution comes last, reached by exclusion rather than by recognition. Note also how little equipment the sequence needs: a glucometer, a thermometer, a saturation probe and a pair of hands. This is a protocol a district hospital can actually run, which is why it is the one worth memorising.

The Royal College of Emergency Medicine guideline supplies the same idea as causes to exclude rather than acts to perform, naming substance intoxication and mental health conditions as the most common factors, alongside substance withdrawal, head injury, hypoglycaemia, seizures, heat

stroke and hypoxia. Serotonin syndrome and anticholinergic syndrome appear on the same list and are named here only; their recognition, discriminating features and treatment belong to the Schizophrenia: management, antipsychotics and adverse effects notes, and nothing resembling a grid comparing them belongs here. Taken as acts, the five this section owns are quick. Hypoglycaemia is excluded by a bedside stick, which takes less time than the argument about whether to do it. Hypoxia is excluded by a probe, which also detects the deteriorating patient nobody is watching because everybody is watching the behaviour. Head injury is excluded by looking, feeling the scalp, and asking whoever brought the patient about a fall or a blow, a question that stops being answerable once those people leave. Intoxication and withdrawal are excluded by history and examination, their entities belonging to the Substance use disorders notes, and delirium by cognitive assessment as far as the patient permits, the syndrome belonging to the Stroke, TBI, delirium and focal brain syndromes notes.

RULE **Assessment and calming are interleaved, not sequential.** The examination may be interrupted by treatment and then resumed, and treatment may precede the diagnosis, because the alternative is a patient who is neither evaluated nor calmed while the team waits for one to permit the other. The corollary is what makes this examinable: because the assessment is interrupted rather than abandoned, somebody must own resuming it. The commonest real failure is not that the sweep is refused but that it is deferred to a moment nobody owns, and the patient is found hours later, calm, undiagnosed, hypoglycaemic and still in the corridor.

LANE RUNNING IN THE FIRST MINUTES	WHAT IS DONE	WHAT IT MAY NOT WAIT FOR
Verbal contact	One designated person makes contact and holds it; if that person is untrained or unable, another is designated immediately	A diagnosis, or a more senior clinician arriving
Team and space	4 to 6 team members in a busy emergency service, drawn from nurses, clinicians, technicians and police and security officers if available	The patient becoming more disturbed before help is called
Bedside physiology	Blood glucose checked and glucose given if low; vital signs including temperature and oxygen saturation checked and oxygen given if needed	The patient becoming cooperative
Physical differential	Delirium and medical causes including poisoning excluded, and drug and alcohol use excluded	Laboratory results, which are directed rather than routine
Collateral	Ambulance crew, police, family, friends, relatives and nursing home personnel interviewed during behavioural stabilisation	The patient becoming interviewable
If restraint occurs	Oxygenation level and finger stick blood glucose done immediately, where they could not previously be obtained	The post-restraint review, or the next shift
History and examination	Interrupted to treat the agitation, then resumed once the patient is less agitated	A definitive diagnosis before any treatment

GOOD TO REMEMBER

Restraint is the moment the two easiest measurements finally become obtainable, and the moment they are most often forgotten. If a patient must be restrained because de-escalation was impractical or ineffective, then oxygenation level and finger stick blood glucose are done immediately where they could not previously be obtained. Build it in as a fixed pairing: hands on, probe on, stick done, before anybody leaves the bedside to write. Restraint converts two impossible tests into two immediate ones, and a team that does not take them has thrown away the one benefit it conferred.

2 arm's lengths MINIMUM DISTANCE ON APPROACHING AN AGITATED PATIENT	**4 to 6** DE-ESCALATION TEAM MEMBERS IN A BUSY EMERGENCY SERVICE	**1** PERSON DESIGNATED TO HOLD VERBAL CONTACT	**Immediate** OXYGENATION AND FINGER STICK GLUCOSE ONCE A PATIENT IS RESTRAINED

14.7 Collateral is taken now, while the patient is being stabilised

Collateral history here is not a step that follows assessment. The Project BETA medical evaluation consensus places it inside the stabilisation itself: during the time the patient is being behaviourally stabilised, the **ambulance crew, police, family, friends, relatives and nursing home personnel** should be interviewed to obtain a history or collateral information. Learn that as a list, because it is a list of people physically present at that moment and at no other.

This is the most perishable resource in the encounter. The ambulance crew has another call; the police stop being responsible once they have handed over. Each holds information nobody else has and the patient, by definition, cannot supply: what the person was like yesterday, when the change began and how fast, whether there was a fall, what was taken and how much, whether the tablets in the house have gone. An hour later, when the patient is calm and the clinician is free to take a history, all of them have gone and the information with them.

The operational answer is to assign it. The team member not holding verbal contact interviews the accompanying people while de-escalation is still running, and before releasing anyone. Two questions justify the exercise even when time is shortest: what is different about this person compared with yesterday, and what could they have taken or been given. In Indian practice the accompanying group is large and its members frequently disagree, and that disagreement is itself information about the timeline. The task is not to arbitrate but to record who said what, because a discrepancy about time of onset is often the first sign that the story offered is not the story that happened.

14.8 When de-escalation has not worked yet, and when it cannot be attempted at all

Two situations look identical from the doorway and demand opposite responses, and telling them apart is the discrimination this section exists to teach. The Project BETA de-escalation consensus states both. There are patients who cannot be effectively engaged and verbally de-escalated, and the example given is the **delirious patient**. Against that, training should emphasise that a patient may not respond to initial efforts at engagement and that **persistence** is indicated, especially where the patient is not showing signs of further escalation towards violence.

The distinction turns on capacity to engage rather than degree of disturbance. The delirious patient is the exemplar because the medium itself has failed: attention cannot be held, so a sentence does not arrive intact, and repeating it more calmly does not repair the channel. Verbal de-escalation there is not merely ineffective, it consumes the time in which the reversible cause should have been found. The syndrome and its assessment belong to the Stroke, TBI, delirium and focal brain syndromes notes, and the front-door management of the confused patient is dealt with elsewhere in this chapter.

The opposite error is commoner and more damaging. A patient who has not answered the first two attempts is frequently written off as unresponsive, when the guidance is explicit that failure of initial efforts is not the end point. The condition attached to persistence is behavioural rather than temporal, which makes it usable without a clock. If the patient is disturbed but not

escalating, keep going, because that is time in which the physical sweep and the collateral are being completed by everyone else in the room. If the patient is escalating despite engagement, or cannot engage at all, the situation has changed category and the response moves to the staged escalation that the Mental health legislation and forensic psychiatry notes and the Schizophrenia: management, antipsychotics and adverse effects notes set out in full, with every agent and dose. The authority under which that is done for a patient who cannot consent is a separate question, addressed with the rapid tranquillisation and legislation material.

One further point, because it is where good answers lose marks. Deciding that de-escalation cannot be attempted is a clinical judgement that must be recorded with its reason, like any other move to a more restrictive intervention. The reason is not that the patient was agitated. It is that this patient could not sustain attention on a sentence, or that a designated person attempted engagement and the behaviour escalated during it. That separates a considered escalation from an impatient one.

14.9 What must be true before the first hour ends

The end of this section is the beginning of everything else, and the handover is best stated as conditions rather than narrative. Before the patient leaves the resuscitation area or assessment room, the following should be true and recordable.

- A glucose and a saturation exist, with a time against each, and if the patient was restrained they were taken at that moment.
- Somebody has been interviewed who saw the patient before this episode, and their name is written down.
- A named person led the verbal contact, and a named person is responsible for resuming the interrupted examination.
- The medical presumption has been tested rather than assumed away, and if set aside, the reason is written.
- The level of care, the level of observation and the disposition have been decided by somebody rather than defaulted to by nobody.

The last of those is where this section hands over. Observation levels and the admission decision, the rapid tranquillisation protocol with its authority question and its monitoring, and the physical safety of a person in restraint each have their own place in this chapter. What has been established here is the material all three depend on: the room was chosen, the team assembled and one voice designated, physical causes excluded while the talking was happening, the people who knew the patient spoken to before they left, and the presumption of a medical cause carried until actively displaced. An answer that reaches the escalation ladder without any of that has described the treatment of a diagnosis nobody has yet made.

> Agitation is a presentation and never a diagnosis: the physical sweep runs alongside the talking rather than after it, and the psychiatric attribution is the last one made, not the first.

15 · Rapid tranquillization protocols

Why the marks are here. Rapid tranquillisation is examined as though it were a pharmacology question, and answered as one: which agent, in what order, at what dose. Those belong to the Schizophrenia: management, antipsychotics and adverse effects notes, which print the sequence and every first dose in it, and they are not repeated here. Take the drug chart away and what remains is the part that actually goes wrong on a ward. Rapid tranquillisation is a procedure. Like any procedure it has an indication statable in one sentence, an authority that must exist before it begins, a practitioner competent to manage what it may cause, a brief that fixes who does what, a written order whose form determines who thinks next, and a monitoring plan that outlives the drug by hours. Not one of those is a milligram.

The front of the emergency sequence, including the environment, the team, verbal de-escalation and the physical differential that runs in parallel with it, is set out with the assessment of the acutely agitated and aggressive patient elsewhere in these notes and is assumed rather than restated. What follows begins once the decision to sedate has been taken. The organising commitment is that the drug is the smallest and least dangerous component of the act, and that the avoidable deaths in this area happen in the hour after the injection rather than at the moment of it.

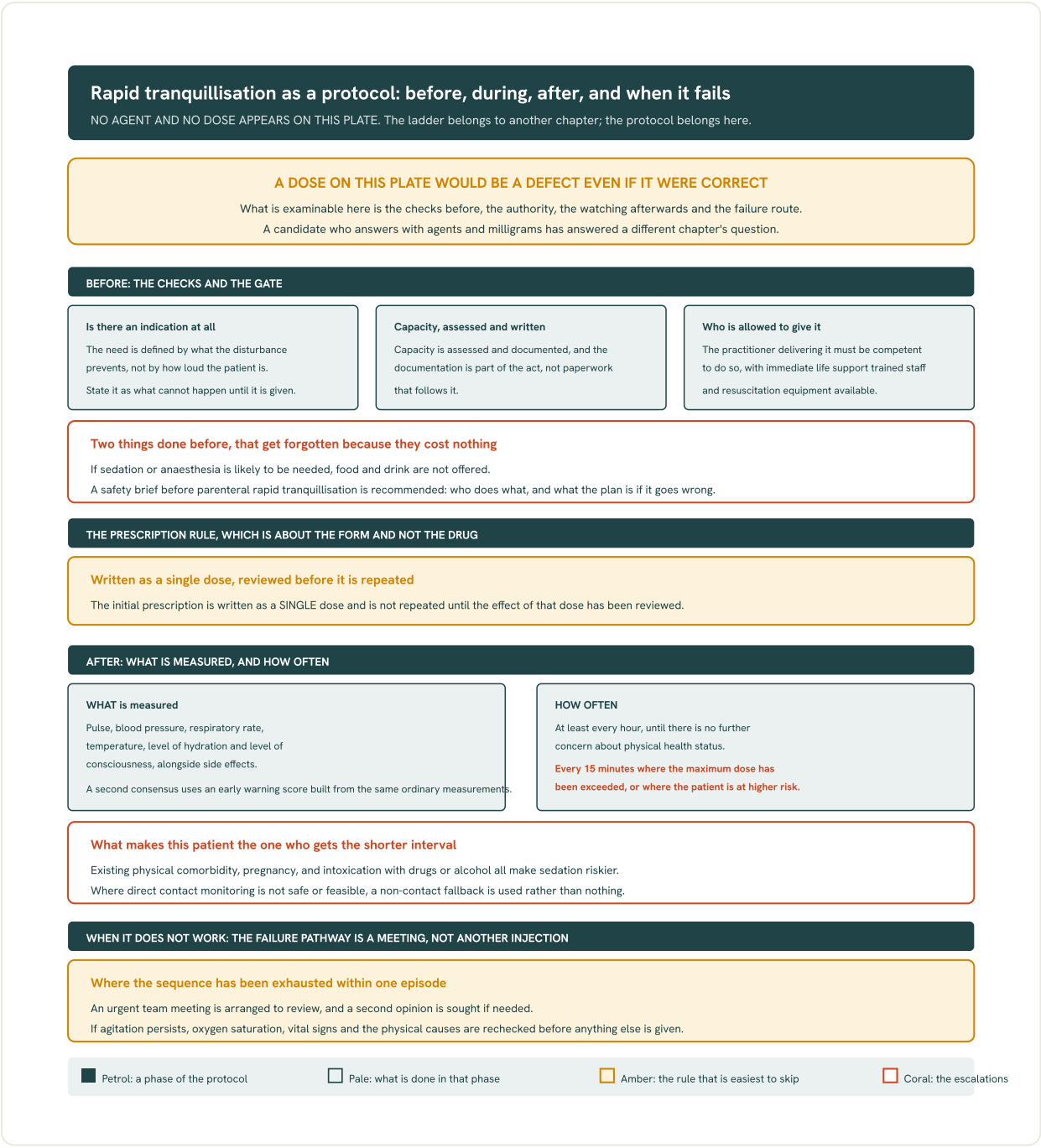


Fig 28.8. Rapid tranquillisation drawn as a protocol rather than as a drug ladder, with the indication test, the capacity assessment and the competence and resuscitation requirements before it, the single-dose prescription rule, the parameters measured afterwards and the two cadences that govern them, the patient factors that shorten the interval, and the failure pathway stated as an urgent team review rather than as a further injection. No agent and no dose appears anywhere on the plate.

15.1 The indication is what the disturbance prevents, not how disturbed the patient looks

The most useful answer to when this is indicated is a definition rather than a threshold. The Royal College of Emergency Medicine, in its best practice guideline on acute behavioural disturbance in emergency departments (version 2, October 2023), defines the need for rapid tranquillisation as the **inability to provide safe assessment or essential treatment**. That deserves a slow reading for what it declines to do. It does not define the indication by the patient's behaviour, by a level of arousal, by how frightened the staff are, or by a score on any instrument. It defines it by what the clinician cannot do while the disturbance continues.

The definition cuts both ways, and both cuts are examinable. A patient who is loud, threatening and frightening to be near, but who can be examined and whose essential treatment can be given, does not meet it. Noise is not the indication, and a department that sedates noise will sedate distress, grief and cultural difference along with illness. Conversely a patient who is barely raising his voice, but who will not permit the examination his physical presentation demands or is pulling out the line that is treating him, does meet it. The quiet obstructive patient is the one this definition catches and intuition misses.

It also imposes a discipline of statement. If the indication is an inability, the clinician must say what it is an inability to do: this assessment, this investigation, this treatment. That sentence belongs in the record before the drug is drawn up, and it does a second job at review, because the question afterwards is not whether the patient is calmer but whether the thing that could not be done can now be done. Where nobody can complete the sentence, what is being treated is the department's distress.

RULE **Rapid tranquillisation is indicated by what the disturbance prevents, never by how disturbed the patient appears.** Everything else in the protocol follows. The indication states a purpose, the purpose sets the endpoint, the endpoint is what the post-dose review tests, and the monitoring exists to keep the patient alive until that review can be made. A protocol entered without a stated purpose has no endpoint, and sedation without an endpoint becomes sedation renewed by habit.

15.2 Authority: capacity is assessed and written down, never assumed

The act contemplated is giving a drug to an adult who has not agreed to it, which requires an authority, and the authority has two halves that candidates collapse into one: legal permission to treat without consent, and clinical competence to carry the treatment out. The second is the next section. The first begins with capacity, and the guidance is blunt about how it is handled. The Royal College of Emergency Medicine states that patients presenting with severe acute behavioural disturbance are likely to lack capacity to make treatment decisions and may require emergency treatment, and that this should be **formally assessed and documented**.

The two clauses pull against each other deliberately, and that tension is the teaching. The first is an empirical expectation: in this population incapacity is the likely finding. The second forbids acting on the expectation without checking it, because a likelihood is not a finding. The error runs both ways. The commoner one treats the disturbance as self-evidently establishing incapacity, so no assessment is made and the record contains a drug and no reasoning. The rarer one accepts a fluent refusal as evidence of capacity, because the patient is talking in sentences, and withholds treatment from someone who cannot retain or weigh what he is being told.

Formal assessment here does not mean an unhurried capacity interview, which the situation does not permit and the guidance does not demand. It means an assessment was attempted and its result recorded: what the patient was told, what he was able and unable to do with that information, and the conclusion. Two or three contemporaneous lines will do; nothing will not. The documentation is load-bearing rather than bureaucratic, because the record is the only later

evidence that the injection was a treatment decision rather than a convenience, and every subsequent review or inquiry begins by reading it.

One jurisdictional caution must be stated rather than smoothed over. The rule above is a United Kingdom statement of the step. The statutory basis on which a patient may be treated without consent in an emergency in India, and the position of restraint within that law, are set out in the Mental health legislation and forensic psychiatry notes, with the consent doctrine itself in the Forensic ethics, consent and legal procedure notes. They are named here and not restated, and no Indian statutory provision is asserted in this section. What survives translation is the structure of the obligation: identify the ground you are acting on, satisfy yourself it applies to this patient now, and write down that you did.

TRAP **Treating the disturbance as though it were the capacity assessment.** Candidates write that the patient was agitated and therefore lacked capacity, which reverses the logic: severe disturbance makes incapacity likely, and likelihood is exactly what an assessment is for. The error is attractive because it saves time in a situation that has none, and because the conclusion is usually correct, which is what makes it dangerous. A correct conclusion reached without an assessment is indistinguishable in the record from no conclusion at all, and it is the record that is examined afterwards. State the assessment and its documentation as a discrete step with its own place in the sequence, before the drug rather than after it.

15.3 Competence: who may give it, and who must be within reach

The second half of the authority question is clinical, and no legal framework answers it. The same emergency medicine guideline states that the practitioner delivering rapid tranquillisation must be **capable of managing those complications** if they arise, that care of the patient presenting with acute behavioural disturbance should be provided by a senior emergency medicine practitioner, and that early critical care support should be considered. The complications in view are recorded in the same source as apnoea, airway obstruction and a subsequent requirement for intubation, associated with most of the sedative agents used in this situation.

Put plainly: whoever gives a drug that may stop the patient breathing must be able to manage a patient who has stopped breathing. This is not about hierarchy or prescribing rights. It is about which skills are physically present in the room when the plunger goes down, and it has an uncomfortable implication for the common arrangement in which the decision is taken by a senior over the telephone and executed by whoever is on the floor. The decision may be delegable. The airway is not.

The standard is stated again from a different direction by the National Institute for Health and Care Excellence in its guideline on the short-term management of violence and aggression, NG10, published in 2015: staff trained in **immediate life support**, and a doctor trained to use resuscitation equipment, should be immediately available to attend an emergency wherever restrictive interventions might be used. Read the limbs together, because the standard is equipment plus a person competent to use it and neither discharges it alone. A resuscitation trolley behind a locked door, and a nurse trained in life support on a ward whose defibrillator is three floors away, both fail it while appearing on paper to meet it.

Note also that the standard attaches to the possibility of a restrictive intervention rather than to its occurrence. It is a rostering and geography requirement settled before any particular patient arrives, which is why it cannot be improvised at the moment of need. The same logic explains considering critical care support early: an early call is made while there is still time for someone to walk to you, whereas a call made once the saturation is falling has become an emergency referral.

15.4 Before the drug: who is less safe to sedate, and the check everyone forgets

Pre-sedation assessment here is compressed and often uncooperative, so it has to be selective. The joint consensus guideline of the British Association for Psychopharmacology and the National Association of Psychiatric Intensive Care and Low Secure Units, published in 2018, names the factors conferring additional risk on the act of sedation itself:

- pre-existing physical health comorbidity, which converts a transient respiratory or haemodynamic effect into a decompensation;
- pregnancy, where the decision is being made for two patients at once and restraint positioning changes as well, taken up with the perinatal emergencies elsewhere in these notes;
- intoxication with, or withdrawal from, drugs or alcohol, the commonest unknown at the front door and the one most likely to be additive with what you are about to give;
- the potential for medication interactions, which in a patient whose regular prescription is unknown is a risk accepted rather than assessed.

The same source adds a category easy to miss because it is not pharmacological at all: non-medication risks are also a factor, and they include **the process of restraint** itself. This changes how the decision is framed. Clinicians weigh sedation against restraint as though they were alternatives and only one risk were being taken; in practice parenteral rapid tranquillisation in a resisting patient is delivered under restraint, so the two risks are additive and arrive together. The physical hazards of holding a person, and the observation that person needs during and after the hold, are taken up separately in these notes.

One further instruction deserves separate billing as the most reliably forgotten line in the protocol. The emergency medicine guideline directs that where sedation or general anaesthesia is likely to be required, the patient should be offered **no food or drink**. It is a short rule with a large consequence, and its difficulty is that it runs against the instinct that de-escalation trains into a good clinician.

PITFALL

De-escalation works partly through ordinary kindness, and the commonest ordinary kindness in an Indian casualty is a cup of tea or a glass of water brought by a relative who has been waiting outside for hours. If the patient is on a path towards parenteral sedation, that kindness fills the stomach of a person who may shortly be obtunded, unable to protect the airway and supine under restraint. The instruction is not to be unkind. It is to decide early whether sedation is likely, say so to the team and to the family in the same breath as the explanation of what is happening, and substitute a kindness that does not enter the stomach. A team that has not made this decision explicitly makes it by default, and the default is the tea.

15.5 The safety brief, and the three elements that make it more than a formality

Parenteral rapid tranquillisation is a team procedure performed at speed on a resisting person, which is the exact configuration in which tasks get duplicated, tasks get dropped, and nobody notices either. The emergency medicine guideline answers this with an instrument borrowed from surgery and resuscitation: it recommends considering a **safety brief** before parenteral rapid tranquillisation where practicable, covering roles, the intended plan, anticipated problems, restraint considerations, the intravenous access plan, the plan for moving to a resuscitation environment, and responsibility for the decision to relax restraint.

Each element removes a specific failure. Roles removes duplication: who holds which limb, who protects the head and airway, who draws up and gives, who keeps time, who continues talking to the patient, and who is doing none of these because they are watching the whole room. The intended plan removes the situation in which two people execute different plans in good faith. Anticipated problems converts a foreseeable crisis into a contingency somebody has already been assigned. Restraint considerations settles position and duration before adrenaline rather than during it.

The last three separate a brief from a formality. The intravenous access plan is settled beforehand because access gets harder as the patient becomes more disturbed and then more sedated, so the moment you urgently need a line is the moment you are least able to get one. The plan for moving to a resuscitation environment is a route, a trolley, a door and a person, worked out while there is time to walk it; a team that has not settled it discovers the lift is on another floor while carrying a patient who is not breathing. Responsibility for the decision to relax restraint is the element most often left unassigned, at the moment it matters most, because releasing too early and holding too long are both harmful and a team with no named owner does neither deliberately.

The guidance qualifies the brief with the words where practicable, and that should be taught honestly rather than quietly dropped. Some situations do not permit a huddle. They do permit a compressed version delivered in the corridor: roles, plan, who calls the release. The brief is a distribution of attention rather than a document, and a shortened brief distributes far more of it than none.

MNEMONIC

Who, What, What if, Hold, Access, Exit, Release

The seven elements of the brief in the order they are needed. **Who**: roles. **What**: the intended plan. **What if**: anticipated problems. **Hold**: restraint considerations. **Access**: the intravenous plan. **Exit**: the route to a resuscitation environment. **Release**: the named owner of the decision to relax restraint. Teams that skip one skip the last, and the last is the one whose absence is felt at the most dangerous moment.

15.6 The order is written as one dose, and the review is what makes it a protocol

How the prescription is written determines who makes the next decision, which makes the form of the order a clinical matter and not a clerical one. The national guideline on violence and aggression recommends that the initial prescription for rapid tranquillisation is written as **a single dose**, and is not repeated until the effect of that dose has been reviewed.

The rule is doing something precise. An order written open, in the familiar form permitting repetition as required, silently transfers the next decision to whoever holds the chart when the patient is next disturbed. In practice that is the most junior person on the floor, at night, under pressure from a ward that wants quiet, assessing a patient who by then is least able to object. A single-dose order makes repetition impossible without a clinician returning to the patient, which is the point: it forces a fresh act of judgement at the moment the risk of accumulation begins.

It is also what makes the monitoring meaningful, so the two are always taught together. Observations recorded with no decision attached are chart-filling, and wards produce a great deal of it. The review of effect is what the observations are for, and it has two limbs that must both be answered. The clinical limb returns to the stated indication: can the assessment now be made, can the essential treatment now be given. The physiological limb asks what the drug has done to breathing, circulation and conscious level. A review answering only the first is how a patient becomes calm, monitored and dead.

GOOD TO REMEMBER

Write four things into the same entry as the order and it becomes a protocol rather than a prescription: the indication in the inability form, the single dose given, the time the effect will be reviewed, and the name of the person who will review it. A team that writes only the drug has documented an event. A team that writes all four has documented a decision, and has left the only instruction that survives a shift change.

15.7 After the dose: what is measured, how often, and until when

This is the genuinely owned part of the topic and the part most often missing from an answer. After rapid tranquillisation, the national guideline on violence and aggression directs that side effects and the patient's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness are monitored at least **every hour**, until there are no further concerns about the patient's physical health status. The interval shortens to **every 15 minutes** where the maximum dose has been exceeded, or where the patient:

- appears to be asleep or sedated;
- has taken illicit drugs or alcohol;
- has a pre-existing physical health problem;
- has experienced any harm as a result of any restrictive intervention.

The first trigger is counter-intuitive and is the one wards get wrong: the more successful the sedation looks, the closer the monitoring gets. A sleeping patient reads to a busy team as a solved problem and to this protocol as an escalation, because sleep and over-sedation are indistinguishable from the end of the bed and the difference between them is the airway. The fourth trigger matters too, because harm sustained during restraint escalates the monitoring of the sedation, which is the protocol acknowledging that the two interventions have combined into one physiological insult.

Every hour	Every 15 min	4	97%
MINIMUM MONITORING INTERVAL AFTER RAPID TRANQUILLISATION, NICE NG10	NICE INTERVAL WHEN ANY ESCALATION TRIGGER IS PRESENT	BAP AND NAPICU MONITORING LEVELS, LOW TO CRITICAL	OF 44 UK RAPID TRANQUILLISATION DOCUMENTS NAMED MONITORING PARAMETERS

Notice what is missing. This cadence has no fixed end. It runs until there are no further concerns about physical health status, which is a clinical stopping rule and not a duration, and the omission is deliberate. A fixed period invites a team to stop at the end of it, and the risk from a sedative does not expire on a clock; it expires when the physiology says so. The corollary is that somebody must be nominated to decide the concern has ended, because a stopping rule with no owner does not stop, it lapses.

The parameter set is worth comparing with the one the other major consensus uses, because they differ instructively. The joint BAP and NAPICU guideline monitors using the **National Early Warning Score**, which it defines as comprising temperature, pulse, systolic blood pressure, respiratory rate, oxygen saturation and level of consciousness. The instrument is named and its constituents are ordinary clinical measurements; no scoring, weighting or trigger threshold from it belongs in an answer.

PARAMETER	WHICH SET NAMES IT	WHAT IT IS WATCHING FOR
Respiratory rate	Both sets	Respiratory depression, and the earliest bedside warning of it
Level of consciousness	Both sets	Depth of sedation, and whether the airway is still protected
Pulse	Both sets	Rate and rhythm disturbance, and the cost of the preceding struggle
Blood pressure	Both sets, systolic specified in the early warning score	Hypotension, including the postural drop seen only on sitting up
Temperature	Both sets	Pyrexia, which after antipsychotic exposure changes the diagnostic frame
Oxygen saturation	Early warning score only	Hypoxaemia, and the measurement a resisting patient will usually tolerate
Level of hydration	NICE set only	Prolonged struggle, refused fluids and a period nil by mouth
Side effects	NICE set only	Drug effects no physiological number displays, found only by looking

15.8 Stratifying the monitoring: level set by route and by state, not by drug

The joint BAP and NAPICU consensus goes beyond a single interval and stratifies direct contact monitoring into **four** levels, each pairing a physical cadence with an observation intensity. Only the physical cadence is taught here. The observation intensity is a sixth vocabulary for a construct that already has five in print, and both the levels and the fact that their names do not agree across documents belong with observation after self-harm elsewhere in these notes; naming an intensity in this consensus's words to a nurse working in another document's words communicates nothing. Its own statement of status travels with it: the source records that these levels rest on the consensus of experts, given the dearth of available evidence. That label is not a reason to discount them. It tells the reader what kind of authority an interval carries, and it is why a local protocol may legitimately differ from this one while a local protocol that differs from a physiological principle may not.

LEVEL	WHICH PATIENTS	PHYSICAL MONITORING	OBSERVATION
Low	Following pre-tranquillisation medication	Early warning score or equivalent every hour, minimum one hour	Standard psychiatric observations every hour
Medium	After intramuscular rapid tranquillisation, no higher level required	Early warning score or equivalent every 15 minutes, minimum one hour	Intermittent psychiatric observations every 15 minutes
High	After intramuscular rapid tranquillisation, over-sedated, asleep or significantly physically unwell	Early warning score or equivalent every 15 minutes, minimum one hour, with pulse oximetry until ambulatory	Continuous, within line of sight
Critical	After intravenous rapid tranquillisation, or unconscious and not rousable, or severely physically unwell	Continuous monitoring, resuscitation facilities essential	Continuous, within arm's length

Two design features are the transferable part. First, the level is set by the route of administration and by the patient's state, never by which agent was used: intravenous administration goes to the top level regardless of what was given, and unrousability does the same. A candidate reasoning from the drug to the monitoring has the logic inverted. Second, the recovery marker at the high level is that the patient is ambulatory rather than talking. Walking tests conscious level, coordination, standing blood pressure and postural airway control at once, which makes it a better endpoint than conversation and available on any ward without equipment.

The observation column belongs to a construct taught in full with the emergency management of suicide risk elsewhere in these notes, where the levels, who sets them, who reviews them and what the handover carries are set out. What this section owns is the pairing: after rapid tranquillisation a physical cadence and an observation intensity are prescribed together, and prescribing one without the other leaves a patient either watched but not measured, or measured but not watched.

15.9 When the monitoring the protocol assumes does not exist

The honest problem. Every cadence above assumes a working pulse oximeter, a cuff the patient will tolerate, a thermometer, a member of staff who can stay in the room, and a resuscitation capability within reach. That set is frequently incomplete, and pretending otherwise produces an answer that is correct and useless. The consensus guideline addresses incompleteness directly, though from a different starting point: for patients in whom direct contact physical monitoring is not safe or feasible, it directs that **non-contact physical monitoring** be conducted until direct contact monitoring can be established, comprising:

- respiratory rate;
- level of consciousness;

- pallor;
- signs of pyrexia;
- evidence of dystonia or akathisia;
- signs of dehydration.

Notice the design of that set. Every item is obtainable from the end of the bed by a clinician with no equipment and no cooperation, which makes it usable both in the situation the guideline describes, where touching the patient is unsafe, and in the situation an Indian ward more often faces, where the equipment is elsewhere. The extension from one to the other should be made explicitly rather than smuggled: the source frames the constraint as safety or feasibility, not as resource scarcity, and a candidate who cites it as guidance about under-resourced settings has overstated it. What transfers legitimately is the principle that when the measured set is unavailable the answer is a different observation set, not an absence of observation. Two further features matter. The fallback is temporary by construction, since it runs until direct contact monitoring can be established, so adopting it carries a standing obligation to keep trying. And it is not a diluted version of the full set but a differently chosen one, weighted towards what a human observer detects reliably without instruments.

Protocol variation in this area is real and has been measured, rather than being a complaint. In national surveys of United Kingdom mental health organisations reported by the same consensus guideline, nearly all of the rapid tranquillisation documents examined specified monitoring parameters, but **14** different parameters appeared across them. Those were United Kingdom documents and say nothing about Indian practice, so the figure establishes only that having a protocol is not the same as having a standard. The consequence for a case sheet is that the phrase as per protocol records nothing: name the parameters actually measured and the interval actually used.

IN INDIA

In a district hospital casualty at night the full monitoring set is often not assembled, and the honest response is neither to recite the guideline nor to abandon it, but to state what is being substituted and what that costs. Name the observer: a cadence assigned to the ward is assigned to nobody, and where staff are few the single most effective act is to write one person's name against the observation until relieved. Run the non-contact set from the bedside, since it needs nothing and can begin the moment the injection is given rather than when a trolley is found. Prioritise the pulse oximeter above every other instrument if only one can be brought, because it is continuous, tolerated by a resisting patient, and directly relevant to the complication that actually kills. And record what was not available, in plain terms. That record is both an honest account of the care given and the only thing that has ever changed what a ward is equipped with.

15.10 Failure: what is done when the patient is still disturbed

Sedation that does not work is a common examination scenario and a dangerous clinical moment, because the instinctive response is to give more of the same and the guidance says something else. Where the sequence of intramuscular options has been exhausted within an episode, the

national guideline on violence and aggression directs that **an urgent team meeting** be arranged to carry out a review, and that a second opinion be sought if needed. The agents and their order belong to the Schizophrenia: management, antipsychotics and adverse effects notes and are not reproduced here; what is owned here is the terminal step, and the striking thing about it is that it is not pharmacological. At the end of the ladder the recommended intervention is more clinicians, not more drug.

The World Health Organization mhGAP Intervention Guide, version 2.0 (2016), written for non-specialised settings, reaches the same destination by a different road. If the person remains agitated it directs the clinician to recheck oxygen saturation, vital signs and glucose, to consider pain, and to refer to hospital; and once agitation subsides, to move to the assessment that identifies what is actually wrong. Failure is treated as a reason to repeat the physical sweep, not to escalate the dose.

Held together, the two pathways teach one thing: failure of sedation is a diagnostic event. One response escalates the number of people making the decision, the other escalates the examination, and neither escalates the syringe. That is clinically right as well as procedurally safe, because the commonest reasons a correctly given sedative fails are that the cause of the disturbance is not the one assumed, that a physiological derangement is driving it, or that something is hurting.

Pain deserves its own sentence, since the instruction to consider it sits in a guideline written for clinicians with the fewest resources and is the cheapest thing on this page. The patient who cannot give a history is the patient whose pain is never asked about: retained urine after hours of restraint and immobility, an injury sustained in the struggle, a surgical abdomen underneath the agitation. An analgesic and a bladder scan have settled patients two rounds of sedation did not. The disposition follows from the same logic. Once the disturbance subsides the assessment begins rather than ends, and where the patient goes next is set by the monitoring level he currently needs rather than by which ward has a bed.

> Rapid tranquillisation is a procedure, not a prescription: an indication stated as something you cannot do, a capacity assessment written down, a practitioner who can manage the airway, one dose with a named reviewer, and a monitoring cadence that runs until someone decides the physical concern has ended.

16 · Suicide risk assessment and emergency management

Why the marks are here. The suicidal patient is examined as though suicide risk were an assessment problem alone, and it is half of one. Assessment produces a judgement; the judgement then has to become something a ward can deliver over the next several hours: a level of observation, decisions about the room and what is in it, an admission decision, and conditions that must hold before the patient leaves. The framework for estimating risk, the disposition ladder and the counselling of patient and family about access to lethal means at home belong to

the Somatic-symptom, sexual, impulse-control disorders and suicide notes and are not repeated here.

One warning governs everything below. The documents that create observation levels do not agree with each other: they use the same word for different things and different words for the same thing, and most decline to fix an interval at all.

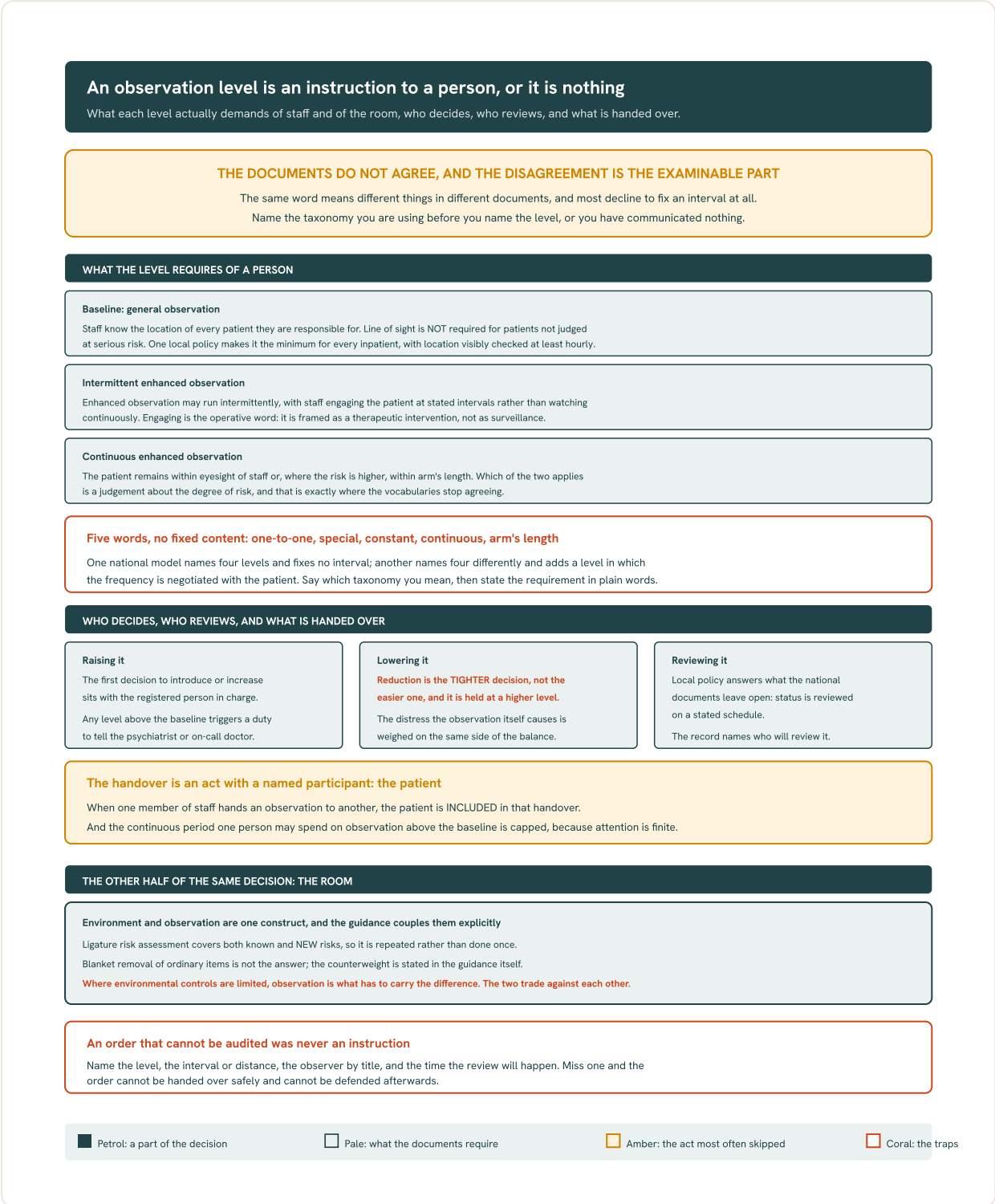


Fig 28.9. Observation as a decision rather than a label, with each level stated as what it requires of a person and of the room, the five interchangeable words that carry no fixed content across documents, the asymmetry by which raising a level is easier than lowering it, the review and the handover in which the patient is a named participant, and the environmental controls that observation has to compensate for when they are absent.

16.1 What an observation level is, and what it is for

Clinical observation is defined in the English self-harm guideline as a therapeutic intervention, used most commonly in hospital settings, that allows staff to monitor and assess the mental and physical health of people who might harm themselves or others, and to be seen as an opportunity for active engagement as well as sensitive supervision. Physical health sits inside that definition, which is where psychiatric observation and medical monitoring stop being separable: the observer is the person most likely to notice a falling conscious level, or developing aspiration in a sedated patient.

The statutory Code of Practice is more explicit about purpose. It calls **enhanced observation** a therapeutic intervention aimed at reducing the factors that contribute to increased risk and promoting recovery, describes its content in deliberately ordinary language as sitting with the person, talking, and supporting participation in activities, and names its indication as the short-term management of behavioural disturbance, or a period of distress, to prevent suicide or serious self-harm.

So a member of staff on a chair at the door, completing a form at intervals and not speaking to the patient, is not delivering the intervention these documents describe. An observation that generates no information is a rota cost with no clinical yield.

16.2 The baseline, and the named levels above it

Every taxonomy begins from a baseline, and the baseline is itself a decision. The Code sets it in one sentence: staff should know the location of all patients for whom they are responsible, and it is not necessary routinely to keep within sight those not considered to present a serious risk of harm to themselves or others. **General observation** is defined by knowledge of location, not by line of sight. One English trust operationalises it as the minimum level for every inpatient, with location and safety visibly checked **at least once an hour**, and rules out closed-circuit television as a substitute: a camera shows that a corridor is empty, not that a patient in a bay is breathing.

Above the baseline the English violence-and-aggression guideline names four levels. **Low-level intermittent observation** is its baseline for a specified psychiatric setting, once every **30 to 60 minutes**; **high-level intermittent observation**, for the patient at risk of becoming violent or aggressive but not presenting an immediate risk, runs once every **15 to 30 minutes**; above these sit continuous observation, built around a designated one-to-one nurse, and **multiprofessional continuous observation** for the highest risk. All four are defeasible: they apply unless a locally agreed policy states otherwise.

The statutory Code covers the same ground differently. Its intermittent enhanced observation is delivered at irregular and unpredictable intervals, and the irregularity is specification rather than accident, because a patient who can time the door knows how long they have. The Code adds that high use of intermittent observation has been shown to be associated with low levels of self-harm and to be tolerated by most patients. Its own **continuous observation**, and the trust's separately named **within arm's length observation**, sit alongside the national scheme rather than mapping onto it.

A second jurisdiction shows how much of this is convention. An Australian state guideline offers what it calls one possible model and fixes no interval anywhere in it: frequency and pattern follow the identified risk factors and the purpose of the observation. Its fourth level, **negotiated observation**, has nurses negotiate the frequency of engagement with people who have no identified risk factors requiring intermittent or constant observation, and is the only level in any of these documents whose frequency is set with the patient rather than for them.

DOCUMENT AND THE LEVEL AS IT NAMES IT	FREQUENCY OR PROXIMITY THAT DOCUMENT FIXES
Code of Practice: general observation	No interval; location known, those not a serious risk need not be in sight
English trust policy: general observation	Visible check of location and safety at least once an hour; cameras excluded
Violence-and-aggression guideline: low-level intermittent	Observation once every 30 to 60 minutes
Violence-and-aggression guideline: high-level intermittent	Observation once every 15 to 30 minutes
Code of Practice: intermittent enhanced observation	Intervals of between 15 and 30 minutes, deliberately irregular
Violence-and-aggression guideline: continuous	Within eyesight or arm's length of a designated one-to-one nurse
Code of Practice: continuous enhanced observation	Within eyesight, or arm's length for the most serious degrees of risk
Violence-and-aggression guideline: multiprofessional continuous	Within eyesight of 2 or 3 staff members and arm's length of at least 1
English trust policy: within arm's length	Close proximity, held during lavatory and bathroom use; care plan states staff numbers and distances
Australian state guideline: constant, arm's length and visual	Continuous one-to-one nursing observation by an experienced nurse
Australian state guideline: intermittent	No interval fixed; risk factors and purpose set frequency and pattern
Australian state guideline: negotiated	No interval fixed; frequency of engagement agreed with the patient

TRAP **Treating one-to-one, special, constant, continuous and arm's length as synonyms.** The confusion sits in the source documents, not in the reader. "Continuous" sometimes means eyesight and sometimes arm's length according to the degree of risk; "constant" is the Australian word for a similar idea and is itself split in two; "one-to-one" is a staffing ratio appearing inside several levels rather than a level of its own. Asked what one-to-one observation involves, say that the term has no fixed content, name the taxonomy you are using, then state the requirement. A level written in a vocabulary the receiving nurse does not use has communicated nothing.

Only four intervals are fixed anywhere in the English violence-and-aggression guideline; everything else is remitted to the provider's own policy. That division between what a national document fixes and what it delegates is the most useful single thing to carry into a question here.

30 to 60 min	15 to 30 min	2 hours	1 week
LOW-LEVEL INTERMITTENT OBSERVATION	HIGH-LEVEL INTERMITTENT OBSERVATION	LONGEST UNBROKEN SPELL ONE OBSERVER MAY HOLD	OBSERVATION THIS LONG TRIGGERS MULTIDISCIPLINARY REVIEW

16.3 Moving up: the trigger, the authority, and who must be told

The escalation rule in the Code is not a score: continuous observation should be carried out when intermittent observation is seen as insufficient to safely manage risks. That is a question about the sufficiency of the lower level rather than about how high the risk is, and it is the better question, because it forces the clinician to say what the lower level would fail to prevent and therefore what would have to change for the level to come down. No sourced document makes an instrument score the trigger, and no suicide-risk instrument's items, anchors or cut-offs appear here; the instruments belong to the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

The first decision is a nursing one. The trust policy places the decision to introduce or increase observation, in the first instance, with the registered person in charge, where possible with medical staff and in response to an assessed risk, while holding that wherever possible it is made jointly by the multidisciplinary team and the patient. Medical involvement follows immediately rather than first: the violence-and-aggression guideline requires that the patient's psychiatrist or the on-call doctor be told as soon as possible whenever observation above the general level is carried out, and requires the record to carry the names and titles of the staff responsible for reviewing observation levels and when that review will happen. A reviewer who is a role rather than a person does not, in practice, review.

The level is never set on its own. The trust policy pairs it with an environmental decision, requiring consideration at the same time of searching the patient and their room or property and removing potentially harmful objects. How much of one is needed depends on how much of the other is already in place.

RULE **An observation level is a prescription, not a mood.** It has a named person who set it, a stated frequency or distance, a named reviewer recorded with their title, and a stated time at which the review will happen. A level entered without those four elements cannot be audited, cannot be handed over safely, and cannot be defended afterwards.

MNEMONIC

Level, interval, distance, observer, review

The five things an observation order must state before it is an instruction rather than an intention. **Level**: which named level, in the taxonomy this hospital's own policy uses. **Interval**: how often, if intermittent, and whether the spacing is deliberately irregular. **Distance**: eyesight or arm's length, and how many staff. **Observer**: who may hold it, and whether it may be delegated. **Review**: by whom, by name and title, and when.

16.4 Coming down, and the review that is supposed to bring it down

What the national guideline does not do is fix how often the routine review happens. Instead it requires every provider organisation to hold a policy on observation and positive engagement, and prescribes its contents:

- the definitions of the levels of observation the organisation will use;
- who can instigate, increase, decrease and review observation;
- when an observer should be male or female;
- how often reviews should take place;
- how patients' experience of being observed is taken into account;
- how observation is underpinned by continuous attempts to engage therapeutically;
- the levels of observation necessary during other restrictive interventions;
- the need for multidisciplinary review when observation continues for **1 week** or more.

The guideline fixes exactly one interval there and hands the routine interval to the local document. So the answer to "how often is an observation level reviewed" is not a number: the provider's own policy is required to state one. The trust policy supplies a worked example, requiring review a minimum of daily for any patient nursed above general observation level, with the care plan setting out in advance the conditions and observed behaviours that would allow a prompt reduction.

Reduction is deliberately the tighter decision. One registered person in charge may raise a level immediately; no one person may lower it. Because these patients are by definition those judged at highest risk, reduction follows a formal process producing a team decision founded on a current mental state and risk assessment and on the views of patient and carers, normally taken by registered nursing staff or a mental health practitioner with the team. One delegated route exists: where the responsible clinician and team have identified the circumstances in advance, 2 registered practitioners may implement the change in their absence.

Without a counterweight the level accumulates, rising on one clinician's judgement in seconds and falling only through a meeting. The Code supplies that counterweight as a duty: staff must weigh the distress that increased observation itself causes, particularly over many hours or days, against the identified risk of self-injury or behavioural disturbance, and must record every decision to increase or decrease.

GOOD TO REMEMBER

Write the exit criterion in the same entry that raises the level, in observable terms: what the patient would have to be doing, and over what period, before the level comes down. A team that has not pre-agreed this keeps patients at enhanced levels long after the clinical reason has gone, because at every review the safest decision for the individual reviewer is to change nothing.

16.5 The observer, the staffing cap and the handover

An enhanced level is a staffing decision before it is a clinical one, and the guideline concedes the point with a number. An individual staff member should not undertake a continuous period of observation above the general level for longer than **2 hours**, and where it is needed for longer, that staff member must be given regular breaks. The rationale is attentional rather than industrial: sustained vigilance directed at one person degrades with time on task. So every hour of enhanced observation must be filled by a named person on a rota, and the cap manufactures handovers inside every shift, which the documents specify:

- when one staff member hands an observation to another during a period of observation, the patient is included in the discussion where possible, so the handover is an event the patient is party to rather than a staff transaction about them;
- the staff member ending a period of additional observation gives a verbal handover, mindful of confidentiality, to the staff member taking over, involving the patient and their family or carer wherever possible;
- at the change of shift, the persons in charge of the outgoing and incoming shift are together responsible for reviewing and signing the observation record, confirming the documentation, and physically seeing the patients.

"Physically see the patients" is the load-bearing phrase. The characteristic serious incident involving an observed patient is not a level set too low; it is a level set correctly, recorded as delivered, and not delivered. A signature shows that a form was completed, and laying eyes on every patient is the only step here that checks the record against the world.

IN INDIA

None of the taxonomies above is Indian, and no Indian national standard for observation levels, intervals or observer-to-patient staffing is quoted here because none was available to quote. The operative document on any Indian unit is that hospital's own policy. The service reality bites hardest at the staffing cap: continuous observation, rotated as the guidance requires, consumes observer-blocks that a district unit with a thin night establishment cannot produce, and the gap is filled by a family attendant sitting with the patient. That is an understandable adaptation and it is not the intervention the guidance describes, because a relative has not been selected by profession and grade, cannot document, cannot be rotated off, and may be the person the patient least wants at the bedside. Where it is unavoidable, record the arrangement, state narrowly what it is relied on to prevent, and compensate through the environmental measures, which cost fixtures rather than nurses.

16.6 Privacy, dignity and the person being observed

The level that best protects life is the level that most intrudes on the body, and the documents handle this by requiring the intrusion to be planned rather than improvised. The Code makes the provider's policy on enhanced observation settle four things in advance: which profession and grade should hold the observation and when the duty may be delegated; how the observer is matched to the patient, with ethnicity, sexual identity, age and gender named; how the intervention is delivered so that it is least likely to be perceived as coercive; and how privacy is protected in states of undress, which the Code specifies as using the toilet, bathing, showering and dressing. The trust policy carries the same into the care plan for its closest level, requiring privacy, dignity and the gender of allocated staff to be written in, while stating plainly that observation is maintained when the patient uses lavatory or bathroom facilities.

The error this prevents is predictable. Faced with an undignified moment and no written plan, a nurse improvises, and the improvisation is almost always to relax the level informally for its duration: to step outside the bathroom door, or to turn away. That is the most predictable point of failure at an arm's length level, it is unrecorded by definition, and the next shift inherits a level that has quietly stopped meaning what it says.

16.7 Observation outside the psychiatric ward

Most patients who have just harmed themselves are not on a psychiatric ward. They are in an emergency department or on a medical ward, where the decision must be made by two teams sharing neither a policy nor a vocabulary nor a line of accountability. The English self-harm guideline makes close observation there a joint decision of mental health and acute ward staff, taken case by case with the person's views taken into account, and attaches three conditions: appropriately skilled and trained healthcare staff, the informed consent of the person or an appropriate legal framework, and regular review. Each fails in a recognisable way. Skilled and trained staff means a security guard posted at a bedside is not an observer, whatever the nursing note records. Regular review means an observation ordered on the night of admission does not silently persist through a long medical stay. And the consent clause is the medico-legal hinge of the subject.

The refusing patient. Observation, and continued presence in hospital, are either consented interventions or legally authorised ones, and no third category exists. Where the patient does not consent and the judgement is that they must be observed, or must remain, the decision moves from a clinical footing to a legal one, and that transition is made deliberately and documented before the observation starts rather than reconstructed afterwards. Which route exists, on what grounds, for how long and on whose signature is a matter for the governing mental health legislation and is set out in the Mental health legislation and forensic psychiatry notes; capacity and the standard of consent belong to the Forensic ethics, consent and legal procedure notes. No statutory ground, procedure, time limit or authorised signatory is asserted here, because none is sourced in this section, and a half-remembered provision is more dangerous than an honest referral to the statute.

The emergency department carries one obligation that is purely architectural: the waiting area for people who have self-harmed must be close to staff who can provide care, support and observation. This is the one place where the requirement is expressed as a floor plan rather than as a level, and a patient waiting where staff cannot see them is unobserved whatever the notes say.

16.8 The ward and the department as physical objects

Environmental safety inside the hospital is a distinct construct from counselling a patient and family about access to lethal means at home, and the difference is one of responsibility: this one belongs to the hospital. The English regulator's ligature guidance requires risk assessments to cover both known and new forms of **ligature anchor point**, treats environmental assessment as an active search for new points and for those manipulated or worn, and reverses earlier practice in terms: in all cases, and contrary to previous guidance, low-lying ligature points should not be judged as low risk and should be removed where possible.

On the fabric of the ward the same guidance names collapsible furniture, reduced ligature fixtures and fittings, and removal of fixed ligature points where possible. Two are not discretionary. Providers must use collapsible shower and curtain rails, and an incident involving a rail that does not conform is reportable as a **Never Event**, the strongest statement of obligation in this material. Services must also regularly assess ward areas to identify and remove ligatures and anchor points where possible.

The counterweight is stated with equal force and candidates consistently omit it. Clothing and other items commonly available on wards and in the home are the main materials used as ligatures, but most items are not dangerous in everyday use, so services should avoid a blanket approach to restricting them. What is removed from a particular patient follows individual risk assessment, regularly reviewed, and denying access to clothing is a last resort. A ward that strips every patient of every cord has converted a targeted intervention into a collective punishment.

The regulator then makes the relationship between environment and level explicit, and this is the reasoning that ties the section together. Where environmental controls are limited, or impinge on the patient's care, privacy and dignity, both individualised and system controls must reduce ligature risk, and the controls it names are an observation level set from individualised risk assessment together with the processes that support it: multidisciplinary working, and the sharing of risk information at handovers and huddles. That is a substitution rule and it runs both ways. An old ward with anchor points that cannot be removed needs a higher observation level than a new one for the same patient; conversely, capital spending on fixtures permanently reduces the nursing hours the ward must otherwise buy.

One part of the physical environment is deliberately left open here. The room a patient is actually assessed in, the cubicle or interview room where a first conversation happens before any ward is involved, has its own requirements: whether it can be spoken in without being overheard, what it contains, and whether it can be left safely by either person. No comparable standard is available

to quote for it, and none is invented here. Treat that as a gap to be closed by local policy rather than as a question this account has answered.

16.9 The admission decision at the door

Two questions get collapsed into one at the emergency department door. The first is whether this person needs to be in a hospital at all; the second is which hospital, and the answer is not always the psychiatric one.

The Indian Psychiatric Society's guideline on suicidal behaviour answers the first with two separate lists, and the separation is the teaching point. The standing-risk list sets out situations in which hospitalisation should be strongly considered, and it reads as four clusters: the act and its planning, being a prior attempt of high lethality, a well-thought-out plan and access to lethal means; the current state, being hopelessness and being uncommunicative; the social surround, being a recent major loss and social isolation; and what is untreated or destabilising, being a history of impulsive, high-risk behaviour, active substance abuse or dependence, and untreated mood, psychotic or personality disorder. Read as clusters, the list becomes a set of questions that can be asked in order.

The second list applies after a suicide attempt or an aborted attempt, and is more specific because there is now an act to interrogate. Hospitalisation is indicated where the patient is psychotic; where the attempt was violent, near-lethal or premeditated; where precautions were taken to avoid rescue or discovery; where a persistent plan or intent is present; where distress is increased or the patient regrets surviving; where the patient is male and older than age 45 years, especially with new onset of psychiatric illness or suicidal thinking; where family or social support is limited; where current impulsive behaviour, severe agitation, poor judgment or refusal of help is evident; or where there is a change in mental status with a metabolic, toxic, infectious or other aetiology requiring further workup in a structured setting.

That last item is where the psychiatric admission decision and the medical decision stop being two decisions, because a patient whose mental state has altered for a reason not yet established is admitted in order to establish it, and the correct destination may then not be a psychiatric bed. Which brings in the second question. The English self-harm guideline gives three indications for considering admission to a general hospital after an episode of self-harm: concerns about the person's safety, for example risk of violence, abuse or exploitation, where psychiatric admission is not indicated; safeguarding planning still to be completed, again where psychiatric admission is not indicated; and the person being unable to engage in a psychosocial assessment, for example because they are too distressed or intoxicated. Two of the three are framed explicitly against psychiatric admission not being indicated, which makes this a separate decision rather than a weaker version of the same one.

16.10 Discharge, and the patient who will not stay

Discharge after self-harm is governed by preconditions rather than an overall impression, and they are conjunctive: all must hold, not most. Before a person who has self-harmed leaves a general hospital, the English guideline requires that each of the following is in place:

- a psychosocial assessment has taken place;
- a plan for further management has been drawn up with all appropriate agencies and people;
- a discharge planning meeting with all appropriate agencies and people has taken place; and
- arrangements for aftercare have been specified, including clear written communication with the primary care team.

The last is the one that quietly fails. Where the receiving service is a private practitioner, a distant district hospital, or nobody at all, that written communication is the entire handover, and the working rule is to treat the discharge as incomplete until it has left the building.

The harder case is the patient who waits for none of this. The guideline treats discharge against advice as a service-design requirement rather than a judgement improvised at the door, requiring standing policies for the person who wishes to leave, and for the person who has already left, before physical and mental health assessment and care is complete. Both limbs matter and they are different problems. The person still in the department needs a procedure executable in minutes by whoever is standing there; the person already gone needs one naming who is contacted, by whom and within what period, and that second procedure is the one almost no department writes until after it has needed it.

One response is closed off explicitly. Mechanical restraint must not be used in emergency departments to prevent self-harm or to prevent a person from leaving the emergency department. Removing the reflex answer is the point of the prohibition: it forces the question back onto the only two legitimate footings, consent and the applicable legal framework, and obliges the department to decide which it is relying on before the patient is at the door. The statutory framework for detention, and for restraint itself, belongs to the Mental health legislation and forensic psychiatry notes and is named here rather than restated.

> An observation level is a prescription: a named person who set it, a stated frequency or distance, a named reviewer with their title, a stated review time, and a written condition that would bring it down.

17 · Management of acute psychotic and manic emergencies

Why the marks are here. The examinable question about psychotic emergencies and manic emergencies is almost never what the syndrome is. It is what is done with the man brought to casualty at two in the morning by his relatives, who has not slept for several nights, talks over everyone in the room, and has given away money the family does not have. The syndrome, its neurobiology and the agents that treat it belong to the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes and to the Mood disorders: pharmacotherapy notes. What is taught here is the decision sequence at the door: what is referred and how quickly, what is excluded before the psychiatric label settles, who may consent to what, which harms are already being done while the assessment proceeds, what is started before the diagnosis is settled, and where the patient goes next.

Two features separate this from every other behavioural emergency. The decision must usually be taken before the diagnosis is available, because a first episode arrives without a history and organic and substance-induced states sit in the same differential. And the harm is not principally violence: much of it is financial, sexual and relational, it is done by a patient who may be cheerful and cooperative, and it accrues by the hour. An answer built around sedation and restraint has addressed the smaller half of the problem, with material owned by other sections of this chapter.

17.1 The decision is triggered by suspicion, not by a settled diagnosis

The referral rule is unusually clean and unusually easy to misquote. The National Institute for Health and Care Excellence guideline on bipolar disorder, **CG185**, written for England and Wales, published in 2014 and last updated in **2025**, recommends referring people urgently for a **specialist mental health assessment** if mania or severe depression is **suspected**, or if they are a danger to themselves or others.

Read the limbs as separate doors into one pathway, because the source joins them disjunctively and either alone suffices. A dangerous patient is referred urgently even where mania is not suspected; a patient in whom mania is suspected is referred urgently even where nothing dangerous has happened. Candidates who remember only the danger limb convert an urgent referral rule into a violence rule, and then have no answer for the patient who is manifestly unwell and manifestly not aggressive.

The word carrying the weight is suspicion. Not confirmation, not a provisional diagnosis, not a specialist opinion. That choice is the point this section is built on, because the information that would settle the diagnosis is unavailable when the decision must be made: a first episode has no prior history to appeal to, the person who could describe the past fortnight is outside the room, and the organic alternatives are excluded by work that takes time the decision does not have. If the trigger were confirmation, every referral would be made after the harm rather than before it.

RULE **The threshold for acting is suspicion of the state or the presence of danger, never a confirmed diagnosis.** This inverts the order candidates are trained into everywhere else in medicine, and it is defensible because what is triggered is itself an assessment rather than a treatment. Nothing irreversible follows from referring urgently and finding no mania. A great deal follows from waiting for certainty in a condition whose defining features include impaired judgement about money, sex and personal safety, all of which keep operating during the wait.

17.2 What is excluded before the psychiatric label is allowed to settle

Before excitement, overactivity or florid psychotic phenomena are accepted as psychiatric, a physical exclusion runs. The most useful statement of it for this setting comes from the World Health Organization mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, Version 2.0, issued in **2016**. Before settling a psychosis or mania label, the clinician evaluates by history, clinical examination or laboratory findings for signs and symptoms suggesting **delirium** due to an acute physical condition. The guide names what to look for:

- infection, and **cerebral malaria** specifically;

- dehydration;
- metabolic abnormalities, hypoglycaemia and hyponatraemia being the examples given;
- medication side effects, with some antimalarial medication and steroids named.

The choice of source matters. This is a guide written explicitly for non-specialised settings, and its list is populated by what actually presents in them: a high-income emergency guideline would not have named cerebral malaria or antimalarial medication at all, and an answer written for Indian practice needs the version that does. The delirium syndrome itself, its criteria, subtypes and assessment belong to the Stroke, TBI, delirium and focal brain syndromes notes and are named here rather than taught; the front-door triage of the undifferentiated confused patient is dealt with elsewhere in this chapter.

Three observations make the list usable rather than decorative. Steroids and antimalarials are prescribed medicines, so the exposure is documented somewhere and discoverable by asking one question of the person who brought the patient, before that person leaves. Hyponatraemia produces nothing visible at the bedside, so it is excluded by a sample or not at all. And dehydration sits here as a cause of delirium while also being a consequence of sustained mania: a patient who has not drunk anything for three nights can arrive with a confusional state layered on the excitement that produced it, and the two are then read as one.

None of this defers the act. The exclusion runs alongside the containment and the collateral history, and the sequence that opens every behavioural emergency is set out elsewhere in this chapter. What it buys is permission to let the label settle; until then the working formulation is an undifferentiated disturbance in a patient who may turn out to be manic.

17.3 Capacity in mania: the fluent examination that hides the failure

Capacity here separates good answers from adequate ones, because the examination that ought to detect the problem is the one that conceals it. A capacity assessment asks whether the patient can take in the information relevant to the decision, hold on to it, weigh it in arriving at a choice, and communicate that choice. The manic patient performs most of those beautifully: orientation is intact, speech is fluent, and information given a minute ago comes back verbatim. The failure is confined to the weighing, where elevated mood has altered not the reception of the facts but their appraisal, so the risk is understood, retained, restated accurately and then judged not to apply. An assessor who stops when the patient answers well has tested everything except the limb that fails.

The sourced counterpart is easy to skate past. Alongside its environmental advice, the bipolar guideline recommends advising people with mania or hypomania not to make **important decisions** until they have recovered. That is a substantial statement dressed as housekeeping. It concedes that decisional impairment is a feature of the whole episode rather than of its worst hour, and that it extends to the ordinary consequential decisions of a life: selling land, resigning a post, marrying, investing, standing surety. Those are decisions no consent form covers and no ward round asks about, and they do the lasting damage.

The same recommendation adds a third limb, that the person be encouraged to maintain their relationships with their carers where possible. It belongs in the same sentence because the people who will actually hold those decisions during the episode are the carers, and mania ruptures exactly those relationships at the moment their protection is most needed. Preserving the relationship is the mechanism by which the advice is enforced.

Two boundaries close this off. The authority question for the specific act of giving a drug to a patient who has not agreed to it is dealt with elsewhere in this chapter. The statutory basis on which a patient may be admitted or treated without consent in India, and the consent doctrine behind it, belong to the Mental health legislation and forensic psychiatry notes and the Forensic ethics, consent and legal procedure notes; no statutory provision is asserted here.

17.4 The risks specific to mania, and the act of assessing them

The risk assessment here has a stated form before it has content, and the form is itself an act. The bipolar guideline recommends carrying it out in conjunction with the person, and with their carer if possible, focusing on the areas likely to present possible danger or harm. Two things follow. It is done with the patient rather than about them, which in an irritable patient is also efficient de-escalation. And the carer is written into the method rather than consulted afterwards, because most of the domains below are invisible to anyone who has not seen the household.

DOMAIN NAMED IN THE GUIDELINE	WHAT IT LOOKS LIKE IN THE FIRST HOUR	WHAT ANSWERS IT NOW
Self-neglect	No sleep for several nights, no meals, no fluids, medicines for physical illness abandoned	Physical observations, hydration, and an explicit question about chronic medicines the family assumes are still being taken
Self-harm, and suicidal thoughts and intent	Irritable dysphoria inside an elevated state, the patient whose mood has begun to fall	Asked directly at this contact; the assessment framework belongs to the Somatic-symptom, sexual, impulse-control disorders and suicide notes
Risks to others, including family members	Irritability on being contradicted, an argument at home that preceded the attendance, children in the house	Who is at home tonight, who has already been hurt, and whether anybody is frightened to take the patient back
Driving	A patient who drove himself in and intends to drive home, at speed, on no sleep	Advice to patient and carer, keys accounted for, and the advice recorded rather than merely delivered
Spending money excessively	Purchases and gifts already made, loans taken, a business commitment entered into this week	What the patient can spend or transfer tonight: cash, cards, the banking application on the phone
Financial or sexual exploitation	New acquaintances of a few days' standing, generosity noticed outside the family	Who has access to the patient and to the patient's money, and who has recently acquired both
Disruption in family and love relationships	An engagement announced or ended this week, a resignation, an accusation made to relatives	Naming it as a feature of the episode in front of the carer, so it is not later read as settled intention
Disinhibited and sexualised behaviour, and risks of sexually transmitted diseases	Behaviour in the department itself, and contacts in the days before attendance	Sexual health follow-up arranged into the disposition, not deferred to a recovery nobody schedules

Two further risks belong to any honest account of the manic emergency and are not among the domains the guideline names: physical exhaustion from sustained sleeplessness and overactivity, and dehydration in a patient too preoccupied to drink. Both are stated as clinical observations with no figure attached, because none is available to quote. They matter because they are the limbs by which a behavioural emergency becomes a medical one.

Suspicion
THE TRIGGER FOR URGENT SPECIALIST REFERRAL WHEN MANIA IS SUSPECTED

Before the label
WHEN DELIRIUM FROM AN ACUTE PHYSICAL CONDITION IS EVALUATED FOR

Environment
WHAT THE GUIDELINE ASKS FOR IN MANIA BEFORE ANY DRUG DECISION

Outside hospital
WHERE THE WORLD HEALTH ORGANIZATION PLACES LONGER-TERM CARE

17.5 Harm realised by the hour, and what can be done about it tonight

Why this is not the aggressive patient's emergency. In most behavioural emergencies the risk under discussion is a future event whose probability the clinician is estimating. In mania a substantial part of it is not prospective at all. Money is being moved now, contracts entered into now, contacts made now, and each hour of delay is an hour in which more of it happens rather than an hour of exposure to a possibility. That changes what the risk assessment is for: not only a prediction feeding a disposition, but a list of things to interrupt before the patient leaves the room. The interruptions available are modest, mostly non-clinical and almost never written down, and they are worth rehearsing because examiners ask what you would actually do and candidates answer with a drug.

- Establish what the patient can spend or transfer before morning, which means the phone as much as the wallet, and agree with patient and carer together who holds what tonight.
- Account for vehicle keys, and give driving advice to both rather than assuming the topic is covered by the admission.
- Identify who has newly acquired access to the patient or the patient's money, which is the practical form of the exploitation question.
- Name to the carer, in the patient's presence, which recent decisions are being treated as features of the episode, so a resignation is not later defended as a settled choice.
- Ask who is at home tonight and whether anybody there is frightened, because the answer changes the disposition more often than any symptom does.

Nothing here authorises confiscating property, and the boundary between what a clinician may do and what only a family or a court may do is not identical across jurisdictions. What is described is advice, negotiation and documentation, and the recorded fact that it was attempted is often the most useful thing in the notes a month later.

TRAP **Reading the absence of aggression as the absence of an emergency.** The manic patient who is euphoric, charming and grateful for the attention presents as the least urgent person in the department, and is given an outpatient appointment and sent home. The error is a category mistake: urgency has been tested against the danger limb of the referral rule while the state limb, which fires on suspicion alone, has been ignored. Candidates make it because emergency teaching is dominated by containment, so an emergency comes to mean a person who must be restrained. The correction is to ask what will have happened by the time that appointment arrives: what will have been spent, signed, promised, driven or contracted in the interval.

17.6 What is started before the diagnosis is settled

Something is done for this patient before anyone knows the diagnosis, and what the guideline asks for is not a drug. It recommends ensuring that people with mania or hypomania have access to **calming environments** and **reduced stimulation**. That is an environmental prescription, available immediately, requiring no consent and not waiting on the label. In an answer it is the cheapest mark on the page and the one most often left uncollected.

It is also mechanistically coherent rather than merely kind. The manic patient's difficulty is a failure to filter and prioritise incoming stimuli, so a crowded casualty with overhead lights, a television and six relatives all speaking is not a neutral background against which the illness is observed. It is an active driver of the presentation being assessed, and reducing it lowers the arousal generating the behaviour.

The physical acts running in parallel are unglamorous and belong here rather than in any pharmacology section: fluids offered and accepted, food offered, a place to lie down, and sleep protected rather than interrupted by the department's own routines. No target figure is attached to any of these, and none should be invented.

Deliberately absent is any drug. The staged escalation ladder, the agents and every first-dose figure belong to the Schizophrenia: management, antipsychotics and adverse effects notes; the choice of antimanic agent and everything about maintenance belongs to the Mood disorders: pharmacotherapy notes; and the rapid tranquillisation protocol considered as a protocol sits elsewhere in this chapter. The ordering taught here, environment before pharmacology, is lost the moment a drug appears in the same paragraph.

MNEMONIC

Suspect, Sweep, Settle, Secure, Site

Suspect: the referral is triggered by suspicion of the state or by danger, not by a diagnosis. **Sweep**: the evaluation for delirium from an acute physical condition runs before the label is allowed to settle. **Settle**: a calming environment with reduced stimulation is what is asked for first, before any drug decision. **Secure**: the risks being realised tonight, meaning money, driving, exploitation, sexual disinhibition and the safety of the household, are addressed as acts and not only as predictions. **Site**: where the patient is nursed tonight and where care sits once the episode has settled are two different decisions.

17.7 Where the manic emergency is routed, and what the routing tells you

There is no bipolar-specific emergency algorithm, and the bipolar guideline says so in the plainest possible way. Where people with bipolar disorder pose an **immediate risk to themselves or others** during an acute episode, it directs the reader out of itself: to the guideline on violence and aggression for advice on managing agitation, challenging behaviour and imminent violence and on rapid tranquillisation, or to the guideline on self-harm for advice on managing acts of self-harm and suicide risk.

That is worth more than its content: a major guideline devoted to a mood disorder, at the point where the disorder becomes an emergency, hands the reader to guidance organised around the behaviour rather than the diagnosis. The implication is direct. The label changes the risk profile and the disposition, but not the act performed in the first hour. The same de-escalation, the same parallel physical assessment, the same authority question and the same monitoring apply whether the excitement is manic, schizophrenic, substance-induced or organic.

WHAT IS IN FRONT OF YOU	WHERE THE BIPOLAR GUIDELINE SENDS IT	WHAT THAT MEANS FOR THE ACT
Suspected mania or severe depression, no immediate danger	Urgent referral for specialist mental health assessment	The referral is the act, and is not deferred pending diagnostic certainty
Immediate risk to self or others, with agitation or imminent violence	The guideline on violence and aggression, including its advice on rapid tranquillisation	Generic behavioural-emergency management, taught elsewhere in this chapter and in the Schizophrenia: management, antipsychotics and adverse effects notes; none of it is mania-specific
Acts of self-harm, or suicide risk within the episode	The guideline on self-harm	Risk assessment and the observation decision, both dealt with elsewhere in this chapter
Excitement or psychosis with a pointer to an acute physical cause	Evaluation for delirium due to an acute physical condition, before the label	The label is withheld, not the treatment; the syndrome belongs to the Stroke, TBI, delirium and focal brain syndromes notes
The episode settling, and where care continues	A supportive environment with family or community members outside the hospital setting	A principle for longer-term care, not an argument about tonight's bed

17.8 The admission decision, and the counterweight that is routinely misquoted

Admission here is not decided by the severity of the mental state, which is the reasoning candidates reach for and which produces both unnecessary admissions and dangerous discharges. It is decided by whether the risks identified above can be held where the patient would otherwise be. Framed that way the question becomes answerable at the door. Can somebody at home stay awake with a patient who will not sleep. Can the money, the phone and the vehicle be secured without a confrontation the household cannot survive. Is anybody in that house afraid. Is the physical exclusion complete, or does it need a setting where blood can be sent and repeated.

What admission buys is the substance of the answer. A place where sleep can be re-established and protected, which is the single change most likely to alter the trajectory. Separation from the instruments of financial and sexual risk for as long as the disinhibition lasts. The physical care a patient in sustained overactivity will not organise for himself. Observation at a level somebody has actually decided upon, that decision being taught elsewhere in this chapter. And completion of the medical exclusion a busy casualty rarely finishes. Where the presentation is life-threatening, manic exhaustion with refusal of fluids being the classic example, electroconvulsive therapy is among the interventions considered; its indications and technique belong to the ECT and neurostimulation notes and are named here and not taught.

Against that sits a principle quoted constantly and almost always out of position. The mhGAP guide states that in general it is better for the person to live with family or community members in a supportive environment outside of the hospital setting, and that **long-term hospitalisation**

should be avoided. It sits in general advice for people living with psychosis and those who care for them, and it speaks to where life is lived over months and years. It is not a statement about tonight and it does not discourage emergency admission. Quoted at the door it becomes an argument for sending home a patient whose risks nobody can hold. Quoted in its proper place it makes admission a bounded intervention with an exit, and puts the burden of justification on continued hospitalisation rather than on discharge.

IN INDIA

Every element of this pathway assumes a service that may not exist where the patient presents. Urgent referral for specialist assessment presupposes a specialist within reach of a district hospital at two in the morning; in much of the country it names a destination that is a bus journey away and open in the morning. Reduced stimulation presupposes a room, and a general casualty with one corridor and a queue offers none; the honest substitute is the quietest available corner with one relative rather than six. Observation presupposes staff, and where it cannot be staffed the family becomes the observation level by default, which should be acknowledged and instructed rather than left to happen silently. The financial acts above are entirely family-operated, because no service mechanism secures a patient's account. And the counterweight against prolonged hospitalisation reads differently where a private nursing home bed is the only one and its cost decides the length of stay. None of this changes the standard. It changes what has to be written down when the standard cannot be met.

17.9 What must be true before the decision is handed on

The handover is best stated as conditions rather than narrative. Before the acutely manic or floridly psychotic patient leaves the assessment area, whether to a ward, another hospital or home, the following should be true and recorded.

- The referral decision has been made against the stated trigger, and where urgent referral was not made in a patient in whom mania was suspected, the reason is written.
- The evaluation for an acute physical cause has been started and one named person owns finishing it, with existing medicines, steroids in particular, asked about while the family is present.
- A capacity assessment relevant to the decision being taken has been attempted and recorded, including what the patient could and could not do with the information.
- Each risk domain has been asked about with the patient and, where possible, the carer, and those being acted on tonight are distinguished from those being watched.
- The advice against important decisions has been given to patient and carer and written down.
- The disposition has been decided by a named person, with the level of care and the observation decision made rather than defaulted to.

GOOD TO REMEMBER

Two objects decide more of the outcome of a manic emergency than anything you will write in the mental state examination: the phone and the vehicle keys. The phone carries the banking application, the contacts, the messages sent at four in the morning and the purchases that clear before anyone wakes. The keys carry the collision. Both are missed because they feel administrative rather than clinical. Build them into the same breath as the advice against important decisions: ask who has the keys, ask what the patient can spend tonight, agree an answer in front of both parties, and record that you did.

In a manic emergency the trigger for urgent specialist assessment is suspicion and not diagnosis, the physical exclusion precedes the label, and the risks that decide disposition are financial, sexual and relational at least as often as they are violent.

18 · Deliberate self-harm and overdose triage

Why the marks are here. A patient who has taken an overdose arrives as a medical problem and is remembered as a psychiatric one, and the interval between those two descriptions is where the avoidable deaths sit. The question here is not whether you can estimate intent: that framework, and the intent-scale domains that go with it, belong to the Somatic-symptom, sexual, impulse-control disorders and suicide notes. What is asked here is narrower and harder to improvise. What is done in the first hour, what has to be true before the patient becomes yours, who is entitled to say that it is true, and where the patient goes next.

Three things make the medical triage of an overdose a psychiatric responsibility rather than a borrowed one. The psychiatrist is often the only clinician who knows what the patient was prescribed, and so what is plausibly inside them. The psychiatrist is who the emergency department is waiting to hand over to, so the handover criteria get set by whoever will state them. And the psychiatrist is the one asked afterwards why an assessment was recorded at an hour when the patient could not have participated.

18.1 Ordering the two assessments, and what medical priority does not buy

The version most of us were taught is a sequence: stabilise, clear, then assess. Two recent national guidelines do not.

The self-harm guideline of the National Institute for Health and Care Excellence, published in 2022, refuses the sequential model: physical healthcare and the psychosocial assessment are carried out concurrently. It then closes the two devices used to postpone the second, and closes them as prohibitions rather than preferences. The psychosocial assessment is not to be delayed until after medical treatment is completed, and breath or blood alcohol levels are not to be used to delay it. Where the person cannot participate, what follows is regular review and completion as soon as possible, not an open wait. Alcohol withdrawal scoring is the Substance use disorders notes'.

The Indian Psychiatric Society guideline on suicidal behaviour, issued in 2022, describes the same moment from inside an Indian casualty and reaches a priority rule instead. It tells the clinician to wait until conditions become conducive to assessment, and states that where the patient becomes drowsy from intoxication, medical management and stabilisation becomes a priority.

These are not contradictory once you see what each protects. A priority rule allocates the resource in the room at a given minute, and a falling conscious level takes it. A concurrency rule stops the assessment being deferred by a treatment with no natural end point.

RULE **Medical priority is a claim on resources, not a licence to postpone.** Stabilisation outranks assessment for the minutes in which it is actually happening and buys nothing beyond them. It is not permission to leave the psychiatric assessment until medical treatment is finished, nor to wait for a number before speaking to the patient. Where the patient truly cannot participate, what replaces the assessment is a stated review interval, not silence.

DOCUMENT, JURISDICTION AND YEAR	WHAT IT FIXES ABOUT THE ORDERING	WHAT IT FORBIDS OR SUBORDINATES
Self-harm guideline of the National Institute for Health and Care Excellence, England, 2022	Physical healthcare and the psychosocial assessment run concurrently, both as soon as possible after the self-harm episode	Delaying the psychosocial assessment until medical treatment is complete, and using a breath or blood alcohol level as the gate on it
Indian Psychiatric Society guideline on suicidal behaviour, India, 2022	The clinician waits until conditions in the emergency department become conducive to assessment	Assessment is subordinated where the patient becomes drowsy from intoxication and stabilisation becomes the priority
Task force of the American Association for Emergency Psychiatry, United States, 2017	Every patient is medically evaluated before transfer to a psychiatric setting, with the judgement recorded in writing	An unresolved question of delirium against psychiatric disorder resolves to medical observation or hospitalisation, never to psychiatric transfer

18.2 Refusing the phrase that used to end the argument, and stating what replaces it

Ask an emergency physician for **medical clearance** and you are asking for something the specialty has formally stopped offering. The American Association for Emergency Psychiatry task force on the medical clearance of adult psychiatric patients rejected the phrase on two grounds: it minimises the presence of chronic medical problems, and it is out of line with the terminology the rest of the emergency department now uses. Nobody is cleared of diabetes at transfer; they are transferred with it.

What replaces it is not a phrase but an assertion with two limbs. The note travelling with the patient states that the patient is **medically stable and appropriate for treatment in a psychiatric setting**: first that the behavioural disturbance is unlikely to be due to a medical condition or physical trauma, and second that medical or surgical treatment for any concomitant conditions falls within the capabilities of the receiving facility. Read the second limb again. It is a

statement about your service. The same patient is appropriate for a general hospital unit with a physician on site and inappropriate for a stand-alone facility an hour away, with nothing about the patient changed in between, and saying so is the mark.

The task force also states what the medical assessment hunts for, and it is two things. The first is **medical mimics**, the potential causative factors for the presenting complaint, with encephalopathy, substance intoxication or withdrawal, infections and central nervous system disease as the examples. The second, dropped under pressure, is medical problems needing ongoing care that contribute nothing to the psychiatric picture. Where the two cannot be separated, the recommendation supplies a decision rule: if there is a question whether the patient has delirium or a psychiatric disorder, that patient is medically observed or hospitalised. The delirium entity itself is the Stroke, TBI, delirium and focal brain syndromes notes' and is named here rather than restated. What belongs here is the direction the doubt resolves in: towards the medical bed, never the psychiatric one.

18.3 Screening every patient, and deciding who needs more than the screen

The same task force sets a deliberately unglamorous floor for universal screening: vital signs, history, physical examination and an assessment of mentation. It then does something more useful than listing them. It prefers a brief cognitive examination to a simple assessment of mentation, because the latter records nothing but alertness and orientation, and says it should ideally cover attention, executive function, orientation and recent memory. The gap between the two is the whole argument: a patient who is alert and oriented but cannot sustain attention or sequence a task has an abnormal **brief cognitive examination** and a normal assessment of mentation, and is precisely the patient the transfer note should not be written about.

Above the floor, the task force lists eight triggers for extending the medical evaluation:

- new-onset psychiatric symptoms after the age of **45 years**;
- advanced age, which the task force gives as 65 years of age and older;
- cognitive deficits or delirium;
- a positive review of systems indicating a physical aetiology, such as cough and fever;
- focal neurological findings, or evidence of head injury;
- substance intoxication, withdrawal, or exposure to toxins or drugs;
- a decreased level of awareness;
- other indications, such as abnormal vital signs that direct further assessment.

Notice how many of these an overdose carries automatically. Substance exposure is the presentation itself, a decreased level of awareness and abnormal vital signs are common, and in an older patient with no psychiatric history three of the eight are live before anyone has taken a history. Self-poisoning is therefore close to a standing indication for evaluation beyond the universal minimum.

The task force also reports an operationalised version of medical fitness that was actually tested. A retrospective review of 485 charts of psychiatric patients evaluated by attending emergency physicians used a five-item screen: stable vital signs, a prior psychiatric history, alert and oriented times four, no evidence of an acute medical problem, and no visual hallucinations. Patients answering yes to all five went to a psychiatric receiving facility without further testing, and only six, 1.2 per cent, came back for further workup, none needing medical or surgical admission. That is a screening algorithm reported inside a consensus statement rather than a validated instrument, reported here at second hand, and its last two items are judgements rather than observations. Its value is the shape of the argument: a short structured screen applied to everyone beats an unstructured impression applied to some.

18.4 Working out what was taken when nobody can tell you

Everything downstream, the decontamination decision, the observation period and the disposition, is a function of the substance and the amount. Yet identification is the part of overdose triage treated as clerical, and the part a psychiatrist is best placed to solve.

The Indian Psychiatric Society guideline on substance intoxication in the emergency setting specifies the task rather than leaving it to instinct. Details of the consumed substances are elicited from the patient if responsive and from attendants; medical records are consulted where available for substance use history and prescription details; past episodes of overdose or seizures are noted; and comorbid psychiatric illness and current psychotropic medication are identified in order to understand drug and substance interactions. That last item changes practice: the current prescription list is part of the toxicological history, not psychiatric background for later, because it names the tablets that were in the house.

Where the history fails, the same guideline turns the examination into the identification tool. Vital signs are monitored, specifically heart rate, blood pressure, respiratory rate, temperature and oxygen saturation, and consciousness is assessed serially; the complete physical examination looks for pupil size, peripheral cyanosis, characteristic odours from the nose or mouth, needle track marks and other tell-tale signs of what was consumed, with the systemic examination weighted towards the central nervous and cardio-pulmonary systems. Serially is the operative word: a single conscious-level entry describes a moment, and the triage decision needs a direction of travel.

For children and adolescents the guideline raises the standard explicitly. The nature of the substance ingested and its dosage per kilogram body weight are to be identified as accurately as possible, and where substance use is suspected but cannot be confirmed by clinical history, a detailed physical examination including a full neurological assessment becomes an important part of substance identification. A dose per kilogram is not a refinement here. It decides whether an ingestion is a reassurance or an admission, and it is unavailable unless somebody weighs the child and counts the strip.

GOOD TO REMEMBER

The prescription is a physical object, usually in somebody's bag in the corridor. Ask for the strips, the bottle and the last prescription while the attendants are still there: once the patient moves to a ward nobody goes back for them, and the tablets missing from a strip are often the only quantitative datum anyone will have. Recording that you asked and were told nothing distinguishes an unknown ingestion from an unexplored one.

18.5 Deciding whether to decontaminate, and how long that decision stays open

Most of us learned a single number for activated charcoal, and it is no longer the recommendation. The Clinical Toxicology Recommendations Collaborative, sponsored by the American Academy of Clinical Toxicology, the Asia Pacific Association of Medical Toxicology and the European Association of Poison Centres and Clinical Toxicologists, published recommendations in 2026 whose conclusions name the traditional **1 h** post-ingestion point as superseded. Single-dose charcoal is recommended beyond it in selected poisons, and a new category, **additional-dose activated charcoal**, is introduced for poison that may remain in the gastrointestinal tract for prolonged periods. Teaching that stops at the single-hour window is out of date.

What replaces it is a window belonging to the poison and its formulation. On an individualised risk assessment, charcoal is appropriate up to 6 h after ingestion for many poisons, and may be given beyond that where ongoing absorption is suspected, with **pharmacobezoar** formation, certain modified-release preparations and a drug burden exceeding the limits of solubility named as the mechanisms by which absorption keeps going.

The dose does not change between the single and the repeated use, and it is the same dose whatever the poisoning: 50 g of activated charcoal in an adult, or 1 g/kg in a child up to the adult dose. The recommendation as issued does not state a route in that passage and none is supplied here. Two repeat concepts sit on top of it and are routinely conflated. An additional dose is given at any point after the single dose where there is evidence or suspicion of ongoing absorption, so its timing follows the suspicion rather than the clock. **Multiple-dose activated charcoal** is a regimen: the same dose repeated every 4 h, or a half-dose every 2 h, to enhance elimination rather than to prevent absorption.

One question settles the matter for some patients entirely. The collaborative concluded that charcoal has no role at all in poisoning by arsenic, caesium, copper, ethanol, methanol, ethylene glycol, iron, lead, lithium and metformin. Three turn up at the psychiatric front door constantly: ethanol, methanol and lithium. For lithium the recommendation is against charcoal in every mode and both formulations, the cleanest example of a decontamination decision settled by the identity of the drug alone. The serum-level bands, precipitants and dialysis chain are the Mood disorders: pharmacotherapy notes'; the acute against chronic against acute-on-chronic typology sits with lithium toxicity and overdose management.

MNEMONIC

What, then when, then who

Taken in that order the decision holds. **What** was taken decides whether charcoal has any role at all, because for a defined list of poisons it has none, at any interval. **When** it was taken sets a window belonging to that poison and that formulation, not to a single remembered figure. **Who** is in front of you decides last, and can withdraw what the first two steps allowed: airway reflexes, peristalsis, perforation risk and the prospect of endoscopy all veto.

THE INGESTION	WHAT THE COLLABORATIVE RECOMMENDS FOR SINGLE-DOSE ACTIVATED CHARCOAL
Immediate-release paracetamol at or above 200 mg/kg	Charcoal recommended up to 2 h after an immediate-release paracetamol ingestion, suggested up to 3 h, suggested against beyond 6 h
Modified-release paracetamol at or above 200 mg/kg	Charcoal recommended up to 5 h after a modified-release paracetamol ingestion, the formulation moving the window outwards
Tricyclic antidepressants, at a dose threshold of 10 mg/kg	Charcoal recommended up to 2 h after a tricyclic antidepressant ingestion, suggested up to 3 h, suggested against beyond 6 h
Lithium, immediate-release or modified-release	Recommended against for lithium as single-dose, additional-dose and multiple-dose charcoal alike, for both formulations
Ethanol, methanol and ethylene glycol	No role for charcoal in poisoning by ethanol, methanol or ethylene glycol, alongside arsenic, caesium, copper, iron, lead and metformin
Many poisons, as a general position	Charcoal appropriate up to 6 h after ingestion for many poisons on an individualised risk assessment, and beyond 6 h where ongoing absorption is suspected

50 g
SINGLE DOSE OF ACTIVATED CHARCOAL IN AN ADULT

6 h
CHARCOAL APPROPRIATE UP TO THIS POINT FOR MANY POISONS

24 hours
MINIMUM OBSERVATION AFTER EXTENDED-RELEASE BUPROPION OVERDOSE

31.6%
SEIZED AFTER EXTENDED-RELEASE BUPROPION OVERDOSE IN HOSPITAL

18.6 Withholding charcoal, and refusing to secure an airway in order to give it

The contraindications are graded by strength of recommendation, and the grading is the teaching: it tells you which is a discussion and which is not. There are strong recommendations against giving activated charcoal where:

- airway protective reflexes are absent in a patient who is not endotracheally intubated;
- those reflexes are at risk, or are expected to become absent;
- the patient is at risk of gastrointestinal perforation.

There are weak recommendations against giving it where:

- administration may increase the risk of aspiration;
- peristalsis is absent;
- the patient is likely to require upper gastrointestinal endoscopy.

The second strong item is prospective, and that is the point. A patient whose reflexes are intact now but who has taken something that will remove them shortly is already in the strong-against group: the reflexes that matter are the ones that will exist when the charcoal is in the stomach.

The drowsy overdose patient generates the question every shift: should the airway be secured so that charcoal can be given? Endotracheal intubation should not be performed solely to administer activated charcoal in patients not anticipated to develop clinically significant complications of poisoning. Where intubation is already indicated on its own merits, the examples given being a compromised or unprotected airway, respiratory failure, a significantly diminished level of consciousness, refractory seizures or haemodynamic instability, a nasogastric or orogastric tube for decontamination is reasonable. A separate statement forbids passing a gastric tube without intubation purely to give charcoal. The logic generalises: an intervention carrying its own mortality is not justified by one of uncertain benefit downstream.

Gastric lavage has left the answer. The joint position paper update of the American Academy of Clinical Toxicology and the European Association of Poisons Centres and Clinical Toxicologists, published in 2013, concluded that it should not be performed routinely, if at all, in poisoned patients, and that where it is indicated it should only be performed by individuals with proper training and expertise. The second clause is where the mark is lost: a rarely-indicated procedure done by whoever is on duty is worse than the same procedure done competently.

18.7 Refusing to be reassured by the patient who looks well

The trap this section exists to close. Triage rewards the sick-looking patient, and self-poisoning contains a class of agents whose early appearance is uninformative. Getting this wrong does not feel like an error at the time. It feels like prioritisation.

Paracetamol is the archetype and the regulator states it plainly. The approved product information tells prescribers that despite a lack of significant early symptoms, patients should be referred to hospital urgently for immediate medical attention, and that symptoms may be limited to nausea or vomiting and may not reflect the severity of the overdose or the risk of organ damage. The time course explains why. Symptoms in the first 24 hours after a paracetamol overdose are pallor, nausea, vomiting, anorexia and abdominal pain, while liver damage may become apparent only **12 to 48 hours** after ingestion, and acute renal failure with acute tubular necrosis may develop even without severe liver damage. Injury and presentation are separated in time, so the triage decision cannot be made on how the patient looks: an asymptomatic patient after a paracetamol overdose is not a reassured patient.

The psychotropic version of the same trap is the modified-release agent. A multi-poison-centre observational study of one hundred seventeen patients hospitalised after extended-release bupropion ingestion, published in the American Journal of Emergency Medicine in 2009, found

seizures in 37 of them, 31.6 per cent, with the first seizure anywhere from 0.5 to 24 hours after ingestion. Of those who seized, 12 patients, 32 per cent of the seizing group, had their first seizure later than **8 hours**, and further seizures followed in 49 per cent. The authors turned that into the disposition rule: the delayed onset suggests a minimum observation period of 24 hours after an extended-release bupropion overdose, and while agitation or tremor may mark greater risk, seizures can occur without preceding central nervous system toxicity. An untroubled early mental state is therefore not a discharge criterion here, which is exactly the criterion a busy department reaches for.

The teaching would be dangerous if it stopped there, because the opposite pole is also a psychotropic. The collaborative records, appraising tricyclic antidepressants, that they are associated with a rapid onset of symptoms and high lethality in overdose. Here the early picture does track the danger, which is why the decontamination window is short and why disposition cannot be deferred. So the discipline is not that appearances always deceive; it is that the relation between early appearance and outcome is a property of the drug, and therefore something you look up rather than judge. The toxidrome, the electrocardiographic picture and the antidotal management belong with anticholinergic toxicity and the other psychotropic overdose syndromes in these notes, where the antidote question is taken agent by agent and the serotonergic antidepressant and antipsychotic overdoses are set out as acts.

TRAP **Reading an asymptomatic overdose patient as a low-acuity one.** Candidates make it because every other part of emergency medicine trains them to triage on appearance, and because a reassuring examination usually is reassuring. The correction is not to distrust every well patient, which is unworkable, but to make disposition depend on the agent and the elapsed time rather than the mental state at the bedside. The question is never whether this patient looks unwell, but whether, for this drug at this interval, a patient who is going to deteriorate would look any different yet.

18.8 Deciding whether to reverse, and what reversal does not end

Antidotes are attractive at three in the morning because they promise to convert a monitoring problem into a completed task. In the undifferentiated overdose that promise is where the harm comes from.

The approved product information for flumazenil requires particular caution in mixed-drug overdose and supplies the mechanism rather than leaving it as a warning. Where benzodiazepines have been taken together with cyclic antidepressants, toxic effects such as convulsions and cardiac arrhythmias, which are caused by the antidepressants but emerge less readily while benzodiazepines are on board, are exacerbated by giving flumazenil. The benzodiazepine has been partly masking a second poisoning, and reversal removes the mask. That is why this antidote is not routine in the undifferentiated overdose, and why the identification work described earlier is a precondition for the antidote decision rather than a parallel activity.

The Indian Psychiatric Society guideline puts the same caution in more portable terms for the polysubstance presentation. Antidotes such as naloxone and flumazenil may be used with caution to avoid **unmasking** the effects of substances with opposing psychoactive effects; definitive

management depends on a confirmed report of the nature of the substances consumed; and sedatives are used judiciously to avoid worsening respiratory depression. In a polysubstance overdose almost every pharmacological act is provisional until you know what is in the patient.

Reversal also does not end the episode, the half of the decision forgotten once the patient opens their eyes. Patients who have received flumazenil are monitored for **resedation**, respiratory depression or other residual benzodiazepine effects for a period appropriate to the dose and duration of effect of the benzodiazepine involved, and with underlying hepatic impairment the effects may be delayed and an extended observation period required. No fixed interval is given and none is supplied here: the observation period follows the agent taken, not a standard number. No dose, route or rate for flumazenil is stated here either, and the full regimen must be read from the product information before the drug is drawn up.

PITFALL

Giving the benzodiazepine antidote to wake a patient so the psychiatric assessment can proceed. It inverts the logic of everything above: the assessment is not the emergency, and the drowsiness is information about the ingestion that the antidote deletes. In a mixed ingestion the same act can turn a sedated patient into a fitting one. Where the reason for reversal is diagnostic convenience rather than respiratory compromise, the answer is a documented review interval and a patient who is watched.

18.9 Setting the observation period, and handing the patient over

Disposition after an overdose has two components and only one is psychiatric. The first is how long this ingestion has to be watched, a property of the drug: the extended-release agent with a minimum observation period, the paracetamol whose injury declares itself long after the tablets, the tricyclic whose window closes fast. The second is the level of care the psychiatric risk requires, taken up where suicide risk assessment and emergency management are dealt with. They are decided together: a patient may need a medical bed for one reason and a particular kind of watching for the other.

What travels with the patient is a document, not a phrase. The task force specifies the contents of the **transfer note**: the details of the assessment performed, the results, and the medical decision-making that led to the judgement that the patient is appropriate for transfer, together with recommendations for the further assessment and care of any active medical problems. That last clause changes practice: active problems are handed over rather than closed. The task force adds a coda: documenting that a patient is stable for transfer to satisfy the American emergency-treatment statute should be treated as the minimum rather than the standard level of evaluation. A legal floor is not a clinical standard, and a note written to satisfy the first usually fails the second.

The psychiatric assessment then inherits three things, and in usable form only if the triage was done properly: a substance and an amount, an elapsed time with an observation period attached, and a list of medical problems that remain live, each with a named plan. An assessment beginning without those is not an earlier assessment. It is an assessment of a different patient.

IN INDIA

A structural gap explains why Indian answers here are assembled rather than looked up. The Indian Psychiatric Society guideline on substance intoxication in the emergency setting states its own scope exclusion: accidental ingestion, and ingestion of substances with intent for self-harm, are not catered to in it, referring the reader instead to the guideline on the management of suicidal behaviour, which carries nothing on decontamination, activated charcoal, gastric lavage, antidotes or toxidromes. The national stack routes deliberate self-poisoning away from its only toxicological chapter into one with no toxicology in it, so this triage must be taken from emergency-medicine and toxicology sources. The service consequence follows: a concurrency rule assumes a psychiatrist in the department at the same hour as the physician, and a minimum observation period assumes a monitored bed that stays free after the patient stops looking unwell. Where neither holds, name the assumption in the notes and record what was done instead.

An overdose is handed over with a document and not a phrase: what was assessed, what it showed, the reasoning that made the patient appropriate for a psychiatric setting, and a written plan for every medical problem that is still active.

19 · Restraint and seclusion (indications, ethics, monitoring)

What is left once the law and the ethics have been taught. When restraint may be used, on whose authority, and the principles constraining that choice belong to the Mental health legislation and forensic psychiatry notes and to the Forensic ethics, consent and legal procedure notes, and none of it is repeated here. Whether seclusion is lawfully available at all in India is likewise a question of statute for the first of those.

What is left over is the person on the floor with several pairs of hands on them, and that is where people die. A restraint correctly indicated, lawfully authorised and proportionate can still asphyxiate a patient, arrest them, or leave them with a clot. None of that follows from the decision; it follows from the execution.

19.1 What a hold does to a body

The clearest statement of mechanism is an emergency medicine one. The Royal College of Emergency Medicine best practice guideline on acute behavioural disturbance in emergency departments, in its 2023 version, holds that ongoing restraint be removed at the earliest opportunity, because continued exertion under restraint can contribute to poor outcomes through rising catecholamine levels, worsening hyperthermia and metabolic acidosis. It adds what candidates least expect: no high-quality data suggest any risk-free method of restraining an undifferentiated, potentially co-morbid patient.

Read those three as a loop. A person fighting a hold does maximal isometric work against a chest wall loaded from outside, so lactate accumulates while the ventilation that would clear the resulting **metabolic acidosis** is mechanically restricted, heat is made by someone who cannot move to lose it, and the catecholamine surge sustaining the struggle is arrhythmogenic.

RULE **There is no safe way to hold a person against their will, only less dangerous ways, and the difference is how much weight sits on the chest and how long it sits there.** The answer names the two modifiable quantities, load and duration, and who owns each.

19.2 Weight, arms and the chest wall

Two experimental studies carry the mechanical teaching. A controlled crossover study in Annals of Emergency Medicine in 1997 concluded that, in its study population of healthy subjects, the prone maximal restraint position produced a **restrictive pulmonary function pattern** without clinically relevant change in oxygenation or ventilation. Carry the scoping clause: those subjects were healthy young men with a negative urine toxicology screen and obesity excluded, not the population who die in restraint.

The second study moved the variable from position to limb placement. Comparing three recognised prone restraint positions in Medicine, Science and the Law in 2013, it found anterior chest pressure substantially lower in the **supported prone position**, where the upper limbs come underneath the shoulder joint rather than abducted from the torso. All three restricted respiratory function, and the reported risk falls as that pressure falls.

WHAT IS DONE TO THE BODY	WHAT WAS MEASURED OR STATED	WHAT IT CHANGES AT THE BEDSIDE
Prone hold, arms abducted from the torso	Mean anterior chest pressure of 102.6 mmHg and 101.4 mmHg across the two positions of this kind	Heaviest measured chest load, and the arms produce it
Supported prone, upper limbs under the shoulder joint	Mean anterior chest pressure of 72.7 mmHg in this position	Same patient, a third less load, adjustable mid-hold
Placement of staff weight in prone containment	Published Indian guidance bars sitting on any part of the patient, places staff weight to the side rather than on top, and prohibits significant body weight including knees, elbows and torso	The prohibited parts are the ones that load the thorax

19.3 Positional asphyxia, and the argument about its name

The term the syllabus uses is contested, and teaching it as settled mechanism teaches a disputed claim. The United States federal regulation on hospital patients' rights, issued by the Centers for Medicare and Medicaid Services and current as published in 2026, requires staff trained to recognise and respond to signs of physical and psychological distress in restraint or seclusion, and offers **positional asphyxia** as its worked example.

Against that, a comprehensive review in Medicine, Science and the Law in 2021 argued that deaths associated with prone physical restraint are not the direct result of asphyxia but of cardiac arrest secondary to metabolic acidosis compounded by inadequate ventilation and reduced cardiac output, proposing **prone restraint cardiac arrest** as the apter name. Weigh it as a single-author narrative review. Between the two sits the emergency medicine guideline, which states the

older prone theory is not supported by recent research and, in the same breath, that it remains prudent to ensure there is no obstruction to ventilation and to minimise the risk of asphyxiation.

The disagreement is about mechanism, not about the act. Whether the terminal event is asphyxial or arrhythmic, the instruction is identical: weight off the thorax, airway free, hold shortened, exertion stopped.

19.4 The positioning hierarchy, and where teaching loses it

The hierarchy comes from the National Institute for Health and Care Excellence guideline on violence and aggression in 2015, in three ordered limbs: avoid the floor at all; if that is unavoidable use the supine, face up, position if possible; and if prone, face down, is necessary, for as short a time as possible. Published Indian guidance in the Indian Journal of Psychiatry in 2019 arrives differently: prone restraint ideally not used; prone containment only where the immediate situation requires it to prevent imminent serious harm; the patient repositioned to sitting, standing or supine as quickly as possible with close attention to respiratory function.

Two features repay attention. Its escape route is a change of position, not release, so a team that cannot yet let go still has an act available. And the document is internally inconsistent: its narrative permits a conditional prone hold while its own precautions list says simply to avoid prone restraint. Follow the stricter limb, and say so.

TRAP **Answering "supine rather than prone" and stopping there.** Candidates make it because the supine against prone comparison is the memorable part, and examiners quote it. The flaw is that it is the second limb: the primary instruction is to avoid the floor at all, so a hold managed seated or standing has already satisfied a recommendation the supine answer is only a fallback within. Nor is supine a licence, since weight across the chest, or anything laid over the face, reproduces the hazard the position was chosen to avoid.

19.5 The airway, the face, and who is holding what

The prohibition defining a safe hold is stated as an absolute: do not use **manual restraint** in a way that interferes with airway, breathing or circulation, the examples being pressure to the rib cage, neck or abdomen, or obstruction of the mouth or nose. The Indian guidance adds what makes a supine hold survivable: the head is allowed to rotate freely, and the face is not covered with a towel, bag or similar. A restrained patient who vomits and cannot turn their head has no airway at all.

The same guideline bars restraint that obstructs the eyes, ears or mouth and so prevents communication, and the reason is clinical: breathlessness in restraint is reported before it is observed, so a patient who cannot be heard has lost the team's earliest warning. One staff member leads throughout the restraint, and that person's duty is not to hold but to ensure colleagues are supported and able to do three things:

- protect and support the head and neck if needed, which makes the head-and-neck hold a protective role and never a controlling one;

- check that airway and breathing are not compromised, a continuous task rather than a single observation;
- monitor vital signs, which needs somebody whose hands are free.

The allocation is to named people, not to the team in general: a hold in which everyone is holding has nobody watching, and that failure is silent.

19.6 The clock, and the rule that settles arguments inside a hold

Duration is the other modifiable quantity. The violence and aggression guideline sets a ceiling in one line: do not routinely use manual restraint for **more than 10 minutes**. The word routinely is part of the recommendation and must be carried: not an absolute prohibition, but a statement that a longer hold is an exception needing a recorded reason and a name against it. The alternatives that source offers include one whose lawful availability in India is a statutory question, left to the Mental health legislation and forensic psychiatry notes. Where sedation is chosen, its agents and first doses belong to the Schizophrenia: management, antipsychotics and adverse effects notes.

The most useful sentence here is Indian and it is a tie-breaker: during an episode of restraint, **medical priorities** supersede psychiatric ones. Every hard moment inside a hold is the same conflict, between containing the behaviour and protecting the body, and this resolves it the same way. The patient who says they cannot breathe is answered before the argument about whether they are exaggerating; the patient who suddenly stops resisting is a physiological event, not a success.

MNEMONIC

Airway, Weight, Clock, Eyes

What must be true at every moment of a hold. **Airway**: nothing pressing the rib cage, neck or abdomen, nothing over the mouth or nose, head free to rotate. **Weight**: to the side rather than on top, never the knees, elbows or torso. **Clock**: the hold not routinely prolonged, the position changed to sitting, standing or supine as soon as possible. **Eyes**: continuous visual observation, the condition written down at the stated interval.

19.7 Watched, assessed, written down: three separate duties

The commonest defect in a restraint policy is to collapse observation, assessment and documentation into one requirement. **Continuous visual observation** is a state holding for the whole restraint; documentation is a periodic act, signed and timed on a restraint form the facility itself has developed; nursing assessment is a clinical examination with its own cadence. A ward that writes an entry every quarter of an hour and never lays hands on the patient has satisfied one duty and failed another.

WHAT HAS TO HAPPEN	WHO DOES IT	HOW SOON, AND HOW OFTEN	WHOSE STANDARD
Visual observation of the restrained patient	Trained staff	Continuous throughout the restraint	Published Indian guidance, 2019
Documentation of behaviour, potential injury, circulation and respiration, with observer, date and time	Trained staff	**At least every 15 min**	Published Indian guidance, 2019
Assessment including respiration and other vital signs, circulation checked as containment begins	A nurse	**Within 15 min of the restraint, then at least every hour while it continues**	Published Indian guidance, 2019
Face-to-face evaluation of the situation, the reaction to it, the medical and behavioural condition, and whether to continue	A physician, another licensed practitioner, or a trained registered nurse	**Within 1 hour of the intervention starting**	United States federal hospital patients' rights regulation

Compare those frameworks; do not merge them. The Indian document puts a nurse at the bedside fast, then hourly; the American regulation, which has no force in India, buys one early medical review instead, and states more plainly than anything else here what monitoring must cover: respiratory status, circulatory status, **skin integrity** and vital signs.

15 min	10 minutes	1 hour	72.7 mmHg
FIRST NURSING ASSESSMENT AFTER A RESTRAINT BEGINS, PUBLISHED INDIAN RESTRAINT GUIDANCE	CEILING ON ROUTINE USE OF MANUAL RESTRAINT, VIOLENCE AND AGGRESSION GUIDELINE	FACE-TO-FACE EVALUATION AFTER RESTRAINT FOR VIOLENT BEHAVIOUR, UNITED STATES REGULATION	MEAN ANTERIOR CHEST PRESSURE WITH UPPER LIMBS UNDER THE SHOULDER JOINT

IN INDIA

Read that cadence as a staffing statement. Continuous visual observation means one person whose only task is to watch, and on most general hospital psychiatry units that person is a family attendant rather than a nurse. A quarter-hourly record needs a form, and the guidance leaves that to the facility, so where nobody has made one the cadence quietly stops existing. Two free acts convert this into practice: name the watcher aloud when the hold starts, so the role is not assumed by everybody and performed by nobody, and keep the printed form in the drawer beforehand.

19.8 The body under a long hold: drink, toilet, movement, skin and clot

Once a restraint outlasts the crisis that began it, the hazard changes character: the acute risk was mechanical, the later risk that of any immobilised patient who cannot get up to relieve it. The Indian guidance requires physical needs, comfort and safety to be addressed by staff competent to recognise signs of distress, and names three provisions:

- the opportunity to drink, offered rather than waited for;

- the opportunity to go to the toilet, as requested;
- a **range of motion** as needed for comfort, which is also what relieves pressure areas and venous stasis.

No frequency attaches to any of the three: as requested and as needed is the whole of the timing given. The acts are offered actively and the offers recorded; for how often, no comparable standard is available to quote, and none is invented here.

The clot risk is real and measured. A retrospective case-control study at one metropolitan psychiatric hospital in Japan, in the Journal of Psychiatric Research in 2025, identified 108 patients, or 0.9 per cent, with venous thromboembolism among 11,819 patients hospitalised. Adjusted for confounders, physical restraint was associated with higher risk at an **odds ratio of 6.7 with a 95 per cent confidence interval of 3.4 to 13.3**. One hospital, and the affected patients were elderly, so it establishes the association and its magnitude, not a figure that transfers to a young man held in an Indian casualty. It grounds no prophylaxis threshold, duration or regimen.

GOOD TO REMEMBER

A restrained patient will not ask for water or for the toilet, because asking is what they have just been overpowered for attempting. The offer is the clinical act, not the response to it, and a declined offer written down is what a later review reads as care. Build the round: offer a drink, offer the toilet, move each limb through its range, check the sacrum and heels, and record the four as one timed line with a name against it.

19.9 Release, and the hour after it

Release is a transition, not an ending, and the Indian guidance treats it as one: upon release from restraint a nurse observes, evaluates and documents the patient's physical and psychological condition. It states who and what, and neither for how long nor at what interval, so no post-release observation period is asserted; no comparable standard is available to quote, and none is invented here.

The principle survives the missing interval. Acidosis, hyperthermia and a catecholamine surge do not reverse when the hands come off, the clot risk has already been incurred, and injury sustained in the hold is easier to find on a patient no longer fighting. The examination impossible during a restraint becomes possible the second it ends, which makes these the best diagnostic minutes of the episode and the ones most reliably spent on paperwork. What the record owes the next team is narrow and usually missing: when the hold started and ended, the position used, who led it, what the first and last assessments found, and the state of skin and limbs seen once the patient was free.

No restraint position is safe: weight off the chest and to the side, head free and face uncovered, the hold as short as it can be, and one person watching who is not holding.

The rigid, hyperthermic and toxidromic emergencies

20 · Catatonia (types, Bush-Francis scale, lorazepam challenge, management)

Why an emergency chapter carries catatonia at all. The signs, their classification, the rating scale used to quantify them, the diagnostic threshold, and the benzodiazepine challenge with its dose, route and response criterion are set out in the Other psychotic disorders, delusional syndromes and catatonia notes, and none of that is repeated here. What is left over is the patient on the trolley: not moving, not drinking, not swallowing, not being turned. Almost everything that kills a catatonic patient in the first days kills through immobility rather than through catatonia, and almost none of it is treated by the drug that treats the syndrome.

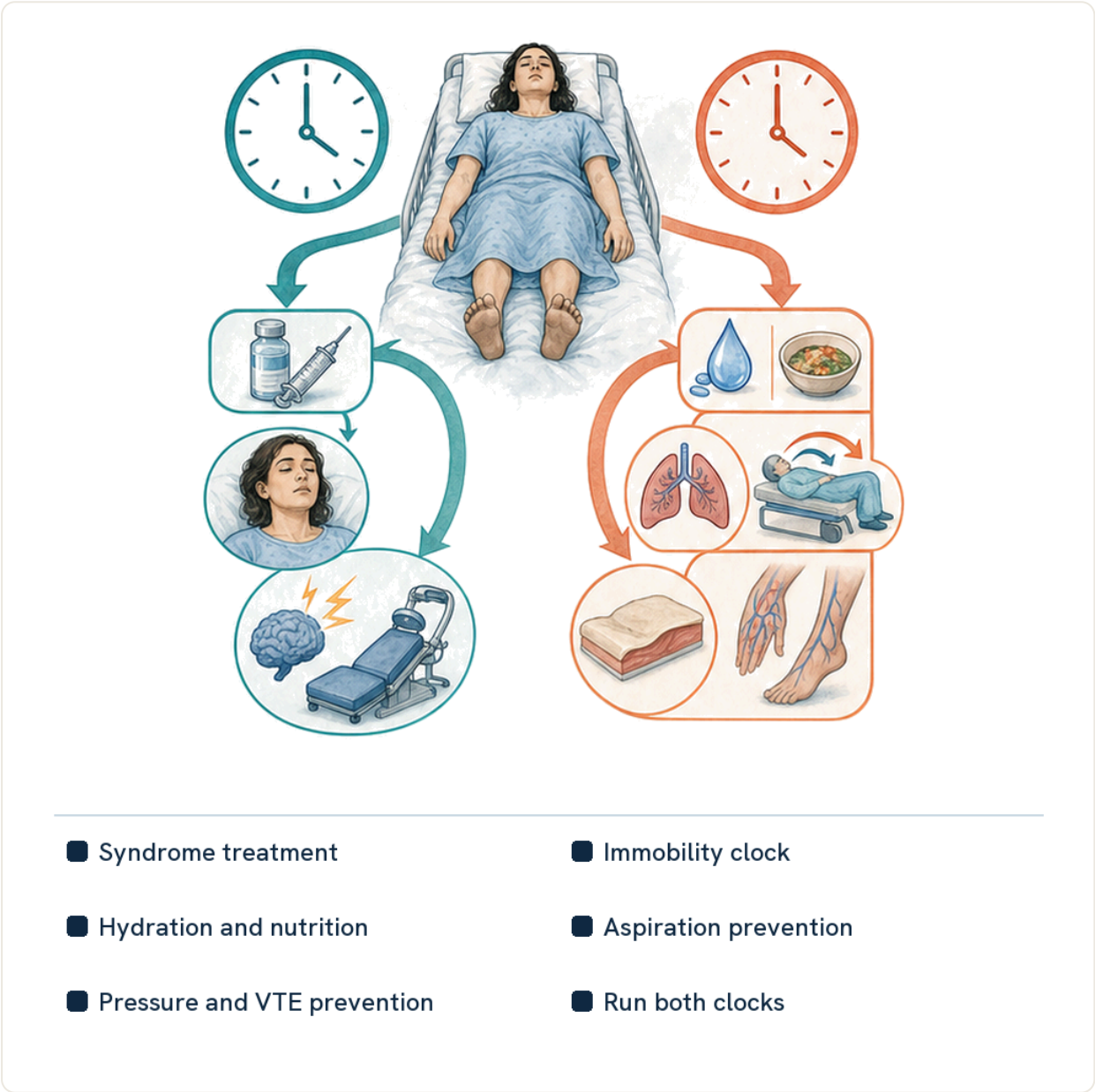


Fig 28.10 Emergency catatonia care runs on two clocks. Lorazepam and ECT treat the syndrome, while hydration, nutrition, aspiration prevention, pressure care and venous-thromboembolism prevention address complications already developing through immobility.

Hold two clocks apart. The therapeutic clock runs from the challenge through the response to the treatment ladder, and it belongs to the Other psychotic disorders, delusional syndromes and catatonia notes. The immobility clock started before the patient reached you and is already well advanced when someone first writes the word catatonia in the notes. Answer only the therapeutic clock and you produce a correct account of the syndrome with an unsafe plan, because the pneumonia, the clot, the ulcer and the electrolyte disaster all mature inside the interval during which the treatment is still being titrated.

20.1 Why the immobile patient is admitted as a medical case

The clearest quantification comes from a retrospective cohort that split **1719 schizophrenia inpatients** into those who exhibited **catatonic stupor** during the hospitalisation and those who never did. Among those inpatients, catatonic stupor carried an increased risk of death against no catatonic stupor, with an **odds ratio of 4.8 and a 95 per cent confidence interval of 2.0 to 10.6**. It is retrospective, single-country and confined to one diagnostic group, so treat it as a signal about magnitude rather than a rate to quote at a family.

The same cohort names what that excess is made of, and it reads as a work list. Increased risk was found for **pneumonia, urinary tract infection and sepsis**; for deep venous thrombosis, pulmonary embolism, arrhythmia and disseminated intravascular coagulation; for rhabdomyolysis, renal failure, dehydration and hypernatraemia; for urinary retention and decubitus ulcers; and for liver dysfunction and neuroleptic malignant syndrome. Fifteen entries that collapse, on the authors' own reading, into **sympathetic hyperactivity, dehydration and immobility**, with the conclusion that meticulous care of both the mental and the medical condition is what reduces them.

Read those three mechanisms as a division of labour. Dehydration is answered by a fluid chart and a route for fluid, immobility by turning, stretching, prophylaxis and a bladder plan, sympathetic overdrive by observations frequent enough to show a trend rather than an event. None of the three is answered by the drug that treats the syndrome, which is why all three get left undone on a ward waiting for a response promised within hours.

RULE **The catatonic patient is nursed as an immobile medical patient from the hour of recognition, not from the hour the treatment fails.** Prophylaxis, skin care, hydration and a feeding decision are not what you escalate to when the benzodiazepine does not work. They run in parallel with it, because a patient who responds beautifully on the third morning can still have thrown an embolus the night before.

4.8	1719	10 kcal/kg/day	5 days
MORTALITY ODDS RATIO, CATATONIC STUPOR AGAINST NO CATATONIC STUPOR, SCHIZOPHRENIA INPATIENTS	SCHIZOPHRENIA INPATIENTS IN THE COHORT BEHIND THAT ODDS RATIO	MAXIMUM STARTING RATE OF NUTRITION SUPPORT AT HIGH REFEEDING RISK	LITTLE OR NO INTAKE BEYOND WHICH FEEDING STARTS AT HALF OF REQUIREMENTS

20.2 The examination that opens the admission

The examination that matters now is not the one that establishes catatonia. The **British Association for Psychopharmacology catatonia guideline of 2023** sets out a physical

examination table with seven entries and no phenomenology anywhere in it. That omission is the teaching point: the specialist examination has done its work by now, and what changes the next hour is the examination any physician would perform.

EXAMINATION DOMAIN IN CATATONIA	THE ACT IT GENERATES
Volume and nutritional status	Establish when this patient last drank and last ate, and get a weight; this fixes the route for fluid and stratifies the feeding decision.
Temperature	Record it and repeat it, because one reading cannot show a trend and a rising temperature is an escalation trigger.
Cardiovascular examination	Emphasised where electroconvulsive therapy is being considered, so it is done early rather than at the treatment decision.
Respiratory status	Emphasised in a patient already on opioids, and before a benzodiazepine is given; a pre-treatment safety check, not a routine observation.
Neurological examination for localising signs	Triggers imaging and a neurology opinion ahead of psychiatric treatment where anything localises.
Evidence of deep vein thrombosis	Converts prophylaxis into investigation where the clot has already formed.
Pressure ulcers on all potential pressure points	Requires the patient undressed and the heels, sacrum, elbows and occiput looked at, giving a documented baseline.

Two entries carry a condition inside them that residents skip, and both are questions of sequence rather than content: the cardiovascular examination comes before the treatment decision it informs, and the respiratory assessment before the sedating drug rather than after it. A list of this kind is an ordering instruction disguised as a checklist.

20.3 The deterioration criteria, and the escalation they trigger

Catatonia sits on a continuum: milder presentations at one end, termed simple or benign, and at the other more severe forms involving hyperthermia and autonomic dysfunction, termed **malignant**. That sentence is all this chapter needs from the entity, and it is used for one purpose. Those two features are the deterioration criteria, the observations that convert a psychiatric admission into a life-threatening one, and they change the level of care before anybody has finished arguing about the label. What malignant catatonia is, how it stands against neuroleptic malignant syndrome and what treatment follows are taught in the Other psychotic disorders, delusional syndromes and catatonia notes; the hyperthermic differential is drawn in the Schizophrenia: management, antipsychotics and adverse effects notes. Neither is redrawn here.

Because the criteria are a temperature and an autonomic pattern, they exist only if somebody is measuring, and measuring often enough for a trend to appear. One admission set of observations cannot demonstrate autonomic instability, which is by definition a variability rather than a value. The practical consequence is a monitoring decision taken at the front door and written down

with a name against it. No temperature threshold and no autonomic parameter is asserted here, because none could be sourced for catatonia specifically.

20.4 Level of care: who is nursed where

The guideline answers this directly and narrowly: initial assessment and treatment of catatonia should be conducted within **secondary care**. Know the footing it stands on, because it is not a trial finding but a consensus position taken in the absence of systematic evidence, the weakest evidential class the guideline uses. That cuts both ways: it cannot be quoted as though outcome data established it, and equally nothing better exists, so a service treating catatonia in an unsupervised setting follows no evidence base at all rather than a weaker one. What secondary care buys can be named, and naming it is how an admission is justified: a bed where fluid can be given and charted, staff who can turn a patient and record it, laboratory access at short notice, and a physician who can be called to the bedside rather than referred to.

IN INDIA

That recommendation describes a United Kingdom service model and no Indian equivalent could be grounded, so the principle travels and the service architecture does not. The stuporous patient here often arrives at a district hospital or a small nursing home where the monitoring the guidance quietly assumes is uneven: continual cardiac rhythm monitoring may exist in one unit only, phosphate and magnesium assays may not run daily, pressure-relieving surfaces may be absent, and one-to-one nursing usually means a family attendant. State in the referral which of those capabilities the receiving setting actually has, and teach the attendant the turning schedule, the mouth care and the fluid chart explicitly, because they are the person who will do it. An unmeetable monitoring requirement is a transfer decision, not something to improvise around.

20.5 Airway, swallow and hydration before anything is given by mouth

Aspiration is what the sourced literature handles worst, and that should be said rather than papered over. The review that assembled the general guidance for this population searched on **4 medical complications: deep vein thrombosis and pulmonary embolism, pressure ulcers, muscle contractures, and nutritional deficiencies**. Airway protection is not among them. The grounding here is indirect: respiratory status is an examination domain, it is flagged before sedation, and pneumonia was among the commonest complications in the cohort. No aspiration protocol, swallow-screen instrument or nil-by-mouth rule specific to catatonia is asserted, because none was sourced.

The principle survives the missing protocol. A patient not swallowing saliva reliably will not swallow a tablet reliably, so assessment of swallow precedes the oral route rather than accompanying it. Sedation is subtractive: whatever lowers conscious level lowers airway protection in someone already immobile and often supine, which is exactly why the respiratory check sits before the benzodiazepine in the examination list. Positioning, suction and an explicit decision about the oral route are the acts; the fluid target that should accompany them is not sourced either.

20.6 Thromboprophylaxis in prolonged immobility

Of the four preventive limbs the guideline records for averting the medical complications of catatonia, **pharmacological thromboprophylaxis** has the clearest reasoning behind it and the least specific instruction attached. The synthesis review reached a decision rule rather than a prescription: prophylaxis guidelines support anticoagulant therapy for **patients with catatonia who are at lower risk of acute bleeding**. Bleeding risk is the variable that decides, and it is assessed and recorded before the first dose rather than after a complication. The underlying evidence is borrowed, and the borrowing must be declared: the **American Society of Hematology venous thromboembolism guidelines of 2018** made four strong recommendations in acutely and critically ill medical inpatients, not in catatonic patients.

- Give pharmacological prophylaxis to acutely or critically ill medical inpatients at acceptable bleeding risk.
- Use mechanical prophylaxis instead where the bleeding risk is unacceptable.
- Do not use direct oral anticoagulants for this purpose during the hospitalisation.
- Do not extend pharmacological prophylaxis after discharge from hospital.

The fourth is the one answered wrongly. A patient immobile for weeks feels like a patient who should go home on an anticoagulant, and the recommendation is explicitly against it: the risk being treated is that of the acute illness and its confinement, which falls when the confinement ends, while the bleeding risk does not. The population is medical inpatients, so applying any of this to a catatonic patient is an inference and should be stated as one. No agent, dose, route or duration specific to catatonia is grounded anywhere in this material, so none is printed; the choice follows local thromboprophylaxis policy, which is the honest answer in an examination as well as on a ward.

20.7 Skin, joints and bladder: the acts nobody writes down

The remaining preventive limbs are unglamorous and they are where the marks sit, because each has a nursing act and a documented interval attached. Pressure ulcer prevention rests on **frequent skin evaluation, support surfaces and repositioning**, with no interval, surface or frequency sourced beyond the word frequent. Contracture prevention is by **stretching**, and the evidence there is openly thin: it has to be extrapolated from studies of patients with neurological injuries, because catatonia-specific data do not exist. Say so when you quote it, because a resident who knows the evidence is borrowed involves physiotherapy early, while one who believes a protocol exists waits for it.

The bladder falls outside every review. Urinary retention carried increased risk in the cohort, and so did urinary tract infection, and that is the whole of the sourced case for attending to it. What follows is a decision rather than a protocol: retention is looked for actively, because a patient who is not speaking will not report it, and catheterisation is then a judgement between an undrained bladder and added infection risk in a patient who already carries one. No catheterisation criterion, residual-volume threshold or bladder-assessment interval is sourced, and inventing one would be worse than the silence.

MNEMONIC

Clot, Skin, Stretch, Feed

The four preventive limbs the catatonia guideline records, in roughly the order they are forgotten: **Clot**, pharmacological thromboprophylaxis; **Skin**, frequent assessment of pressure areas; **Stretch**, stretching to avoid muscle contractures; **Feed**, consideration of artificial feeding. Each carries a named person and a named interval in a good plan, and not one is a medication for catatonia.

20.8 The feeding decision, and the rate

Feeding is the limb where a wrong act does immediate harm, because a starved patient fed at full requirement is a patient in refeeding danger. No catatonia-specific feeding protocol exists, so the rules come from the National Institute for Health and Care Excellence nutrition support guideline, learned as a stratification followed by a rate. Somebody mute and immobile for a week has met an intake criterion by definition, and the only question is which one.

WHICH RULE APPLIES	WHAT HAS TO BE TRUE	HOW FEEDING STARTS
The general rule for anyone who has not been eating	Little or no intake for more than 5 days	**No more than 50 per cent of requirements for the first 2 days, then increase to full needs if monitoring shows no refeeding problems**
High refeeding risk on one criterion	Any one of: **body mass index below 16 kg per square metre; unintentional weight loss above 15 per cent in the last 3 to 6 months; little or no nutritional intake for more than 10 days; low potassium, phosphate or magnesium before feeding**	**A maximum of 10 kcal per kilogram per day, increased slowly to meet or exceed full needs by 4 to 7 days**
High refeeding risk on two criteria	Any two of: **body mass index below 18.5 kg per square metre; unintentional weight loss above 10 per cent in the last 3 to 6 months; little or no nutritional intake for more than 5 days; a history of alcohol misuse, or of insulin, chemotherapy, antacids or diuretics**	As for high risk above
Extreme starvation	**Body mass index below 14 kg per square metre, or negligible intake for more than 15 days**	Only 5 kcal per kilogram per day, with cardiac rhythm monitored continually in these patients and in any patient who has or develops an arrhythmia

Two things in that table are the examinable ones. The stratification is met on history rather than investigation: weight, weight change and the date of the last proper meal decide the starting rate, and all three come from a relative rather than a laboratory. And the monitoring clause

attached to the lowest rate is one of the few places in catatonia care where a guideline states what is watched and how often. Beside it sits the electrolyte cadence from the same source: **magnesium and phosphate at baseline, then daily where there is a risk of refeeding syndrome, then three times a week until stable, then weekly**, on the stated reasoning that depletion of both is common and under recognised. That laboratory table was written with parenteral nutrition principally in view and may be applied selectively to enteral or oral support, particularly in a patient who is metabolically unstable or at refeeding risk. The vitamin limb of the same recommendation is taught in the Substance use disorders notes.

GOOD TO REMEMBER

The date of the last proper meal is a prescribing datum, not social history, and it decays within a day as the family's account smooths into "he has not been eating properly". Take it at first contact in a form that can be counted, take a weight on arrival even if it must be estimated, and record who estimated it. Those two entries decide the starting calorie rate and neither can be reconstructed a week later.

20.9 The second episode, and what the handover carries

The most useful act-level rule here applies to the patient who has been in before. When a patient presents with a recurrent episode of catatonia, the assessing clinician should not presume that an adequate workup was completed previously; the **adequacy of prior medical evaluation** should be confirmed. It reads as an administrative courtesy and it is a safety rule, because the second and third presentations are where a medical cause hides: the first admission attracts a full investigation, the second attracts diagnosis by recognition, and "known catatonia" in a referral letter is an efficient way of stopping a physician from looking.

TRAP **Treating a recurrent presentation as a repeat of the first one, and inheriting its workup unread.** Clinicians and candidates both make this error because recurrence genuinely does raise the probability of an idiopathic or psychiatric cause, so the inference feels sound. The flaw is that it is an inference about the population while the question is about this patient, whose earlier evaluation may have been curtailed the moment the treatment worked. Confirming adequacy means reading what was done and finding the results. The correct answer to "was he worked up last time" is a list, never a yes.

What the emergency episode owes the team that inherits the patient is a record precise enough to make the next decision without repeating this one. Four entries belong in it and are routinely missing:

- the date and content of the last oral intake and the last drink, with the arrival weight and who measured it;
- the baseline observation set, the interval observations were then taken at, and who set it;
- whether thromboprophylaxis was started, when, on what bleeding-risk assessment, and if withheld, why;

- a pressure-area map from the admission examination, so a new ulcer can be told from an old one.

> Catatonia kills through dehydration, immobility and sympathetic overdrive, so the first hour buys the clot, the skin, the airway and the feed while the diagnosis is still being settled.

21 · Neuroleptic malignant syndrome (features, diagnosis, management)

Why this belongs in an emergency chapter at all. The syndrome itself is taught elsewhere. Its clinical picture, its tempo, the risk factors, the agents used to treat it and the rule for restarting an antipsychotic are set out in the Schizophrenia: management, antipsychotics and adverse effects notes, and none of it is repeated here. What is left over is where an emergency paper puts its marks, because the standard account of neuroleptic malignant syndrome describes the illness and then stops. It prints no formal criteria set, no scoring rule, no temperature functioning as a criterion rather than an observation, and no threshold at which a psychiatric inpatient becomes a critical-care one. Those four objects, with the laboratory limb the usual account leaves vague and the act performed while all of it is unsettled, are what is owned here.

Hold two decisions apart from the moment the patient arrives, because they run on different numbers at different speeds. The first is nosological: does this presentation satisfy a criteria set, and what must be excluded before that is said out loud. The second is dispositional: how deranged is this patient now, where can they safely be nursed, and who else needs to be at the bed. The second does not wait for the first, and it is the one that changes outcome. A candidate who fuses them describes the syndrome when asked what to do, and describes a ward round when asked how the diagnosis is made.

21.1 What kind of instrument the criteria set is

The criteria set to name in an answer came from a formal **Delphi** procedure over an international multispecialty panel in which psychiatrists were the largest group, alongside neurologists, anaesthesiologists and emergency physicians. That composition is not decoration. A syndrome recognised on the psychiatric ward, in theatre and at the front door accumulates three house styles of diagnosis, and the panel existed to force them into one statement. The instrument is a consensus product and not a trial-derived one: it encodes what experienced clinicians agreed they do, and inherits whatever they were collectively getting wrong.

The panel printed a caveat on its own work. The criteria were published with an explicit warning that they **required validation before clinical application**. That sentence is the difference between a criteria list and a decision rule, and it is the part most reproductions drop. A list says what a syndrome contains. A decision rule says what happens when it is applied to consecutive patients: how often it says yes when the answer is yes, and how often it says no when the answer is still yes. Until that is measured, a criteria set is a well-organised opinion.

RULE **Diagnosis and disposition are two decisions taken from two different sets of numbers.** The criteria and their critical values answer whether this is the syndrome. The temperature and the heart rate now answer where the patient is nursed and who is called. Fusing them produces the clinical failure in which a patient with a convincing story waits on an open ward for a creatine kinase result before anyone escalates, and the examination failure in which a candidate recites a presentation and never states a threshold.

21.2 The criteria themselves, and the values fixed to them

The consensus set runs to **eight** criteria, best held as four questions with an audit trail attached: was the dopaminergic system interfered with, is the patient hot and stiff, are the brain and the sympathetic outflow disturbed, and has anything else been ruled out. Four criteria carry a fixed quantitative value. For the rest, no critical value is recorded in the consensus statement of critical values available here, which is a limit of what can be quoted rather than evidence that the criteria set left them open. The table sets each against its value and against what it obliges the clinician to do, because a criterion that generates no act at the bedside is an examination artefact.

CONSENSUS CRITERION	CRITICAL VALUE FIXED WITH IT	WHAT THE CRITERION OBLIGES YOU TO DO
Recent dopamine antagonist exposure, or dopamine agonist withdrawal	No numerical value set	Reconstruct every dopamine-blocking exposure, including antiemetics prescribed by other teams and long-acting injectables given weeks earlier, and time the last dose. Stopping a dopamine agonist counts, and is missed because the chart records a subtraction.
Hyperthermia	**Temperature above 38.0 degrees Celsius, equivalently above 100.4 degrees Fahrenheit, recorded on at least two occasions**	Measure again, and write the second reading down. One elevated temperature does not satisfy this criterion, so the criterion is an instruction to re-observe rather than to conclude.
Rigidity	No numerical value set	Document tone now and again later, so a trajectory exists for whoever takes over.
Mental status alteration	No numerical value set	Record conscious level and orientation in enough detail that deterioration is visible to a clinician meeting the patient for the first time.
Creatine kinase elevation	**Creatine kinase at least four times the upper limit of normal**	Send it with renal function and potassium, and take the upper limit of normal from the laboratory running the assay, because the criterion is a multiple and not an absolute figure.
Sympathetic nervous system lability	**Blood pressure elevation at or above 25 per cent over the patient's own baseline, or blood pressure fluctuation of at or above 20 mm Hg diastolic or at or above 25 mm Hg systolic within 24 hours**	Find a baseline. The criterion is unusable where pre-morbid observations were never recorded, which is the argument for taking them on every admission that starts a dopamine antagonist.
Tachycardia with tachypnoea	**Heart rate at or above 25 per cent over baseline, together with respiratory rate at or above 50 per cent over baseline**	Count the respiratory rate yourself. It is the observation most often invented on a busy chart, and here it is half a criterion.
A negative work-up for other causes	No numerical value set	Do the work-up. This limb is satisfied not by considering alternatives but by investigations that come back and are recorded.

Read those values as a family rather than as separate numbers. Most of the quantitative criteria are referenced to the patient's own baseline rather than a population figure. A young man whose resting pulse normally sits low satisfies the tachycardia criterion at a rate that would not trouble a medical ward, and a chronically hypertensive patient satisfies the blood pressure criterion at a figure that looks routine. Such criteria are sensitive to the individual and wholly dependent on documentation, which is why the observation chart of the first hours of an admission is a diagnostic instrument here and not an administrative one.

Two further points are examinable. Creatine kinase enters as a multiple of the upper limit of normal, a different object from the absolute figure the Schizophrenia: management, antipsychotics and adverse effects notes already teach; the two must not be merged in an answer. And leukocytosis, which almost every textbook description lists, is not among the criteria at all.

21.3 The negative work-up limb, where the work hides

The eighth criterion looks like a formality and is the most laborious of the set. Its content comes from the regulator: the **United States prescribing information for haloperidol injection** states that the diagnostic evaluation is complicated, and directs the clinician first to identify presentations in which serious medical illness, pneumonia or systemic infection for instance, coexists with untreated or inadequately treated extrapyramidal signs. That pairing rewards attention, because it is how the diagnosis goes wrong in both directions at once: a febrile parkinsonian patient with a chest infection can look exactly like the syndrome, and a patient with the syndrome can be dismissed as a chest infection in someone who was always stiff.

The same source then names what else must be considered before this limb is satisfied: central anticholinergic toxicity, heat stroke, drug fever and primary central nervous system pathology. As a list of alternatives it is unremarkable, and that is not the point of it. As an instruction it is demanding, because every entry converts into an act with a time cost: an environment and exposure history, cultures, a lumbar puncture or imaging where the neurological picture warrants it, and a second reading of the drug chart for agents nobody thought of as psychotropic. Discriminating this syndrome from its hyperthermic mimics is taught in the Schizophrenia: management, antipsychotics and adverse effects notes and is not restated here; what belongs here is the obligation the criterion creates, that the exclusions are performed and written down rather than entertained.

> **GOOD TO REMEMBER**
>
> The exposure history is the one criterion nobody can reconstruct later. Which dopamine-blocking agent was given, when, by whom, and what was stopped lives in a drug chart, an emergency prescription and a relative's memory, and degrades within hours. Take it first, take it in writing, and take it before the patient moves to a department the chart travels to separately.

21.4 Scoring the criteria, and what a low score does not mean

The set is not applied by counting items met. Each criterion is weighted, so it is scored in priority points and a total is compared against a threshold. The threshold appeared only at validation, which was retrospective: it scored **archived reports of clinician-initiated calls to a national**

telephone consultation service against the set. Agreement was best where the threshold was set at **74 priority points, which gave a sensitivity of 69.6 per cent and a specificity of 90.7 per cent** against the modified research criteria used as the reference standard.

8	74	4x ULN	>40 C
CRITERIA IN THE CONSENSUS SET	PRIORITY-POINT CUT-OFF SCORE	CREATINE KINASE CRITERION	TEMPERATURE DEFINING THE SEVERE BAND

Read those two operating characteristics as clinical instructions. High specificity with modest sensitivity describes a rule-in instrument. Reaching the cut-off is strong evidence the syndrome is present. Failing to reach it means little, because a rule whose sensitivity sits below seventy per cent misses close to a third of true cases, and a third is not a rounding error when the missed diagnosis is this one. Use of the score is asymmetric: it can justify escalation to a sceptical colleague, and never justifies returning a patient to the ward.

State the limitation whenever you quote the cut-off. The criteria were scored against archived consultation records, not against patients examined prospectively at the front door, so the population in which the threshold performed as reported is one of cases already interesting enough to telephone about. That is not the undifferentiated patient in front of you, and the operating characteristics in that patient are unknown. This is not a reason to discard the cut-off, only to quote it as the best available calibration of a consensus instrument rather than a property of nature.

The same validation produced a second finding with direct bedside consequences. Experienced consultants' own diagnoses agreed considerably better with a modified reference standard, one that accepted less than **severe rigidity**, than with the original standard that demanded it, and the authors concluded that the severe rigidity requirement is more restrictive than what knowledgeable clinicians actually use. As an act: waiting for lead-pipe tone before treating a patient as having this syndrome is not what the criteria evidence supports, and the wait is paid for in hours during which the temperature and the muscle are still climbing.

TRAP **Treating a sub-threshold score, or an absence of severe rigidity, as evidence against the diagnosis.** Candidates make this error because a scored criteria set looks like a diagnostic test, and tests are taught as two-sided objects that confirm and exclude. This one is not. It was assembled by consensus to standardise agreement between specialties, calibrated against a selected population, and its sensitivity was never good enough to rule out. State the cut-off, then state in the same breath what a score below it does not entitle you to do.

21.5 The laboratory limb: what leukocytosis is worth

Leukocytosis is asserted in almost every description of this syndrome and almost never given a figure, leaving candidates repeating a finding they cannot quantify. Two things can honestly be said. The first is a frequency with a population attached: in a systematic review of published case reports of neuroleptic malignant syndrome in children and adolescents, creatine kinase elevation and leukocytosis were the commonest laboratory findings, each present in **42.1 per cent** of cases. That figure belongs to **children and adolescents described in published case reports**, a

population selected twice, first by being young and again by being interesting enough to publish. It is a proportion of cases and not a white cell count, and must never be transplanted into an adult sentence or quoted as a threshold. No adult numerical leukocyte cut-off is asserted here, because none could be sourced.

The second thing that can be said is that the standing of the leukocyte count as a criterion has been challenged directly. A single-centre retrospective case-control study of psychiatric admissions argued that the **neutrophil to lymphocyte ratio** and the lymphocyte percentage may serve as alternative minor criteria, more sensitive and more specific than the leukocyte level and creatine kinase. The direction of the finding is teachable. Its magnitude is not, because it rests on **a small single-centre sample of case and control hospitalisations drawn from the same patients**, and discrimination reported from a sample that size is almost certainly over-fitted. No ratio and no cut-off is printed here for that reason.

What survives at the bedside is short. A raised white cell count supports the picture and never establishes it, and a normal count is not reassurance. This syndrome's laboratory limb is dominated by muscle and kidney, and the tests that change the next hour are creatine kinase, potassium, renal function and a blood gas. Order the white cell count because sepsis sits on the exclusion list, not because it is a criterion, because it is not one.

21.6 The act in the department, stated without a single drug

The arrival sequence is common to every emergency in this chapter and is set out where that sequence is taught: recognise, stabilise, establish who holds the authority to act, act, monitor, decide the destination. What is specific here is that the first therapeutic move is a subtraction. The regulator states the management as three numbered steps, a structure worth keeping because it is the most authoritative statement available of what to do when the pharmacological evidence runs out. Per the **United States labelling for haloperidol injection revised in 2022**: immediate discontinuation of antipsychotic drugs and of other drugs not essential to concurrent therapy; intensive symptomatic treatment and medical monitoring; and treatment of any concomitant serious medical problem for which a specific treatment exists. The same source adds the sentence that keeps an answer honest: there is no general agreement about specific pharmacological treatment regimens for the uncomplicated form. Which agents are used, when, and at what dose is taught in the Schizophrenia: management, antipsychotics and adverse effects notes and is deliberately not carried here.

The supportive half of that middle step has been put in more operational terms by the **British Association for Psychopharmacology catatonia guideline of 2023**, on a consensus footing rather than a trial one, and it is the cleanest available statement of what intensive symptomatic treatment means:

- assessment and appropriate management of airway, ventilation, temperature and swallow;
- monitoring of fluid input and output, with aggressive fluid resuscitation where it is required;
- assessment for hyperkalaemia, renal failure and rhabdomyolysis;

- careful monitoring for cardiorespiratory failure, aspiration pneumonia, thromboembolism and renal failure, alongside early consideration of high-dependency care.

Notice what is absent. There is no drug in that list, and no interval either: the guideline says careful monitoring and does not say how often. No sourced observation cadence for this syndrome is asserted here, and an invented interval would read as universal when it would be nothing of the kind. The principle is defensible without a number: observation frequency is set by the rate at which the patient is changing, reviewed at every escalation, and recorded with the name of whoever set it. Note where "early" sits in that final clause: a higher level of care is considered alongside the surveillance, not after it fails.

> The criteria settle what to call it; the temperature and the heart rate settle where it is nursed, and the second decision never waits for the first.

21.7 Severity banding and the level-of-care decision

The same guideline bands severity by two observations available within a minute of arrival and needing no laboratory. The bands were written to structure a treatment choice; the treatment clause belongs to the chapter that owns the drugs, and what is used here is the half answering the question nobody else answers, which is where this patient should physically be. Two measurements needing no investigation are worth a great deal in an Indian emergency department, where the creatine kinase result may be hours away and the decision cannot wait.

BAND	PHYSIOLOGY THAT DEFINES IT	WHAT THE BAND DECIDES ABOUT LEVEL OF CARE
Mild, early	**Temperature below 38 degrees Celsius with heart rate below 100**, with mild rigidity, catatonia or confusion	The patient may remain in a psychiatric setting only if repeated observations are genuinely taken and read by somebody competent to act on a change. If that is not true of the ward, this band does not apply to it.
Moderate	**Temperature between 38 and 40 degrees Celsius with heart rate between 100 and 120**, with moderate rigidity, catatonia or confusion	Medical co-management from here: a named physician, secure intravenous access, fluid balance charting and laboratory surveillance for the complications listed above. This is the band in which transfer is arranged rather than contemplated.
Severe	**Temperature above 40 degrees Celsius with heart rate above 120**, with severe rigidity, catatonia or coma	The critical-care conversation, not a further period of observation. Airway protection becomes an active question, and high-dependency or intensive care is the destination being negotiated.

Two things about that table are this account's work rather than the guideline's. The third column is a level-of-care decision written here; the bands are the guideline's, but what each one buys in a district hospital is not, and no treatment recommendation is being lifted. And the bands are conjunctive, stating a temperature AND a heart rate, while real patients arrive discordant, hot with an unremarkable pulse or tachycardic and afebrile. No source consulted rules on that case, and none is invented. The working rule is that the higher band governs, because every consequence of over-calling is reversible and the consequence of under-calling is a patient watched on a ward that cannot watch.

A banding this crude is useful for a reason that is not biological. Temperature and pulse are continuous variables cut at round numbers, and their value here is procedural: they give two clinicians who disagree a common object to point at. A resident asking a physician at two in the morning to accept a patient is far stronger saying the temperature is above forty and the pulse above one hundred and twenty than saying the patient looks unwell. The bands convert an impression into a referral that is hard to refuse, and that is most of what a threshold is for. What they do not encode is speed: a patient climbing rapidly through the moderate band deserves the response of the band above.

IN INDIA

Each band assumes a service that may not be present. The mild band assumes observations are actually taken on an open psychiatric ward and that somebody reads them, where in practice the chart is often completed at the end of a shift. The moderate band assumes a physician will co-manage a patient who stays under psychiatry, usually achievable in a general hospital psychiatry unit and frequently not in a standalone mental hospital. The severe band assumes an intensive care bed exists and will accept a patient carrying a psychiatric diagnosis, which is where transfers stall. Plan for it before the patient arrives: know which medical unit takes your escalations, whether the laboratory runs creatine kinase after hours, where the nearest dialysis service is and whether it accepts referrals overnight, and record every refusal with its time. That is not defensive paperwork; it is the only thing that makes a delayed transfer visible afterwards.

21.8 Organ support and the renal replacement decision

The organ that fails first is the kidney, and the route is worth stating because it dictates early management. Sustained rigidity with hyperthermia produces rhabdomyolysis; myoglobin, with the volume depletion of a hot immobile patient who is not drinking, produces acute kidney injury; and that injury with the potassium released from the same muscle produces the hyperkalaemia that kills. The chain is why fluid resuscitation and potassium surveillance are early acts, and why the creatine kinase criterion has an operational meaning outliving its diagnostic one.

The threshold for replacing renal function is where candidates expect a number and there is not one to give. The **Kidney Disease: Improving Global Outcomes acute kidney injury guideline of 2012** states the emergent trigger as a clinical rule rather than as a value: renal replacement therapy is initiated emergently when life-threatening changes in fluid, electrolyte and acid-base balance exist. It then closes the door on the number explicitly, directing the clinician to the

broader clinical context, to conditions that replacement therapy can modify, and to the trend of laboratory tests, **rather than to single urea and creatinine thresholds alone**. An account promising a dialysis number promises something the guideline deliberately declines to supply, and a candidate who produces one has invented it.

What does have operational content is the set of situations widely accepted as emergent indications, which the guideline names while acknowledging that no randomised trial exists for dialysis on life-threatening indications:

- severe hyperkalaemia;
- severe acidosis;
- pulmonary oedema;
- uraemic complications.

Turn that into a psychiatric instruction. The psychiatrist does not start dialysis and is often the only person who knows the patient is heading towards needing it. The act owned here is anticipatory: recognise that a rigid hyperthermic patient is a rhabdomyolysis patient, repeat the potassium and renal function rather than sending them once, keep the fluid balance chart honest, and refer on the trend rather than a single value, because trend is what the guideline says the decision rests on. The equivalent statement for the airway is weaker and should be given as such: airway, ventilation and swallow are named as domains of supportive care, but no numerical threshold for intubation is asserted here, because none was sourced. The principle stands without a number. Swallow is assessed before anything is given by mouth, and a patient whose chest wall movement is limited by rigidity is an anaesthetic problem before a psychiatric one.

21.9 Disposition and handover

Disposition here is not one event but a series of transfers, and each loses information unless it is written to prevent that. The receiving team needs four things only the referring psychiatrist holds: the exposure history with times, which criteria were met and which explicitly were not, what the negative work-up covered and what is outstanding, and the observations establishing the trend rather than the single worst value. A referral saying the patient has the syndrome invites a debate about the diagnosis. One saying which criteria are satisfied, at what values, over what interval, and what has been excluded transfers the reasoning rather than the conclusion, and is much harder to send back.

The internal handover matters as much. Restarting an antipsychotic afterwards, including how long to wait and what to choose, belongs to the Schizophrenia: management, antipsychotics and adverse effects notes and is decided by the team carrying the psychiatric care, not at the front door. What the emergency episode owes that team is a record clean enough to make the later decision possible: the agent, the route, the cumulative exposure, the interval between exposure and onset, the peak physiology, and whether the diagnosis was made against a formal criteria set or on clinical impression. Two entries belong there that residents routinely omit:

- the score, where the criteria set was scored, together with the explicit note that a total below the threshold was not treated as exclusion;
- who decided the level of care, at what time and on what observations, since that is the decision reviewed first if the patient deteriorates afterwards.

One thing is worth carrying out of this section. Everything owned here is a discipline of writing things down while they are still measurable: a baseline observation set that makes a percentage criterion usable at all, a second temperature that turns the first into a criterion, an exposure history that decays within hours, a trend that justifies a referral, and a level-of-care decision with a name and a time on it. The syndrome is treated with drugs the Schizophrenia: management, antipsychotics and adverse effects notes teach. It is survived on organisation.

22 · Serotonin syndrome (Hunter criteria, differentiation from NMS, management)

Why the marks sit on the rule and not on the syndrome. What serotonin toxicity looks like, which agents produce it, and how it is told apart from the other hyperthermic emergencies is set out in the Schizophrenia: management, antipsychotics and adverse effects notes, and none of that is repeated here. What that account does, in common with almost every textbook account, is name the Hunter criteria and move on. A criteria set that is named but never set out is a dangerous object in a curriculum: every candidate can produce the name, very few can say what the rule actually asks, and a rule nobody can state is a rule nobody can apply or properly refuse to apply. Setting it out, with the patients it was built on and the accuracy that bought, is owned here. So is everything that follows once it has returned an answer: what is stopped first, what is cooled, what is sedated, whether an antidote has any place at all, how long the patient is watched before anyone uses the word discharge, and where that watching happens.

One structural point governs how much weight the rule can carry. It was derived in a poisoning service, on patients whose exposure was already known and whose remaining question was diagnostic: given this overdose, is this serotonin toxicity. The psychiatric emergency runs the other way. The physiology is in front of you and the exposure is not, because an agitated, sweating, tremulous patient arrives with a relative unsure what was taken and a prescription list months out of date. The rule is commonly used backwards from the direction it was built in, and the consequence is that a positive result is worth far more than a negative one. That asymmetry, rather than the list of features, is the examinable content of this topic.

22.1 The instrument: a decision rule, and what it displaced

The set to name in an answer is the **Hunter Serotonin Toxicity Criteria, published in QJM in 2003**. The object it is always contrasted with is **Sternbach**'s earlier criteria, and the contrast is not about which features appear on which list. Sternbach's set was a list: features associated with the condition, assembled from the literature, applied by recognition. The Hunter set is a different class of instrument. It was derived empirically from a consecutive admission series, measured against a stated reference standard, and its output is a decision rather than an impression.

The derivation both makes the criteria defensible and bounds them. Every patient admitted to a single regional toxicology service after overdose of a serotonergic drug across a long consecutive series was studied, and the outcome everything was measured against was the diagnosis of serotonin toxicity made by a **clinical toxicologist**. Predictive features were identified first in a learning dataset restricted to overdoses of a selective serotonin reuptake inhibitor taken alone, which strips out the confounding of mixed ingestions, and the rules were then built by **classification and regression tree analysis** and tested on all serotonergic overdose admissions.

2222	473	84%	97%
SEROTONERGIC OVERDOSE ADMISSIONS IN THE DERIVATION SERIES	SSRI-ALONE OVERDOSES FORMING THE LEARNING DATASET	SENSITIVITY OF THE HUNTER DECISION RULES	SPECIFICITY OF THE HUNTER DECISION RULES

Two properties of that design need stating, because the accuracy figures are usually quoted without them. The reference standard is expert clinical judgement: there is no assay and no imaging finding that settles this diagnosis, so the criteria were trained to agree with experienced toxicologists rather than with a biological truth, and that is the ceiling on the performance of every criteria set in this family. Second, a rule built by recursive partitioning is not a summary of what the condition contains. It is a sequence of questions chosen because they separate groups efficiently, so a feature can be entirely characteristic of the illness and still be absent from the rule, simply because another feature was already doing that work.

22.2 The features the rule uses, and the two that arrived by a different route

Counted as the criteria set enumerates them, the rule rests on **seven** features: **clonus** counted once, in any of its three forms, inducible, spontaneous or ocular, together with agitation, diaphoresis, tremor, hyperreflexia, hypertonicity and a maximum temperature above 38 degrees Celsius. Five of those were what was needed to predict the toxicologist's diagnosis and everything else associated with the condition fell out of the rule as redundant; the last two arrived by a different route, which is the next paragraph and is the examinable part.

Two further features were added afterwards, and the reason is itself examinable. The learning dataset contained no life-threatening cases, so features belonging to the sickest patients could not emerge from it statistically. Hypertonicity and a maximum temperature **above 38 degrees Celsius** were universal in such patients and were added on clinical grounds. The rule's coverage of severe toxicity therefore rests on expert consensus about what those patients look like, while the rest of it rests on the derivation that produced its accuracy figures. Two kinds of evidence sit inside one instrument, and an answer that notices the difference is better than one reciting the list.

The features are set out below as what they are, the inputs to a rule, and not as a portrait of the illness, which is taught elsewhere. The second and third columns earn the table its place: a feature never elicited cannot enter a decision rule at all, and the commonest way this rule fails is not disagreement about a finding but that nobody performed the examination which would have produced it.

FEATURE THE RULE USES	HOW IT IS ACTUALLY OBTAINED	WHAT IT OBLIGES AT THE BEDSIDE
Inducible clonus	Sustained brisk passive dorsiflexion of the ankle. It is elicited, never observed.	Examine both legs deliberately and record that clonus was sought and not found, rather than leaving the entry blank. A blank is read later as an absent finding when it was an absent examination.
Spontaneous clonus	Present without any manoeuvre, and visible only on uncovered limbs.	Look before you cover the patient and before you sedate. Sedation suppresses the finding, so the observation must precede the treatment or be lost.
Ocular clonus	Sought by watching the eyes at rest and on pursuit, which requires looking at the eyes on purpose.	Make the eye examination routine in any hot or agitated patient with a possible serotonergic exposure. It is the feature most often absent from the notes and present in the patient.
Agitation	Observed, then distinguished from the agitation of whatever brought the patient into contact with services.	Establish whether this agitation is new and time it against the last known dose. Agitation attributed to the primary illness is the commonest route to a missed diagnosis in a psychiatric setting.
Diaphoresis	Recorded by touching the patient.	Make the observation rather than infer it. This is the finding most often transcribed from an earlier entry without anyone reexamining the skin.
Tremor	Observed in the outstretched limbs.	Document it at first contact, so that a change later has something to be a change from.
Hyperreflexia	Requires a tendon hammer and a neurological examination.	Do the examination. Reflexes are the limb of this rule most often skipped in an emergency room, and skipping them removes a feature the rule depends on.
Hypertonicity, added for life-threatening presentations	Assessed by passive movement of the limbs, and reassessed rather than assessed once.	Treat its appearance as a change of category, not one more positive item. Rigid muscle is the tissue generating the heat, so this finding sets the tempo of what follows.

FEATURE THE RULE USES	HOW IT IS ACTUALLY OBTAINED	WHAT IT OBLIGES AT THE BEDSIDE
Maximum temperature above 38 degrees Celsius, added for life-threatening presentations	Measured, ideally centrally, and recorded as the maximum reached rather than the most recent reading.	Chart the trajectory, not a value. The criterion refers to a maximum, so a falling reading taken after cooling does not undo a peak that has already occurred.

TRAP **Treating the criteria as a checklist and counting how many features are present.** Candidates do this because the set being implicitly compared with was a list, and lists are counted, and because secondary reproductions lay the branch conditions out as bullet points that look countable. This set is a decision tree. Particular features in particular combinations are diagnostic and others are not, so two patients with the same number of positive items can fall on opposite sides of it. The verbatim branch structure is not reproduced here, because it could not be verified against the primary publication, and a branch condition recalled from a secondary source is the kind of detail that is wrong in a way nobody notices until it is applied to a patient.

22.3 What the accuracy figures actually bought

The rules were simpler than their predecessor and performed better on both axes: **84 per cent against 75 per cent for sensitivity, and 97 per cent against 96 per cent for specificity**. Read the two gains separately, because they are not of comparable size and do not carry the same meaning. The specificity gain is arithmetically trivial; both instruments were already highly specific, and what matters there is the level rather than the improvement, because within the population studied a positive result is close to conclusive, and that is what licenses acting on the rule instead of waiting for something else to confirm it. The sensitivity gain is the substantial one, and it is why the newer rule displaced the older, since it materially reduces the proportion of genuine cases missed while making the instrument simpler rather than more elaborate.

Turn both into instructions. A positive rule in the right setting is strong enough to justify stopping the drug, starting physical treatment and escalating the level of care over a colleague's scepticism. A negative rule is not strong enough to send anybody home, because an instrument that misses a meaningful minority of true cases is not an exclusion test, and because its sensitivity was measured against agreement with an expert rather than against a fact of nature. One further qualification changes the weight of both figures considerably, and it is the subject of the next section.

22.4 Where the rule was validated, and where you will be using it

The group that derived the criteria addressed this in the **Medical Journal of Australia clinical update of 2007**, and their statement is more restrictive than the way the criteria are usually quoted. The rules were validated in a **toxicology service** in which other drug-induced syndromes are frequent, and that setting is precisely why they are so much more specific than the older criteria for features belonging to serotonin toxicity alone. Because they are that specific, the authors say, they can be used for adverse drug reactions; but they have not been validated for that purpose.

Sit with what that excludes, because it describes most of the situations in which a psychiatrist reaches for the rule. A patient on therapeutic doses who becomes tremulous, sweaty and agitated after a prescription change is an adverse drug reaction, not an overdose. There is no time zero, no ingested quantity, and no toxicology service around the patient. Applying the criteria there is defensible and is what the authors themselves say the specificity permits, but the operating characteristics above were not measured in that population and are not properties of the rule in it.

What follows is a discipline of documentation rather than of treatment. Use a positive result to justify what you are about to do; do not use a negative result to justify not doing it, and write the reasoning in that form, because a note recording that the criteria were not met reads later as an exclusion when it was nothing of the kind. The honest entry names the setting, states which features were sought and which were found, and says explicitly that a negative rule was not treated as excluding the diagnosis.

22.5 The branch that changes the clock: severe toxicity

Severity, not the diagnostic label, determines the next hour, and the severe band has its own name and definition. Severe serotonin toxicity, or **serotonin crisis**, is characterised by a rapidly increasing temperature together with muscle rigidity, and it will progress to multiorgan failure if not treated within hours. It is a medical emergency, and it is almost exclusively associated with combinations of drugs acting at different sites rather than with any single agent. Three things follow, and each is an act.

The first concerns the word hours. Every other interval in this topic is counted in hours too, which is exactly why the distinction matters: the observation period and the expected recovery are periods during which you watch, while this is a period during which you must already have acted. It is the only clock here that finishes before a laboratory result does.

The second concerns the drug history. If the severe band is almost always a combination, the question asked of the patient and the relatives changes shape. It is not what was taken, it is what was taken together, over what period, and whether anything was started or stopped recently by a team other than yours. A single-agent answer, accepted and written down, closes the enquiry at the point where the severe band would have been identified.

The third concerns what is measured. The definition names a rapidly increasing temperature, not a high one, with rigidity beside it. A patient whose temperature has climbed steeply is in a different situation from one sitting at the same reading unchanged for some hours, and only one of those facts appears on an observation chart that records values without times. Insist on times.

> A rising temperature with rigidity is the branch that runs on hours, and it is answered by cooling, sedation and paralysis, never by an antidote.

22.6 What the differentiation from neuroleptic malignant syndrome actually changes

The grid is not the teaching here. How this syndrome is distinguished from neuroleptic malignant syndrome and the other hyperthermic emergencies is taught as a recognition exercise in the Schizophrenia: management, antipsychotics and adverse effects notes, and it is not redrawn on this page. What belongs here is the question a recognition exercise never answers: what the discrimination buys. A candidate who can separate the two syndromes on features but cannot say what changes when they do has learned the half that carries fewer marks.

- **Almost nothing changes in the opening minutes.** Both converge on the same physical act: airway, temperature, fluids, sedation, and a decision about where the patient is nursed. A resident who suspends cooling while the label is argued has the order of operations exactly backwards. The discrimination is made in parallel with resuscitation, never before it.
- **What is subtracted differs, so the history differs.** One picture asks what dopamine blockade was given or what agonist was withdrawn; this one asks what serotonergic agents were on board and, in the severe band, in what combination. That is a different conversation with the relative and a different reading of the drug chart, and it has to happen early because the information decays.
- **The expected trajectory after stopping differs, and only one of them can be stated with a source here.** Serotonin toxicity has a recovery window, set out below; no equivalent interval for the other syndrome is asserted on this page. That asymmetry is useful rather than awkward, because it means failure to improve inside the stated window is a reason to reopen your own diagnosis and is not by itself evidence that the other syndrome was the answer.
- **The antidote question exists on one side and is unsettled even there.** Getting the discrimination right does not hand you a drug, which is what most candidates expect it to do.
- **The disposition logic differs because the exposures differ in shape.** One typically follows an ingestion with an identifiable time zero, which is what makes a fixed observation period meaningful. The other may follow an exposure running for weeks, where a period counted from a moment has nothing to be counted from.

22.7 The order of operations, and why the antidote is a second-order decision

RULE **Supportive care takes precedence over any specific pharmacological treatment.** The clinical update of 2007 states it in those terms and gives the reason: hyperthermia and muscle rigidity are the effects that matter, and it is supportive care that prevents the secondary complications, rhabdomyolysis, renal failure and disseminated intravascular coagulation. Every question about which drug to give is therefore asked after the physical work is under way, not instead of it.

The arrival sequence itself is common to every emergency in this chapter and is set out where that sequence is taught: recognise, stabilise, establish who holds the authority to act, act, monitor, decide the destination. What is specific here is the content of the stabilise step, which the same source names as four physical interventions:

- passive cooling, and active cooling where passive measures are not keeping pace;

- sedation;
- intubation;
- muscle paralysis.

Those four are less an escalating menu than a single mechanical argument. Rigid, active muscle is the tissue producing the heat, so sedation reduces the drive to it, paralysis stops the production outright, and cooling removes what has already been made. Intubation is not a complication of that plan but a precondition for its last step, which is why it sits among supportive measures rather than among disasters. Once the chain is understood the sequence stops needing to be memorised, and the reason the antidote question sits downstream becomes obvious: no antiserotonergic agent removes heat from a patient, and heat is what causes the harm.

State the limits of that list honestly, because it stops short of several numbers a candidate will expect. No temperature at which active cooling should begin is asserted here, and no criterion for intubation, because neither could be sourced. The principle survives without them: the trigger for escalating physical treatment is the trajectory of the temperature and the presence of rigidity rather than any single reading, and the decision belongs to whoever will manage the airway. The sedative is named generically in the source and carries no dose there, so no dose, route or titration for sedation appears here either. A number invented at this point would be read as protocol, and there is no protocol behind it.

22.8 Stopping the agent, and the washout question

The first therapeutic act is a subtraction, and the same authors put cessation of the serotonergic medication alongside supportive care as the whole of what treatment should focus on. That is easy to say and routinely done incompletely, because stopping the drug that is charted is not the same as stopping the exposure. The relevant list is everything reaching the patient: what another department prescribed, what was bought without a prescription, what a relative supplied from home, and what was taken as a preparation the patient does not think of as medicine. Each entry needs a time against its last dose, because the times are what convert a list into a history.

GOOD TO REMEMBER

The exposure history is the one part of this presentation that cannot be reconstructed later. Names, doses and above all the timing of the last dose of each agent live in a relative's memory, a home strip of tablets and a chart that travels separately from the patient, and all three degrade within hours. Take it at first contact, take it in writing, and take it before the patient moves department. Record whether decontamination has been given, because it forecloses one of the treatment options discussed below.

The recovery window is the yardstick for everything afterwards: most patients improve within **24 hours** of ceasing the serotonergic medication. That figure earns its place by making an otherwise vague bedside question answerable. A patient not improving inside it has three explanations worth working through: the agent is still being absorbed or still present in quantity,

an exposure has been missed and is continuing, or the diagnosis is wrong. Each has a different next action, and none of them is to wait longer.

The reintroduction question is where this section stops. How long to wait before any serotonergic agent is restarted is not sourced here, and it plainly cannot be a single number, because it depends on the elimination of the agents involved and on which combination produced the episode. The principle is stateable and the number is not: the wait is governed by clearance of what was taken, the decision belongs to the team carrying the longer-term psychiatric care rather than to the emergency episode, and what that team is owed is a record precise enough to make the decision possible.

22.9 The cyproheptadine decision, stated honestly

This is where most accounts produce a dose, and the most authoritative statement available does the opposite. The group that derived the criteria write that although some **antiserotonergic agents** have been used in clinical practice, the preferred agent, the dose and the indications are not well defined. That sentence is the honest content of the decision. It is not a gap in this account; it is the state of the evidence, and an answer reporting it accurately is stronger than one reciting a regimen as though the question were settled.

One fact about the agent does more practical work than any regimen would, and it is a route constraint. Because **cyproheptadine** can only be given orally, it is unlikely to be effective in a patient who has been given activated charcoal, and it has limited use in severe toxicity. Follow that through and the antidote turns out to be least usable in exactly the patients who most invite the thought of using it: the patient in the severe band frequently has a compromised airway or is about to be paralysed, has often already been decontaminated, and may be vomiting, so the oral route either does not exist or cannot be trusted. The antidote is a second-order decision by construction rather than by preference, and that is a better answer than a dose.

No dose is printed here, and the reason should be given rather than left as an omission. The source most authoritative on this agent says its indications are unsettled, and printing a regimen beside that sentence would represent as protocol what is at best a practice habit. Where a dosing schedule is taught it belongs with the pharmacology of the antidepressants and not in an emergency pathway, and the division is the point: the pathway owns whether the agent has a place, the pharmacology owns what goes on the chart if it does.

22.10 Observation, disposition and what the receiving team is owed

The disposition rule has no counterpart anywhere else, and it rests on one physiological observation from the same clinical update: serotonin toxicity may increase progressively over a number of hours after ingestion. The patient assessed at the door and found well is therefore not a cleared patient but a snapshot taken early on a curve that may still be rising, and the whole logic of an observation period follows from that sentence.

Patients with moderate serotonin toxicity should be observed for **6 hours, extended to 12 hours where a slow-release formulation such as venlafaxine has been ingested**. The extension is not a safety margin added out of caution; it tracks the formulation, because a

preparation designed to release drug slowly moves the patient up that rising curve slowly as well, and a period long enough for an immediate-release ingestion simply ends before the peak.

What the period does not come with is a cadence. How often the patient is examined during it, what is measured and by whom, is not sourced here, and an interval invented at this point would read as standard when nothing establishes that it is. The principle is defensible without a number: the frequency of observation is set by how fast the patient is changing and reviewed whenever that rate changes; the examination repeated is the one that produced the finding, so if clonus was what was found, clonus is what is re-elicited rather than a set of vital signs alone; and whoever set the level of observation is named in the notes with the time, because that is the decision reviewed first if the patient deteriorates. Nor is there a sourced criterion here for fitness for discharge at the end of the period, beyond the period itself and the recovery window.

IN INDIA

An observation period is a service, not an instruction, and the two commonly come apart here. A stated period of several hours assumes somewhere with observations: a bed in an area where temperature and pulse are actually recorded at intervals, staff who read them, and someone competent to act on a change at three in the morning. A standalone psychiatric hospital often has none of that, so a patient needing the longer period after a slow-release ingestion needs it in a general hospital emergency department, which converts an observation decision into a transfer decision taken at the front door rather than six hours later. Physical treatment has the same problem, since active cooling and muscle paralysis require an anaesthetist and a monitored bed. Settle these before a patient arrives rather than during one: which medical unit accepts your escalations, whether an intensive care bed is negotiable for a patient carrying a psychiatric diagnosis, whether the pharmacy stocks an antiserotonergic agent at all, and whom you telephone when the answer is no. Record every refusal with its time, because a transfer that was sought and declined is invisible afterwards unless somebody wrote it down.

The handover is where this episode either survives or is lost, and the receiving team needs several things only the clinician who was present can supply:

- which features were sought, which were found and, explicitly, which were sought and absent, since a rule of this kind is unreadable later without the negatives;
- the exposure list with a time against the last dose of each agent, and whether a combination was involved;
- whether decontamination was given, because it removes the oral route for the antidote and changes what the next team can offer;
- the peak temperature with the time it was reached and the readings around it, so that the trajectory transfers and not just the worst value;
- the observation period chosen, the reason for the longer or shorter one, who chose it, and when it started.

Everything owned in this topic reduces to a single discipline. The rule is only as good as the examination that fed it, the severity branch is visible only to someone recording times as well as values, the recovery window is useful only to someone who knows when the drug was actually stopped, and the disposition is safe only if the place the patient is sent to does the thing the period assumes. The syndrome is named elsewhere and its pharmacology is taught elsewhere. What is decided here is whether anybody looked, when, and what they wrote down.

23 · Acute dystonia and other acute drug-induced emergencies

Why an emergency chapter carries this at all. What the reaction is, which agents provoke it, how it sits in relation to the other movement disorders of antipsychotic treatment, and the drugs that abolish it with their doses and routes are all set out in the Schizophrenia: management, antipsychotics and adverse effects notes, together with akathisia, drug-induced parkinsonism and tardive dyskinesia. None of that is repeated here. What is left over is the half that decides the outcome, and it is the half a ward improvises: whether anyone looked at the airway before the syringe was drawn, how long you are entitled to wait for the injection to work, what you do when it does not work, and why a patient whose spasm melted away in front of you can be back in casualty the same week on the same prescription. The Indian Psychiatric Society's guideline on medical emergencies associated with psychotropic medications settles the framing by classing **acute dystonia** as an emergency rather than as an adverse effect, and by attaching immediate intervention to it.

The second half of this topic is the wider class, and no chapter in these notes teaches it as a class: the acute emergencies that a psychotropic drug can produce in an organ system that is not the brain. Four of them are worth holding together, because they share one act-level spine and almost nothing else. Airway-threatening dystonia, the hypertensive crisis on a monoamine oxidase inhibitor, the severe cutaneous adverse reaction, and priapism all present to someone who is not a psychiatrist, all have a clock, and in all four the first act is not the antidote. It is stopping the drug and protecting the threatened organ while the antidote is being found.

23.1 The airway question, asked before the syringe is drawn

A dystonic reaction is usually described by where it is visible, which is why the neck and the eyes dominate the textbook picture and the throat does not. Read the same territories as an emergency map and the priority inverts. The Indian guideline maps each muscle group to the function it removes, and the **oromandibular territory** is where that mapping stops being cosmetic: most of those territories are swallow and airway problems wearing the label of a movement disorder. The guideline then singles one out from all the rest: **laryngeal dystonia** is the form that produces stridor and can be life-threatening.

United States approved labelling for a high-potency first-generation antipsychotic sets out the same escalation in the order it happens, which is more useful at the bedside than a list of sites: spasm of the neck muscles, then tightness of the throat, then difficulty swallowing, then difficulty breathing, with or without protrusion of the tongue. That ordering is what converts a dystonic reaction into an airway assessment. A patient with torticollis alone is at the first step of a

sequence a regulator has written down, and the question the first clinician answers is not whether the posture is dystonic but how far along that sequence the patient already is: can they speak in full sentences, can they swallow their own saliva, is there stridor.

The *oculogyric crisis* belongs in the same first look for a different reason. It threatens nothing anatomically, but a patient whose eyes are locked upward cannot see the person examining them, is frequently terrified, and is very often read by a busy department as behavioural disturbance or as psychosis worsening. The act does not change. What changes is who gets called, and how long the patient waits.

RULE **The first decision in an acute dystonic reaction is anatomical, not pharmacological: which territory is involved, because only some of them can obstruct.** The drug that is given is the same either way, which is exactly why the question gets skipped. What differs is the setting the injection is given in and who stays at the bedside for the next twenty minutes. A neck held to one side and a throat that is tightening are the same diagnosis and a different level of care, and the second one is not safely managed in a side room by a single nurse who has been told to call if there is a problem.

23.2 The drug that caused it is usually not on the psychiatric chart

Dopamine blockade is not confined to antipsychotics, and the drug histories that produce this emergency most often are not psychiatric ones. Current United States labelling for metoclopramide, an antiemetic, records that dystonic reactions have rarely presented as stridor and dyspnoea, attributed to **laryngospasm**. That single sentence carries two teaching points. The airway presentation is a property of dopamine antagonism rather than a property of antipsychotic drugs, so a patient who has never been prescribed a psychotropic can present with it. And the causative drug will usually not be volunteered, because the patient does not think of an anti-vomiting injection as a medicine that acts on the brain.

What this changes about the history. The useful question at the door is not what psychiatric medication the patient takes. It is what has been given or swallowed in the last few days, including in another department, including by a general practitioner, including over the counter, and specifically including anything given for vomiting or for gastric upset. In a general hospital the reaction is frequently iatrogenic within the same building and within the same shift, and the drug chart that explains it sits in a casualty file rather than in the psychiatric notes.

GOOD TO REMEMBER

When you are called to a young patient with an odd posture, an arched neck or eyes rolled upward, and the referral says the presentation is functional, hysterical or behavioural, ask one question before you examine anything: what injection or tablet was given, anywhere, in the last few days. The commonest answer that changes the diagnosis is an antiemetic. The referral being wrong is not the interesting part; the interesting part is that the reaction is still being produced by a drug that is still being prescribed on that ward for other patients.

23.3 The timed act, the repeat interval and the failure ladder

The agents used and their doses belong to the Schizophrenia: management, antipsychotics and adverse effects notes and are not printed here. What this section owns is the clock attached to them, and it is unusually well specified. The Indian guideline expects the symptoms to resolve within 15 to 20 min of the parenteral drug, and records that most patients respond to the first dose, with very few needing a second or third. That expectation is what makes the injection an assessment as well as a treatment: a reaction that has not settled inside that window is telling you something.

15 to 20 min	30 min	72 h	4 hours
EXPECTED RESOLUTION OF ACUTE DYSTONIA AFTER THE PARENTERAL DRUG, INDIAN PSYCHIATRIC SOCIETY 2022	INTERVAL AFTER THE INITIAL PARENTERAL DOSE BEFORE THE SAME DRUG IS REPEATED IN A PERSISTING EPISODE, INDIAN PSYCHIATRIC SOCIETY 2022	WINDOW WITHIN WHICH CORTICOSTEROIDS ARE PREFERABLY STARTED IN STEVENS-JOHNSON SYNDROME AND TOXIC EPIDERMAL NECROLYSIS, INDIAN DERMATOLOGY GUIDELINE 2016	ERECTION DURATION BEYOND WHICH ACUTE ISCHAEMIC PRIAPISM IS A MEDICAL EMERGENCY, AMERICAN UROLOGICAL ASSOCIATION AND SEXUAL MEDICINE SOCIETY OF NORTH AMERICA 2021

The **Indian Psychiatric Society guideline of 2022** then gives a repeat interval and a failure ladder, and the value of both is that neither contains a drug name. If the episode persists after the initial parenteral dose, the same drug may be repeated about 30 min later. If the patient has not responded to two doses, the medication is changed rather than repeated a third time. If the changed medication also fails, the instruction is to consider a diagnosis other than acute dystonia. That last rung is the one candidates omit and the one that protects the patient, because the differential at that point contains conditions that a further anticholinergic injection will not touch and may obscure.

The airway presentation is treated as a separate line in the same stepwise table, and the guideline names a different agent class as the treatment of choice for acute laryngospasm, stated to be equally efficacious with the first-line option used for dystonia generally. The agents and figures in that table cell are owned by the Schizophrenia: management, antipsychotics and adverse effects notes and are not reproduced here; what this section teaches is that the airway presentation has its own line rather than being the same treatment given more urgently. One thing the source does not give, and it should be said rather than filled in: no observation cadence is attached to that waiting period. How often the airway, the swallow and the saturation are rechecked between the first dose and the second is not specified anywhere retrieved for this section, so the interval is set locally and the principle is all that can be taught.

23.4 What runs after the spasm stops, and why discharge is a decision

The single most important thing about this emergency is that its resolution is not its end. Once the episode is managed, the Indian guideline recommends continuing anticholinergic cover for at least **24 to 48 h** specifically to avoid recurrence, and separately records that in routine Indian practice the cover is continued up to 4 to 7 days. Those are two different figures doing two different jobs, a recommended minimum and an observed habit, and they should be quoted as such rather than averaged into a single number.

Recurrence after an apparently complete response is not treatment failure. The injection that abolished the spasm is short-acting relative to the drug that caused it, so the cover falls away while the cause is still there.

The formal definition contains a limb that makes this concrete, and it is the limb most readers skip. Dystonia counts as antipsychotic-induced not only when it follows starting the drug or increasing its dose but also when it develops on reducing or removing the medication used to treat or prevent acute extrapyramidal symptoms. Stopping the cover is itself a recognised precipitant. That converts the taper from an afterthought into a planned act with a date, a person responsible for it and a warning given to the patient, which is exactly what a discharge prescription written as an open-ended supply fails to provide.

Prophylaxis is a separate decision and the guideline rules on it. Everyday prophylactic anticholinergic use is not recommended; where prophylaxis is used, three things are weighed:

- the patient's own risk factors for acute dystonia;
- the type of antipsychotic and the dose it is being used at;
- the other medications the patient is already taking.

Re-exposure is the last limb of the plan, and the hardest available anchor for it sits in regulatory text rather than in a guideline. For metoclopramide, a previous dystonic reaction to the drug is not a caution but a labelled contraindication to giving it again. That is drug-specific and must not be generalised: no equivalent labelled prohibition on antipsychotic rechallenge after a dystonic reaction was found for this section, and none is asserted. What survives generalisation is the discipline the contraindication models. A patient who has had an airway-threatening reaction to a named drug leaves with that drug named in the record as the cause, with the decision about ever giving it again recorded rather than left to whoever admits them next.

TRAP **Treating the response to the injection as the end of the episode.** The error is seductive because the response is genuinely dramatic and genuinely fast, and the patient is grateful and comfortable within the expected window. Candidates then write a management answer that finishes at resolution. What that answer omits is everything that determines whether the patient is back: the duration of continued cover, the fact that removing the cover is itself a precipitant, whether the causative drug is being continued, changed or reduced, and what the patient has been told to do if it happens again. An answer that stops at the injection has treated the spasm and not the patient.

23.5 The hypertensive crisis on a monoamine oxidase inhibitor

This crisis is the one psychiatric emergency in which the decision point sits before any measurement. The modern labelling for tranylcypromine instructs that therapy be interrupted on symptoms that may be prodromal, naming palpitations or headaches, and that the patient then be evaluated immediately. Read as an act, that means a patient who telephones with a bad headache is told to stop the drug first and be seen, not told to come in so that a blood pressure can decide the matter.

The same labelling supplies the threshold that turns a crisis into a **hypertensive emergency**: severe hypertension, given as a blood pressure of **more than 180/120 mm Hg**, together with evidence of organ dysfunction, requiring immediate attention. Having a criterion rather than an adjective matters, because it is what lets a psychiatrist hand over to a physician in terms that will be acted on. The same source requires immediate blood pressure reduction once that combination is present, and separates the temperature problem into two: fever is managed by external cooling, while hyperthermia driven by psychomotor agitation, increased neuromuscular activity or persistent seizures may need measures aimed at those causes instead. Cooling a patient whose temperature is being generated by muscle activity treats the reading and not the cause.

The act for a hypertensive crisis on a monoamine oxidase inhibitor is written out in the approved labelling for phenelzine and is unusually complete: discontinue the drug immediately, institute blood-pressure-lowering therapy immediately, give **phentolamine 5 mg** intravenously, administer it slowly so as not to produce an excessive hypotensive effect, and manage fever by external cooling. Two honest limitations belong on the page with it. The labelling requires the reduction to be immediate but names no target pressure and no ceiling on the rate of reduction, so neither is taught here. And phentolamine's own approved labelling confines its indication to the prevention or control of hypertensive episodes in phaeochromocytoma during preoperative preparation and surgical excision; crisis on a monoamine oxidase inhibitor is not among its labelled indications. The antidote recommended by one label is therefore used outside the indications of its own. A candidate who knows that is not less safe, but better prepared for the conversation with the physician who is asked to give it.

Disposition carries its own instruction, and it is the one most often lost. Patients are told to avoid high-tyramine foods and drinks while on tranylcypromine and for **2 weeks** after stopping it. This is a dietary rule that outlives the prescription, and it is a different question from the washout arithmetic used when switching antidepressants, which belongs to the Mood disorders: pharmacotherapy notes. Merging the two is how a patient gets discharged as safe on the day the tablets finish.

23.6 The severe cutaneous reaction: the three acts that are the psychiatrist's

Telling a benign drug rash from a dangerous one, and the stop-rules for the anticonvulsant mood stabilisers, belong to the Mood disorders: pharmacotherapy notes. What this section owns begins one step later, at the moment someone has decided the reaction is serious, and the psychiatrist's part in it is three acts rather than a spectator role.

The first is cessation, and the Indian dermatology guideline puts it above everything else it recommends. Instant cessation of the offending drug is of supreme importance; the earlier the causative drug is withdrawn the better the prognosis; and patients exposed to causative drugs with long half-lives have an increased risk of dying. That last clause is the one that bites in psychiatry, because several of the agents that most often cause **Stevens-Johnson syndrome and toxic epidermal necrolysis** in our patients are long-acting anticonvulsant mood stabilisers. Stopping them is not a neutral act either, which is precisely why the decision is a psychiatric one.

The second act follows from polypharmacy. Where the culprit cannot be identified, the guideline says it is generally logical to stop every drug the patient is taking, and then carves out the case that matters here: where a drug is absolutely essential, naming patients with epilepsy explicitly, it may be substituted with a structurally unrelated agent, and that decision is taken jointly with the treating clinician through an interdisciplinary approach. Choosing the structurally unrelated substitute for a patient on an anticonvulsant is work no dermatologist can do alone.

The third act is knowing what is being decided around you. For a severe cutaneous adverse reaction, meaning Stevens-Johnson syndrome and toxic epidermal necrolysis, the **Indian dermatology guideline of 2016** recommends prompt withdrawal of the culprit drug, meticulous supportive care and early systemic corticosteroids, given as prednisolone **1 to 2 mg/kg/day** or equivalent by the oral or parenteral route, preferably started within 72 h and tapered rapidly within 7 to 10 days. A psychiatrist does not prescribe that, but a psychiatrist whose patient is transferred and who does not know that the steroid decision has a window will not ask whether it was taken. The same guideline asks for an isolation room where possible, for infection and temperature control, and names the disciplines the treating team should contain: dermatologist, physician, ophthalmologist, plastic surgeon, chest physician, dietician, and others as required. One of those referrals has a cadence attached and it is the one a psychiatrist is most likely to forget: daily examination by an ophthalmologist, with vigorous treatment, reduces the risk of long-term ocular complications. A patient survives the reaction and lives with the eyes.

IN INDIA

The Indian guideline is unusual and useful in that it writes down what to do when the setting it recommends does not exist. Admission to an intensive care setting or a burns unit is preferred where such facilities are available. Where resources are limited, in a rural or district hospital, or where the patient is unfit for transfer, it accepts management in the general or dermatology ward, or in a high-dependency unit, with strict infection control and with nurses trained to deal with such cases. That is the honest architecture of this emergency in most of the country, and it converts the referral question from an ideal into a decision with two named branches. The practical consequence for a psychiatrist is that the transfer conversation is about capability rather than about category: whether the receiving ward can nurse an exposed skin surface, control infection and get an ophthalmologist to the bedside every day.

23.7 Priapism, which is a clock rather than a symptom

Priapism is the drug-induced emergency most likely to be delayed by embarrassment, on both sides of the consultation, and delay is the only variable that determines the outcome. The guideline of the American Urological Association and the Sexual Medicine Society of North America defines **acute ischaemic priapism** as prolonged, meaning more than 4 hours, with little or no cavernous blood flow and cavernous blood gases that are hypoxic, hypercarbic and acidotic, and states plainly that it is a medical emergency which may lead to cavernosal fibrosis and subsequent erectile dysfunction. The threshold and the consequence belong in the same sentence, because the consequence is what makes a four-hour threshold reasonable.

The act at the door is a test rather than a treatment. The **American Urological Association and Sexual Medicine Society of North America guideline of 2021** directs clinicians to obtain a **corporal blood gas** at the initial presentation, and records it as a clinical principle rather than as a graded recommendation. It separates the ischaemic emergency from the non-ischaemic form, which is not one, and it is what the urologist will ask for first. First-line management is then intracavernosal phenylephrine together with corporal aspiration, with or without irrigation, and the guideline places it before any operative intervention. The dose of intracavernosal phenylephrine is not stated here: the guideline places its dosing in an appendix and describes the use as off-label, and an incomplete dose is worse than a named referral.

The negative act is the one a psychiatric ward improvises when it does not recognise an emergency. In a patient with diagnosed acute ischaemic priapism the guideline states that conservative measures are unlikely to succeed and must not delay definitive therapy, naming four of them:

- observation, in the hope that it will settle;
- oral medication;
- cold compresses;
- exercise.

The act that belongs at the point of prescription. Current labelling for trazodone reports cases of priapism as painful erections greater than 6 hours in duration, warns that untreated priapism can cause irreversible damage to erectile tissue, and instructs that a man with an erection lasting greater than 4 hours, painful or not, should immediately discontinue the drug and seek emergency medical attention. Note the discrepancy inside the label itself: the reported cases are described at the longer duration, and the instruction to the patient triggers at the shorter one, which is also the guideline threshold. Teach the shorter one. The receptor pharmacology that explains why particular psychotropics do this belongs to the Neurochemistry, Neuroendocrinology, Neuroimaging and Basic Psychopharmacology notes; what belongs here is that the counselling sentence is part of the prescription, and that a man who has not been given it will wait until morning.

23.8 The spine the four have in common

PRESENTATION	WHAT MAKES IT AN EMERGENCY	THE FIRST ACT	WHAT FOLLOWS
Airway-threatening acute dystonia	Involvement of the laryngeal territory, which can produce stridor	Parenteral treatment, given where the airway can be watched while it works	Resolution expected within 15 to 20 min of the injection; a change of drug after two doses without response
Hypertensive crisis on a monoamine oxidase inhibitor	Blood pressure more than 180/120 mm Hg with evidence of organ dysfunction	Stop the drug and begin lowering the pressure immediately	External cooling for fever, with separate measures where agitation, neuromuscular activity or seizures are generating the heat
Stevens-Johnson syndrome and toxic epidermal necrolysis	A long half-life of the causative drug raises the risk of dying, so the interval to withdrawal is itself the emergency	Instant cessation, and all drugs stopped where the culprit is unclear	Intensive care or a burns unit where available; general or dermatology ward or a high-dependency unit where it is not
Acute ischaemic priapism	An erection lasting more than 4 hours, with the risk of cavernosal fibrosis behind it	A corporal blood gas at the initial presentation	Intracavernosal phenylephrine with corporal aspiration, before any operative intervention

Read down the columns rather than across the rows and the shape of the class appears. Every one of the four is defined as an emergency by an interval or a threshold rather than by severity of appearance; in every one the first act is available to a non-specialist; and in every one the specialist act that follows is time-bound in a way that makes the referral itself urgent. That is why these four are worth learning together even though they involve four different organ systems and four different specialties. They fail in the same place, which is the gap between recognising and acting.

MNEMONIC

Stop, Secure, Specific, Setting, Sign-off

The act-level spine of any acute drug-induced emergency. **Stop** the drug, which is the only act whose value falls with every minute of delay. **Secure** the threatened organ: the airway, the pressure, the skin and the eyes, the corpora. **Specific** intervention within its stated window, whether that is the injection, the antidote, the steroid or the aspiration. **Setting**: the level of care the next hour requires, and its named fallback where the ideal one does not exist. **Sign-off**: the causative drug named in the record and the decision about ever giving it again written down rather than left to whoever admits the patient next.

In every acute drug-induced emergency the first act is stopping the drug and protecting the threatened organ, and the episode ends not when the sign resolves but when the cover, the taper and the re-exposure decision have been written down.

24 · Lithium toxicity and overdose management

Why the marks sit on the history and not on the drug. What lithium toxicity looks like, the serum bands that grade it, the precipitants behind it and the chain ending in extracorporeal treatment are set out in the Mood disorders: pharmacotherapy notes and are not restated here. What that account does not carry is the question an emergency team settles first: not how toxic is this patient, but which of three poisonings this is. The answer is not in the assay but in a history assembled from a relative, an empty strip and an outpatient card nobody brought.

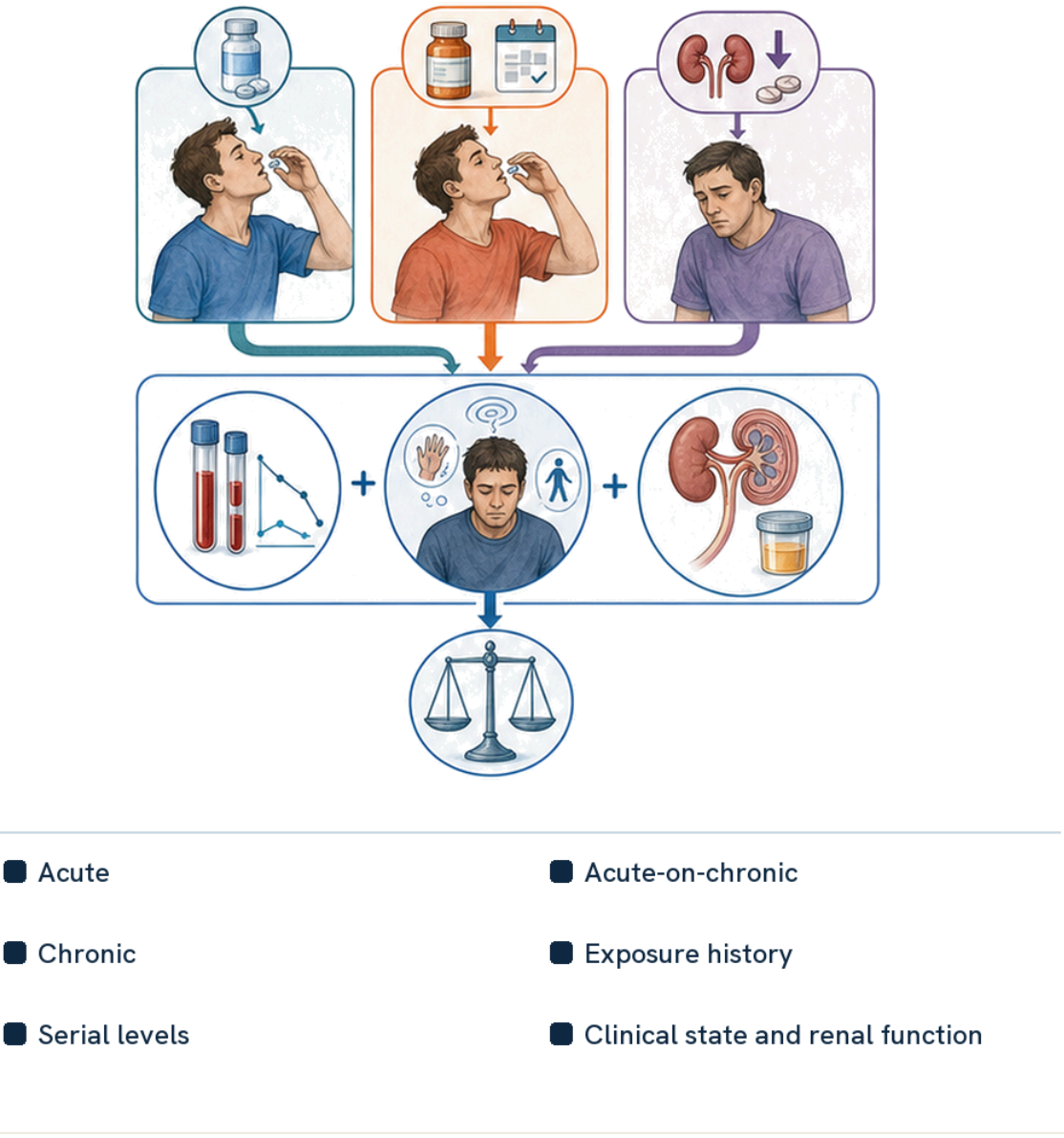


Fig 28.11 Lithium poisoning is classified from the exposure history as acute, acute-on-chronic or chronic. The pattern changes the kinetics and meaning of a measured concentration, so serial levels are interpreted with clinical state and renal function.

Three things move with it: the kinetics, the meaning of a measured concentration, and the decontamination decision, which exists in one arm and not at all in another. That last is the only point here where acting early still changes the ceiling of the illness. The ordered first-hour sequence is set out in this chapter's section on assessing and managing the acutely agitated and aggressive patient; intent after a deliberate ingestion belongs with the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

24.1 Establish which of the three poisonings this is, and establish it from the history

The EXTRIP workgroup, in its 2015 systematic review of extracorporeal treatment for lithium poisoning, names **three** clinically recognised patterns and defines each by how it arose, not how it looks. **Acute lithium poisoning** occurs in a lithium-naive patient who overdoses. **Acute-on-chronic** poisoning occurs where an existing body burden from maintenance therapy meets an acute large exposure. **Chronic lithium poisoning** occurs on maintenance therapy where elimination has been compromised, by a recently increased dose, a decline in kidney function or an interacting drug; those precipitants belong to the Mood disorders: pharmacotherapy notes and appear here only because they are the definition.

The Indian Psychiatric Society's 2022 guideline on medical emergencies associated with psychotropic medications gives the same three types and controls Indian practice. It attaches a signature to each: acute manifests primarily with gastrointestinal symptoms and may progress to neuromuscular signs which usually appear after **2 to 3 days**; acute-on-chronic presents with both gastrointestinal and neurological symptoms; chronic presents primarily with neurological symptoms. It states the acute-on-chronic case separately, as long-term lithium plus an overdose taken either deliberately or accidentally. The second adverb catches teams out: an accidental overdose declares no intent, so nobody asks.

The bedside will not sort the arms out for you. EXTRIP is explicit that only the **gastrointestinal symptoms** tend to distinguish acute poisoning, where they are expected and prominent, from chronic toxicity, where they are almost invariably absent. One discriminating clause is all the examination offers, which is why this is a front-door history-taking task.

MNEMONIC

On it, on top of it, which tablet

On it: was there a maintenance body burden before today. **On top of it:** was something taken acutely as well, deliberately or accidentally. **Which tablet:** immediate-release or modified-release, because the formulation sets the absorption curve, the decontamination window and the risk after treatment.

PATTERN	HOW IT ARISES	WHAT THE HISTORY MUST ESTABLISH	WHAT A CONCENTRATION TELLS YOU	DECONTAMINATIO N
Acute	A lithium-naive patient overdoses.	No prior maintenance therapy, and when the tablets were swallowed.	Risk ahead, not harm done: the brain has not yet received what the plasma reports.	On the table. Drug may still be in the gut.
Acute-on-chronic	A patient already on long-term lithium overdoses, deliberately or accidentally.	Both halves; the second is missed when no intent is declared.	Two overlapping quantities, so the least interpretable of the three.	On the table, and the arm where timing has been studied.
Chronic	Maintenance therapy in which elimination has become compromised.	That no acute ingestion occurred, a negative that must be sought.	The population the severity grading was written for.	Not on the table. Nothing recent to remove.

24.2 Set the observation horizon from the kinetics, not from the first result

The typology changes the expected course because lithium is not a single-compartment drug. Its tissue distribution follows a **multiple compartment model** with delayed diffusion from the extracellular to the intracellular compartment; it is taken up rapidly by kidney, thyroid and bone, but its diffusion into the cerebrospinal fluid and the brain is delayed by approximately 24 hours compared with its appearance in plasma. In an acute ingestion, then, the sample in your hand reports the compartment that is not producing the illness you fear.

Clearance is equally uncooperative. The **terminal elimination half-life** is widely variable and depends on age, kidney function and duration of therapy, its upper end well beyond what a single overnight observation assumes. An identical swallowed amount in a naive young adult and in an older patient a decade into treatment is not the same exposure. The pattern therefore sets the observation horizon.

12 to 27 h	**up to 58 h**	**30 min to 2 h**
TYPICAL TERMINAL ELIMINATION HALF-LIFE OF LITHIUM	HALF-LIFE IN THE ELDERLY AND IN PATIENTS TAKING LITHIUM CHRONICALLY	PEAK CONCENTRATION AFTER THERAPEUTIC IMMEDIATE-RELEASE LITHIUM

24.3 Read the concentration as a guide to risk, never as a severity score

Candidates arrive carrying the severity grading. What is rarely taught with it is the population restriction the Indian Psychiatric Society attaches when introducing it: it is severity in patients with chronic intoxication, meaning those on long-term therapy, that the serum levels determine. The grading is a chronic-toxicity construct, never built for the acute ingestion in front of you, and the bands belong to the Mood disorders: pharmacotherapy notes.

EXTRIP supplies the mechanism that makes that restriction sensible rather than arbitrary: the delayed diffusion of lithium into the brain explains the absence or delay of symptoms in acute

poisoning despite highly elevated concentrations. Serum concentrations are therefore only a guide to potential risk of toxicity, always read against three things:

- **The history**, meaning which pattern this is and when the exposure occurred, since a rising figure and a falling one carry opposite implications.
- **The clinical findings**, meaning what the patient is doing now, and whether the neurological picture is worsening between examinations.
- **Kidney function**, which sets how fast the burden falls and whether it falls at all, and which in the chronic arm is often why the poisoning happened.

The error runs both ways, and the guideline closes the second: the toxic effects of lithium may also be seen in patients with therapeutic serum levels. A figure inside the therapeutic range is not a discharge criterion. A patient on maintenance lithium who is ataxic, coarsely tremulous and confused has a clinical problem whatever the laboratory returns, and the discrepancy is answered by disbelieving the reassurance.

RULE **The pattern comes from the history; the concentration estimates the risk ahead, not the severity in front of you.** The observation horizon, the decontamination call and the transfer threshold all follow from which arm the patient is in. The assay contributes to that decision and does not make it, and a team that waits for the result has spent the only interval in which decontamination was possible.

TRAP **Grading an acute ingestion against a scale built for chronic intoxication.** The candidate applies the grading to a lithium-naive patient who swallowed a bottle two hours ago, finds a striking figure in someone who looks well, and either panics or, worse, is reassured an hour later when that patient still looks well. Both readings ignore that the brain has not yet received the dose. The examiner is testing whether you know whose severity the grading grades.

Which of the three poisonings this is comes from the history, not the assay; the concentration then estimates the risk ahead, and grades severity only in the patient who was already taking lithium.

24.4 Reject the reflex decontaminant, and choose against the drug you are actually treating

Where the typology turns into an act. After therapeutic dosing, immediate-release lithium is almost completely absorbed and peaks early, whereas modified-release preparations peak generally at **4 to 5 hours**. Overdose does not simply scale that curve up: prolonged gastric absorption and clumping from insoluble aggregates may occur, especially with lithium carbonate, the least soluble of the lithium salts, providing a **reservoir for continued absorption**. That reservoir is why a decontamination decision exists in the two acute arms and not in the chronic one.

The first branch is the one a generic overdose protocol gets wrong, and it is the reason this topic mentions decontamination at all: **activated charcoal** is not favoured after an acute lithium overdose, for the plain reason that it does not bind lithium. That is a lithium fact and it survives

no matter what the general decontamination policy says; the current decontamination source carries the same position for lithium, and it is that source, not this one, which the overdose triage account in these notes holds. The general policy itself, including where gastric lavage now stands and what the current windows are, belongs with the medical triage of the overdose patient in these notes and is not restated here.

OPTION	WHERE THE GUIDANCE STANDS	WHOSE POSITION, AND WHEN
Activated charcoal	Not favoured after acute lithium overdose, because it does not bind lithium.	EXTRIP workgroup, 2015
Gastric lavage	May be performed if required, against a general position that it is not routine and belongs in trained hands.	EXTRIP workgroup, 2015; AACT and EAPCCT, 2013
Whole bowel irrigation with polyethylene glycol electrolyte lavage solution	May be performed if required, and separately named for substantial lithium ingestion because morbidity is high and other options are lacking.	EXTRIP workgroup, 2015; AACT and EAPCCT, 2015
Sodium polystyrene sulfonate	Suggested for this purpose, but yet to have a clearly demonstrable role.	EXTRIP workgroup, 2015

PITFALL

The commonest error is not a wrong drug but a reflex one. Charcoal given because the overdose protocol says so binds nothing here, the clock runs, and the notes record a decontamination that did not occur; with that box ticked nobody revisits the question while an option that might work is still open. Where a mixed ingestion makes charcoal right for a co-ingestant, give it for that and say so, leaving the lithium decision visibly open.

24.5 Rule whole bowel irrigation in, or rule it out before the patient rules it out for you

The joint position paper on **whole bowel irrigation**, updated in 2015, names lithium twice over. It can be considered for potentially toxic ingestions of sustained-release or enteric-coated drugs, particularly in patients presenting later than 2 h after ingestion when activated charcoal is less effective, which captures modified-release lithium by formulation; and separately for patients who have ingested substantial amounts of iron, lithium or potassium, because morbidity is high and other effective options are lacking, which captures it by name. The same paper records what makes it unavailable:

- **Bowel obstruction, perforation or ileus**, a mechanical bar to committing litres of solution to a gut that cannot move them.
- **Haemodynamic instability**, since the procedure is neither brief nor undemanding and an unstable patient needs the team elsewhere.

- **A compromised unprotected airway**, for lithium the contraindication with teeth, since the neurotoxicity itself is what produces it.

That last gives the decision its expiry date. A patient far enough into lithium neurotoxicity to be obtunded is by that fact no longer a candidate for the decontamination that could have helped an hour earlier. The option closes as the illness advances, which inverts the instinct to wait and see how bad this becomes: waiting removes the intervention. One thing is deliberately not asserted here. The volume and rate at which the polyethylene glycol solution is run, and the amount of sodium polystyrene sulfonate, come from the receiving unit's poisons protocol, and no figure for either is asserted.

IN INDIA

The typology gets settled at the door in most Indian emergency rooms whether the team intends it or not, because serum lithium is often a send-out assay returning after the decontamination window has closed. That is not a reason to defer the decision; it is why the history is the instrument. Whole bowel irrigation is also a staffing question before a clinical one: a nasogastric tube, a large volume of solution, a nurse to keep it running and an airway-capable clinician are rarely available together at night in a district hospital. Where they are not, what remains is early transfer, decided on the pattern and the clock.

24.6 Treat the decontamination decision as a timed one, and know how contested it is

The evidence is thin and divided, and presenting it as settled overstates it. EXTRIP records that gastric lavage or whole bowel irrigation may be performed if required, while stating in the same breath that there are no data to show improved outcome with any decontamination procedure. Against that sits the one cohort assembled inside this typology, a retrospective observational study from the Angers Poisons and Toxicovigilance Centre, published in 2013, which took acute-on-chronic overdoses and divided them into those undergoing **early decontamination**, by sodium polystyrene sulphonate or whole bowel irrigation or both, and those in whom decontamination was delayed beyond **12 h** or not performed.

On multivariate analysis, early digestive tract decontamination was significantly associated with a lower risk of severe poisoning, with an odds ratio of 0.21, a 95 per cent confidence interval of 0.04 to 0.99 and a p value of 0.049, and the association held regardless of the lithium dose ingested or the serum concentration. Read the caveats with the estimate: a retrospective design, so those decontaminated early may simply be those who arrived early; an interval that nearly crosses one; a single centre. What survives is the final clause: any benefit was independent of dose and of concentration, which describes the shape of the decision rather than its size.

GOOD TO REMEMBER

Establish the formulation before the evidence of it disappears. Ask the family to bring the strip, the bottle or the outpatient card, and ask whether the preparation was modified-release, because the answer changes the absorption curve, the case for irrigating rather than lavaging, and the risk in the hours after treatment. None of it can be reconstructed from a serum concentration.

24.7 Plan the period after treatment from the formulation that was swallowed

The typology has one more consequence, and it falls after the intervention rather than before it. EXTRIP distinguishes two kinds of rebound following extracorporeal treatment, and the one that concerns an emergency team is **rebound from ongoing absorption**. It occurs with extended-release formulations or decreased gastrointestinal motility, can be noticeably much greater in extent, and may be associated with recurrence of symptoms or clinical deterioration, because the absorbed drug will ultimately distribute into the central nervous system and other tissues. The indications for extracorporeal treatment are taught in the Mood disorders: pharmacotherapy notes; the corollary belongs here, that a good result at the end of a session does not close the episode.

This is where the arms separate for good. The chronic patient's burden is a distribution problem, and it descends predictably once the precipitant is corrected; the modified-release ingestion carries a second event in the gut whose timing nobody can specify, and the monitoring plan is written for that. Disposition is not answered by one improving result.

The handover carries the same content. A patient handed over as lithium toxicity with a number attached has been handed over with the least useful part of the assessment. Handed over as an acute-on-chronic ingestion of a modified-release preparation taken at a stated hour, decontaminated or explicitly not and why, tells the receiving team what to do next. The typology is not a classification appended to the case. It is the case.

25 · Anticholinergic toxicity and other psychotropic overdose syndromes

Why the marks sit on the act and not on the picture. What anticholinergic toxicity looks like, and how an antimuscarinic overdose is told from the other hyperthermic emergencies, belongs to the Schizophrenia: management, antipsychotics and adverse effects notes, and none of that is repeated here. Those accounts reduce the antidote to one clause: physostigmine, for specialist hands. What follows recognition is owned here: whether an antidote question has arisen, what is read before the drug is drawn up, who it must be refused to, and what is done instead.

The organising fact is an overlap: the commonest deliberate overdose presenting as antimuscarinic is a tricyclic antidepressant, which is also the overdose in which this antidote has killed people. So the first act is not pharmacological but an electrocardiogram.

25.1 Deciding whether an antidote question has arisen at all

The labelled indication is narrower than the drug's reputation. The United States prescribing information for **physostigmine salicylate injection**, in the label version updated in January 2023, indicates it to reverse the effect upon the central nervous system caused by clinical or toxic dosages of drugs capable of producing the anticholinergic syndrome. The operative word is central. A patient with peripheral effects alone, awake and oriented, is not what the indication describes.

Nor is the agent interchangeable with what a pharmacy is likelier to stock. Physostigmine contains a tertiary amine and penetrates the blood brain barrier easily, whereas **neostigmine**

carries a quaternary ammonium ion and cannot cross it.

RULE **The antidote decision in an antimuscarinic overdose is made on the agent, the electrocardiogram and the contraindication list, never on how antimuscarinic the patient looks.** Recognition names the family of poisons, not the member, and members diverge on whether this drug helps or kills. Where a tricyclic or other sodium-channel-blocking agent is known or suspected, physostigmine is refused whatever the current QRS, because a narrow complex early does not exclude progression.

25.2 Reading the electrocardiogram before anything is given

A prospective study of 49 patients with acute tricyclic antidepressant overdose, in the New England Journal of Medicine in 1985, set serum drug levels against **maximal limb-lead QRS duration** as predictors of seizures and ventricular arrhythmias. It concluded that QRS duration predicts the risk of seizures and ventricular arrhythmias while serum drug levels are not of predictive value. Where a level cannot be had in useful time, that is what makes it usable.

Among the 13 patients whose maximal limb-lead QRS duration was less than **0.10 second** there were no seizures and no ventricular arrhythmias; among the 36 whose duration was 0.10 second or longer, seizures occurred in 34 per cent and ventricular arrhythmias in 14 per cent. The consequences then part company: seizures occurred at any QRS duration of 0.10 second or longer, while ventricular arrhythmias were seen only from **0.16 second** or longer. Collapsing them into one figure loses the point: the bed is earned at the lower line, the arrhythmia arrives at the upper.

The American Heart Association focused update on poisoning of 2023 states that characteristic electrocardiogram changes usually precede ventricular dysrhythmias in sodium channel blocker poisoning, and names two: intraventricular conduction delay, meaning QRS prolongation, and a terminal rightward axis deviation best appreciated in lead aVR. Precede is what makes a tracing a triage instrument rather than a record.

TRAP **Giving physostigmine because the presentation is antimuscarinic, when what was taken was a tricyclic antidepressant.** The report that changed practice, in Annals of Emergency Medicine in 1980, described two patients with tricyclic antidepressant toxicity who developed asystole after physostigmine was given to treat seizures, when the drug was a commonly used therapy for the antimuscarinic manifestations of tricyclic overdose. The tracing separates them first.

25.3 Giving sodium bicarbonate, and knowing when to stop

Where the QRS is wide the act is **sodium bicarbonate**, which the same guideline names the intervention with the most evidence in sodium channel blocker poisoning, typically given as bolus intravenous administration of hypertonic solutions, 1000 mEq per litre in adults and 500 mEq per litre in children. Its antidote table completes the tuple: for sodium channel blockers and cocaine, an initial adult dose of 50 to 150 mEq and an initial paediatric dose of 1 to 3 mEq per kilogram, with a maintenance infusion prepared as a 150 mEq per litre solution and infused at 1

to 3 millilitres per kilogram per hour, by the intravenous or intraosseous route, watching for hypernatraemia, alkalaemia, hypokalaemia and hypochloraemia.

What makes it an act rather than a prescription is the endpoint. Boluses are titrated to resolution of hypotension and of QRS prolongation, so the monitor stops treatment, not a cumulative total, and whether to follow them with an infusion is unsettled. Two ceilings then make it a monitored infusion: serum sodium is not to exceed 150 to 155 mEq per litre and serum pH is not to exceed 7.50 to 7.55. Potassium is replaced during treatment, since hypertonic bicarbonate causes hypokalaemia.

The antidote table's footnote belongs in any answer printing a dose: the maximum paediatric dose should not exceed the adult dose, most antidotes should be repeated frequently and titrated to control of critical signs and symptoms, and the ideal dose of most antidotes is not known and is often controversial.

25.4 Reading the contraindication list before the syringe is filled

It is printed whole, because a partial contraindication list is more dangerous than none. Physostigmine salicylate injection should not be used in the presence of asthma, gangrene, diabetes, cardiovascular disease, mechanical obstruction of the intestine or urogenital tract, or any vagotonic state, and not in patients receiving choline esters or depolarising neuromuscular blocking agents, decamethonium and succinylcholine being named.

One clause carries almost all the mortality. **Cardiovascular disease** bars the drug in exactly the patient in whom the reflex to give it is strongest, because a poisoning that disturbs cardiac conduction presents as antimuscarinic at the same time.

The product record for this label also carries the marketing status of an unapproved drug, with a disclaimer that the drug has not been found by the regulator to be safe and effective and that the labelling has not been approved. It is the best primary statement of how to give the drug, and not an approval.

25.5 Pushing the drug slowly, and keeping its own antidote at hand

For overdose of drugs that cause anticholinergic effects the label gives physostigmine salicylate injection **2.0 mg** intramuscularly or intravenously at a slow controlled rate, repeatable if life-threatening signs such as arrhythmia, convulsions or coma occur. The repeat trigger is a sign, not a clock. The label's repeat interval of 10 to 30 minutes if the desired patient response is not obtained attaches to its post-anaesthesia indication, which carries a smaller amount; carrying it into a poisoning is a common transcription error.

The rate is the safety-critical figure and it governs the antimuscarinic-overdose dose too. In this poisoning as in every other indication the label carries, intravenous administration is to be at a slow controlled rate of **no more than 1 mg per minute**, and the reason belongs beside the syringe: rapid administration can cause bradycardia, hypersalivation leading to respiratory difficulty, and convulsions. Each converts a reversible delirium into an airway emergency.

Two preconditions remain. Because of the possibility of hypersensitivity in an occasional patient, atropine sulfate injection should always be at hand, since it is the antagonist and antidote for physostigmine, so the drug is not given anywhere its own antidote is not already drawn up. And overdose of physostigmine can cause a **cholinergic crisis**, for which the appropriate antidote is atropine sulfate, so one ampoule answers both.

> **GOOD TO REMEMBER**
>
> Write the clock time of the dose, the rate it was given over, and the time of the examination that follows. Without those three, bradycardia gets blamed on the poison rather than on the push, and recurrence reads as deterioration rather than as expected.

25.6 The airway question that gates decontamination in this poisoning

Whether gastric decontamination is worth attempting at all, which poisons are worth adsorbing, and for how long after ingestion each window stays open, is settled with the medical triage of the overdose patient elsewhere in these notes, and none of it is restated here: the windows are poison-specific, they have moved, and a chapter that fixes them in two places will eventually print them differently. What belongs to this topic is the question that gates the act whatever the window says. Charcoal is not given to a patient whose airway is unprotected, and in an antimuscarinic overdose the relevant limb is prospective as well as present: a patient whose protective reflexes are at risk, or can be expected to become absent as the toxidrome advances, is a patient in whom the decision has already been made against. The airway question here is answered by where the patient is heading rather than by where they are, so a decision deferred while the toxidrome advances is usually a decision made. For an agitated patient that usually settles it.

Three questions settle it at the door:

- is the airway intact or protected now, by somebody who can keep it so if the patient vomits;
- how long since ingestion, counted from a stated time not from arrival, and is that past the measured window;
- does charcoal now foreclose something better later, since the oral route is spent afterwards.

FINDING THAT FORCES A DECISION	ACT IT SELECTS	WHAT MUST BE TRUE FIRST	WHAT ENDS IT
Antimuscarinic exposure, consciousness disturbed, tracing clear, and no tricyclic or other sodium-channel-blocking agent known or suspected	Physostigmine considered	Contraindications read and clear, atropine drawn up, somewhere the patient is watched. A tracing is clear only if the QRS is inside the seizure line AND there is no terminal rightward axis in aVR, on a tracing repeated rather than taken once	Orientation returns, then a watch for recurrence
Peripheral effects only, patient oriented	No antidote, recorded as a decision	Conscious level assessed, not inferred	Nothing to end. Observe
QRS past the seizure line after a tricyclic ingestion	Bicarbonate bolus, physostigmine refused	Access, monitoring, and sodium, potassium and pH measurable on site	Hypotension and QRS prolongation resolve, inside the two ceilings
QRS past the arrhythmia line	The same act in a monitored bed, critical care in early	That the bed exists and was agreed beforehand	The same endpoint, and care not stepped down as the tracing narrows
A charcoal-adsorbable ingestion, inside the window that poison and formulation actually carry	Activated charcoal considered, per the overdose triage account	An intact or protected airway, and reflexes not expected to fail. If either is in doubt, the decision is made for you	Given per the regimen that account sets, never assumed to be a single dose

25.7 Holding the patient when the antidote is refused or unavailable

What the comparison against sedation showed. A blinded randomised trial in Clinical Toxicology in 2021 enrolled patients aged at least 10 and under 18 with at least one central and two peripheral antimuscarinic symptoms, together with delirium and moderate agitation, an adolescent population, not an adult one. Its physostigmine arm received a 0.02 mg per kilogram bolus followed by a four hour infusion at 0.02 mg per kilogram per hour, in adolescents. Physostigmine was superior to the benzodiazepine comparator in controlling delirium and agitation after bolus dosing and in controlling delirium at the fourth hour of infusion, with no serious adverse events in either arm, and the authors confined their recommendation to adolescent patients. The trial was small and its arm sizes are not asserted here.

Two things are deliberately absent. There is no sedative agent, dose, route or titration for the agitation: benzodiazepine dosing in the emergency belongs to the Schizophrenia: management, antipsychotics and adverse effects notes. Nor is there a temperature threshold at which cooling begins, a method or a target: no comparable standard is available to quote, and none is invented here. Heat here is generated by agitation in someone whose thermoregulation the poison has impaired, so sedation is a temperature intervention as well as a behavioural one, and what is charted is temperatures with times against them.

25.8 What changes at the door in the other psychotropic overdoses

The title of this topic promises more than one poison, and the promise is kept as acts rather than as a second toxidrome. Most psychotropic overdoses have no antidote of any kind, which makes what is examinable in each narrower and more useful than a picture: whether an antidote question arises at all, which single measurement selects the next act, and which reflexive act is refused.

For the serotonergic antidepressants the antidote limb closes at the first line. The approved product information for a **selective serotonin reuptake inhibitor** states that there are no specific antidotes to it, and directs instead an airway established and maintained, oxygenation and ventilation ensured where necessary, and general symptomatic and supportive measures; induction of emesis is not recommended. The measurement that does the work is the tracing. QTc prolongation and torsade de pointes have been reported following overdose, so electrocardiogram monitoring is recommended in all ingestions of it. In all ingestions is the phrase to hold: the tracing is not reserved for the patient who looks unwell, which is what makes it a triage instrument in a poisoning that has nothing else.

The negative act here is what separates this overdose from the one taught with the lithium toxicity account in these notes. Because the volume of distribution is large, forced diuresis, dialysis, haemoperfusion and exchange transfusion are unlikely to be of benefit. In the lithium overdose the decision at the door is precisely about elimination and level of care. Same word, opposite act, and the reason is pharmacokinetic and stated by the regulator rather than reasoned at the bedside. Where a second serotonergic agent is on board the question stops being overdose management altogether and becomes the serotonin toxicity decision rule, which the Hunter criteria account in these notes owns.

For the antipsychotics the shape repeats and the refusal is sharper. There is no specific antidote, and induction of emesis is not recommended. Cardiovascular monitoring is necessary to detect possible arrhythmias, and close medical supervision and monitoring continue until the patient recovers, so here too the stopping rule is the patient and not a clock.

RULE **In an antipsychotic overdose that becomes hypotensive, adrenaline, dopamine and the other beta-agonist sympathomimetics are refused.** The approved product information directs treatment of hypotension and circulatory collapse and support of respiratory function, then states the bar in terms: those agents are not to be used, since beta stimulation may worsen the hypotension. It is a refusal and not a caution, and it names what a team reaching for a pressor reaches for first. No alternative pressor is recommended by the source and none is asserted here.

Nor is an antipsychotic overdose finished when the patient wakes. Neuroleptic malignant syndrome is listed among the medically significant sequelae of overdose, alongside delirium, convulsion, coma, respiratory depression, aspiration, blood pressure disturbed in either direction, cardiac arrhythmia and cardiopulmonary arrest. The consequence is a disposition one: the criteria set taught elsewhere in these notes can become the relevant instrument hours after the overdose itself has been survived.

The remaining members of the class are held elsewhere on this chapter and are named here so that nobody is sent looking:

- the benzodiazepine overdose, its reversal agent, and why that agent is not routine in an undifferentiated ingestion, with the medical triage of the overdose patient;
- the mixed or unidentified ingestion, and the overdoses whose early appearance is deceptively benign, with the same account;
- lithium, with the lithium toxicity account, where the ingestion typology governs the kinetics and the elimination decision;
- serotonin toxicity, with the Hunter criteria account, which owns the decision rule and the antidote question that follows it;
- the tricyclic antidepressant, which is the rest of this topic and the one member of the class in which an antidote decision is both live and lethal.

25.9 Deciding where the patient goes, and for how long

Disposition follows from one pharmacological fact. Reversal can be expected within minutes of intravenous administration if the diagnosis is correct and the patient has not suffered anoxia or other insult, but the duration of action of physostigmine is relatively short, approximately **45 to 60 minutes**. The agents reversed outlast that, so recurrence is expected rather than a complication, and one dose is a diagnostic and temporary act. A failure to respond is informative: either the patient was not antimuscarinic, or something the antidote cannot touch has done harm.

The antidote therefore changes a disposition, and there is evidence on which one. A single-hospital retrospective chart review in Annals of Pharmacotherapy in 2019 found no difference between groups in age, sex or initial heart rate, and concluded that physostigmine use was associated with decreased resource utilisation, including intubation and intensive care placement, without increasing rates of bradycardia, vomiting or seizures. Retrospective, single-centre and unblinded, it gives a direction and not a cause.

141	46%	32%	20%
PATIENTS WITH AN ANTIMUSCARINIC TOXIDROME IN THE SINGLE-HOSPITAL REVIEW	PROPORTION OF THAT COHORT GIVEN PHYSOSTIGMINE	PROPORTION OF THAT COHORT ADMITTED TO INTENSIVE CARE	PROPORTION OF THAT COHORT INTUBATED

Whether the drug can be had is a separate question. A series in the American Journal of Emergency Medicine in 2025 records that supply of physostigmine has been limited because the United States manufacturer stopped production, and proposes **rivastigmine**, a long-acting acetylcholinesterase inhibitor approved for dementia, as a potential alternative. Read that as a signal about scarcity, not a substitution you may make: no dose or regimen is asserted here.

IN INDIA

Physostigmine does not appear in the antidote section of the National List of Essential Medicines 2022, whose specific antidote list begins with atropine, calcium gluconate, D-penicillamine, desferrioxamine and methylthioninium chloride and continues to N-acetylcysteine, naloxone, neostigmine, pralidoxime chloride, snake venom antiserum, sodium nitrite and sodium thiosulphate, while activated charcoal is the sole entry under non-specific measures. The local position is exact: the antidote's own antidote is on that list, the anticholinesterase that cannot reach the brain is on it, and the drug itself is not. So the antidote limb usually ends in a decision about a drug that is not in the building. What is scarce is not a molecule but a monitored bed with an anaesthetist attached. Settle in advance which medical unit accepts a wide-QRS poisoning and whom you telephone when the answer is no, and record each refusal with its time.

Three things belong in the handover, which only the clinician present can supply:

- the tracings in sequence with times, since direction of change matters more than any width;
- whether physostigmine was given, refused or unavailable and on which ground, so a cardiovascular refusal is not quietly reversed by a fresh team;
- whether decontamination was given and when, since it changes what can be offered by mouth.

Read the electrocardiogram and the contraindication list before physostigmine is drawn up, keep atropine beside it, give it no faster than the label allows, and treat one dose as an act that wears off before the poison does.

The medical emergency and the perinatal overlay

26 · Delirium triage and emergency management

Why the marks sit on the first ten minutes. What acute confusion is, how it is defined, separated from its mimics, investigated and prevented is set out in the Stroke, TBI, delirium and focal brain syndromes notes, and none of that is repeated here. That account, like almost every account in the literature, is written from the ward and the intensive care unit, and assumes a patient already recognised, admitted and labelled. This topic covers the window before any of that is true: an elderly man is brought in by relatives who say he has not been himself since morning, and nobody yet knows whether the answer is metabolic, a drug, a head injury, an infection or a psychiatric illness. What is done in that window, in what order, by whom, and where he goes at the end of it is a different object from the syndrome.

Two features make this a discipline of its own. Nothing is differentiated yet, so every act must be justifiable without a diagnosis; and the department is a throughput system with a queue, in which a quietly confused patient makes no demand at all. The general shape of the first hour, and the assessment of the patient who arrives agitated or aggressive, are taught where that assessment is set out in these notes. What follows takes the confused patient through it, built around acts rather than causes.

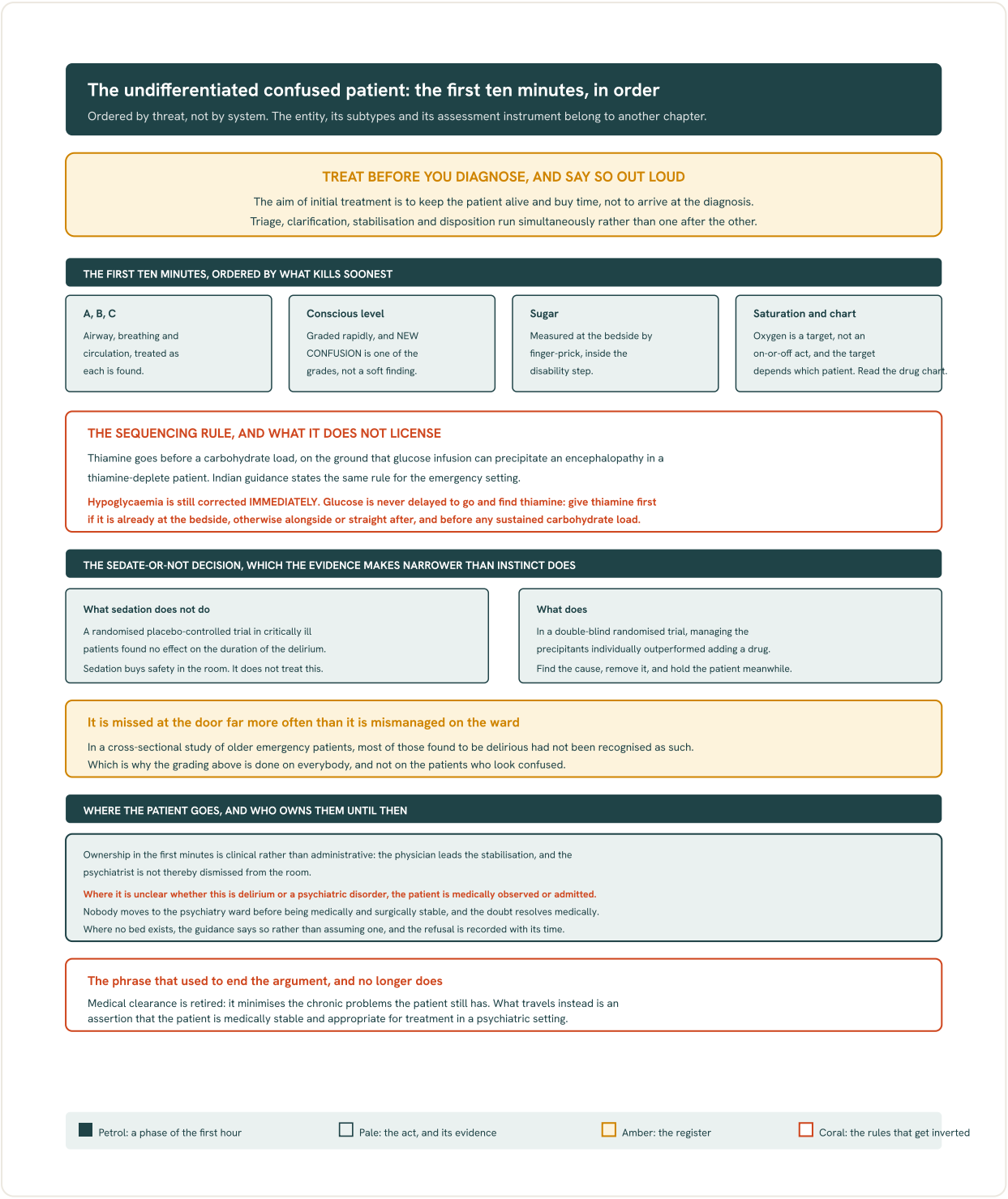


Fig 28.12. The undifferentiated confused patient at the front door drawn as a timed sequence ordered by threat, with conscious level, blood sugar, oxygen saturation and the drug chart taken in the first ten minutes, the thiamine and carbohydrate sequencing rule stated as a rule together with the correction that hypoglycaemia is never left waiting for it, the sedate-or-not decision set against the trial evidence on either side, and the disposition rule that doubt between delirium and a psychiatric disorder resolves towards the medical bed.

26.1 Recognising confusion at the door, and how often it is not recognised

The warrant for treating this as a separate skill is that the front door is where confusion is most reliably lost. In a cross-sectional study published in Academic Emergency Medicine in 2009 by Han and colleagues, a convenience sample of emergency department patients aged sixty-five and over in a single tertiary care academic centre in the United States was assessed formally, and the

result compared with the treating emergency physician's own conclusion. The great majority of those who were delirious had not been recognised as delirious by that physician.

19 of 25	76.0%	54.9 to 90.6%
DELIRIOUS OLDER EMERGENCY DEPARTMENT PATIENTS NOT RECOGNISED AS DELIRIOUS BY THE EMERGENCY PHYSICIAN	THAT UNRECOGNISED PROPORTION, IN A SINGLE TERTIARY CARE ACADEMIC EMERGENCY DEPARTMENT	95 PER CENT CONFIDENCE INTERVAL AROUND THE UNRECOGNISED PROPORTION

Read the estimate honestly: one department, one convenience sample, a small numerator and a wide interval. What is secure is a direction and an order of magnitude, not a precise failure rate, and the direction is the justification for the topic.

The reasons are structural rather than a matter of individual carelessness. Confusion without agitation makes no noise, and a system that allocates attention by noise allocates none to it; the history that would establish an acute change from baseline is not in the patient but in the relative sent to the registration counter; and the vital signs chart has no field into which a change in thinking can be written unless somebody creates one.

26.2 Treating what will kill the patient before naming what is wrong

Assessment of the undifferentiated patient is ordered by threat rather than by diagnosis. In **the ABCDE approach**, set out by the Resuscitation Council UK and last updated in 2024, the stated underlying principles carry the whole front-door lens. Each life-threatening problem is treated at the point in the assessment where it is found, before the assessment moves on. The effect of that treatment is then assessed rather than assumed. And the need for extra help is recognised and called for early, rather than once the assessment is complete.

RULE **Treat the life-threatening problem at the moment you find it and then reassess; do not carry it forward to the end of the assessment.** A candidate trained to take a history, examine, formulate and then act will complete the survey before intervening, because every clinical method they have been examined on is built that way. In an undifferentiated patient that is the wrong order: the problems which kill in the first minutes are the ones correctable in the first minutes, and each window closes while the survey goes on.

The same source states the aim of initial treatment explicitly, and it is worth quoting to yourself when a senior colleague asks what you think is going on: the aim is to keep the patient alive and achieve some clinical improvement, and doing so buys time for further treatment and for making a diagnosis. The diagnosis is not the first task and is not delayed by stabilisation; it is what stabilisation makes possible. And because every act here is justified by threat rather than by diagnosis, none of it is invalidated when the diagnosis turns out to be psychiatric; whereas deferring a correctable physiological problem because the presentation looked psychiatric is indefensible on any account of what happened.

26.3 Deciding who owns the patient, and running the first hour in parallel

Ownership in the first minutes is a clinical question, not an administrative one, because a patient who belongs to nobody is a patient in whom every act waits for a conversation. In the Indian Psychiatric Society's 2023 clinical practice guidelines on elderly patients presenting with

psychiatric emergencies, first importance in clinical stabilisation is given to airway, breathing and circulation, and the physician rather than the psychiatrist should primarily do this. The psychiatrist is not thereby dismissed from the room: the psychiatric contribution in that window is to manage the psychiatric manifestations that would otherwise obstruct physical stabilisation, since a patient pulling out a cannula or striking at the person taking blood is one in whom the physician cannot proceed.

The same guidance corrects a second misunderstanding: the measures of an emergency episode are carried out almost simultaneously rather than sequentially. A chapter that presents the first hour as a numbered list teaches it wrongly, because a numbered list implies each step waits for the one before it.

- **Triage and prioritisation**, beginning the moment the patient is inside the door and not when a bed is found.
- **Diagnostic clarification and clinical stabilisation**, each informing the other.
- **Patient safety and prescribing decisions**, taken while the physiology is still being corrected.
- **Briefing the family**, who in Indian practice are the history, the consent conversation and often the observation, and can supply none of it from the corridor.
- **Monitoring and the treatment-setting decision**, formed from the first minute and not announced at the end.

The work is therefore distributed rather than serialised, and the commonest reason a confused patient waits is that one clinician has taken all of it on and is doing it in sequence.

> **GOOD TO REMEMBER**
>
> When acts run in parallel, the record is the only thing that can reconstruct them afterwards. Write the clock time beside each act and the reassessment that followed it: the time the sugar was taken and its value, the time glucose was given and the conscious level afterwards. The instruction to assess the effects of treatment is unverifiable without it.

26.4 Triaging the confused patient: managing the environment as the first intervention

Triage is usually taught as a sorting decision made at a desk, determining how long somebody waits. For the confused older patient it is better understood as the first clinical intervention, because the environment the patient is placed in changes the presentation before any drug is given. Indian guidance is the one source here that describes the act concretely rather than merely naming it, and the five measures it names are worth learning as a set.

- **Reduce the waiting time.** Waiting is unstructured time in an unfamiliar place with nobody attached to the patient, and it worsens both the presentation and the assessment.
- **Ensure the patient's physical comfort.** Pain, a full bladder, cold, thirst and an uncomfortable trolley are all correctable, and all are commonly read as agitation belonging to the illness.
- **Reduce external stimuli.** The department is bright, loud and continuously in motion, which is the environment a disturbed sensorium handles worst.

- **Manage the patient in an isolation room where possible.** A single-patient space for the patient's benefit, not a segregation measure; the qualification is in the guidance itself.
- **Ensure there are no potentially dangerous objects in the treatment setting.** Done to the room before the patient arrives in it, not to the patient after something has happened.

These are interventions with an expected effect, not courtesies. A patient who settles once the lights are lowered and the bladder is emptied has told you something clinically useful, without a sedative and without confounding the neurological examination that follows. The environment is also the only intervention deliverable before the patient is assessed, which is why it belongs to triage rather than management.

26.5 Grading conscious level inside the primary survey

The single change that most improves recognition costs nothing and takes seconds: conscious level is graded during the primary survey, in the same pass as airway, breathing and circulation, and new confusion is one of the available grades. The Resuscitation Council UK approach makes a rapid initial assessment of conscious level by the **ACVPU** method, and offers the Glasgow Coma Scale as the alternative.

- **Alert.** Awake and engaged, with no qualifier attached.
- **Newly Confused.** A grade in its own right, and the one that matters here, because it gives the emergency chart a place to record disordered thinking at the moment it is noticed.
- **Responding to Vocal stimuli.** Not spontaneously awake, but rousable by voice.
- **Responding to Painful stimuli.** The stimulus the guidance names is supra-orbital pressure, applied at the supraorbital notch.
- **Unresponsive** to all stimuli.

For a psychiatric reader the placement matters more than the letters. New confusion is recorded inside the primary survey, alongside airway and circulation, not deferred to a mental state examination performed later by somebody else. That puts the observation in the hands of whoever meets the patient first; it timestamps the finding, so a later deterioration has an earlier grade to be a deterioration from; and it makes the observation part of the physiological record rather than the psychiatric one, which is what stops it being filed as somebody else's business.

The word new cannot be verified from the patient: establishing it requires somebody who knew the patient last week, which in an Indian department is the attendant in the corridor, so obtaining that comparison is part of grading the level, not a separate exercise afterwards.

26.6 Excluding reversible causes as a timed act rather than a list

Every textbook lists the reversible causes of an acute confusional state, and candidates reproduce the list well. What it does not carry is what makes it usable in an emergency: each item has a specific act, a specific moment at which that act must happen, and a specific result that looks reassuring and is not. Reorganised that way it becomes a sequence to be performed rather than a taxonomy to be recalled. The acts below are those the primary survey contains; the wider aetiological workup belongs to the Stroke, TBI, delirium and focal brain syndromes notes.

THE ACT AT THE DOOR	WHAT IT IS LOOKING FOR	WHY IT IS TIMED, NOT MERELY LISTED	THE RESULT THAT MUST NOT REASSURE YOU
Grade the conscious level	New confusion as a recorded grade rather than an impression	Taken inside the primary survey, so it exists before any history or label	An impression of alertness in a patient never actually graded
Measure the blood glucose at the bedside	Hypoglycaemia, correctable within a minute and lethal if left	The correction is given where the result appears, not after the survey	A normal finger-prick in a shut-down or peri-arrest patient, where the method is unreliable
Set the oxygen target, then give oxygen	Hypoxaemia, and the wrong target for this patient	The target is chosen when oxygen is started, and both errors follow that decision	A saturation inside the general target in a patient at risk of hypercapnic respiratory failure
Order thiamine and carbohydrate correctly	The patient in whom giving glucose is not a neutral act	Thiamine first if it is already at the bedside, otherwise with or straight after the glucose, and always before any sustained carbohydrate load	A low sugar treated as a self-contained problem with a self-contained answer
Read the drug chart and reverse what is reversible	Depressed consciousness that has a specific antagonist	An antagonist not given in this window is usually not given at all	A plausible psychiatric or social explanation that quietly ends the search

MNEMONIC

Conscious level, Sugar, Saturation, Chart

What is done at the bedside before anyone commits to a diagnosis: **Level** of consciousness graded inside the primary survey, blood **Sugar** measured and corrected where low, oxygen **Saturation** measured against a target chosen for this patient, and the drug **Chart** read for a reversible drug cause. The thiamine sequencing rule sits inside the sugar step.

26.7 Measuring the blood sugar, and knowing when not to believe it

Blood glucose is measured to exclude hypoglycaemia by a rapid finger-prick bedside method, inside the primary survey rather than in the batch of blood sent afterwards. The reason is arithmetic about time: hypoglycaemia is the fastest exclusion on the list, and a process that defers it to a laboratory result has spent an hour on it.

The correction follows local protocols, and the worked example the Resuscitation Council UK gives is a complete instruction rather than a bare number: in an unconscious patient whose blood sugar is **less than 4.0 mmol/L**, an initial dose of **50 mL** of 10 per cent glucose solution is given intravenously. Note what that threshold is and is not. It is a treatment threshold for hypoglycaemia in an unconscious patient at the front door, not a diagnostic band for any

psychiatric syndrome; it does not define a level below which confusion is explained, and a patient whose sugar sits above it has not acquired an alternative diagnosis.

The caveat attached to the method is the part most often dropped in reproduction, and it matters most in the sickest patients. In a **peri-arrest** patient a venous or arterial sample is used instead, because finger-prick glucose measurements can be unreliable in sick patients. The reason: a finger-prick samples capillary blood from a peripheral bed, and peripheral perfusion is exactly what fails in shock.

> **PITFALL**
>
> A normal finger-prick reading in a cold, shut-down, peripherally vasoconstricted patient is not a negative result. It is an unreliable result that happens to be reassuring, which is worse than no result, because it goes on the chart and is read thereafter as an exclusion. In any patient who is peri-arrest or profoundly shocked, take the glucose from a venous or arterial sample and record which you used, so a later reader can tell whether hypoglycaemia was excluded or merely tested for.

26.8 Giving thiamine before carbohydrate

Two acts each correct alone can be harmful in the wrong order, and this is the sequencing rule of the first minutes. Thiamine is given before any sustained carbohydrate load. Read that precisely, because the common misreading is dangerous in the other direction: a documented low sugar is corrected immediately and glucose is never held back while thiamine is looked for. Give thiamine first where it is already at the bedside, otherwise with the glucose or straight after it, and before any infusion, feed or oral intake that follows. The European Federation of Neurological Societies, in its guideline on Wernicke encephalopathy published in the European Journal of Neurology in 2010, states the rule and its ground together: it is important to give thiamine before any carbohydrate, because glucose infusion precipitates Wernicke encephalopathy in thiamine deficiency.

Indian guidance states the same rule for the emergency setting and supplies the mechanism, which is the version worth carrying into an examination because it explains rather than asserts. In the Indian Psychiatric Society's 2023 guidelines on patients with substance intoxication presenting to the emergency department, thiamine is administered before glucose replenishment so that the glucose is used in ATP generation, a process which itself uses thiamine as a co-factor. Giving carbohydrate first therefore sequesters an already limited store into metabolism, and that sequestration precipitates the encephalopathy. The glucose is not toxic; it is a demand placed on a supply that is not there.

The rule applies to the undifferentiated patient, because the population at risk is defined by nutritional state and alcohol history and neither is known at the door: the safe reading is that thiamine goes in first, or at latest with the glucose, in any confused patient in whom deficiency is even plausible. It requires no diagnosis, because the order is fixed before anyone has decided what is wrong. The thiamine dose, its route and duration, and the syndrome of Wernicke encephalopathy itself are taught in the Endocrine and metabolic psychiatry notes, and the withdrawal regimens carrying their own thiamine schedules belong to the Substance use

disorders notes. No dose is asserted here, deliberately, because a half-remembered regimen is more dangerous at this point than an explicit handover.

26.9 Setting an oxygen target rather than turning oxygen on

Oxygen is prescribed to a target, not delivered at maximum because the patient looks unwell, and the confused patient is where that distinction is most often lost. The Resuscitation Council UK gives two targets. In acute respiratory failure the aim is to maintain an oxygen saturation of **94 to 98 per cent**. In patients at risk of **hypercapnic respiratory failure** the aim is lower, at **88 to 92 per cent**.

The teaching lies in the existence of two targets rather than in either figure. A confused patient is not simply given the highest available flow, because the correct target depends on which failure is in front of you, and choosing wrongly is an error in both directions. Under-oxygenating a hypoxaemic brain prolongs exactly the state you are trying to reverse. Over-oxygenating a patient at risk of hypercapnic respiratory failure produces a rising carbon dioxide, and a rising carbon dioxide produces a drowsy, confused patient: the treatment reproduces the presenting complaint, and reads as deterioration of the original illness. The same saturation reading is therefore a success in one patient and a warning in another, and the chart cannot distinguish them unless somebody has written down which target was aimed at. Where the risk of hypercapnic failure is unknown, that uncertainty is handed over rather than resolved silently by turning the flow up.

26.10 Reading the drug chart, and giving an antagonist where one exists

Within the same step of the primary survey the drug chart is checked specifically for reversible drug-induced causes of depressed consciousness, and an **antagonist** is given where appropriate; the example the guidance names is naloxone for opioid toxicity. The important word is specifically: not the general medication review that happens later on the ward, but a targeted search, performed during the survey, for a cause with an immediate reversal.

Framed as a decision rule rather than as poisoning management, each part of it is a separate failure point. A reversible drug cause is actively looked for, which means somebody obtains the chart or the tablets the family brought, rather than recording that the history was unavailable. If one is found the antagonist is given, meaning now and not requested for later. And the effect is then assessed, because an antagonist given and not evaluated has produced a record rather than a result.

The opioid toxidrome, the naloxone dose, its titration and its re-dosing are taught in the Substance use disorders notes; what belongs to the front door is only the decision that a reversible drug cause is sought and reversed. In a psychiatric population the drug chart is two-sided: a list of possible causes, and a list of what the patient may have stopped taking. Neither reading is available unless somebody finds the chart, which in Indian practice usually means asking an attendant to bring the medicines from home, in the first minutes rather than at the end of the shift.

26.11 Deciding whether to sedate, and knowing what sedation does not buy

What the decision to sedate is actually for. A confused patient climbing off the trolley or pulling at lines obstructs the very stabilisation the preceding steps require, so there are legitimate reasons to sedate. What a candidate must be able to say is what sedation achieves and what it does not, because the commonest error is to treat a sedative as a treatment for the confusional state itself. Two trials settle it, and neither concerns dosing.

The first is the randomised, double-blind, placebo-controlled trial reported in the New England Journal of Medicine in 2018 by Girard and colleagues, in critically ill patients with acute respiratory failure or shock who were delirious in the intensive care unit. Haloperidol and ziprasidone, compared with placebo, did not significantly alter the duration of delirium. Whatever a sedative buys in that setting, it does not buy a shorter confusional state, and a plan built on the assumption that it does is a plan with no endpoint.

The second identifies the comparator that does work. In a double-blind, dose-titrated randomised trial in inpatient hospice and hospital palliative care services in Australia, reported in JAMA Internal Medicine in 2017 by Agar and colleagues, individualised management of the **delirium precipitants** together with supportive strategies produced lower scores and a shorter duration of the targeted distressing symptoms than the same care with risperidone or haloperidol added. What beat the drug was not nothing; it was doing the precipitant work properly. The caveat travels with the finding: these were palliative care patients with life-limiting illness, and the result is not transposed unqualified onto an undifferentiated emergency population.

TRAP **Recording the decision to sedate as the treatment of the confusional state.** Candidates make this error because sedation is the only act that visibly changes the patient in front of them, and because the notes have a space for what was given and none for what was corrected. Written as treatment it closes the episode: the patient is settled, the search for the precipitant stops, and the next clinician inherits a quiet patient with an unexamined cause. Written correctly it is an enabling act with a stated purpose, to let the physical assessment, the access and the imaging proceed, and it leaves the precipitant work still owing. The agent, its dose and the cardiac monitoring attached to it are taught in the Schizophrenia: management, antipsychotics and adverse effects notes.

26.12 Deciding where the patient goes, and writing the handover that says so

Disposition is where a wrong decision costs most, because the emergency department is the last point at which medical and psychiatric resources are both immediately present. Four questions arise, each answered in a named document from a named body.

THE QUESTION AT THE DOOR	WHAT THE GUIDANCE SAYS TO DO	WHOSE RULE, AND WHEN
It is not clear whether this patient has delirium or a psychiatric disorder	The patient is medically observed or hospitalised, after an appropriate medical screening examination and appropriate documentation for the presenting complaint	American Association for Emergency Psychiatry Task Force, 2017, by expert consensus
Can this patient be moved to the psychiatry ward	Not until the patient is medically and surgically stable	Indian Psychiatric Society, 2023, written for elderly patients
How long should the patient remain in the emergency setting	The shortest possible time; the emergency department is transit and not a destination	Indian Psychiatric Society, 2023, written for elderly patients
What does the transfer note actually say	That the patient has been evaluated medically and is medically stable and appropriate for treatment in a psychiatric setting, rather than that the patient is clear	American Association for Emergency Psychiatry Task Force, 2017

The first row is the most useful decision rule here. Uncertainty between a confusional state and a psychiatric disorder resolves towards medical observation, because the two errors are not symmetrical: a patient with a primary psychiatric illness observed medically for some hours loses very little, while a patient with an unrecognised medical cause admitted to a psychiatric ward loses the monitoring, the investigations and the medical team in one movement. Quote the grading with the rule, since the task force states its recommendations rest on expert consensus and should be treated as preliminary until further evidence is obtained. Note too what the requirement to be **medically and surgically stable** does to the sequence: it makes the physical stabilisation of the preceding steps a precondition for the psychiatric disposition rather than a parallel courtesy.

The fourth row is a point about language that turns out to be a point about safety, and it is made in full with the medical triage of the overdose patient in these notes rather than here: the same task force retires the term **medical clearance**, and what replaces it keeps the two claims a handover can actually support. What this topic needs from that argument is only its consequence for the confused patient, which is the row above: where it is unclear whether this is delirium or a psychiatric disorder, the doubt is resolved medically and not by transfer.

IN INDIA

Indian guidance addresses the case protocols elsewhere assume away. Where a patient requires inpatient care and cannot be moved to an inpatient ward or intensive care unit because no bed is available, the Indian Psychiatric Society's 2023 guidance states that the family should be allowed to shift the patient to another treatment setting. Disposition here is therefore partly a decision about where a bed exists, so the enquiry begins early rather than after the decision to admit. And the transfer that follows is a clinical act: the receiving setting must be told what has been done, what is still owed and what the patient was stable enough for, because a patient moved by a family without that handover arrives as an undifferentiated confused patient for a second time. The same reasoning covers the single room, the observation and the monitoring these pathways assume: where the department cannot provide them, that is recorded and factored into the disposition, not quietly assumed met.

In an undifferentiated confused patient, each life-threatening problem is treated the moment it is found and its effect reassessed; conscious level is graded inside the primary survey with new confusion as a grade of its own; glucose and oxygen are corrected to a target, thiamine before any carbohydrate; sedation is an enabling act, not a treatment for the confusional state; and where it is unclear whether this is delirium or a psychiatric disorder, the patient is medically observed or hospitalised rather than sent to a psychiatric bed.

27 · Acute alcohol withdrawal and delirium tremens (emergency aspect)

Why this is examined as an act. A man is brought in at night by relatives who say he drinks. He is drowsy, sweating, pulling at the trolley rails, and cannot account for himself. Nothing in that sentence is a diagnosis, and the one word everybody in the room has already supplied is the word that must be withheld longest. What the withdrawal syndrome is, when it declares itself, how its severity is scored and which regimens treat it belong to the Substance use disorders notes, which own that entity in full. What is owed here is the sequence that runs before any of it is known, and the decision about where this patient spends the night.

The examination question has the same shape: what is done first, what is excluded before anything is attributed, and which of three destinations the patient leaves for. The ordered sequence of arrival, safety, parallel differential, act and disposition is the spine every emergency presentation runs on, set out in the section of these notes on the assessment and management of the acutely agitated and aggressive patient, with the general front door of the confused patient in the section on delirium triage and emergency management. This section takes the version alcohol distorts.

27.1 The patient who arrives before the history does

The structural difficulty is that the diagnosis arrives ahead of the patient, and from somebody else. The escort supplies it, the smell appears to confirm it, and the patient cannot contest it, because the state being explained is the one that stops him explaining anything. Treat the

reported drinking history as collateral information with a source and a reliability, not as an established mechanism.

Before any of that is adjudicated, the same priority governs this arrival as every other. NICE guideline NG232 on head injury assessment and early management, published in 2023, sets it in one line: stabilise airway, breathing and circulation before attending to other injuries. In a patient who may be intoxicated this is not a formality. A depressed conscious level, a blunted gag, vomiting and the flat position he has been laid in make an aspiration set, and the restlessness that follows hypoxia is indistinguishable at the door from the restlessness of withdrawal. The airway is answered on the state in front of you, never on the mechanism you suspect.

27.2 Exclusion first, attribution second

The sentence this lens turns on is one recommendation from the same guideline, and its grammar teaches as much as its content. A depressed conscious level may be assumed to be due to intoxication only after an **important traumatic brain injury** has been excluded. The permission is genuine, but conditional, and it sits at the end of the sequence rather than the start. The injury itself and its imaging decision rules belong to the Stroke, TBI, delirium and focal brain syndromes notes; the order is what is owed here.

RULE **Intoxication is a conclusion, never a premise.** It is the label you arrive at once the exclusions have been performed, not the one you begin with and then defend. Written the other way round the assessment has no stopping rule: every abnormal finding is absorbed into the explanation already chosen, and the patient improves on paper by being observed rather than examined.

The order matters because the two states share almost every surface feature, diverge completely in what the next hour requires, and coexist in any drinker who has fallen. The wrong order also fails silently: a missed injury in a patient assumed to be drunk produces exactly the course everyone expects, and the deterioration reads as the alcohol taking its time.

TRAP **The smell closes the assessment.** The smell of alcohol is evidence of recent drinking, a different proposition from the cause of the conscious level, and compatible with every other diagnosis on the list. The examined version is the patient documented as sobering up while an extradural collection fills.

27.3 The parallel sweep, and what it is looking at

The 2023 Indian Psychiatric Society clinical practice guideline on substance intoxication presenting to the emergency department instructs that other causes of **altered sensorium** be ruled out, naming the metabolic set first with the investigations that answer it. The word carrying the teaching is parallel: the sweep does not wait for the alcohol assessment to finish, and is not a second opinion sought when the first explanation disappoints.

The same guidance adds a bedside step routinely skipped in a psychiatric assessment. Unresponsive patients may be harbouring an **occult head injury** identifiable from raised intracranial pressure, so direct ophthalmoscopy is advised, looking for papilloedema as a clinical sign of that pressure. It carries its own qualification: papilloedema without raised intracranial

pressure may also be seen in **methyl alcohol poisoning**, which matters greatly in Indian practice, so the sign narrows the field without settling it.

LIMB OF THE SWEEP	WHAT IS BEING EXCLUDED	THE ACT THAT ANSWERS IT
Metabolic	Hypoglycaemia, electrolyte imbalance, hyperosmolar hyperglycaemic state, diabetic ketoacidosis, metabolic acidosis	Blood glucose, renal function tests, arterial blood gases
Traumatic	An important traumatic brain injury, excluded before a depressed conscious level is attributed to drink	The head injury pathway, with imaging where it indicates
Raised pressure, at the bedside	Occult head injury in the unresponsive patient	Direct ophthalmoscopy, looking for papilloedema
Toxicological look-alike	Methyl alcohol poisoning, in which papilloedema appears without raised intracranial pressure	Raised whenever the fundal sign appears and the pressure story does not fit

MNEMONIC

Sugar, salts, gases, fundi

Blood glucose, renal function tests, arterial blood gases, then the fundi through a direct ophthalmoscope. The first three go with the first draw; the fourth costs nothing, needs no laboratory, and is available in every room where this patient is seen.

27.4 What converts a behavioural presentation into a medical one

The sweep answers what to exclude. When a patient presenting behaviourally should be pushed towards medical assessment at all is a separate question, and it is answered by a consensus TRIGGER LIST rather than by a battery. That list, its provenance and each of its items are taught with the medical triage of the overdose patient in these notes and are not restated here. What belongs to this topic is that intoxication and withdrawal sit ON that list: they are reasons to do MORE medicine rather than less, which is the exact inversion the drinking history invites.

Read where alcohol sits in that list. Substance intoxication and withdrawal appear as reasons to do more medicine, not as explanations permitting less, which is the exact inversion made at the door every night. Two other entries repay attention: age alone triggers the evaluation with no abnormal finding, and abnormal vital signs are a trigger rather than an expected accompaniment of agitation. The task force calls its own recommendations consensus and preliminary, so this is a prompt to think rather than a validated rule.

Airway, breathing, circulation
STABILISED FIRST IN EVERY EMERGENCY DEPARTMENT ARRIVAL, BEFORE OTHER INJURIES ARE ATTENDED TO

Never assumed
THAT A CONFUSED DRINKER IS CONFUSED BECAUSE OF THE DRINK, WHICH IS THE INVERSION THIS TOPIC EXISTS TO STOP

Papilloedema
BEDSIDE SIGN OF RAISED INTRACRANIAL PRESSURE SOUGHT ON DIRECT OPHTHALMOSCOPY IN THE UNRESPONSIVE PATIENT

Intoxication
LISTED FIRST AMONG THE FACTORS THAT WITHHOLD DISCHARGE AFTER A HEAD INJURY ASSESSMENT

27.5 Two diagnoses missed in the state that hides them

Where suspicion collapses. Some diagnoses are missed at random. Two here are missed systematically, because the feature that should raise suspicion is the feature that lowers it. NICE clinical guideline CG100 on the physical complications of alcohol use disorders, published in 2010 and last updated in 2017, meets this head on: maintain a high level of suspicion for the possibility of **Wernicke encephalopathy**, particularly if the person is intoxicated. That clause names the very situation in which the diagnosis is lost, since confusion and unsteadiness in a man who smells of drink are read as drunkenness. The clinical picture defining the syndrome belongs to the Endocrine and metabolic psychiatry notes, and the parenteral thiamine that follows suspicion, with its route and duration, to the Substance use disorders notes. What belongs here is the direction of travel: intoxication raises suspicion, it never lowers it.

The second runs the same way in a patient with liver disease. The 2014 joint American and European hepatology practice guideline on hepatic encephalopathy in chronic liver disease records that overt hepatic encephalopathy remains **a diagnosis of exclusion** in a population itself highly susceptible to mental state abnormalities from medications, alcohol misuse, drug use, the effects of hyponatraemia and psychiatric disease, so exclusion of other aetiologies by laboratory and radiological assessment is warranted, as clinically indicated, in such a patient with altered mental status. One sentence names three traps at once: the confused drinker with cirrhosis can be misattributed to the alcohol, to the liver, or to a psychiatric illness, each error made by a different team on grounds that look reasonable from where it stands. The safeguard is the head injury rule again: attribution after exclusions that were performed rather than assumed.

27.6 The level-of-care decision

Disposition is where this presentation is most often settled by habit. The Indian guidance draws the line at consciousness and medical involvement rather than at any score: mild and moderate cases, meaning those without impairment of consciousness or significant medical issues, can be managed in relatively simple surroundings without much medical intervention, while those who are **severely intoxicated** should be admitted and managed where high-dependency or intensive care can be provided. Two clinical variables carry the decision, and both are assessable without a laboratory.

Where the presentation is withdrawal rather than intoxication, NICE CG100 gives the admission rule a different logic. Admission for **medically assisted alcohol withdrawal** is offered to people in acute alcohol withdrawal who have, or are assessed as being at high risk of developing, alcohol withdrawal seizures or delirium tremens. The decision is driven by predicted complication and not by present distress, which inverts how emergency beds are usually allocated: a distressed,

tremulous, fully oriented patient may not need one, and a quieter patient with the risk profile does. The severity instrument, the withdrawal time course and the epidemiology of delirium tremens belong to the Substance use disorders notes, and none of them replaces this decision.

The line then moves with the person. For **certain vulnerable people** in acute alcohol withdrawal a lower threshold for admission is considered: those who are frail, have cognitive impairment or multiple comorbidities, lack social support, have learning difficulties, or are **16 or 17 years old**. Read as a group, those examples are not about severity. They describe who will be unobserved, unable to report deterioration, or unable to come back, none of which a severity score sees. Disposition is a clinical judgement with a score inside it, not a score with a clinician attached.

DESTINATION	WHAT SELECTS IT	WHAT MUST BE TRUE FIRST	WHAT FOLLOWS
Relatively simple surroundings, little medical intervention	Mild and moderate presentations: no impairment of consciousness, no significant medical issues	The sweep performed and negative, not waived	Observation by a named person, and a stated point of review
Admission for medically assisted alcohol withdrawal	Acute alcohol withdrawal with, or at high risk of, withdrawal seizures or delirium tremens	A threshold lowered where the person is vulnerable, isolated or very young	The regimen itself, owned by the Substance use disorders notes
A setting providing high-dependency or intensive care	Severe intoxication	Capability actually present, not a monitored bay nobody watches	Care led by the team the indication selects, psychiatry alongside

27.7 Admission, and who owns the bed

The Indian guidance is unusually concrete here. Inpatient admission of an intoxicated patient may be considered for:

- severe intoxication, or persistent disorientation;
- medical complications such as Wernicke encephalopathy or alcoholic hepatitis;
- dysrhythmias or convulsions, or continued abnormality of cardiopulmonary parameters;
- known chronic systemic illnesses requiring independent medical attention;
- prolonged aggressive behaviour, or perceptual abnormalities.

It then adds the clause psychiatrists most often skip, and it is the useful one: the speciality under which the patient is admitted is determined by the indication for admission. That settles the corridor argument. A patient admitted for dysrhythmias or a continued cardiopulmonary abnormality is a medical admission with psychiatric input, not a psychiatric admission with a medical consultation pending; one admitted for prolonged aggression or perceptual abnormality is the reverse. It also produces a defensible record, since the reason for the bed and the owner of the bed become one fact written once.

IN INDIA

The sweep assumes a working blood gas analyser, an urgent renal panel and a functioning ophthalmoscope at two in the morning. Many district emergency rooms have a glucometer, a slower overnight biochemistry and a borrowed fundoscope, so the honest local version is to do the bedside sugar and the fundi at once, send what the laboratory will process at night, and record which exclusions were performed and which deferred. The speciality rule assumes more than one speciality is admitting; where the bed goes to whoever has one free, that rule is the corrective, turning an availability decision back into a clinical one.

27.8 Discharge, and what this section hands on

The last decision is made quickest and defended worst. Returning to the head injury guideline: where imaging is not indicated and there is no suspicion of clinically important traumatic brain injury, discharge still requires that there be no other factors warranting hospital admission, and drug or alcohol intoxication is listed first among them, alongside other injuries, shock, suspected non-accidental injury, meningism and cerebrospinal fluid leak. Discharge additionally requires appropriate support structures for safe discharge and subsequent care, the example given being **competent supervision at home**.

Two consequences follow. Intoxication is not merely a confounder of the assessment; on its own it is a reason the patient does not go home yet, so a negative scan and a normal examination are not between them a discharge. The second requirement is about the destination rather than the patient: someone safe to leave has somewhere to be watched, which the department must ask about rather than infer from a relative in the waiting area.

What is not available here is the cadence. For the patient held because of intoxication, no comparable standard is available to quote, and none is invented here. Teach the principle instead: the reason for keeping the patient dictates what is watched for, that determines how often somebody must look, and the interval is agreed and recorded by name.

GOOD TO REMEMBER

Record which exclusions were performed and which were assumed. Notes on these patients carry the conclusion and not the work, so a later reader cannot tell whether the metabolic set was sent or the fundi seen. Three lines close it: what was excluded and by what test, why the patient is or is not going home, and who is watching him and where.

At handover the receiving team needs what cannot be reconstructed afterwards: which exclusions were completed, what was still pending when the patient moved, the indication that selected both bed and speciality, and who was told to look at him and how often.

In a drinker with a depressed conscious level, exclusion comes first and attribution second: an important traumatic brain injury is excluded, the metabolic sweep and the fundi run alongside, and intoxication is the label you arrive at, never the one you begin with.

28 · Psychiatric emergencies in pregnancy and the postpartum period

Why the marks are here. Psychiatric emergencies in pregnancy and after it are not different emergencies. An acutely agitated woman is still an acutely agitated woman, an overdose is still an overdose, a collapse is still a collapse. What changes is the act: where she is put, what may be used, what must not follow it, who is standing in the room while it happens, what is watched afterwards, and where she goes next. That is a short list, and it is examinable precisely because almost nobody rehearses it. Every one of the underlying conditions is taught in full elsewhere in these notes and none is restated here. What this section owns is the overlay: what is done differently, emergency by emergency, because the patient in front of you is pregnant or has recently delivered.

Two facts make this the highest-stakes intersection in emergency psychiatry. The first is that there are two patients and only one can be interviewed, examined or consented; the second is silent, is affected by every drug and every position, and is the one most often missing from the note. The second fact is where the mortality actually sits. On the confidential enquiry into maternal deaths for the United Kingdom and Ireland, reporting in 2025, suicide is the most common cause of maternal death in the period between six weeks and one year after the end of pregnancy, and mental health conditions together account for **over one third** of the deaths in that same late period. The dangerous window is not the pregnancy, where obstetric attention is concentrated, but the postnatal year, where nobody is looking.

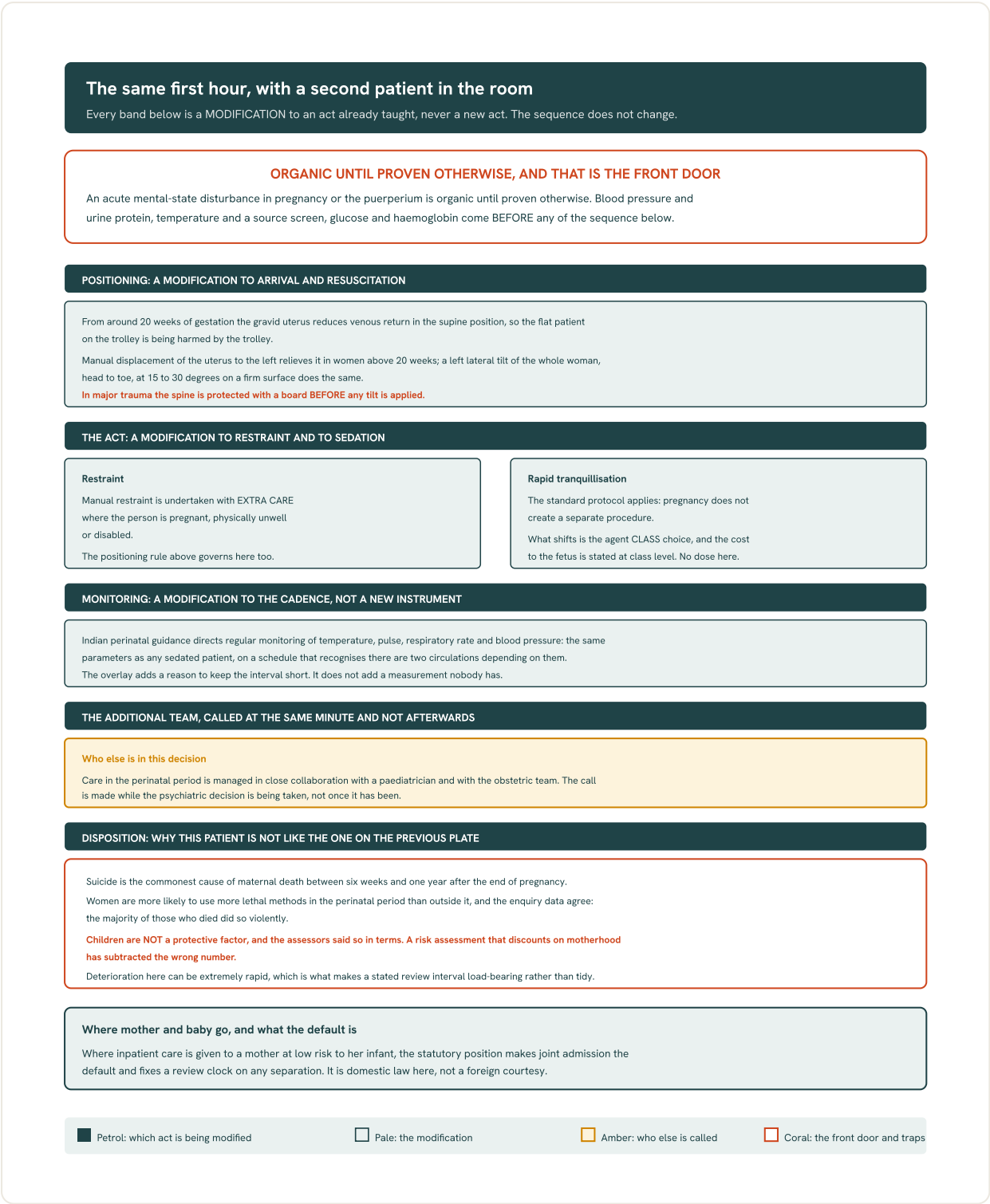


Fig 28.13. What changes when the emergency patient is pregnant or newly delivered, drawn as modifications overlaid on the first-hour sequence rather than as a separate algorithm: the organic exclusion that comes before everything, the positioning rules from around twenty weeks and the trauma exception to them, the extra care in restraint and the class-level agent shift in sedation, the monitoring cadence, the obstetric and paediatric team called at the same minute, and the disposition facts that make this patient's risk assessment different, including that children are not a protective factor.

28.1 Establish the second patient before you do anything to the first

The first act in a perinatal emergency is neither pharmacological nor physical. It is to establish, and to write down, that there are two patients and how far along the second one is. Everything downstream keys off that determination: the positioning rule, the resuscitation algorithm, the agent-class decision, the monitoring set and the destination.

The obvious problem is that the woman who most needs this determination is the one least able to give it. She may be agitated, mute, intoxicated, thought-disordered or brought in by neighbours who know nothing about her. Resuscitation guidance solves this with a physical criterion rather than a historical one: the manoeuvres that follow are indicated in women above 20 weeks of gestation, or wherever the uterus is palpable at or above the level of the umbilicus, on the Royal College of Obstetricians and Gynaecologists guidance on maternal collapse in pregnancy and the puerperium (2019). The second limb is the clinically useful one for us: an abdominal palpation takes seconds, needs no cooperation and no dates, and converts an unknown into a rule the whole team can follow. It also protects against the opposite error, since the positioning rules below answer a specific mechanical problem that does not exist early in pregnancy.

On the postnatal side the equivalent determination is the interval since delivery and whether an infant is physically present. The interval decides whether an obstetric team still has an active interest in her; the presence of an infant decides who is holding that infant while the emergency is managed, which has to be answered out loud in the first minutes. The wider framework for weighing a decision made for a mother and a fetus or infant at once, including the risk of the untreated illness as one of the risks being weighed rather than as the baseline, belongs to the topic on prescribing psychotropics in pregnancy in these notes and is not re-derived here.

28.2 Exclude the organic causes before you run any of what follows

This section comes first because everything after it assumes the answer. Acute disturbance of mental state in pregnancy or the puerperium is organic until proven otherwise, and the proving is done at the door rather than after admission. The reason is not caution in the abstract. The conditions that present this way are common, they are time-critical, and several of them are found by measurements a district casualty already has at the bedside.

Take the blood pressure and test the urine for protein, because hypertensive disease of pregnancy reaches well beyond delivery and can present as headache, visual disturbance, confusion or seizure in a woman whose pregnancy ended weeks earlier. Take the temperature and look for a source, because puerperal sepsis presents as agitation and confusion before it presents as anything a psychiatrist recognises. Take a capillary glucose. Look at the haemoglobin, because severe anaemia after obstetric haemorrhage produces exactly the picture that gets referred. None of these is a psychiatric act, and all of them precede one.

The trap is structural rather than clinical: a woman who arrives disturbed in the puerperium arrives with a psychiatric referral already attached to her, and the referral is itself a piece of anchoring. The general approach to the acutely confused patient, and what an organic screen contains, is taught with the emergency triage of the confused patient elsewhere in these notes. What belongs here is the order. No comparable perinatal standard is available to quote for which tests, at what threshold, in what sequence, and none is invented here; the acts above are named without figures for that reason.

RULE **A psychiatric diagnosis in the puerperium is a diagnosis of exclusion made at the door, not a diagnosis of first resort made in the referral.** The positioning, sedation and disposition decisions that follow are all correct, and all of them are wrong if the woman is eclamptic or septic.

28.3 Decide the position she is left in, and treat it as an intervention

This is the act most often omitted, and the omission is invisible because a woman lying flat looks like a woman lying down. From around 20 weeks of gestation the gravid uterus reduces venous return in the supine position, and cardiac output falls in consequence by **up to 30 to 40 per cent**. That is **aortocaval compression**, and it is the physiological fact that turns a positioning instruction into a clinical intervention rather than a comfort measure. A restrained or sedated pregnant woman left flat is not merely uncomfortable; she is being actively harmed by an omission no drug chart records.

20 weeks GESTATION FROM WHICH THE SUPINE POSITION REDUCES VENOUS RETURN	**15 to 30 degrees** ANGLE OF WHOLE-BODY LEFT LATERAL TILT, ON A FIRM SURFACE	**4 minutes** CORRECTLY PERFORMED CPR WITHOUT RESPONSE BEFORE PERIMORTEM CAESAREAN SECTION	**5 minutes** TARGET FROM MATERNAL COLLAPSE TO DELIVERY AT PERIMORTEM CAESAREAN SECTION

The corrective act has three checkable elements, and candidates lose the marks on the second and third rather than the first. A **left lateral tilt** of the woman from head to toe, at an angle of 15 to 30 degrees, on a firm surface, relieves the compression in the majority of pregnant women while still allowing effective chest compressions. Head to toe matters because tilting the trunk alone folds her at the waist and leaves the uterus where it was. The stated angle matters because a token lean achieves nothing and an extreme one rolls her off. The firm surface matters because a soft mattress absorbs the tilt and, if she arrests, makes compressions useless.

Where a tilt cannot be achieved, or where compressions are being given, the alternative is **manual displacement of the uterus to the left**, described in the same guidance as an up, off and over movement. Its value is that it relieves the compression while she stays supine, which is the only way to keep compressions effective during an arrest, and it needs no equipment.

One situation subordinates the whole positioning rule. In major trauma the spine is protected with a **spinal board** before any tilt is applied, and where no board is available manual displacement of the uterus is used instead. This is not an obstetric footnote for us. A pregnant woman who has jumped, fallen, been assaulted or been taken to the floor during a struggle on the ward is a trauma patient first, and tilting her may be the wrong act performed with the right intention.

SITUATION AT THE BEDSIDE	WHAT IS DONE	WHY IT IS THAT AND NOT SOMETHING ELSE
Uterus palpable at or above the umbilicus, and she is sedated, restrained or otherwise unable to move herself	Whole-body left lateral tilt, head to toe, at an angle of 15 to 30 degrees, on a firm surface	A tilt of the trunk alone bends her at the waist and does not lift the uterus off the great vessels
Chest compressions are needed	Keep her supine and displace the uterus manually to the left	Compressions are ineffective on a tilted or yielding surface; displacement relieves the compression without tilting her
Major trauma: a fall, a jump, an assault, or a struggle that ended on the floor	Protect the spine with a spinal board before any tilt is applied	Spinal protection outranks the positioning rule, and tilting an unprotected spine turns one injury into two
Major trauma, and no spinal board on the premises	Use manual displacement of the uterus instead of a tilt	It relieves the same compression without moving the spine, which is why it is the named fallback
An observation area with no tilting trolley and no firm wedge	Nurse her supine with the right hip elevated	Elevating the right hip is the same manoeuvre described from the other side, and it can be improvised

MNEMONIC

Board, then tilt, and displace when you cannot tilt

The precedence order for any pregnant woman who has to be laid down. The board comes first where there has been major trauma, because spinal protection outranks the positioning rule. Where there is no trauma, the whole-body left lateral tilt on a firm surface is the manoeuvre. Where a tilt cannot be achieved, where compressions are being given, or where no board is available, manual displacement of the uterus to the left does the same physiological work.

RULE **The position a sedated or restrained pregnant woman is left in is part of the prescription, not part of the nursing.** A woman who has just been given a sedating drug, or who is being physically held, cannot reposition herself. The position therefore stops being something she adopts and becomes something the team has chosen for her, and must keep choosing at every observation and handover. Written into the order alongside the drug, it survives the shift change; left to whoever last moved the trolley, it does not.

28.4 Adapt the restraint, and be honest about where the guidance stops

Pregnancy is named explicitly in general restraint guidance: manual restraint is to be undertaken with extra care if the service user is physically unwell, disabled, pregnant or obese, on the National Institute for Health and Care Excellence guideline on the short-term management of violence and aggression (2015). The perinatal guidance from the same body adds, inside its rapid tranquillisation recommendation, that restraint procedures should be adapted to avoid possible harm to the fetus.

Both statements stop at the level of principle. Neither specifies a hold, a position, a maximum duration, an observation interval or a gestational threshold at which the adaptation begins. That gap is load-bearing and should be stated rather than papered over: for how a hold is to be modified in pregnancy, no comparable standard is available to quote, and none is invented here. What can be said is what follows from sourced material, and a good answer says that and no more.

Three things follow. The positioning rule is the substance of extra care once the uterus is palpable at or above the umbilicus, so a hold that ends with her flat on her back and held there is the one configuration that must not become the resting state. Force applied over the gravid abdomen has no place in any hold, which is a statement about where hands go rather than about which technique is taught. And a woman taken to the floor has been through a mechanism of injury, so the trauma precedence above applies from the moment the hold ends. The general physical safety of any person in restraint, including the prone hazard, airway access and the risks of prolonged immobilisation, is the business of the topic on restraint and seclusion in these notes; the statutory authority for restraining anyone at all belongs to the Mental health legislation and forensic psychiatry notes, and the test of least restriction to the Forensic ethics, consent and legal procedure notes.

28.5 Choose the agent class, and refuse the seclusion that would normally follow

A pregnant woman who requires rapid tranquillisation is treated according to the standard guidance on violence and aggression, on psychosis and on bipolar disorder, with two named exceptions, on the perinatal guideline of the National Institute for Health and Care Excellence (published 2014, last updated 2020):

- she is not to be secluded after rapid tranquillisation;
- restraint procedures are to be adapted to avoid possible harm to the fetus.

Notice what those two have in common: neither is a dose. The protocol is not softened and the ladder is not rewritten. What changes is that two of the things normally available afterwards are withdrawn. The seclusion exception repays a moment's thought, because candidates reproduce it without being able to justify it. Seclusion is by construction a place where a patient is neither continuously observed nor physically accessible. A woman sedated in the second half of pregnancy needs the opposite: someone to keep her off her back, to take observations that include the fetus, and to reach her quickly if either patient deteriorates.

The agent decision is stated at the level of drug class and of the neonate, which is the level this section owns. When choosing an agent for a pregnant woman, an antipsychotic or a benzodiazepine with a short half-life should be considered; if an antipsychotic is used it should be at the minimum effective dose, because of **neonatal extrapyramidal symptoms**, and if a benzodiazepine is used the risks of **floppy baby syndrome** are taken into account. The short half-life preference and the minimum effective dose rule are one idea applied twice: what matters is the exposure still present in the neonate at delivery, so duration is being minimised alongside amount.

No dose appears in this section, deliberately. The rapid tranquillisation ladder and every first-dose figure belong to the Schizophrenia: management, antipsychotics and adverse effects notes, and a dose recalled from memory into a pregnancy answer is the error this material exists to prevent.

28.6 Monitor two patients afterwards, and give the cadence a name

Standard post-sedation monitoring watches one person. The Indian Psychiatric Society's guidance on the management of psychiatric disorders during the perinatal period (2022) extends the set: regular monitoring of temperature, pulse rate, respiratory rate, blood pressure and **fetal wellbeing measures** may be essential, and care is taken to ensure the patient is lying supine with **right hip elevation** to avoid compromising the blood supply to the fetus.

Two things there are worth separating. Right hip elevation and the left lateral tilt of the resuscitation guidance are the same manoeuvre described from opposite sides, and a resident who has memorised one phrasing will not always recognise the other. And the addition of a fetal parameter to a routine observation set is what makes this a two-patient protocol rather than an obstetrically flavoured version of the usual one.

What no sourced statement gives is a frequency. Neither the perinatal guidance nor the general restraint guidance sets an interval for observations after sedation or during restraint in pregnancy: for that cadence, no comparable standard is available to quote, and none is invented here. The principle is still teachable and is the operationally important part. An observation described only as regular belongs to nobody. Whoever writes the sedation order writes the interval and the parameters beside it, names the person who will take them, and states what change triggers a call. Observation levels as a construct are developed in the topic on suicide risk assessment and emergency management in these notes.

IN INDIA

The monitoring set above is national guidance, and its fifth item meets a wall. Fetal wellbeing measures need equipment and someone competent to interpret the trace, and in most district hospitals and general psychiatry units that person is in another building and off duty at night. The honest position is not to pretend the standard is met but to plan around it: for a woman beyond the middle of pregnancy who is likely to need sedation or restraint, the siting decision comes before the drug decision, and an observation area within reach of an obstetric response is worth more than a quieter one that is not. What is genuinely portable costs nothing, which is the positioning, the four maternal parameters and a named interval. Where guidance names a specialist perinatal mental health service as the destination, most of the country does not have one, and the referral that exists is to a general unit with an obstetric department attached.

28.7 Assess self-harm on the perinatal method profile, not the general one

What the lethality profile changes at the door. A general risk assessment weighs stated intent heavily and reads a low-lethality act as reassuring. That inference is unsafe here. On the same confidential enquiry, the majority of women who died by suicide died violently, and the commonest mode was hanging, accounting for **66 per cent** of those deaths, 58 women in the

reporting period. Indian perinatal guidance (2022) states the same clinical point from the other direction: women are more likely to use more lethal methods in the perinatal period.

Three consequences follow, and all three are acts rather than formulations. Method and access are asked about specifically and early, because the method distribution in this population is shifted towards those that leave little margin for rescue. An index act of apparently low lethality earns less reassurance than the same act would in a general presentation, so it raises rather than settles the question of admission. And the enquiry is not about one person: Indian guidance states that suicidal risk and infanticidal risk may occur together and require attention, so the infant's safety is asked about in the same conversation and recorded in the same note.

What this section does not do is re-teach the assessment itself. The framework, the disposition ladder, means restriction and the structured enquiry into intent are the property of the Somatic-symptom, sexual, impulse-control disorders and suicide notes. The classification of filicide and the forensic frame around it belong to the Mental health legislation and forensic psychiatry notes, and the assessment of the mother's relationship with her infant to the topic on mother-infant bonding and infanticide risk in these notes. What is owned here is narrower: the perinatal method profile changes what a given act means, and the risk assessment covers two people.

28.8 Refuse the two reassurances that discharge a woman who should be admitted

Most perinatal disasters are not diagnostic failures. The illness was recognised; the disposition was wrong. Two specific reassurances do that work, and both are addressed in the confidential enquiry material.

The first is the reassurance of the cross-sectional appearance. Deterioration of mental health in pregnancy or the postnatal period can be extremely rapid, so how she looks in the room now is a poor guide to where she will be tomorrow. The enquiry names the changes that must not be underestimated and that should prompt early review, urgent assessment and intervention, and two of the four appear in no general risk formulation:

- a significant change in mental state;
- the emergence of new symptoms;
- thoughts or acts of violent self-harm;
- expressions of incompetency as a mother, or estrangement from the infant.

Those are **red flags** in the strict sense: each is a trigger for an act, not an item to be scored and weighed against protective factors. The last is the one a general assessment reliably misses, because a woman saying she is not a good enough mother sounds like a depressive cognition and gets filed as one. Read as a red flag, it brings the review forward. The practical translation is that a perinatal presentation is triaged on its trajectory over recent weeks, so the collateral history covers direction of travel and not only the current picture.

TRAP **Counting her children as the reason she will not act.** The enquiry assessors concluded that the idea of children as a protective factor against suicide and substance use should be challenged and not taken as a matter of fact, even where the woman herself expresses it, because some women may be too unwell to keep themselves safe despite wanting to protect their children from harm. Candidates write "protective factors: young children at home" and then discharge, and the sentence does double duty it has not earned: it is treated as evidence about her intentions when it is only evidence about her values. Devotion is not capacity for self-protection, and in severe illness the two come apart.

28.9 Decide the mother and infant question as a decision with a clock on it

When an acutely unwell mother is admitted, somebody decides within the first hour whether her infant stays with her. In most Indian units that decision is made at night, by the duty team, on incomplete information, and is then never revisited because nobody was appointed to. Indian perinatal guidance (2022) restates the statutory position that stops this.

Where inpatient care is given to a mother at low risk of suicidal or infanticidal risk, **rooming-in** of mother and infant is the position Indian law takes, and the shape of that rule is what a candidate must be able to state. Rooming-in is the default up to a stated age of the child. A decision to separate is the deviation, it must be authored by the treating psychiatrist, it EXPIRES at a fixed statutory interval rather than running until somebody revisits it, and beyond a further fixed period it stops being the clinician's decision at all and passes to an external review body. The age, the two intervals, the body and the section they sit in are restated with the Mental health legislation and forensic psychiatry notes and are not reproduced here. What matters at the bedside is that in India the review clock is not the team's to set.

Read the structure rather than the numbers. Joint care is the default and separation the deviation, so the burden of justification sits on whoever proposes to separate. Separation is a decision and not a ward arrangement, which means it has an author, a reason and an expiry. The review interval is fixed in law rather than left to the team's convenience, so a separation that quietly persists is a lapse against a statutory duty. And beyond a defined period the decision leaves the clinician altogether and needs external permission, which is the statute's way of saying that indefinite separation is not a clinical decision at all. What a mother-baby unit is, and how the separation decision is worked up where there is a unit, are developed in the topic on lactation and mother-baby unit care in these notes; what is owned here is that decision taken in the emergency, before any of that assessment exists.

GOOD TO REMEMBER

Three lines that change what an admitting resident writes tonight. First, the gestational age or the interval since delivery, with how it was established, including by palpation where no history was available, because every rule below it depends on that entry. Second, the position she is to be nursed in, written in the same entry as the sedation or restraint order rather than left to the nursing note, with the observation interval and who takes it. Third, where mother and infant have been separated, the statutory review date entered as an actual date, since that interval is fixed in law and is not the team's to set.

28.10 Call the right team early, because the clock is shorter than the corridor

The same perinatal guideline of the National Institute for Health and Care Excellence attaches a team requirement to the rapid tranquillisation recommendation itself, which is deliberate placement: during the perinatal period the woman's care is to be managed in close collaboration with a paediatrician and an anaesthetist. Those two disciplines, named by title, are not the ones a psychiatrist instinctively calls. The anaesthetist is there for the airway of a sedated woman whose physiology has changed and who may need an operative delivery at short notice; the paediatrician for a neonate just exposed to whatever was given to the mother. Calling the obstetrician alone is the common half-answer. No timing threshold is attached to either involvement, so how early each is brought in is not sourced and no interval is invented here; the defensible position is to inform both when the decision to tranquillise is taken rather than after it.

The reason to build that habit is the arrest clock. In women over 20 weeks of gestation, if there is no response to correctly performed cardiopulmonary resuscitation within 4 minutes of maternal collapse, or if resuscitation continues beyond that point, **perimortem caesarean section** is undertaken to assist maternal resuscitation, ideally achieved within 5 minutes of the collapse, on the same Royal College of Obstetricians and Gynaecologists guidance (2019). The teaching point is arithmetical rather than surgical: both intervals are shorter than the time it takes to summon an obstetric and neonatal team from another building, so the call goes out at the moment of collapse and not at the four-minute mark. The procedure is performed to resuscitate the mother, which is the part most often misunderstood.

THE EMERGENCY AT THE DOOR	WHAT CHANGES BECAUSE SHE IS PREGNANT OR NEWLY DELIVERED	WHO IS BROUGHT IN, AND WHEN
Acute agitation requiring rapid tranquillisation	Short half-life agent class considered; an antipsychotic used at the minimum effective dose; no seclusion afterwards; she is not left supine and unattended	Paediatrician and anaesthetist, from the point the decision is taken
Manual restraint of a disturbed woman	The procedure is adapted to avoid harm to the fetus; the resting position is the tilt or the displacement, never flat and held	Ward team briefed on the position before the hold; obstetric advice once the uterus is palpable at or above the umbilicus
Collapse or cardiac arrest on the ward	Uterine displacement to the left so compressions remain effective; spinal protection takes precedence in trauma	Obstetric and neonatal teams summoned at the moment of collapse, not once the arrest is established
Self-harm or overdose presentation	Method and access asked about specifically; low apparent lethality earns less reassurance; the infant's safety is asked about in the same conversation	Medical or toxicology team in the usual order, with obstetric review to follow
Sudden disturbance in the postnatal weeks	Assessed against the perinatal red flags and on trajectory rather than cross-section; a timed referral standard applies	Secondary mental health service, preferably a specialist perinatal service where one exists
Admission of an acutely unwell mother with her infant	Rooming-in is the default where suicidal and infanticidal risk are low; any separation is authored, time-limited and statutorily reviewable	Paediatrician for the infant; the review board where separation runs long

One disposition interval deserves naming, because it is the only perinatal response time counted in hours. Where a woman has sudden onset of symptoms suggesting postpartum psychosis, she is referred for immediate assessment inside a response time that the same English perinatal guideline counts in hours and that the topic on postpartum psychosis prints; the presentation itself is developed in the topic on postpartum psychosis in these notes and in the Other psychotic disorders, delusional syndromes and catatonia notes. No equivalent Indian standard is available to quote, and none is invented here, so what transfers is the principle that a perinatal emergency referral is timed and audited rather than queued. Where the emergency is a woman who is not eating or drinking, or whose suicidality does not remit, electroconvulsive therapy remains a live option in pregnancy, and its indications, modifications and outcome data are the ECT and neurostimulation notes' in full and are not restated here.

Three acts in a perinatal emergency belong to the psychiatrist and to nobody else: the position she is left in once she has been sedated or held, the seclusion that must not follow rapid tranquillisation, and the call that brings obstetric, paediatric and anaesthetic colleagues into the room rather than after it.

Cross-cutting synthesis

29 · Cross-cutting synthesis

Every other account in this chapter teaches one presentation; this one is about what all of them have in common. What the two bands of this chapter share is an interlock rather than a boundary. The material looks like two bodies of knowledge sharing a cover, and that reading survives until the first patient who is both. What runs underneath is the same kind of object, and it is not a body of fact. Both halves are **sequences of decision**: ordered, timed, answerable in the order given rather than the order the information arrives. The entities are taught elsewhere, in full and with their numbers. What is left over, and what is examined, is the order.

Owned here and nowhere else: how the two seams sit against one another, where they repeat the same reasoning in different clothes, and what happens where they cross. Named in a clause and never re-derived: the front of the emergency sequence, the two-patient framework, and every entity, dose, level, interval and criterion belonging to either half. No figure appears on this page, because a number lifted out of the account that grounds it arrives without the conditions that made it true.

Sequence	Second patient	Written down
WHAT BOTH HALVES OF THIS CHAPTER TURN OUT TO BE, RATHER THAN BODIES OF FACT TO BE RECALLED	THE PERINATAL SEAM, ASKED OF EVERY STEP OF THE EMERGENCY ONE	WHAT SEPARATES AN ORDER FROM A DISPOSITION ON EITHER SEAM

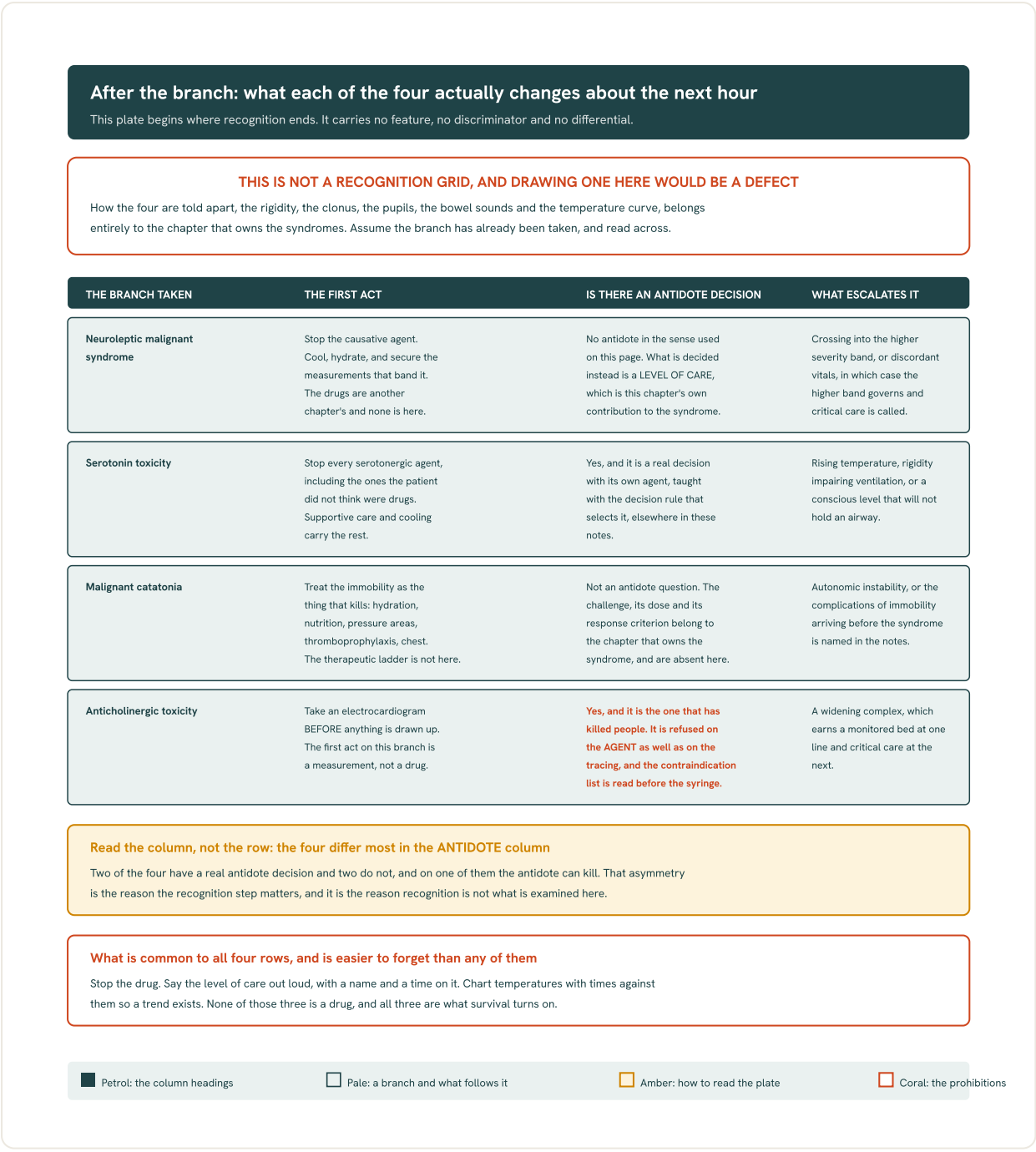


Fig 28.14. What follows each branch of the hyperthermic and toxidromic differential once the branch has already been taken, giving for neuroleptic malignant syndrome, serotonin toxicity, malignant catatonia and anticholinergic toxicity the first act, whether an antidote decision exists at all, and what escalates the level of care, with no discriminating feature anywhere on the plate because recognition belongs to the chapter that owns the syndromes.

29.1 Two seams, and the same kind of object underneath both

The emergency half turns on an ordered sequence every one of its presentations invokes: recognise, stabilise, establish who holds the authority to act, act, monitor, dispose. The order is the content. It is not a list of things that must all happen, but a statement about which question may not be answered until an earlier one has been. Its front end, from arrival to the treatment decision, is developed in this chapter's account of the acutely agitated and aggressive patient.

The perinatal half looks different and behaves the same. Every decision in it is made for a mother and a fetus or infant at once, only one of whom can be asked what she wants, and the risk of the

untreated illness is one of the risks being weighed rather than the baseline the others are measured against. That framework belongs to this chapter's account of prescribing psychotropics in pregnancy. What it shares with the emergency seam is its form: it too fixes an order of questions, and it too goes wrong when they are answered in the order the information arrives. The second seam is not a separate structure. It is the first one asked twice.

THE STEP	WHAT IT ASKS WHEN THERE IS ONE PATIENT	WHAT THE SAME STEP ASKS ONCE THERE ARE TWO
RECOGNISE	What is this, with the psychiatric answer reached last rather than assumed first, and the presumption of a physical cause carried until actively displaced.	Who else is here, established by examining her rather than by history, because the woman who most needs this is least able to supply it; and if an infant is present, who is holding it meanwhile.
STABILISE	Treat the life-threatening problem when it is found and reassess it, rather than carrying it to the end of an assessment that runs alongside the talking.	The same work, plus a position that is itself an intervention. A sedated or held patient cannot reposition herself, so the position is something the team chose and must keep choosing.
ESTABLISH AUTHORITY	Who may act for a patient who cannot agree, recorded as an assessment with a basis rather than inferred from how disturbed she looks.	Only one of the two can be asked, and she is not always the one at greater risk of being forgotten. Doing nothing is itself an exposure for both.
ACT	The intervention this presentation calls for, performed as a discrete act with a named reviewer rather than as a standing permission.	The same intervention, chosen additionally for the exposure still present in the second patient later, and stripped of whatever normally follows it that would put either out of reach.
MONITOR	A stated interval, a named person who takes it, an endpoint at which it stops, and a written change that triggers a call.	The observation set acquires a parameter belonging to the other patient. That single addition makes it a two-patient protocol rather than the usual one with an obstetric flavour.
DISPOSE	Where the patient goes, decided by somebody rather than defaulted to by nobody, and handed over as reasoning rather than as conclusion.	The destination must accept both, and any decision separating them is authored, timed and reviewable rather than a ward arrangement nobody remembers making.

29.2 The same error twice, in two different costumes

The commonest failure in each half is one failure. The emergency half states it repeatedly: a behaviour is a presentation and never a diagnosis; the smell of alcohol is evidence of drinking, not of the cause of a conscious level; intoxication is a label you arrive at, not one you begin with

and then defend. The perinatal half states it as often, and almost nobody sees it is the same sentence. A reproductive event is a **context** and not a diagnosis. A context tells you what else to ask and whom to involve, not what to treat.

Both guard against a ready-made explanation that closes a question before it is asked. In the emergency half that explanation is the psychiatric history, which is why the patient with an established diagnosis is the one in whom a physical cause is missed: the history explains why this person might become disturbed, a different question from why they are disturbed today. In the perinatal half it is the pregnancy or the puerperium. An episode is attributed to a transition and goes untreated; a distressing answer is attributed to mood, and the bond with the infant is never enquired about separately, so a negative mood enquiry is read as excluding something it never examined.

Only the costume differs, which gives the rule a usable form as a question about direction. Ask whether the account in your head was generated by this patient today or supplied by something you knew before meeting them. Explanations of the second kind are often correct; they are simply not entitled to close an enquiry, because they were equally available whatever the answer turned out to be. **Attribution** is the last act on both seams.

29.3 The option that looks careful is the one that has to be argued for

A second pattern crosses both halves and inverts an intuition. In each there is a choice presenting itself as the cautious one that is in fact the **deviation**, carrying the burden of argument and requiring a written reason.

The perinatal half says so explicitly. Stopping a drug is not a move into an unexposed condition, because no arm of that decision has nothing in it; the apparently careful option is a different exposure, usually the more poorly characterised. Separating a mother from her infant looks like safety and is the deviation from a default of joint care, which is why it needs an author, a reason and an expiry rather than a bed allocation. The emergency half runs the same inversion without naming it. Discharging the patient who looks well after an overdose feels like proportionate triage, and is the deviation in a presentation that may still be climbing. Routing a confused patient to a psychiatric bed while it is unclear whether the confusion is medical feels like appropriate referral, and is the deviation from continued medical observation. Recording that sedation was given feels like recording a treatment, and is the deviation from recording what was corrected. What makes one member of each pair the default is not that it is gentler. It is that it can be reviewed, reversed and undone while the other cannot, or cannot in time.

RULE **The default is the option that can still be changed, and the deviation is the one that has to be written down with a reason.** Intuition sorts these pairs by which act feels more careful, and here it sorts them wrongly about as often as rightly. Sorting them by reversibility is mechanical, works in both halves, and produces what an incident review actually looks for, which is never what was decided but what it rested on and who could still have changed it.

29.4 What converts an act into an order

Strip both halves of their entities and almost everything this chapter owns is one discipline: writing things down while they are still measurable. That is why the material is examinable, because the acts are often obvious and it is their conversion into an **order** that separates a plan from a mood. Four elements appear wherever this chapter makes a clinical instruction out of something ordinarily left to whoever is nearest.

- **An author.** A named person who decided it, recorded with their title, so the decision has somebody attached to it at handover.
- **A quantity.** An interval, a distance, a frequency, a position, a duration: stated rather than described, because an act described only as regular belongs to nobody and cannot be audited.
- **A time.** Against the measurement, so a single value becomes a trend; and against the review, so the instruction expires rather than persisting because nobody was appointed to end it.
- **A condition that would change it.** Stated in advance and behaviourally, so whoever takes the observations knows what to watch for and when to call, and a step down is a decision rather than a drift.

Read the chapter through that filter and its scattered instructions resolve into one. The level at which somebody is watched is a prescription with a setter, a stated frequency or distance, a named reviewer and a review time. A tranquillising drug given urgently is a procedure rather than a prescription, with an indication, one dose, a named reviewer and a cadence running until somebody decides it may stop. The position a sedated or restrained patient is left in belongs in the order beside the drug, where it survives a shift change, not in the nursing note, where it does not. A reassuring judgment about a settling postnatal state is permitted only if the threshold that would unmake it is stated aloud and handed to somebody who will still be there.

> **GOOD TO REMEMBER**
>
> Three sentences turn a defensible emergency entry into an indefensible one by their absence, and none is a diagnosis. Who decided the level of care, at what time, and on what observations. What was measured while somebody else was talking, with a time against each value rather than a value alone. And what has been handed on: the person who will resume the interrupted assessment, the interval until then, and the change that brings somebody back.

29.5 What taking a branch actually buys

The rigid and hyperthermic presentations are where candidates expect the marks to sit on telling them apart. Telling them apart is taught in full by the Schizophrenia: management, antipsychotics and adverse effects notes; nothing on this page compares those presentations by their features. The question a recognition exercise never answers is the one this chapter owns: once the branch has been taken, what changes. The plate accompanying this account carries the answer as acts.

Two findings emerge only from looking across the branches. How little changes at the front: whichever branch proves correct, the opening minutes converge on the same physical work, so a

clinician who suspends cooling, fluids or airway attention while the label is argued has the order reversed. And that the first therapeutic move on every branch is a subtraction.

THE BRANCH, ONCE TAKEN	WHAT IS SUBTRACTED, AND HOW FAR	WHAT THIS BRANCH ADDS TO THE SHARED PHYSICAL WORK	WHAT SETTLES WHERE THE PATIENT IS NURSED
NEUROLEPTIC MALIGNANT SYNDROME	The offending agent and every other drug not essential to concurrent treatment, discontinued immediately rather than tapered.	Surveillance of the chain running from sustained rigidity through muscle breakdown to kidney injury and the potassium that follows, which is why fluid balance is charted honestly and the relevant bloods repeated rather than sent once.	Two bedside observations available within a minute and needing no laboratory, which convert an impression into a referral hard to refuse; then the trend, since the emergent decision on replacing renal function is a clinical rule and not a threshold.
SEROTONIN TOXICITY	Every serotonergic exposure, which is wider than the chart: what another department prescribed, what was bought without a prescription, what a relative supplied from home, each with a time against its last dose.	Cooling, sedation and, where rigid active muscle is making heat faster than it can be removed, paralysis with the airway secured first, which is why intubation sits among the supportive measures and not among the disasters.	An observation period keyed to what was swallowed rather than to how she looks, because a presentation seen early may still be rising; the antidote question sits downstream and never substitutes for this.
THE CATATONIC PATIENT	Nothing pharmacological first. The opening acts are nursing acts, begun at the hour of recognition rather than the hour a treatment is found to have failed.	Airway and swallow settled before anything is given by mouth, hydration, prophylaxis against the clot prolonged immobility invites, attention to skin, joints and bladder, and a feeding decision that names a rate.	Deterioration criteria, and the honest question of who can nurse an immobile medical patient overnight, which makes this a level-of-care decision rather than a psychiatric one.
THE ANTIMUSCARINIC BRANCH	The agent, on the same principle, with the subtraction treated as the first therapeutic act rather than a preliminary to it.	The one branch on which a specific antidote question genuinely arises, and the one place the answer is read off objective evidence gathered before anything is drawn up rather than off how the patient appears. Its indications, exclusions and alternative belong to this chapter's account of anticholinergic toxicity and psychotropic overdose.	The duration of the poisoning rather than the patient's condition when the decision is taken, which is the logic the other branches reach by different routes.

That last cell deserves stating on its own, because three branches reach it independently and for unrelated reasons. Improvement is not clearance. A presentation may still be climbing when first assessed; a response to one intervention may outlast neither the poisoning nor the illness; a patient calmed and then left alone has received the half of the treatment given for the sake of the half then omitted.

29.6 Where the two seams cross

The patient who is both is not a special case; she is the general case with both seams running at once. Nothing about the emergency changes when the patient is pregnant or newly delivered. A disturbance is still a disturbance, an overdose still an overdose, a collapse still a collapse. What changes is every act performed on it, and that **overlay** is developed emergency by emergency in this chapter's account of psychiatric emergencies in pregnancy and the postpartum period.

The seams are ordered by different things. The emergency seam is ordered by time: a later question may not be answered before an earlier one. The perinatal seam is ordered by number: no question is finished when it has been answered once. Where they cross, both orderings apply at once, and the failure is not that a step is omitted but that it is completed for one patient and recorded as completed. The second patient is silent, is affected by every drug and every position, and is the one most often missing from the note.

The crossing is also where sourced guidance most reliably stops at principle. It says a procedure is adapted without saying how, that monitoring is regular without saying how often, that a specialist service is the destination without saying what to do where there is none. That is not a hole in the teaching; it is where the teaching is. State the principle, say plainly that no comparable standard is available to quote, then supply the quantity yourself under the discipline set out above: your interval, your name against it, your condition for calling somebody. A number you have authored is defensible; one you have recalled and cannot source is not.

29.7 The Indian seam, which has one shape in both halves

Read across both halves and the Indian difficulty is not a series of separate shortages. It is one shape repeating: the pathway exists on paper and the post does not exist on the roster. A de-escalation team of several trained people, a post-sedation cadence somebody takes and somebody else reads at three in the morning, an observation level that is a staffing decision wearing a clinical name, a fetal parameter needing equipment and a person competent with it, a joint mother-and-infant admission: each is a person on a duty roster before it is a line in a guideline. Neither easy answer earns marks. Claiming the specification is met collapses on the first follow-up question; abandoning it because it cannot be met locally throws away the standard the arrangement is judged against. What is defensible is the **substitution** stated in terms: name the standard, name what replaces it, name what that costs. Where staff are short, the parallel physical work is the first thing dropped and the last thing that should be, because the people who would have done it are the ones missing.

IN INDIA

Sort what this chapter asks for into what costs money and what does not, because the second list is longer than residents expect. Equipment and staffing decide the observation area, the trained team, the tracing somebody can interpret, the unit that admits a mother with her infant. Almost nothing else this chapter owns costs anything. The order of the sequence is free. Designating one person to hold verbal contact is free, and gets easier rather than harder when only two staff are on duty. Taking collateral from the people present before they leave is free and cannot be done later at any price. The position a sedated patient is left in is free, and so is a written interval with a name and a review time against it.

MNEMONIC

Recognise, stabilise, establish authority, act, monitor, dispose - and name the second patient first

Recognise: what this is, with the psychiatric attribution reached last. **Stabilise**: treated when found and reassessed, alongside the talking. **Establish authority**: who may act, recorded with its basis. **Act**: one act, with a reviewer. **Monitor**: an interval, a person, an endpoint, a trigger. **Dispose**: decided by somebody, handed over as reasoning. The perinatal half adds no further step and changes none of these. It moves the last clause to the front, and every step above is then asked twice.

Both halves of this chapter are sequences of decision rather than bodies of fact: the emergency seam runs recognise, stabilise, establish who may act, act, monitor, dispose, and the perinatal seam asks every one of those questions for two patients of whom only one can be asked anything. An act anywhere on either seam becomes safe in the same four ways: a named person who decided it, a stated quantity, a time against it, and a written condition that would change it.

TRAP **Answering the crossing point for one patient and recording it as complete.** The seams of this chapter meet at the moment a decision taken for the person in front of you is also a decision taken for someone who is not: an infant who is not yet the ward's patient, a fetus with no chart of its own, a family who will be doing the observing tonight. A candidate who has learnt both halves separately will answer the emergency correctly and the second patient not at all, and the answer reads as finished because nothing in it is wrong. The check is mechanical: for every act named, say who else it was a decision about, and where that was written down.

Apply and consolidate

30 · Applying the chapter

A vignette in this territory almost never asks what the illness is called. It asks what is done before the name is settled, on what ground it may be done to a person who has not agreed to it, who is watching afterwards, and where both patients are when the hour is over. Those are

separate findings reached by separate reasoning, and a candidate who prepared this material as a set of syndromes answers a question nobody asked.

These cases assert nothing of their own. Every threshold, interval, dose and statutory provision they touch is taught, and cited to its source, by the account that owns it, and is named here rather than restated. Cover the answer, decide what you would do at the bedside, then read on.

Act	Authority	Watch	Where
WHAT IS DONE IN THE FIRST HOUR, BEFORE THE LABEL IS ALLOWED TO SETTLE	THE GROUND FOR ACTING, ASSESSED AND WRITTEN DOWN RATHER THAN ASSUMED	WHAT IS MEASURED, HOW OFTEN, AND BY WHICH NAMED PERSON	THE DESTINATION DECIDED, NOT DEFAULTED TO BY WHICHEVER WARD HAS A BED

30.1 How to work a vignette in this chapter

Read the stem and ask which kind of question it is putting to you, because each has its own source of authority and none supplies another's answer.

- An **act question** asks what is done now, in what order, while the diagnosis is still open and may never turn out to be psychiatric.
- An **authority question** asks on what ground a person who has not agreed may be treated, held, observed or kept, and is answered from capacity and statute, never from how unwell the patient looks.
- An **observation question** asks what is measured, at what interval, by whom, until when, and on whose review.
- A **disposition question** asks where the patient goes, who is going with them, and what has to be true before either moves.

Every case below is more than one of these at once, and the marks go missing where a candidate discharges the easy one and treats the paper as finished. Deciding that a presentation is a psychiatric emergency settles the act question and none of the other three.

RULE **The name of the condition is not the answer to any question in this chapter.** What these disorders are, how they declare themselves and how they separate from their mimics are taught in full by the chapters that own them, and reproducing that material here scores nothing. What is examined is narrower and much harder to improvise: the act, the ground for it, the watch that follows it, and the destination. A case that ends at the name has stopped exactly where the patient in front of you begins.

30.2 Vignette: the stop request that is not the cautious option

Presentation. A woman in her late twenties has been well for over a year on an antidepressant, after two severe depressive episodes, the second needing admission. She has missed a period and tested positive at home. She brings a printed sheet from the internet grading her tablet on the old lettered risk scale, which her mother-in-law has read aloud in the waiting area. She wants to stop today, and the resident agrees and writes that the patient wishes to stop and the medication has been stopped.

Decision point. What is actually being compared here, and what leaves the room with her.

Reasoning to show. Refuse the comparison as offered. There is no unexposed arm: she will carry drug exposure or illness **exposure** and usually some of each, so counselling that quantifies one arm and leaves the other qualitative is not balanced, however carefully the drug figures are quoted. That frame belongs to the section of these notes on prescribing psychotropics in pregnancy. Deal with the sheet as history: the scale was read as an ordinal grade the data never supported, implied that agents sharing a rung carried the same risk, could not separate animal evidence from human, and saw only structural harm, which for psychotropics is the decisive objection. It was withdrawn from labelling and replaced by a **narrative labelling** structure, and the prescribing account dates it at both ends and names its replacement. Reciting a rung from it is a factual error, not a shortcut.

Then take the request apart, because stopping is two decisions wearing one word. Whether to stop is largely hers; how to stop is entirely yours, and the manner changes the outcome as much as the choice. Name every arm aloud and price each in her hearing, since continuing, switching, reducing and stopping are each a positive act with a bill, and reducing is the arm that can buy the exposure without buying the benefit. The figures pricing each belong to mood and anxiety disorders in pregnancy in these notes and to the Mood disorders: pharmacotherapy notes; quote neither from memory. And stopping today does not undo an exposure that has already happened, so it has to be justified forward rather than as a retrospective repair.

Answer. Do not stop the drug this afternoon on a printed sheet. Say what the sheet is and what replaced it, put both arms on the table, price each, and let her choose. If she still chooses to stop, the task becomes damage limitation and the **taper** is the instruction rather than the decision, with restarting, switching, a psychological intervention and increased monitoring all still on offer. Then the disposition, where this case is usually lost: she does not leave without a review date, a named person who owns the dose as gestation advances and its reversal after delivery, and an entry written where the antenatal team will read it. Record what she decided in her own words and what would change it, so a later clinician can tell a settled choice from an unresolved one.

PITFALL

The act that is recorded rather than done. A note reading that medication was stopped is half an instruction, and the missing half predicts the outcome. The same defect runs through every case here in different clothing: observation signed for at the right interval and not delivered, a decontaminant charted for a drug it does not bind, an evaluation abandoned because the patient was disturbed and never diarised again, a referral written into a plan that will arrive long after the problem has resolved itself one way or the other. Each reads correctly and delivered nothing. The only step in this chapter that checks the record against the world is the one the shift handover names, which is to go and physically see the patient.

30.3 Vignette: the mother, the infant, and the appointment for next week

Presentation. A woman delivered a fortnight ago is brought to casualty at night by her husband and mother-in-law. Over several days she has stopped sleeping, become perplexed and frightened, and said more than once that the baby in the house is not hers. Between episodes she is lucid and

apologetic. The infant is asleep in the mother-in-law's arms in the corridor. The duty resident, finding her settled and polite in the room, gives an outpatient appointment for the following week and records that she has good family support and would never harm her child.

Decision point. What happens tonight, and where do the two of them sleep.

Reasoning to show. Act before the diagnosis is available. The trigger is a sudden onset of symptoms suggesting the presentation rather than a confirmed one, and the response standard is a timed referral to a service that can admit; that standard and its interval belong to the postpartum psychosis account in these notes, and the disorder itself to the Other psychotic disorders, delusional syndromes and catatonia notes. It is classified as an obstetric and a psychiatric emergency at once, which is the operative part, because neither service may then hold her as a referral to the other. Begin the act, then call the other team. Two supervision rules bite from the moment the presentation is suspected, before the bed and before anyone agrees a name: she is not to be left alone, and she is not to be left unattended with the infant. The second is not a separation order but a statement about who else is in the room, compatible with feeding and holding. A **supervision plan** that names nobody is not a plan, so record which adult is with her, which adult is with the infant, who takes over at the next handover, and what would change the arrangement.

Then refuse both reassurances the resident relied on. How she looks now is a poor guide to tomorrow, because deterioration here can be extremely rapid and the triage is made on **trajectory** over recent weeks rather than on the cross-section, which is what the collateral history is for. And counting her children as the reason she will not act is to be challenged rather than accepted, even where she says it herself, because devotion is evidence about her values and not about her capacity to keep herself safe. The perinatal method profile is shifted toward acts leaving little margin for rescue, so an apparently minor act raises the admission question rather than settling it.

Answer. Assess her tonight, by somebody with the authority to admit. Put both supervision rules in force now and name the two adults who discharge them. Admit, and say what the admission buys, which is the physical evaluation that cannot be finished in a corridor and a place where sleep can be re-established; treat that evaluation and any sedation decision as one plan with one owner, or the workup is abandoned the moment she is disturbed again. On disposition, joint admission is the default and separation is the deviation that has to be argued in terms, authored, dated and reviewed, with the review interval and the point at which the decision leaves the clinician altogether fixed by statute rather than by the team's convenience. Where no mother and baby unit is within reach, which is the position of most Indian services, assemble what the ward permits: a side room rather than an open bay, a named female relative resident alongside with somewhere to sleep, infant care agreed with the family beforehand rather than assumed, and the separation reviewed out loud on a stated date. Hand over the clock, the risk assessment on both sides, the supervision instruction and the reason for the destination, because a handover carrying the diagnosis and not the supervision plan has passed on the label and dropped the safety.

30.4 Vignette: the injection, the authority for it, and the bed that does not exist

Presentation. A man in his thirties is brought to a district hospital casualty in the small hours by his brothers, who tied his wrists with a cloth for the journey. He has not slept for several nights, talks over everyone, has given away money the family does not have, and is certain nothing is wrong. His brothers say he was treated somewhere years ago. He is loud, has struck nobody, and refuses to sit. The resident is alone with one nursing officer and a security guard, wants to give an intramuscular injection, and plans to send him home afterwards because there is no bed.

Decision point. On what ground is the injection given, and where does he go when it has worn off.

Reasoning to show. Sedation is indicated by what the disturbance prevents, never by how disturbed the patient appears, so the clinician must be able to finish the sentence: this assessment cannot be made, this treatment cannot be given. Noise is not the indication, and a department that sedates noise will sedate distress and grief along with illness. Meanwhile the physical sweep runs alongside the talking rather than after it, because new agitation is presumed to arise from a general medical condition and a known psychiatric history is no exemption: the history explains why this man might become agitated, not why he is agitated tonight. Glucose, saturation and temperature cost minutes, and the brothers hold the only account of the past week and will be gone within the hour.

Then the authority, which is the half the resident has not begun. Incapacity is the likely finding in this population, and a likelihood is exactly what an assessment is for, so **capacity** is assessed and written down rather than inferred from the disturbance. Mania makes that harder, because the examination that ought to detect the problem conceals it: orientation intact, speech fluent, information returned verbatim, and the failure confined to the weighing, where the risk is understood, retained, restated accurately and then judged not to apply. The statutory ground for treating or holding a patient without consent in India belongs to the Mental health legislation and forensic psychiatry notes and the consent doctrine to the Forensic ethics, consent and legal procedure notes; name the ground and improvise no provision. The competence half is separate and no statute answers it, since whoever gives a drug that may stop him breathing must be able to manage a man who has stopped breathing: the decision may be delegable and the airway is not. Every agent and first dose belongs to the Schizophrenia: management, antipsychotics and adverse effects notes and appears nowhere in your answer.

Answer. State the indication as an inability and record it. Sweep while somebody else talks, and take the collateral before the brothers leave. Assess capacity, write the finding, name the ground. Decide early that sedation is likely, and stop the cup of tea otherwise brought to a man who may shortly be unable to protect his airway. Write the order as a single dose with a named reviewer and a review time, because an open order hands the next decision to whoever holds the chart at the worst hour, and set the monitoring by route and by state rather than by agent, a sleeping patient being an escalation and not a solved problem. Where the equipment is in another building, what replaces it is a different observation set taken from the end of the bed with one person's name written against it, never an absence of observation. If he is held, the load goes to

the side and never onto the thorax, the head stays free and the face uncovered, and one person watches who is not holding. Then refuse the disposition as proposed, because admission is decided by whether the identified risks can be held where he would otherwise be. Ask who can stay awake with a man who will not sleep, whether anybody in that house is frightened and whether there are children in it, what he can spend or transfer before morning, which means the phone as much as the wallet, and where the vehicle keys are. Where there is genuinely no bed, that is a thing to be escalated and recorded with the time of each refusal, never a clinical reason.

TRAP **Writing a plan with no person's name in it.** Monitor regularly, observe, family to watch, review, as per protocol: each reads as an instruction and none of them is one, because an interval assigned to a ward is assigned to nobody and a reviewer who is a role rather than a person does not in practice review. Candidates write this way because it is how the case sheets they have copied are written, and because naming somebody feels like an accusation waiting to happen. It is the opposite. Every duty in this chapter has an owner in the source material, and the mark is in supplying one: who set the level, who takes the observations, who reviews and when, who holds the infant, who finishes the evaluation that was interrupted.

30.5 Vignette: three antidotes offered, and which of them is read first

Presentation. A woman in her forties is brought some hours after being found drowsy at home beside empty strips. The family bring a cloth bag of tablets collected from three prescribers over several years and cannot say what she took or how much. She is flushed, dry, febrile, disoriented and has not passed urine. The intern proposes activated charcoal now, physostigmine to clear the delirium so that the psychiatric assessment can be completed, and asks whether flumazenil would speed matters up.

Decision point. Which of the three is given, in what order, and what is read before any syringe is filled.

Reasoning to show. Identification comes first, and it is a psychiatric job rather than a clerical one, because the psychiatrist is often the only person who knows what she was prescribed and therefore what is plausibly inside her. The prescription is a physical object in a bag in the corridor: ask for the strips, the bottle and the last outpatient card while the attendants are still here, count what is missing from a strip, and record that you asked and were told nothing, which distinguishes an unknown ingestion from an unexplored one. Then the antidote question, decided on the electrocardiogram and the contraindication list and never on how antimuscarinic she looks, because recognition names the family of poisons and not the member, and members diverge on whether this drug helps or kills. Where the width is past the line at which seizures become possible, the act is sodium bicarbonate and the antidote is refused; past the line at which ventricular arrhythmias appear, the same act happens in a monitored bed with anaesthesia and critical care in from the start. One clause of the contraindication list carries almost all the mortality, since cardiovascular disease bars the drug in exactly the patient in whom the reflex to give it is strongest. Given at all, it goes with the list read whole, atropine drawn up beside it because that is this antidote's own antidote, no faster than the label allows, and as one diagnostic dose that wears off long before the poison does.

The other two requests answer faster. **Decontamination** is settled by asking what, then when, then who. What was taken decides whether charcoal has any role at all, since for a defined list of poisons it has none at any interval; when it was taken sets a window belonging to that poison and that formulation rather than to a single remembered figure; and who is in front of you can withdraw what the first two allowed, because the airway reflexes that matter are those that will exist when the charcoal is in the stomach, and an airway is never secured in order to administer a decontaminant. The benzodiazepine antidote is refused on the right ground, which is not that it is unsafe in the abstract but that the reason offered is diagnostic convenience: the drowsiness is information about the ingestion that the antidote deletes, and in a mixed ingestion reversal removes a mask and can turn a sedated patient into a fitting one. Medical priority is in any case a claim on resources rather than a licence to postpone, so the psychosocial assessment is not deferred until treatment is finished, and where she genuinely cannot participate what replaces it is a stated review interval, not silence.

Answer. Electrocardiogram before anything is drawn up, and a second timed against the first, since direction of change matters more than any single width. Bicarbonate if the width demands it, and the antidote refused with the ground written down so that a fresh team does not quietly reverse a cardiovascular refusal. Charcoal only if the identified agent, the elapsed time and the airway all permit it. No flumazenil to make her interviewable. On disposition, refuse the phrase **medical clearance** and state the two limbs instead: that the disturbance is unlikely to be due to a medical condition or trauma, and that treatment of the concomitant problems falls within the capabilities of the receiving facility, the second being a statement about your service and not about her. The observation period belongs to the drug rather than to the mental state, and modified-release agents declare themselves late, so an untroubled early picture is not a discharge criterion. Where doubt between a confused state of medical origin and a psychiatric one is unresolved, she is medically observed and never transferred; the syndrome itself is the Stroke, TBI, delirium and focal brain syndromes notes'. Hand over the tracings in sequence with their times, whether the antidote was given, refused or unavailable and on which ground, and whether decontamination was given and when.

> **GOOD TO REMEMBER**
>
> Almost everything you will need in these cases is standing in the corridor and is about to leave. The relatives who saw the patient yesterday and can date the change, the strip with the missing tablets, the outpatient card, the ambulance crew, the person who could hold the infant tonight, the answer to what else is in the house: none of it can be reconstructed at the ward round, and all of it can be had while the patient is being stabilised by somebody else. Assign it to the team member who is not holding verbal contact, ask before anybody is released, and write down who said what, because a disagreement about when this started is usually the first sign that the story offered is not the story that happened.

30.6 The four cases on one grid, and the thread through them

Set side by side, the cases are one discipline in different clothes, and the right-hand column is a single family of mistakes.

VIGNETTE	THE QUESTION IT REALLY ASKS	WHERE THE ANSWER COMES FROM	THE CLASSIC WRONG ANSWER
THE STOP REQUEST	Which two exposures are being compared, and what leaves the room	The prescribing-in-pregnancy account, then the account that prices each arm	Stopping on a withdrawn scale, and recording a decision with no taper, no review and no owner
THE MOTHER AT NIGHT	What is done before the name is settled, and where the pair sleep	The postpartum psychosis account, and the perinatal emergency overlay	An appointment for next week, justified by how she looks and by the children at home
THE INJECTION IN CASUALTY	The ground for treating a man who has not agreed, and what holds the risk afterwards	The rapid tranquillisation account, the agitation assessment, and the statute named but not restated	An open order given on the disturbance itself, then discharge because the ward is full
THE UNKNOWN OVERDOSE	Which instrument selects the act, and what the receiving service can actually do	The overdose triage account, and the antidote and decontamination account	Charcoal by reflex, an antidote given on appearance, and reversal to make the patient interviewable

The thread, stated once. Every case turns on refusing to let one finding stand in for another. A clinical indication does not answer an authority question. A reassuring appearance does not answer a question about trajectory. A recognised toxidrome does not select an antidote, because a measurement does that. And a decision recorded is not a decision delivered, which is why every act here ends with a person's name, an interval and a place.

IN INDIA

Four service facts decide these cases more often than any clinical one. No funded pathway puts a psychiatrist inside the antenatal clinic, so nearly every contact a pregnant woman has belongs to somebody who was never asked to ask, and an arm of a decision that cannot be delivered locally should change which arm is chosen rather than be recorded as though it had been offered. Mother and baby units are very few across low- and middle-income settings, so the disposition question is usually which relative rather than which agency, and whether she can genuinely do it. The monitoring a sedation protocol assumes is often in another building at night, so what is owed is a different observation set, a named observer, and an honest record of what was unavailable. And the antidote is frequently not in the hospital at all, which leaves the tracing and the bicarbonate as the limb you actually use; what is scarce there is a monitored bed with an anaesthetist attached rather than a molecule, so settle in advance which unit accepts such a patient and whom you telephone when the answer is no.

MNEMONIC

Two patients, the inability, the name, the interval, the destination

Rebuild any case in this chapter from these when a vignette empties your head. **Two patients**: establish the second before doing anything to the first, whether that is a fetus, an infant in the corridor, or an untreated illness that is itself an exposure. **The inability**: the act is indicated by what the disturbance prevents, and if nobody can finish the sentence, nothing has been indicated. **The name**: an authority assessed and written down, and a person named against every duty, the reviewer, the observer, the adult with the infant, the owner of the evaluation that was interrupted. **The interval**: a cadence, a review time and an observation period belonging to the drug or the statute rather than to the ward's convenience. **The destination**: decided by whether the risks can be held where the patient would otherwise be, never by which bed happens to be free.

Every question in this chapter is answered in the imperative and ends with a destination: what is done now, on whose authority, watched by whom at what interval, and where both patients are when the hour is over.

31 · Consolidation

The last useful thing to do with this material is not to read it again but to produce it from memory, with nothing in front of you. Everything below is active recall against a risk category or a decision, and each is a question and nothing is answered, which is the design: **active recall** forces an answer out before it can be checked, whereas an answer printed beside its prompt converts the exercise back into reading, which feels identical from the inside and does far less.

Two things separate this list from a summary. It asks almost nothing about what a syndrome is, because throughout this material the marks sit in **the act** and **the setting**: what is done, in what order, on whose authority, watched how often, and where the patient goes next. And it prints no figure at all, partly because an answer beside its question destroys the exercise, and mostly because the numbers belong to the chapters owning the entities: sedation and the escalation ladder to the Schizophrenia: management, antipsychotics and adverse effects notes, suicidal intent to the Somatic-symptom, sexual, impulse-control disorders and suicide notes, the confusional syndrome to the Stroke, TBI, delirium and focal brain syndromes notes, and the catatonic signs and the benzodiazepine challenge to the Other psychotic disorders, delusional syndromes and catatonia notes.

Retrieve	Act	Authority	Destination
THE DEVICE THIS SECTION RUNS ON, NEVER REREAD	WHAT EVERY PROMPT ASKS FOR, NOT WHAT THE THING IS CALLED	NAMED BEFORE ANYTHING IS DONE TO A PATIENT WHO CANNOT AGREE	DECIDED BY SOMEBODY, NEVER DEFAULTED TO BY NOBODY

31.1 How to use this list

Six groups follow the order the material was built in, one prompt per topic. Answer aloud or on paper, in sequence, because sequence is most of what is examined: correct acts in the wrong order satisfy nothing. Two habits are worth imposing. Name who performs each act, because almost

every failure described here is an act nobody owned rather than an act nobody knew. And finish each answer where the patient leaves you, not where the patient settles.

RULE **Every question here is answered with an act, never with an entity.** Naming the syndrome earns very little, because it is taught in the chapter that owns it and the examiner knows that. What is asked is what happens in **the first hour**: what is excluded before anything is attributed, who has authority to act on a patient who cannot agree, what is done and by when, what is measured afterwards and how often, and which destination the patient leaves for. Answer the entity and you have written a correct paragraph from another chapter, scoring on none of it.

31.2 Group one: prescribing and treating in pregnancy and lactation

Every decision here is taken for **the second patient** as well, and no arm of any of them is unexposed.

1. A woman who may become pregnant needs a psychotropic. Which patients is the decision for, and why is doing nothing an exposure? Then: what replaced the withdrawn letter-based risk system, when did that take effect, why could one ordered label never carry the information, and what must a current label state instead?
2. She is breastfeeding. What does the standard exposure metric measure, and what does it silently omit? Why is a missing figure for an agent not a reassurance, which infants do the published figures not describe, and what is watched in the baby, by whom, and what would stop the drug?
3. She is already well on treatment and is pregnant or planning to be. Name the arms this decision actually has, price each against her illness rather than against nothing, and say which part is hers and which is entirely yours.

31.3 Group two: the postpartum period

Every prompt here has two subjects, and the second can report nothing at all.

1. Tearful and labile in the first days after delivery. What act does the front door owe her, into whose hands does the judgment then pass, and what must be said aloud and written down before that judgment is allowed to close?
2. Build the perinatal screening pathway as a service rather than an instrument: who is screened, at which contacts, by whom, and what actually happens to a woman who answers yes, and how soon? Then what does the Indian position supply, and what does it not?
3. A fortnight past delivery, behaving strangely, the family frightened. What does assessing her immediately oblige somebody to do, and by when? What does admission buy that no outpatient plan can, and which adults must be named before she or the baby is left alone?
4. Why is a mood enquiry not an enquiry about the relationship? How is the bond observed at the bedside rather than inferred from the mood, what does the formulation oblige you to arrange before she leaves your care, and when is the question asked again?
5. What is a mother-baby unit for, and which clause of its specification prevents which predictable failure? Where does the burden of proof sit when separation is considered, who

reviews it, and what does an Indian team assemble when no unit is within reach?

31.4 Group three: women's mental health across the lifespan

Three of these are routing problems before they are clinical ones; the fourth has a statute inside it.

1. A week of irritability and hopelessness each month, lifting as her period starts. Where does the classification file this, and what does that do to your pathway? What must be documented before anyone commits to a label, and in which direction across time does that record run?
2. Low mood and broken nights in midlife, with the explanation already agreed by everyone. Why is the transition a context and not a diagnosis, what must be established before anything is attributed to it, and how is the decision divided where there is nobody to divide it with?
3. What has to be true before you are entitled to ask a woman about violence at home? How is the question put, what is done in the minutes after the answer is yes, and what changes in an emergency department? Then name the Indian legal and service frame in words.
4. Reproductive medicine hands psychiatry separate tasks. Take each: what must be discussed in a fertility clinic and on whose statutory duty; which question a termination opinion actually answers and on what ground; and what must be in place before a contraceptive conversation is defensible when the drug complicating it is your own.

> **GOOD TO REMEMBER**
>
> Do not run this list once, the night before. Sweep the six groups now and mark two kinds of failure apart: prompts you could not answer, and prompts you answered by describing a syndrome. The second matters more, because it is the exact error this material exists to correct and it feels like knowledge while you produce it.

31.5 Group four: the behavioural emergency

The sequence itself, door to destination. Answer as an ordered account of who did what, and resist starting at the drug.

1. Before any escalation ladder begins: what is settled about the room and its exits, how many people are in it and which one may speak, where do you stand and why does the geometry matter, what is measured while somebody else talks, and which presumption do you carry about new agitation until it is displaced?
2. Take the drug chart away from rapid tranquillisation. What is left: the indication in the form the guidance uses, the authority when the patient cannot consent, who must be competent and within reach, what is checked before, what is measured afterwards and until when, and what happens when it fails?
3. What is an observation level as an object rather than as a feeling? What must be written for one to exist, who may raise it and who must review it, what may the observer not simultaneously be doing, and what must the ward be checked for as a physical space?

4. Brought in at night, elated, sleepless, certain nothing is wrong. What triggers urgent specialist assessment, what is excluded before the psychiatric label settles, why is the capacity assessment in this state most often got wrong, which harms accrue while you deliberate, and where is he routed?
5. An overdose arrives. How are the two assessments ordered, and what does medical priority not license? What replaces the phrase that used to end this argument, how do you establish what was taken when nobody can tell you, how long does decontamination stay available, why is the well-looking patient dangerous, and what must the handover contain?
6. Somebody is being physically held. Where may the weight go and where may it not, and why? What is done about the head and face, what governs how long the hold lasts, which duties are separate from watching, what does the body need if it is prolonged, and what happens in the hour after release?

31.6 Group five: the rigid, hyperthermic and toxidromic emergencies

Each entity here is taught elsewhere, so each prompt asks only what follows recognition. An answer listing features, or comparing one with a mimic, has answered the wrong question.

1. An immobile, mute patient is admitted. Setting the challenge and the rating scale aside: what is secured in the first hours while the diagnosis is unsettled, which complications of immobility are prevented rather than treated, what would convert this into a life-threatening emergency, and who nurses this patient where?
2. What kind of instrument is a formal criteria set, and what does its negative limb oblige you to do? What does a result below the threshold not mean, and which observations, quite separate from those criteria, decide where the patient is nursed and when organ support and renal replacement are called for?
3. The decision rule for serotonin toxicity: in what population was it derived, in which direction are you running it at a psychiatric front door, and why does that make a positive worth more than a negative? What does the distinction from the rigid hyperthermic alternative change about the next hour, and where does an antidote sit in the order of operations?
4. A patient's neck and eyes have deviated after a first injection. Which question precedes the syringe, why is the culprit drug often not on the psychiatric chart, how long may you wait and what follows when nothing happens, why is the episode not over when the spasm melts, and what do the drug-induced emergencies outside the brain share?
5. How do you establish which of the lithium poisonings is in front of you, and from what source? What does a measured concentration tell you about the patient you can see and what does it not, which decontamination decision exists in one pattern and not another, and what sets the length of observation?
6. An antimuscarinic picture follows an overdose. What is read before any antidote is drawn up, which overlap makes that antidote lethal, who must it be refused to, how is it given and what is kept beside it, and what is done instead for the patient who cannot have it?

31.7 Group six: the medical emergency and the perinatal overlay

The final prompt closes the loop, taking every emergency above and asking what changes when a second patient cannot be examined.

1. An elderly man, confused since morning. What is treated the moment it is found rather than carried to the end, how is conscious level graded inside the primary survey, which bedside measurements are taken and when is one not to be believed, what is given before any carbohydrate, what does sedation not buy, and where does he go when the answer is still unclear?
2. A man who drinks, drowsy and unable to account for himself. Which word has everyone already supplied, and why is it withheld longest? What is excluded before anything is attributed, what runs alongside it and what in that is routinely skipped, which diagnoses are missed in the state that conceals them, and where does he leave for?
3. The emergency patient is pregnant or newly delivered. What is established before anything is done to her? Why is the position she is left in after sedation or restraint part of the prescription rather than the nursing, how is a hold adapted and where does the guidance honestly stop, what must not follow sedation, what is monitored afterwards and how often, and who is called into the room rather than after it?

IN INDIA

Several prompts above have an honest Indian answer that is not the specification, and saying so earns more than reciting a standard the setting cannot meet. The de-escalation team the consensus describes is not what a district casualty holds at two in the morning. An observation level is a person, so a service that cannot supply the person cannot supply the level, whatever the chart says. The monitoring a sedation protocol assumes needs equipment and somebody free to use it. A mother-baby unit may be hundreds of kilometres away, and the referral a violence pathway names may have nobody at the far end. In each case the marks are in naming what is substituted, who does it instead, and what has been accepted by substituting.

31.8 The answers this material punishes

More marks are lost here to a small set of confident wrong answers than to genuine ignorance, because each is a compact sentence that sounds like clinical sense and each answers a question that was not asked. If anything you produced matches the middle column, reopen that section first.

AXIS	THE ANSWER THAT LOSES THE MARK	THE ANSWER THAT EARNS IT	WHERE TO REOPEN
THE AGITATED PATIENT	Starting at the escalation ladder, as though the question began at the decision to calm somebody	Room, team, one designated voice and the parallel sweep come first, and new agitation is presumed medical until displaced; the ladder is another chapter's	the acutely agitated and aggressive patient
SEDATING WITHOUT CONSENT	Answering with agents, sequence and doses, because the question looks like pharmacology	An indication stated as what the disturbance prevents, capacity written down, an airway-competent practitioner, one dose with a named reviewer, monitoring that outlives the drug	rapid tranquillisation protocols
HOLDING A PATIENT	Saying the patient is turned onto their back rather than their front, and stopping there	No position is safe: weight off the chest, head free and face uncovered, the hold as short as it can be made, one person watching who is not holding	restraint and seclusion
PRESCRIBING IN PREGNANCY	Reciting a letter from the withdrawn labelling system as though it were current practice	Name the system, date its withdrawal, name the narrative rule that replaced it, then reason from the evidence against a background rate that was never zero	prescribing psychotropics in pregnancy
THE WOMAN ALREADY ON TREATMENT	Stopping the drug the day the test comes back positive, and calling that cautious	The exposure has already happened, her untreated illness is the competing exposure rather than the baseline, and the manner of stopping matters as much as the decision	mood and anxiety disorders in pregnancy
THE CONFUSED PATIENT WHO DRINKS	Attributing the confusion to alcohol because there is a history of alcohol	Exclusion first, attribution second: injury and the metabolic causes are excluded alongside each other, and intoxication is a conclusion arrived at, never a premise begun from	acute alcohol withdrawal and delirium tremens

PITFALL

One error runs underneath all six, and it is why this list prints no figures. Every number that answers a prompt above belongs to a document and to a population, and stops being true when separated from either. A guideline's threshold is that guideline's. A rule derived in a poisoning service behaves differently at a psychiatric front door. An exposure figure calculated for a term, healthy, exclusively breastfed infant says nothing certain about a preterm one. Quote a figure with its source and its population, or quote the reasoning and say plainly that you assert no figure.

31.9 The frame to run on an unseen question

All of it collapses into one procedure, run in order on anything familiar or not, so that an unseen presentation becomes a sequence of decisions rather than a search for the nearest remembered rule. The word names the mistake: the patient who gets missed is the one nobody established was there, and the half of the answer that gets missed is the half that comes second.

MNEMONIC

SECOND

Second patient: before anything is done to the person in front of you, establish whether there is another, because every perinatal decision is taken for two at once and only one can be asked, examined or consented. **E**xclude before you attribute: the physical sweep runs alongside the talking rather than after it, and the psychiatric label is the last attribution made, not the first. **C**apacity and authority: written down before the act, never inferred from the disturbance, never confused with the judgment that the act is warranted. **O**n the clock: the act is timed and the window closes, so state how long you may wait and what follows when it does not work. **N**ame the cadence: what is measured, how often, by whom, until when, and the **level of care** that follows. **D**isposition: where the patient goes, who decided it, and a handover carrying what was assessed, what it showed, and what is still active.

TRAP **Ending the answer at the injection.** The commonest structural failure here is an answer that stops when the patient becomes calm, the spasm melts, the antidote is given or the diagnosis is finally named, as though the emergency were the problem and the calm were the solution. The avoidable deaths sit in the hour afterwards, which is why so much of this material is **monitoring cadence**, level of care and **disposition**. Whatever the question appears to be about, keep writing until you have said who watches this patient, how often, on whose authority, and where they are when the shift changes.

Establish whether there is a second patient before you touch the first, exclude before you attribute, settle whose authority the act runs on before it is performed, then name what is monitored, how often and until when, and where the patient goes: the marks here sit in the order of the acts and never in the name of the entity.

Previously asked

There is no indexed past-question bank for this chapter, so nothing in the table below is a catalogued past question and no board or year is claimed for any of them. Attributing a paper the index does not hold would be a fabrication, so each row is marked Representative and written in the register an examiner uses. Almost every question in this area is a mixed question, and only one of its halves belongs here. The naming half has been taught elsewhere and is expected rather than supplied: the rigid and hyperthermic drug reactions by the Schizophrenia: management, antipsychotics and adverse effects notes, catatonia by the Other psychotic disorders, delusional syndromes and catatonia notes, the confusional state by the Stroke, TBI, delirium and focal brain syndromes notes, the withdrawal syndrome by the Substance use disorders notes, and the authority to act on a patient who cannot agree by the Mental health legislation and forensic psychiatry notes with the Forensic ethics, consent and legal procedure notes. Bring those. What the table asks for is the doing.

QUESTION	FORM	ASKED
A woman established on a psychotropic is confirmed pregnant. How is continuing, switching, reducing or stopping decided, and what must the record show?	Long answer	Representative
Choosing an agent for a mother who is breastfeeding, and what the usual metric leaves out.	Long answer	Representative
Screening after delivery as a service question: who screens, at which contacts, and what happens to a positive answer.	Long answer	Representative
Postpartum psychosis at the point of contact: the act, what admission buys, and who holds the infant.	Long answer	Representative
Assessing the mother and infant relationship, and how risk to the infant becomes supervision and a discharge plan.	Long answer	Representative
Intimate partner violence: the decision to enquire, the preconditions for asking, and support in an emergency department.	Long answer	Representative
The mother and baby unit, and what is done where there is none.	Short note	Representative
The psychiatric opinion sought before a termination of pregnancy.	Short note	Representative
Premenstrual dysphoric disorder and the menopausal transition: which clinic each woman reaches psychiatry from.	Short note	Representative
The acutely agitated patient from the door to the handover: the room, the team, the parallel sweep, and what must be true before it ends.	Long answer	Representative
Rapid tranquillisation as a procedure: the indication, the authority, the check before the drug, the monitoring after it.	Long answer	Representative

QUESTION	FORM	ASKED
Observation levels written as a prescription: the named levels, who may move a patient up, and the review that brings it down.	Long answer	Representative
Physical restraint: what a hold does to a body, the positioning hierarchy, the clock, and who watches.	Long answer	Representative
The confused patient at the front door, including the drinker: exclusion before attribution, and which bed he occupies.	Long answer	Representative
Deliberate self-harm and overdose at triage: the order of the two assessments, and the decontamination clock.	Long answer	Representative
The rigid, hyperthermic patient in casualty: the criteria set as an instrument, the level of care, and organ support.	Long answer	Representative
Serotonin toxicity: the decision rule, where it was validated, and the branch that changes the clock.	Long answer	Representative
Acute dystonia and the other acute drug-induced emergencies.	Short note	Representative
Lithium overdose, and the antidote decision in psychotropic poisoning.	Short note	Representative
A psychiatric emergency in a pregnant woman: the position she is left in, the adapted hold, and monitoring two patients.	Long answer	Representative

Two things about the wording repay attention before the content does. The first is the verb. Manage and describe what you would do ask for an ordered act with a time in it, answered from the first minute forwards; discuss asks for a decision and its reasoning, with the alternatives named and priced rather than listed. The second is the setting, written into almost every stem and used in almost no answer. Casualty at night, the antenatal clinic and the postnatal ward are not scenery: each fixes who is in the building, what can be monitored, and where the patient can be moved to. An answer that would read the same in all three has not used its stem. Two habits then earn marks across the list. Answer in the order the marks sit in, what is done now, where, on

whose authority and where the patient goes next, rather than opening with what the thing is. And where an answer needs a figure this material does not hold, name the source instead of the number: the serum bands are in the Mood disorders: pharmacotherapy notes, the risk-assessment instruments in the Somatic-symptom, sexual, impulse-control disorders and suicide notes, and the infant-exposure metric in the Neurochemistry, Neuroendocrinology, Neuroimaging and Basic Psychopharmacology notes. A candidate who reproduces a dose he has not checked is doing the one thing this material is arranged to prevent.

The quick review

One table, read down the left column and cover the right. Every line is taught in full somewhere above and nothing here is new: each is that topic's single must-hold line, so a line you cannot recover is a topic to reread rather than a fact to memorise here. Five things are load-bearing across the chapter. Every section answers what is done now, where, on whose authority, and where the patient goes next, and none of them answers what the thing is, so a section that says little about a disorder you already know has been written on the assumption that you know it. In the perinatal half all four of those questions are answered twice over, because two patients are in front of you and only one of them can be asked, examined or consented. Exclusion runs before attribution everywhere: the psychiatric attribution is the last one made, and a known psychiatric history is the distractor rather than the answer. The default is the option that can still be changed and the deviation is the one that has to be written down with a reason, which sorts these decisions more reliably than asking which act feels more careful. And an act becomes an order the same way on both seams: a named person who decided it, a stated quantity, a time against it, and a written condition that would change it. The figures printed below are the ones this chapter itself owns, thresholds, intervals, cadences and denominators, each carried back from the section that grounded it; every treatment dose, and every figure that belongs to an entity rather than to an act, stays in the chapter that owns it, and those chapters are named here in words.

ASK	HOLD
PRESCRIBING AND TREATING IN PREGNANCY AND LACTATION	
THE ARM OF THE DECISION WITH NO DRUG IN IT	There is no unexposed arm, only two exposures: she will carry drug exposure or illness exposure and usually some of each, untreated illness being itself an exposure. The illness arm is measurable and belongs in the same sentence as the drug arm. Among women euthymic at conception, 68 per cent of those who discontinued an antidepressant relapsed across pregnancy against 26 per cent of those who maintained it, a hazard ratio of 5.0; in bipolar disorder the overall recurrence risk in pregnancy was 71 per cent. Counselling that quantifies the drug arm and leaves the illness arm qualitative is not balanced counselling.

ASK	HOLD
THE LETTER GRID, AND THE ONLY WAY IT MAY BE USED	A historical object, admissible only with both ends dated on the page and the instrument that replaced it named. The pregnancy categories A, B, C, D and X were adopted in 1979 and ceased to apply to new labelling from 30 June 2015, when the Pregnancy and Lactation Labeling Rule replaced them with a narrative labelling structure; older products had to strip the letter from their labelling within 3 years of that date, so the disappearance was staggered product by product. Two boundaries are routinely misstated: the letters never covered breastfeeding, so a lactation category is something that never existed, and the instrument reached prescription products only. A bare letter offered as current practice is a factual error, not a shortcut.
HOW A TERATOGENIC RISK FIGURE IS QUOTED	Every figure is an increase above a background that is not zero, on a clock you must name. The background major birth defect rate is 2 to 4 per cent and loss is reported in 15 to 20 per cent of clinically recognised pregnancies, and both are stated before any drug is mentioned. Absolute risk is then separated from relative: a tenfold rise in one rare defect, from 0.04 per cent to 0.4 per cent, can leave the total rate across a population unmeasurably changed. And the harm is placed against the window that could produce it, organogenesis at 3 to 8 weeks after conception for gross structural harm, the brain's most critical period running 3 to 16 weeks and past it. The comparator that makes these numbers mean something is the untreated ill woman.
WHAT HAPPENS TO THE DOSE AS THE PREGNANCY RUNS	The dose that was right at booking is frequently not right at term, and that is pharmacokinetics rather than the illness worsening: a woman whose symptoms creep back in the second half may be underdosed by her own physiology. The worked example is glucuronidation, where pregnancy upregulates UGT1A4 and lamotrigine clearance rises by up to 330 per cent, quoted purely as kinetics and never as a statement about that agent's safety. The direction of change is broadly predictable from the elimination route, which makes it teachable rather than merely cautionary. The reversal after delivery is the step this material names as owned by nobody.
WHAT A RELATIVE INFANT DOSE IS, AND IS NOT	An intake figure, not an exposure figure: calculated from what enters the infant and assuming he can clear it, with below 10 per cent of the maternal weight-adjusted dose treated as a notional line rather than as a test that settles anything. Every caveat in the topic, prematurity, the first postnatal days, dehydration, intercurrent illness and maternal genotype, is a statement about a clearance term the metric does not carry. Quote none of it without naming the metabolite it excludes and the infant it assumes, who is term, healthy and exclusively breastfed. What is acceptable in a thriving infant can be wrong in a jaundiced newborn on the same milk.

ASK	HOLD
THE BLANK CELL, AND THE METABOLITE	Where an agent has an active metabolite the drug name and the number in front of you describe different molecules: measured with its metabolite, fluoxetine averages about 7 per cent across a range of 3 to 12 per cent, the upper bound crossing a line the average sits below. The spread across the table is the teaching rather than any single entry, quetiapine at 0.09 per cent at one end and lithium at 12.2 per cent at the other, the latter from a series of 11 mothers and the only central estimate above the notional line. A blank in the percentage column is neither reassurance nor warning: the calculation was not made, and the reason differs by agent, being methodological for the anticonvulsant mood stabilisers. What is watched is watched in the infant, by a named person.
THE FOUR ARMS, AND WHERE THE BURDEN SITS	Continue, switch, reduce, stop, each priced aloud in her hearing so the conversation stops being a request for permission. The default is not neutrality: for most people and most medications the risk of the exposure is lower than the risk of exacerbation or relapse, so continuation stands unless a case is made against it, and the clinician who stops owes the argument. Whether to stop belongs largely to her; how to stop belongs entirely to you, and the manner is itself measurable, median recurrence latency running 11 times shorter after abrupt or rapid discontinuation than after a gradual one, with 47 per cent of recurrences falling in the first trimester. A progressive taper over 2 to 4 weeks is the other half of the instruction.
THE REFLEX STOP, AND THE WOMAN WHO HAS ALREADY DECIDED	Stopping the day the test comes back positive usually cannot reverse a first-trimester exposure that has already happened, and it adds a discontinuation in the very trimester in which recurrences cluster: a visible act substituted for a useful one. Where she has decided anyway the task becomes damage limitation, and the conversation carries restarting, switching and a psychological intervention. Antenatal anxiety and perinatal obsessive-compulsive symptoms are asked about in terms, because what you find depends on how you ask: obsessive-compulsive prevalence runs 1.08 per cent in the general population against 2.07 per cent in pregnancy and 2.43 per cent postpartum, while perinatal generalised anxiety reads 24.4 per cent by screening tool against 11.5 per cent by diagnostic interview, so roughly half the apparent prevalence is a property of the method.
THE POSTPARTUM PERIOD	

ASK	HOLD
BLUES AS A DISPOSITION RATHER THAN A DESCRIPTION	The front door chooses between reassure and review, treat now, and do not discharge, and the choice turns on what is safe to do next rather than on which picture fits best. The act is reassure, inform, return: awareness raised rather than experience dismissed, information about the depressive episode and the symptoms that announce it, and a return threshold held by a named person who will still be there. You may record blues only if you also state what would make you unmake it. This is the chapter's one topic carrying no figure here, and that is a property of the ledger rather than of the state: onset, course, duration and the three-way separation are owned by the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes, and nothing quantitative about blues was grounded here to restate.
WHY A SCREEN IS NOT A SERVICE	Who is screened, at which contacts, with what enquiry, and what happens next. The instrument is the second step of the pathway and never the first. A pathway is judged against its intervals, assessment for treatment within 2 weeks of referral and a psychological intervention within 1 month of that assessment, with the one guaranteed postnatal review at 6 to 8 weeks after the birth. Where a service cannot say who assesses the positives, within what interval, and who follows her if treatment starts, a questionnaire increases documented distress without increasing treated distress. India is where that bites: against a stated requirement of one psychiatrist per 100,000 population, the reported range runs from 0.05 in the lowest state to 1.2 in the highest.
THE SEQUENCING RULE INSIDE THE PATHWAY	Screening for bipolar disorder comes before pharmacotherapy for depression or anxiety is started, if it has not already been done. That is a rule about the order of the pathway rather than a fact about either illness, and it is the front door's most consequential ordering decision: a depression screen is cross-sectional and knows nothing of lifetime course, so a pathway beginning with a positive screen can end in a precipitated episode of a different kind. In India the contacts exist and the instruction does not.
POSTPARTUM PSYCHOSIS: ACTED ON BEFORE IT IS CONFIRMED	Immediate assessment within 4 hours of referral, by a secondary service that can admit, an admission that buys the medical evaluation, and a supervision plan naming an adult for the mother and an adult for the infant, written before either is left alone. It is the only perinatal presentation in the guidance given a response time in hours. Never alone, and never alone with the baby, the second being about who else is present rather than where the baby is. Both bite from the moment the presentation is suspected, which is the point of a rule that does not wait for confirmation.

ASK	HOLD
THE TWO TEAMS, AND WHERE THE BURDEN OF PROOF SITS	Each service assumes the other owns her: the obstetric team sees a psychiatric problem in an obstetric bed, the psychiatric team sees a recently delivered woman with a wound, a fundus and a feeding infant, the referral moves sideways while the clock runs. Begin the act, then call the other team. Joint admission is the default and separation is the deviation that must be stated in terms with its reason, because a written reason can be dated, reviewed and reversed.
BONDING: MOOD AND BOND ARE SEPARATE ENDPOINTS	Enquired about separately, recorded separately and recovered from separately: two passes at the same interview, first how she feels in herself and then how she feels towards this baby, in that order because the second is harder to disclose. Bonding disturbance is present in 29 per cent of mothers diagnosed with postnatal depression, so a negative mood enquiry has excluded a mood disorder and nothing else. Among over 200 mothers referred to specialist services, 10.6 per cent showed established rejection and 14.6 per cent threatened rejection, while 28.6 per cent had pathological anger, severe in 8.3 per cent. Ask her, watch them, ask them. The bond is re-examined after the mood recovers, and that second answer decides who is watching the baby at discharge.
THE INTRUSIVE-THOUGHT DISCRIMINATION	Distress about the thought is reassuring, conviction is not, and the enquiry continues either way. Reading a disclosed ego-dystonic thought as evidence that the baby is in danger costs both ways: the mother who described the most frightening thing in her head watches her infant removed and will not disclose again, while the presentation that genuinely warrants urgency, an idea held with conviction and without distress, is quieter, is not offered spontaneously, and is missed by a clinician whose alarm is already spent. The formulation becomes supervision, surrogate care and a discharge plan.
THE MOTHER AND BABY UNIT AS A SPECIFICATION	Read the definition as a specification and not as a description: an inpatient psychiatry service with at least four beds separate from other wards, a facility for joint admission of mother with baby, staffed 24 hours a day, 7 days a week by dedicated multidisciplinary staff. So is the reason there are so few of them, each network covering a population with between 25,000 and 50,000 live births a year. Joint admission is the default and separation the deviation that has to be justified, recorded and reviewed, and it happens: separations occurred in 23 per cent of consecutive joint admissions in one European series. The separation decision is made on safety and never on diagnosis; converting the diagnostic gradient into a decision rule fails both ways, separating manageable dyads and reassuring a team about a benign-sounding diagnosis attached to an unsafe home.

ASK	HOLD
THE TWO LACTATION QUESTIONS, ASKED SEPARATELY	How much drug reaches the baby, which decides whether the feed is safe, and what the drug does to the mother's prolactin axis, which decides whether there is a feed at all. Both are answered explicitly, and the second is answerable: in the Indian cohort of 237 admissions with a mean stay of 17.23 days, lactation was restored in 75 of the 87 mothers who had stopped, 86 per cent, by dispelling myths, correcting positioning, timing the feed and using expressed milk when she is too sedated. The familiar argument from the harms of separation is a chain its own source states as what the absence of a unit may produce: a mechanism argument, not a measured effect, and presenting it as measured is overclaiming. Where there is no unit, the family-caregiver model and its scaled-down variants are named.
WOMEN'S MENTAL HEALTH ACROSS THE LIFESPAN	
PREMENSTRUAL DYSPHORIC DISORDER: FILED UNDER GYNAECOLOGY	Coded GA34.41, in the genitourinary chapter rather than among the mental disorders, so psychiatry must go and collect it, since adjacency will never hand it to a psychiatrist. A premenstrual complaint is a routing decision before it is a diagnosis and a diagnosis before it is a prescription, and what decides the routing is information about time, which cannot be had in the consultation where the question is first asked. So the record is kept forward across cycles, with a named reviewer and a plan for the interval; compressing that into one sitting substitutes recall for observation.
THE PERIMENOPAUSE IS A CONTEXT, NOT A DIAGNOSIS	The transition has a nosological home of its own, GA30, and it is not in the mental disorders chapter. Most depressive episodes in the transition occur in women who have been depressed before, so the transition is where the episode happened rather than what it is. A context tells you what else to ask and whom to involve, never whether to treat. Collapse it into the diagnosis and two opposite errors open at once, an episode explained away and untreated, and a transition needing a gynaecological opinion absorbed into a psychiatric formulation. Waiting for the transition to finish is the comfortable error, and she often offers it herself. The endocrine material sits in the Endocrine and metabolic psychiatry notes.
READING A VIOLENCE OR DISPARITY FIGURE	The denominator is part of the number: who was counted, over what period, and under whose definition, and a figure quoted without them is not the same claim. The sex difference in depression has a shape that constrains which explanations survive it, an overall female-to-male odds ratio of 1.95 that is already present at age 12, peaks at 3.02 at ages 13 to 15 and then narrows. In India the female risk of a common mental disorder runs 1.53 times that of men, and the treatment gap for women is 81.5 per cent, which is why the gap belongs beside the prevalence rather than after it: the excess sits inside a population that is overwhelmingly untreated.

ASK	HOLD
ASKING ABOUT VIOLENCE IS A COMMITMENT, NOT A QUESTION	Alone, trained, and somewhere to send her. The size of the thing is not in doubt, 25.8 per cent of ever-partnered women worldwide reporting lifetime partner violence, 31 per cent in southern Asia, 22.3 per cent of ever-married Indian women and 2.7 per cent reporting physical violence during a pregnancy. Enquiry is targeted by presentation, unconditional inside those presentations, and routine in antenatal care alone; universal screening is the answer the guidance explicitly rejects where referral options are limited, because enquiry with nowhere to refer, no privacy and no trained response converts a disclosure into new risk she carries home. In an emergency department do everything at that contact, because there may not be another. The Indian civil statute is the Protection of Women from Domestic Violence Act, 2005, and the duties it places on medical facilities are named in words and never renumbered.
TERMINATION: WHICH STATUTORY QUESTION YOU ARE ANSWERING	The Medical Termination of Pregnancy Act, 1971, as amended in 2021, asks whether continuance of the pregnancy would involve grave injury to mental health, and grave injury to mental health is a statutory ground. It does not ask whether termination will damage mental health and does not ask you to predict outcome afterwards, so an opinion discussing later regret answers a question the statute does not pose and can defeat a lawful request while appearing thorough. Where she alleges the pregnancy was caused by rape, the anguish is presumed to constitute that injury; the extended window, beyond 20 weeks till 24 weeks on the opinion of two registered practitioners, turns on falling within a prescribed category of vulnerable women. Write about continuance.
INFERTILITY, AND READING THE ABORTION LITERATURE HONESTLY	The referral is mapped across the cycle, before, during and after treatment, on the psychosocial need domains, the burden being an outcome rather than a side issue: in a systematic review the commonest reason for discontinuing fertility treatment was postponement at 39.18 per cent, with psychological burden alone accounting for 14 per cent. Read the guidance's own caveat with it, only 45 of its 125 recommendations, 36.0 per cent, resting on strong evidence, and Indian law places a counselling duty on the fertility clinic. In the abortion literature the direction of a finding tracks methodological quality, the weakest designs generating the strongest claims of harm, and the comparison group is where most answers fail: comparing women who have an abortion with women never pregnant leaves the unwanted pregnancy itself, the exposure that predicts distress, uncontrolled. Calling the evidence conflicting and stopping there sounds balanced and is wrong.
THE BEHAVIOURAL EMERGENCY	

ASK	HOLD
AGITATION IS A PRESENTATION AND NEVER A DIAGNOSIS	The physical sweep runs alongside the talking rather than after it, and the psychiatric attribution is the last one made. Assessment and calming are interleaved, not sequential: the examination may be interrupted by treatment and then resumed, which makes somebody the owner of resuming it. The commonest real failure is not that the sweep is refused but that it is deferred to a moment nobody owns, and the patient is found hours later, calm, undiagnosed and still in the corridor.
ROOM, TEAM, VOICE, SWEEP	The space and its exits settled before the patient is in it, with attention to doors, stimulus and ligature points; enough people and the right ones present before the approach, a de-escalation team of 4 to 6 in a busy emergency service; one designated person who makes and keeps verbal contact; and what is measured while somebody else is talking. Keep at least 2 arm's lengths of distance on the approach. Where you stand is part of the plan, including your own way out. Collateral is taken now, during stabilisation. When de-escalation has not worked yet, and when it cannot be attempted at all, are different situations.
RAPID TRANQUILLISATION IS A PROCEDURE, NOT A PRESCRIPTION	Indicated by what the disturbance prevents, never by how disturbed the patient appears, and everything else follows: the indication states a purpose, the purpose sets the endpoint, the endpoint is what the post-dose review tests, and the monitoring keeps the patient alive until that review can be made. Monitor side effects, pulse, blood pressure, respiratory rate, temperature, hydration and consciousness at least every hour until there are no further concerns about physical health, and every 15 minutes where the maximum dose has been exceeded or the patient appears asleep or sedated. A protocol entered without a stated purpose has no endpoint, and sedation without an endpoint becomes sedation renewed by habit. Agents and first doses belong to the Schizophrenia: management, antipsychotics and adverse effects notes.
AUTHORITY, COMPETENCE, ONE DOSE, A CADENCE	Capacity is assessed and written down as a discrete step, before the drug rather than after it: severe disturbance makes incapacity likely, and likelihood is exactly what an assessment is for, so a correct conclusion reached without one is indistinguishable in the record from no conclusion at all. Somebody present who can manage the airway, and life-support-trained staff within reach. Who is less safe to sedate is checked first, the safety brief is run, and the order is written as a single dose with a named reviewer. Monitoring level is set by route and by state rather than by drug, stratified into four levels, and it runs until somebody decides the physical concern has ended. Name your parameters rather than assuming them: 97 per cent of 44 surveyed protocols specified monitoring parameters, and between them they listed 14 different ones.

ASK	HOLD
AN OBSERVATION LEVEL IS A PRESCRIPTION, NOT A MOOD	A named person who set it, a stated frequency or distance, a named reviewer recorded with their title, a stated review time, and a written condition that would bring it down. The frequencies are published: low-level intermittent observation once every 30 to 60 minutes, high-level intermittent once every 15 to 30 minutes, continuous within eyesight or at arm's length of a designated nurse, and multiprofessional continuous within eyesight of 2 or 3 staff members and at arm's length of at least 1. It is a rota problem before it is a clinical one, no staff member holding an above-general observation for more than 2 hours continuously. Going up and coming down carry different authority, somebody must be told when it rises, and the review that is supposed to bring it down is a duty rather than a courtesy. Privacy and dignity belong to the person being observed.
THE VOCABULARY PROBLEM, AND THE WARD AS A PHYSICAL OBJECT	One-to-one, special, constant, continuous and arm's length are not synonyms, and the confusion sits in the source documents rather than in the reader: name the taxonomy you are using, then state the requirement, because a level written in a vocabulary the receiving nurse does not use has communicated nothing. The department and the ward are physical objects, with ligature points, a waiting area and built-environment controls, and controls do not replace observation. The risk assessment itself is taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes.
MANIA: SUSPICION IS THE TRIGGER, NOT DIAGNOSIS	Urgent specialist assessment fires on suspicion of the state or the presence of danger to self or others, never on a settled diagnosis, and it is defensible because what is triggered is itself an assessment: nothing irreversible follows from referring urgently and finding no mania. The physical exclusion precedes the label. The risks that decide disposition are financial, sexual and relational at least as often as violent, so absence of aggression is not absence of an emergency: ask what will have been spent, signed, promised or contracted by the time an outpatient appointment arrives. Capacity here fails behind a fluent examination.
MEDICAL PRIORITY IS A CLAIM ON RESOURCES, NOT A LICENCE TO POSTPONE	Stabilisation outranks assessment for the minutes in which it is actually happening and buys nothing beyond them. It is not permission to leave the psychiatric assessment until medical treatment is finished, nor to wait for a number before speaking to the patient, and intoxication is not a gate on assessment either. Where the patient genuinely cannot participate, what replaces the assessment is a stated review interval, not silence, and the phrase that used to end this argument is refused rather than reinterpreted.

ASK	HOLD
WHAT, THEN WHEN, THEN WHO	What was taken decides whether charcoal has any role at all, because for a defined list of poisons it has none at any interval; when it was taken sets the window, appropriate up to 6 h after ingestion for many poisons on an individualised risk assessment; who is in front of you settles the rest. The window is formulation-specific, immediate-release paracetamol recommended up to 2 h and the modified-release form up to 5 h. Charcoal is withheld where the airway is unprotected rather than bought by securing an airway in order to give it. The asymptomatic patient is the trap: after extended-release bupropion overdose, seizures occurred in 31.6 per cent and first seizures ran 0.5 to 24 hours from ingestion, so the disposition is a minimum observation of 24 hours and not a mental state at the bedside. The patient is handed over with a document and not a phrase.
THERE IS NO SAFE WAY TO HOLD A PERSON	Only less dangerous ways, and the difference is how much weight sits on the chest and how long it sits there. The clock is written down: manual restraint is not used routinely for more than 10 minutes, a nurse assesses respiration and vital signs within 15 min of the restraint and at least every hour while it continues, and the medical face-to-face evaluation falls within 1 hour of initiation. Airway, weight, clock, eyes: nothing pressing the rib cage, neck or abdomen, nothing over the mouth or nose, the head free to rotate, weight to the side rather than on top, the hold as short as it can be, and one person watching who is not holding.
THE POSITIONING HIERARCHY, AND THE SEPARATE DUTIES	Supine rather than prone is the second limb of the answer, not the whole of it: the primary instruction is to avoid the floor at all, so a hold managed seated or standing has already satisfied a recommendation the supine answer is only a fallback within, and supine is not a licence either, since weight across the chest or anything laid over the face reproduces the hazard the position was chosen to avoid. Prone, arm position is measured and not a preference, mean anterior chest pressure falling from 102.6 mmHg with the arms abducted to 72.7 mmHg with the upper limbs brought under the shoulder. Watched, assessed and written down are three separate duties with different owners. Drink, toilet, movement, skin and clot belong to the body under a long hold, restraint carrying an odds ratio of 6.7 for venous thromboembolism in a hospitalised psychiatric cohort, and the hour after release is part of the episode.
THE RIGID, HYPERTHERMIC AND TOXIDROMIC EMERGENCIES	

ASK	HOLD
CATATONIA IS A MEDICAL ADMISSION FROM THE HOUR OF RECOGNITION	Not from the hour the treatment fails. It kills through dehydration, immobility and sympathetic overdrive, and the mortality is measured: catatonic stupor carried an odds ratio for death of 4.8, confidence interval 2.0 to 10.6, against inpatients without it. So the first hour buys the clot, the skin, the airway and the feed while the diagnosis is still being settled: clot, skin, stretch, feed, which is exactly the 4 medical complications the prophylaxis literature actually covers, venous thromboembolism, pressure ulcers, contractures and nutritional deficiency. Prophylaxis, skin care, hydration and the feeding decision run in parallel with the benzodiazepine rather than after it, because a patient who responds beautifully days later can still have thrown an embolus before he did.
AIRWAY AND SWALLOW FIRST, AND THE SECOND EPISODE	Airway, swallow and hydration are settled before anything is given by mouth, and the feeding decision carries a rate: at high risk of refeeding problems, nutrition support starts at a maximum of 10 kcal per kilogram per day and builds to full needs by 4 to 7 days; below that threshold, someone who has eaten little or nothing for more than 5 days starts at no more than 50 per cent of requirements for 2 days. A recurrent presentation is not a repeat of the first with its workup inherited unread: recurrence does raise the probability of an idiopathic cause, but that is an inference about the population while the question is about this patient, whose earlier evaluation may have been curtailed the moment treatment worked. The right answer to whether he was worked up last time is a list, never a yes. Entity, rating scale and benzodiazepine challenge sit in the Other psychotic disorders, delusional syndromes and catatonia notes.
NEUROLEPTIC MALIGNANT SYNDROME: TWO DECISIONS, TWO SETS OF NUMBERS	The criteria and their critical values answer whether this is the syndrome: hyperthermia above 38.0 degrees Celsius on at least 2 occasions, creatine kinase at least 4 times the upper limit of normal, and rises of 25 per cent over the patient's own baseline in blood pressure and heart rate. The temperature and the heart rate now answer where the patient is nursed and who is called, and the second decision never waits for the first: moderate is 38 to 40 degrees Celsius with a heart rate of 100 to 120 and severe is above 40 degrees Celsius with a heart rate above 120. Fusing them produces the patient waiting on an open ward for a creatine kinase result before anyone escalates. Severity is banded on two observations available within a minute of arrival and needing no laboratory.

ASK	HOLD
WHAT A LOW SCORE DOES NOT ENTITLE YOU TO DO	The criteria set was assembled by consensus to standardise agreement between specialties and calibrated against a selected population, and its sensitivity was never good enough to rule out: at the validated threshold of 74 priority points, sensitivity was 69.6 per cent against a specificity of 90.7 per cent. So a sub-threshold score, or the absence of severe rigidity, is not evidence against the diagnosis. State the cut-off, then state in the same breath what a score below it does not permit. The negative work-up limb is where the work hides. The act in the department is written without naming a drug, because the drugs belong to the Schizophrenia: management, antipsychotics and adverse effects notes.
SEROTONIN TOXICITY: A DECISION RULE, NOT A CHECKLIST	The named criteria are a decision tree derived empirically from 2222 consecutive serotonergic overdose admissions, with a learning dataset of 473, and measured against a stated reference standard; the older set they displaced was a list of associated features applied by recognition. Counting positive items is therefore the error: particular features in particular combinations are diagnostic and others are not, so patients with the same number of positive items can fall on opposite sides of the rule. The gain was real and modest, 84 per cent against 75 per cent for sensitivity and 97 per cent against 96 per cent for specificity. The reference standard was expert clinical judgement, since no assay settles this diagnosis, and that bounds what the accuracy figures mean.
WHERE THE RULE WAS VALIDATED, AND WHAT IT BUYS	Validated in a toxicology service in which other drug-induced syndromes are frequent, which is why it is so specific, and explicitly not validated for adverse drug reactions, which is most of the situations a psychiatrist reaches for it in. Use a positive result to justify what you are about to do; never a negative result to justify not doing it. Almost nothing changes in the opening minutes: supportive care takes precedence over any specific pharmacological treatment, because supportive care is what prevents rhabdomyolysis, renal failure and disseminated intravascular coagulation. A rising temperature with rigidity runs on hours and is answered by cooling, sedation and paralysis, never by an antidote. Most improve within 24 hours of stopping the drug, and moderate toxicity is observed for 6 hours, extended to 12 hours where a slow-release formulation was taken.

ASK	HOLD
ACUTE DYSTONIA: THE FIRST DECISION IS ANATOMICAL	Which territory is involved, because only some of them can obstruct. The drug given is the same either way, which is exactly why the question gets skipped; what differs is the setting the injection is given in and who stays at the bedside afterwards. A neck held to one side and a throat that is tightening are the same diagnosis and a different level of care, and the second is not safely managed in a side room by a single nurse told to call if there is a problem. Resolution is expected 15 to 20 min after the injection, a persisting episode is repeated at about 30 min, and failure to respond to two doses means changing the drug and then questioning the diagnosis. The causative drug is usually not on the psychiatric chart.
THE EPISODE DOES NOT END WHEN THE SIGN RESOLVES	It ends when the continued cover, the taper and the re-exposure decision have been written down: cover runs 24 to 48 h at minimum and in routine Indian practice up to 4 to 7 days, because the antidote wears off while the causative drug is still in the body. An answer that stops at the injection has treated the spasm and not the patient. The same spine carries the hypertensive emergency on a monoamine oxidase inhibitor, defined as a blood pressure more than 180/120 mm Hg with organ dysfunction and a tyramine restriction that outlives the drug by 2 weeks; the severe cutaneous reaction, where corticosteroids are started preferably within 72 h; and priapism, which is a clock rather than a symptom, an emergency beyond 4 hours. Every dose belongs to the Schizophrenia: management, antipsychotics and adverse effects notes.
LITHIUM: ON IT, ON TOP OF IT, WHICH TABLET	Which of the three poisonings this is comes from the history and not from the assay: whether there was a maintenance body burden before today, whether something was taken acutely as well, and whether the preparation was immediate-release, peaking at 30 minutes to 2 hours, or modified-release, peaking at 4 to 5 hours, because prolonged absorption and clumping provide a reservoir, and the reservoir is what creates a decontamination decision at all. The observation horizon is set from the kinetics rather than from the first result: the terminal half-life is typically 12 to 27 hours but reaches 58 hours in the elderly and the chronically treated, so the same ingested amount behaves differently in the two arms of the typology.

ASK	HOLD
WHAT THE CONCENTRATION IS ACTUALLY FOR	It estimates the risk ahead and grades severity only in the patient who was already taking the drug, and it is not reading the compartment that matters: diffusion into cerebrospinal fluid and brain lags appearance in plasma by about 24 hours. A grading built for chronic intoxication, applied to a naive patient who has just swallowed a bottle, gives a striking figure in somebody who looks well, and the team is either alarmed then or reassured later: both readings ignore that the brain has not yet received the dose. Charcoal does not bind this drug, and the alternative is ruled in or out before the patient rules it out for you; early decontamination was associated with less severe poisoning at an odds ratio of 0.21, confidence interval 0.04 to 0.99, regardless of the amount ingested or the level. Serum bands belong to the Mood disorders: pharmacotherapy notes.
THE ANTIMUSCARINIC ANTIDOTE DECISION IS MADE ON THE TRACING	Read the electrocardiogram and the contraindication list before the syringe is filled, never how antimuscarinic the patient looks: recognition names the family of poisons, not the member, and members diverge on whether this drug helps or kills. The tracing carries two thresholds and they are not the same threshold: at a limb-lead QRS of 0.10 second or longer, seizures ran at 34 per cent and ventricular arrhythmias at 14 per cent, while arrhythmias appeared only at 0.16 second or longer. The report that changed practice described asystole after the antidote was given in tricyclic toxicity, and the tracing separates them first. Sodium bicarbonate is given to a titration endpoint, which also means knowing when to stop.
ONE DOSE WEARS OFF BEFORE THE POISON DOES	The antidote's duration of action is approximately 45 to 60 minutes while the agents it reverses last far longer, so recurrence is the expected course and the disposition follows from that. Keep atropine beside it, push it no faster than the label allows, and treat a single dose as an act with a duration rather than a cure. When the antidote is refused or unavailable the patient is held instead, and that is not hypothetical: a 2025 series records supply failing after the manufacturer stopped production. Where the source gives no complete tuple of agent, amount, unit and route, the gap is declared rather than completed from memory. Decontamination is decided against a clock, and disposition names both the place and the period.
THE MEDICAL EMERGENCY AND THE PERINATAL OVERLAY	

ASK	HOLD
TREAT WHAT WILL KILL THE PATIENT BEFORE NAMING WHAT IS WRONG	Each life-threatening problem is treated the moment it is found and its effect reassessed, rather than carried to the end of the assessment: the problems that kill in the first minutes are the ones correctable in the first minutes, and each window closes while the survey goes on. Conscious level is graded inside the primary survey, with new confusion a grade of its own, because it is otherwise lost: of 25 older emergency patients found to be delirious, 19, or 76.0 per cent, were not recognised as delirious by the treating physician. Level, sugar, saturation, chart. Oxygen is corrected to a target rather than simply turned on, 94 to 98 per cent in acute respiratory failure and 88 to 92 per cent where hypercapnic failure is a risk. Glucose is corrected to a target too, thiamine goes before any carbohydrate, and an antagonist is given where a reversible drug cause exists.
SEDATION IS AN ENABLING ACT, NOT A TREATMENT	Written as treatment it closes the episode: the patient is settled, the search for the precipitant stops, and the next clinician inherits a quiet patient with an unexamined cause. Written correctly it has a stated purpose, to let the physical assessment, the access and the imaging proceed, and it leaves the precipitant work still owing. Where it is unclear whether this is delirium or a psychiatric disorder, the patient is medically observed or hospitalised rather than sent to a psychiatric bed, and the handover says which. The entity is taught in the Stroke, TBI, delirium and focal brain syndromes notes.
INTOXICATION IS A CONCLUSION, NEVER A PREMISE	It is the label you arrive at once the exclusions have been performed, not the one you begin with and then defend. Written the other way round the assessment has no stopping rule: every abnormal finding is absorbed into the explanation already chosen, and the patient improves on paper by being observed rather than examined. The triggers for further medical evaluation are worth holding as a list, because intoxication and withdrawal are on it rather than exempt from it, alongside new-onset psychiatric symptoms after 45 years, advanced age at 65 years and older, cognitive deficit or delirium, focal neurology or head injury, reduced awareness and abnormal vital signs. The smell of alcohol is evidence of recent drinking, a different proposition from the cause of the conscious level and compatible with everything else on the list.
SUGAR, SALTS, GASES, FUNDI	The first three go with the first draw; the fourth costs nothing, needs no laboratory and is available at the bedside. An important traumatic brain injury is excluded and the diagnoses that hide inside this state are looked for rather than waited for. Intoxication blocks discharge, the level-of-care decision turns on impaired consciousness with significant risk, and the threshold is lower in the vulnerable, the frail, the cognitively impaired, those with multiple comorbidities or no social support, and those who are 16 or 17 years old. The withdrawal regimen and its monitoring instrument are taught in the Substance use disorders notes.

ASK	HOLD
ESTABLISH THE SECOND PATIENT BEFORE YOU TOUCH THE FIRST	Three acts belong to the psychiatrist and to nobody else: the position she is left in once she has been sedated or held, the seclusion that must not follow rapid tranquillisation, and the call that brings obstetric, paediatric and anaesthetic colleagues into the room rather than after it. Position is part of the prescription and not part of the nursing, because a woman just sedated or being held cannot reposition herself, so it is chosen for her and re-chosen at every observation and handover. From about 20 weeks the gravid uterus reduces venous return when she is supine and cardiac output falls by up to 30 to 40 per cent. Board, then tilt whole-body from head to toe at 15 to 30 degrees on a firm surface, and displace the uterus manually when you cannot tilt.
THE CADENCE FOR TWO, AND THE REASSURANCES REFUSED	Monitoring afterwards is for both patients and is given a name, and self-harm is assessed on the perinatal method profile rather than the general one, since the majority of perinatal suicides are violent and hanging accounted for 66 per cent. Two reassurances discharge a woman who should be admitted, and both are refused: the cross-sectional appearance, because deterioration here can be extremely rapid and the red flags are triggers for an act rather than items scored against protective factors; and her children, since devotion is not capacity for self-protection. Where suspicion of postpartum psychosis is the presentation, assessment falls within 4 hours of referral, and where a treating psychiatrist separates mother from baby the decision is reviewed every 15 days, with the Review Board informed and permission sought beyond 30 days and rooming-in recommended for a child under 3 years of age; the statute itself is taught in the Mental health legislation and forensic psychiatry notes. Call the right team early, because the clock is shorter than the corridor.

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Every specific in this chapter is bound to one of the sources below, and the count is the number of claim rows each carried. 11 of those rows are statutory and were read at the primary Act on India Code rather than from any textbook's summary of it, because a stale or paraphrased section changes what a clinician is legally obliged to do. Doses were read at current regulatory labelling, and each carries its own source receipt naming the regulator, the product, the label version and the retrieval date. 25 row(s) are recorded at partial confidence and 0 as a declared gap: a declared gap is a correct answer here, and no number has been supplied to fill one. The must-have-papers cross-check was NOT performed for this Paper III chapter, because the paper lists do not yet exist in the intel index; for Paper III the topic bank plus the syllabus scaffolding is the completeness authority. This table records provenance, not proof: it says where each specific came from, not that the chapter's prose uses it correctly, which the content pass and the ship review test.

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Trazodone Hydrochloride Tablets, film coated, Oxford Pharmaceuticals LLC, section 5.6 Priapism	1
Use of the Stafford Interview for assessing perinatal bonding disorders. BMJ Case Rep 12(12):e228696. doi:10.1136/bcr-2018-228696	1
Violence and aggression: short-term management in mental health, health and community settings, NICE guideline NG10, levels-of-observation recommendation 1.4.11	1

SOURCE	CLAIMS CARRIED
Violence and aggression: short-term management in mental health, health and community settings, NICE guideline NG10, recommendation 1.4.27, Manual restraint	1
Why do patients discontinue fertility treatment? A systematic review of reasons and predictors of discontinuation in fertility treatment	1
Women's Mental Health and Well-being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study	1

PART X

X

Consultation-Liaison, Geriatric and Transcultural Psychiatry

The consult on somebody else's ward, what changes at seventy-eight, culture as clinical data, and the practical exam.

01 Orientation: four questions, one patient

02 The consult as an act

03 What arrives on the ward

04 The high-stakes settings

05 What changes at seventy-eight

06 The late-life presentations

07 Culture and the explanatory model

08 Cancer, dying and grief

09 The OSCE and practical exam bridge

10 Cross-cutting synthesis

11 Apply, consolidate and close the paper

PAPER III

Consultation-liaison, geriatric and transcultural psychiatry

Eleven bands . one complete notes document . the last chapter of Paper III

Orientation: four questions, one patient

1 · Orientation: two doors, one patient

One patient, and four different reasons somebody wants a psychiatrist. A woman of seventy-eight is on a surgical ward. The team has sent for you, though the slip carries a bed number and the word confused. Her son has already told the ward what he believes is wrong with her, and told you what he does not want said to her. Nobody has asked what she was like a month ago. The same encounter, compressed and performed aloud, is what examiners will mark. Four questions are being put to one bedside: who asked and in whose ward, what is different because she is seventy-eight, whose account of the cause reached the room before you did, and how all of it is said aloud under observation.

This opening is the chapter's **advance organizer**. It asserts no dose, interval, threshold or figure of its own, because each belongs to the section that owns it, and it describes no syndrome, because not describing syndromes is the design rather than an omission in it. What it owns is the shape: the decision the chapter is organised around, the four questions that run through it as seams, the bands and their order, the map of what it deliberately does not carry, and the reason its last band sits where it does.

Who asked	What age changed	Whose explanation	Said aloud
THE FIRST QUESTION, AND THE SEAM RUNNING THE LENGTH OF THE GENERAL-HOSPITAL BANDS	THE SECOND QUESTION, RUNNING THROUGH BOTH OF THE LATE-LIFE BANDS	THE THIRD QUESTION, AND THE ONE THE TRANSCULTURAL BAND IS BUILT AROUND	THE FOURTH QUESTION, AND THE WHOLE SUBJECT OF THE PRACTICAL EXAMINATION BAND

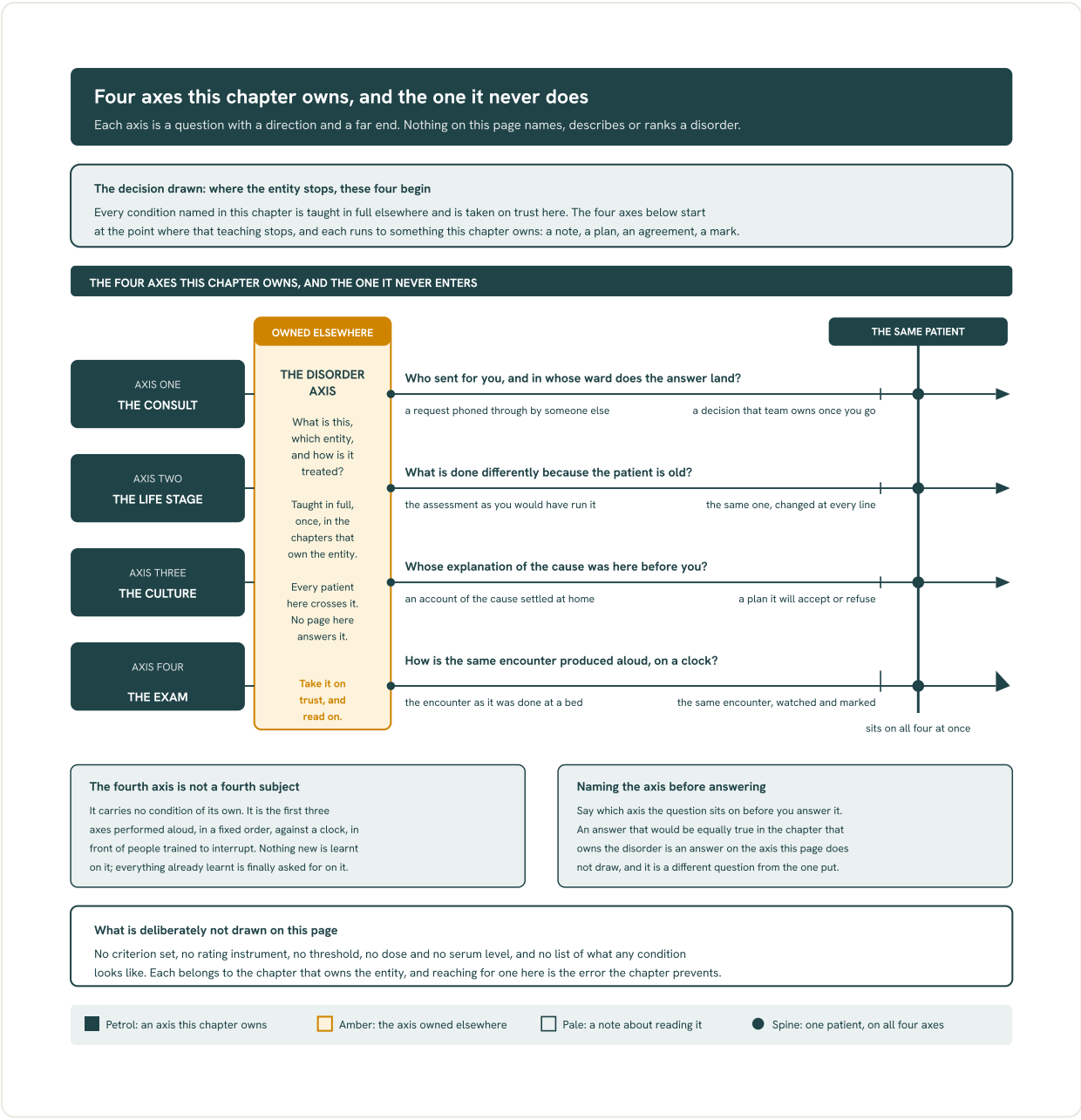


Fig 29.1. The chapter drawn as four axes rather than four topics, each one a question with a direction, running from the point at which the teaching of the condition stops to something these pages own, with the axis that asks what the condition is set alongside them as the one axis this chapter never enters, and the same patient marked as sitting on all four of the owned axes at a single bedside.

1.1 The decision this chapter is organised around

Almost every condition named in the pages ahead has already been taught properly elsewhere in these notes, with its clinical features, its differential, its investigation and its drug treatment. That body of work is the **entity**, and it is not repeated here in any form, at any length, in any box. The chapters that teach what the thing is sit largely in Paper II and Paper IV.

This chapter owns the other half, and nothing else in these notes carries it whole. That half is the **encounter**: who sent for a psychiatrist and what they actually wanted, in whose ward the patient is lying and therefore whose agreement any plan needs, what is different about the assessment because the patient is old, what the people around the bed had settled about the cause before anyone telephoned, and how all of it is produced aloud, in order, in front of somebody marking it.

The chapters that own the disorders answer *what is this*. This one answers *who asked, in whose ward, what changed because she is seventy-eight, whose explanation was already in the room, and how do I say it.*

That division is a decision and not a shortage of material. It is also the harder of the two, and the one practised badly and examined badly. A candidate who names a confusional state correctly but cannot say who to telephone first, what had to be established before walking to the bed, or which bed the patient should be in by morning has the entity right and the encounter wrong, and it is the second error the patient carries home. Every cross-reference in this chapter follows from the same division: it is a routing decision taken once, so that a subject is taught in full in one place rather than partly in three.

RULE **A section here is finished when it has said what was done, by whom and to what end. It is finished even if it has said almost nothing about the disorder.** Hold that while you read, because it settles what a complete section looks like here. A section that says little about a condition you already know is not thin: it is written on the assumption that you know it, and everything it does say is content the owning chapter does not carry. The corollary is where the marks sit. If you can describe a condition fluently but cannot say who called, what they wanted, what you would have established before the bedside, who owns the decision afterwards and when the patient is seen again, you have read the wrong half.

1.2 The four questions, and why each is a seam rather than a topic

The four questions are not four subjects placed side by side. Each is a **seam** running the length of a stretch of the chapter, so that the sections inside that stretch are variations on one question. Knowing which question your section varies is most of what makes this chapter quick to read.

The first is the **referral**. A consultation is asked for by somebody whose felt need is not the patient's, and the answer is owed to a team that will act on it with you absent. Everything in the general-hospital stretch follows from those two facts: what the request must be turned into before it can be answered, what is established before the bed rather than at it, what the written record has to settle, and who owns the next decision.

The second is what age changes. The question is not what conditions older people get, which is an entity question with owners elsewhere. It is what the clinician does differently: whose account the history now comes from and how well placed that person is to know, what must be made possible before an examination measures anything at all, what a drug decision costs in a body that handles drugs differently, and what a plan silently assumes about the household that will deliver it.

The third is the **explanatory model**. By the time most of these patients reach a psychiatrist, somebody has decided what is wrong and why, something has been tried on that basis, and a view has been taken about how much the patient should be told. Eliciting it is assessment and not courtesy, because it predicts what will be accepted and what happens next if your plan disappoints.

The fourth is the **examined performance**. An examination does not ask what you know; it asks for the encounter reproduced aloud, in a fixed order, against a clock, in front of people trained to

interrupt. The content is the same and the constraints are different, and the constraints are examinable in their own right.

MNEMONIC

Who asked. What age changed. Whose explanation. What is said aloud.

Four beats, and they are the whole chapter. **Who asked**: the request, the ward, the record, and the person who owns the decision after you leave. **What age changed**: not a new list of conditions but a changed meaning for every line you were already writing. **Whose explanation**: the account of the cause settled before the referral, in the words of the people who hold it. **What is said aloud**: the same encounter reproduced in front of examiners, which is how all of it is finally asked for.

1.3 The bands, in the order the chapter runs them

Between this opening and the close the chapter runs in nine **bands**. The order is a clinical progression rather than the syllabus taken flat, and eight of the nine carry the teaching while the ninth draws them together.

- **The consult as an act.** The consultation itself as the object rather than any setting or syndrome: what a liaison service is for, what a medical illness does to the psychiatric picture, and what a physical illness demands of the person carrying it.
- **What arrives on the ward.** The recurring short list of reasons a general-hospital team actually sends for psychiatry. Grouping them says what no single section says: the reasons are few and they repeat on every ward.
- **The high-stakes settings.** Transplantation, dialysis and intensive care, chronic infection, the organ-specific liaison work and the neurological interface: the settings in which the consult is hardest and the decision least reversible.
- **What changes at seventy-eight.** Normal ageing against pathology, the assessment that surrounds any cognitive testing, the prescribing decision, the sleep history, and the safeguarding question, which belongs inside an assessment and not in an appendix.
- **The late-life presentations that mislead.** The band's work is the differential between them, which no chapter can draw from inside a single entity it owns.
- **Culture and the explanatory model.** What changes when the account of the cause is not biomedical, run from the concept through the formulation to what a clinician does with it in an Indian clinic.
- **Cancer, dying and grief.** Recognition when the ordinary somatic signals have been taken over by advanced disease, and the conversations that carry most of the clinical work in that setting.
- **The practical examination bridge.** The observed station, the long and short case, the bedside demonstration, the difficult conversation, and the instruments a viva puts in front of you.
- **The cross-cutting synthesis.** The one place the four questions are shown converging on a single encounter and a single document.

After the ninth band come the chapter's own closers, and then one more that no earlier chapter has needed. This chapter closes Paper III, so its final section looks back across the whole paper rather than across these pages alone. The last thing you meet here is a map of ten chapters, not a summary of one.

1.4 What is deliberately not here, and where it is taught

An organizer is as much about the edge of the frame as about what sits inside it. Read the middle column of the map first: it is what this chapter does with each subject, and the reason the subject appears here at all. The right column is where the condition itself is taught, in full, once.

WHAT YOU MEET IN THESE PAGES	WHAT THIS CHAPTER TEACHES ABOUT IT	WHERE THE CONDITION ITSELF IS TAUGHT
Acute confusion, on a medical ward and in an older patient	Who calls and what the ward is actually asking for; and separately, what frailty, sensory loss and multiple drugs do to the same picture in later life	the Stroke, TBI, delirium and focal brain syndromes notes
Progressive cognitive decline in an older referral	The wider assessment it sits inside, and the behavioural picture as a reason a family or a ward asks for help	the Dementias and neurocognitive disorders notes
A first psychotic presentation late in life	What is different about assessing a first presentation at this age, and why its label has a contested history	the Other psychotic disorders, delusional syndromes and catatonia notes
Low mood late in life, and in advanced physical illness	How it is recognised when the somatic features belong to the disease or its treatment, and what age does to prescribing	the Mood disorders: pharmacotherapy notes
Fear and distress at a bedside, and after a diagnosis is disclosed	The reaction the setting itself produces, and when a reaction has become something to treat	the Anxiety, OCD and trauma-related disorders notes
Poor sleep in an older patient	The history to take before the complaint is attributed to age, and what that attribution costs when it is wrong	the Eating and sleep-wake disorders notes
Bodily symptoms without an explanation, fabricated illness, and self-harm on a medical ward	Why the team referred, what they are asking you to take off their hands, and what the note must settle before you leave	the Somatic-symptom, sexual, impulse-control disorders and suicide notes
The mental state examination, and the psychological work of a consultation	How it is performed at a busy bedside and presented aloud against a clock	the Psychotherapies, clinical assessment, MSE and nosology notes
Seizures, and the psychiatric picture around them	What a neurology team is asking psychiatry for, and where the consult enters that relationship	the Epilepsy and psychiatry notes

WHAT YOU MEET IN THESE PAGES	WHAT THIS CHAPTER TEACHES ABOUT IT	WHERE THE CONDITION ITSELF IS TAUGHT
Localisation and the bedside neurological examination	Which parts of it a general-hospital consultation requires, and when it cannot be deferred	the Neurology foundations for psychiatrists notes
Chronic infection, organ failure and the systemic disease behind a referral	The psychiatry of the setting: the unit, the team, the decision due this week, and who follows the patient afterwards	the Neuropsychiatry of systemic and neurological disease notes

Nothing in that table is an apology. A pointer here sends you to the full teaching and not to a second summary, and it expects to be followed once and then never again.

1.5 The band that is carried nowhere else

Read the last band even if you read nothing else twice. The practical examination bridge is the only band here with no clinical entity standing behind it, which is why it is placed last: from there it can look back across everything before it, and it hands directly to the close of the paper. It covers the observed station and what is being scored in it, the long and short case as they are actually presented, the demonstration of a scale or a bedside cognitive test with an examiner watching, the difficult conversation treated as an examined act, and the interpretation of investigations and instruments put in front of you without warning.

It is also the only body of material in this chapter that appears in no other chapter of any paper. Everything else here has an owner somewhere, so a reader who skips a section can pick the subject up at that owner and lose only time. This band has no owner. A candidate who skips it has read it nowhere, and meets the format for the first time in the room, where the cost is paid in marks rather than in preparation.

TRAP **Reading a short section as a low-yield section.** The length of a section here is a statement about ownership, not about yield. A section is short because the disorder it names is taught in full elsewhere, which means every line it does carry is a line no other chapter carries, and those are the lines examiners ask for. The failure has a recognisable shape across a table: asked what you would do about a patient, the candidate who skimmed produces the entity answer at speed, which is fluent, correct, and about a different question, and then has nothing left when the follow-up asks who they would telephone first and what they would write. The practical band is where this costs most, because there is no owner to fall back on.

1.6 How to read it

Three habits make the chapter read as one argument rather than as a heap of separate acquisitions, and each is a habit about what you do with a section rather than about how much of it you memorise.

- Read for what a section instructs you to do, and take the disorder it names on trust from the chapter that owns it. If you cannot recall that disorder, that is a signal to go and read it there, not a signal that this section is incomplete.

- When a section hands a point to another chapter, follow it before you answer on that point. Following a pointer here lands you on the full teaching, so it is done once and does not need repeating.
- Treat a stated absence as a finding. Where a section says that no figure is available to quote, that sentence is doing work: it stops a half-remembered number being written into an answer under pressure, which costs a candidate more than not knowing.

IN INDIA

Indian practice is the subject of this chapter, not a note appended to a Western one, and that has two consequences for reading it. Where the question is how a service is configured, who may lawfully decide, what a family expects to be told and when, or where a complaint about an older person's treatment at home is actually heard, an Indian source settles it and a familiar Western default does not substitute. And the route a patient took before reaching you, including any traditional or religious healing sought first, is a fact about access to care and a proper question to ask; it is never by itself a finding about pathology, and this chapter draws that boundary in prose, in the patient's own words and the family's own explanation, rather than in a list of features. The encounter you will be examined on is an Indian encounter, in an Indian hospital, with the relative in the room.

This chapter answers four questions about one encounter: who asked and in whose ward, what changed because the patient is old, whose account of the cause was already in the room, and how all of it is performed aloud under observation. It answers none of them by describing a disorder, because every disorder it touches is taught in full elsewhere and is named here without its features.

The consult as an act

2 · Principles and models of consultation-liaison psychiatry

Why the marks are here. Almost every other question in the syllabus asks what a condition is. This one asks what you did, in whose ward, at whose request, and what became of the decision afterwards. Liaison work is the only part of psychiatry in which the psychiatrist is a guest: the bed, the record and the plan of care belong to another team, and the patient did not ask for a psychiatrist. Procedure, unlike a syndrome, is examinable in fine detail. A candidate who lists service models without saying who telephoned, what they wanted, and who was left holding the clinical decision has answered a different question.

Two consequences follow from being a guest, and the rest of this topic works them out. First, the request is not the patient's: ordinarily the need to see a psychiatrist is a felt need of the patient or a relative, whereas here the need to appoint a psychiatrist is felt by the primary treating team, and the patient may be learning of it as you introduce yourself. Second, what you produce enters a decision that is settled with the primary team rather than announced to it. Both are set out in

the consultation-liaison chapters the Indian Journal of Psychiatry published in 2022, the fullest account of Indian general-hospital practice and the source used throughout.

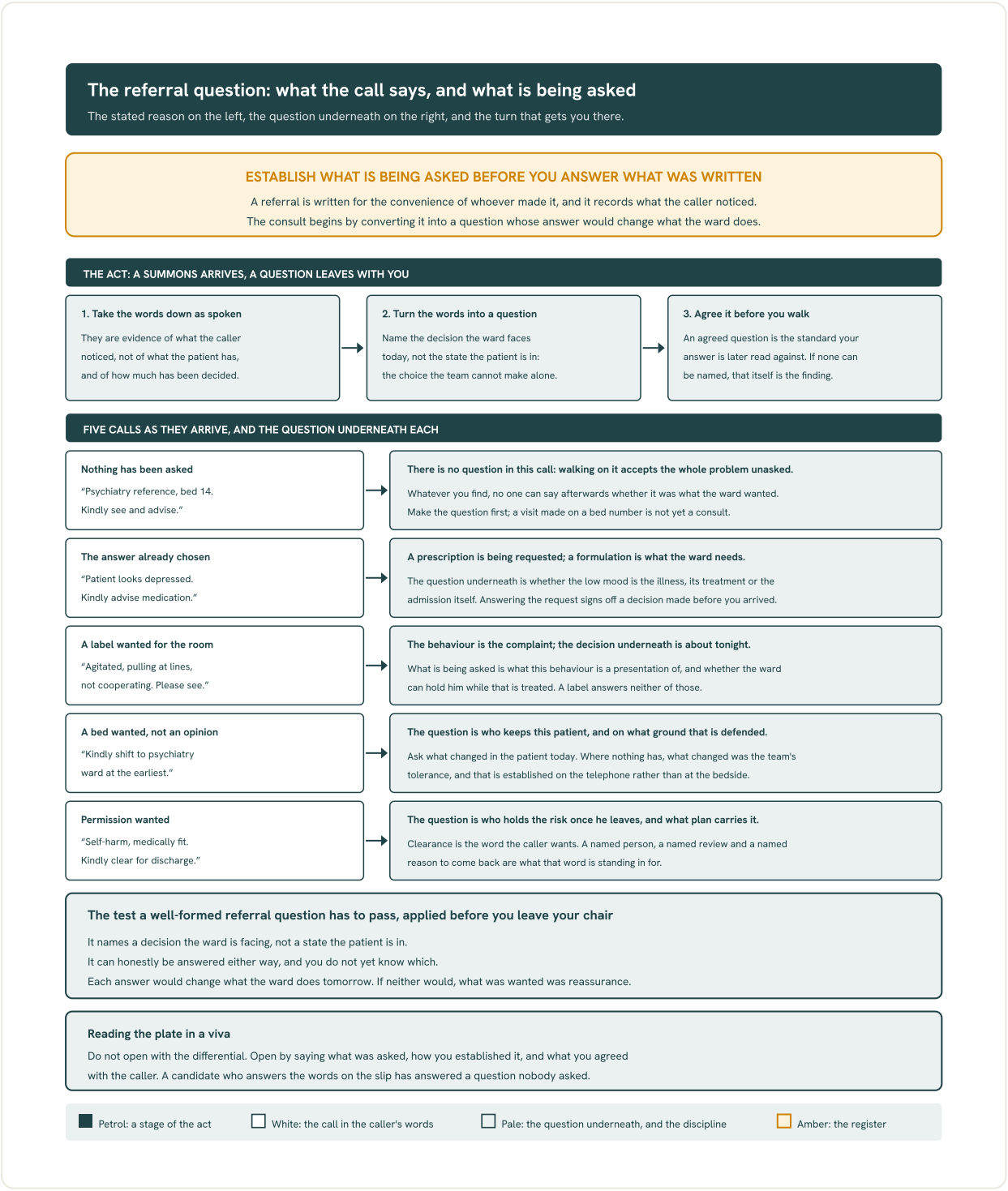


Fig 29.2. The referral question drawn as an act of extraction rather than as a list of reasons for referral, with the three stages by which a summons is turned into a question the consult can answer, five ordinary ward calls set beside what each is actually asking and what is lost by answering the words instead, and the test a well-formed referral question has to pass before the psychiatrist leaves the chair.

2.1 Whose need the consult answers, and what changes because of it

The person who telephones is the **consultee**, and naming them properly fixes three things candidates get wrong. Consent to be seen cannot be inferred from the referral, because the referral was not made by the person being seen. The referral question cannot be read off the

request, because the request was written for the convenience of whoever made it. And the output is a recommendation inside somebody else's treatment, so it must be written for a physician to implement rather than for a psychiatrist to admire.

RULE **The referral is the treating team's felt need, not the patient's request, and everything procedural in this topic follows from it.** It is why consent to be seen must be established rather than assumed, why the referral question must be extracted rather than received, why the psychiatrist speaks to the consultant and not only to the file, and why a patient may decline without anything having gone wrong. A consult conducted as though the patient had walked into a clinic is procedurally wrong even when the diagnosis is right.

2.2 Where general-hospital psychiatry began in India, and how the service is actually run

Indian psychiatric services were confined to mental hospital settings until the general hospital psychiatric unit appeared. The Indian account credits the first such unit, in the early 1930s, to **Girindra Shekhar** at R. G. Kar Medical College and Hospital, Calcutta, with rapid growth through the late 1960s and early 1970s; the source sentence dates it inconsistently within one clause, so the decade is given and no year asserted. The point is not historical. Most Indian postgraduate psychiatry training now happens inside general hospitals, and the same chapter observes that liaison work is still not emphasised within it. The trainee stands in the setting and is not taught it.

What the service looks like has been measured. A survey of ninety Indian training centres, as the 2022 overview reports it, found liaison work delivered as an on-call service in **three quarters** of institutes, with a junior resident as the initial respondent in **60 per cent** of teams. Only a handful included psychiatric nurses, psychiatric social workers or clinical psychologists. Most had no specific liaison posting for junior or senior residents, and fewer than half ran joint academic activity with other specialties. The respondents' own prescription was a dedicated liaison team.

That describes a failure mode, not simple under-resourcing. A service answered on call by its most junior member, with no protected posting and no shared teaching, can only respond: it accumulates no case-mix, no relationship with a ward, no reputation to generate the next referral. The commonest diagnostic categories across those centres were delirium, substance use disorders, self-harm and depression, the case-mix produced by whatever is loud enough for a busy team to notice.

2.3 The referral rate, and the gap it conceals

There is no single Indian referral rate, and quoting one is an error of construct rather than of arithmetic. Reviewing Indian data across institutes, Grover and Singh give it by setting: 0.01 to 3.6 per cent from the inpatient setting, 1.42 to 5.4 per cent from the emergency setting and 0.06 to 7.17 per cent from the outpatient setting, against a cross-institutional international range reported as low as under 1 per cent and as high as 13 per cent. Three settings, three denominators. An inpatient rate asks how often a ward that already holds the patient thinks of psychiatry; an outpatient rate measures a filter operating before admission.

The same discipline governs the morbidity figures the rate is compared against. Grover and Singh estimate psychiatric morbidity at about 30 per cent among medically ill inpatients and 50 per cent among primary care attenders. The overview chapter states that 20 to 46 per cent of patients with physical disorders admitted to medical or surgical wards have at least one diagnosable psychological comorbidity. The cardiology chapter puts prevalence in liaison populations at 48 to 87 per cent across cardiovascular, musculoskeletal and orthopaedic patients. These are not competing estimates of one quantity: unselected admissions, already-referred patients and single-specialty cohorts are three populations, and the population is part of the number. A percentage quoted without its denominator is not a fact.

Where the argument becomes clinical. Two Indian studies close the loop by measuring prevalence and referral in the same unit, which removes the denominator objection and makes them the most useful pair of figures in the topic.

68.5%	1.71%	65.5%	2.4%
DELIRIUM PREVALENCE MEASURED IN ONE INDIAN INTENSIVE CARE UNIT	PSYCHIATRIC REFERRAL RATE FROM THAT SAME INTENSIVE CARE UNIT	PSYCHIATRIC MORBIDITY AMONG ELDERLY ATTENDERS AT A MEDICAL EMERGENCY	PSYCHIATRIC REFERRAL RATE FROM THAT SAME EMERGENCY SETTING

TRAP **Reading a low referral rate as a low burden of psychiatric illness.** Candidates quote the Indian referral figures as though they measured the psychiatric morbidity a hospital contains. They measure how much of it is sent. The same-setting pairs settle it: the denominators are identical and the gap is not a rounding difference. A service with a very low referral rate is not a service with little to do; its case-finding has failed, and what needs interrogating is the referral pathway rather than the prevalence.

2.4 Who is referred, and what the caller owes you

The 2022 overview adopts a six-group classification of liaison patients, attributed to a consensus of the European Association of Consultation-Liaison Psychiatry and the Academy of Psychosomatic Medicine. It is the only compact answer to what a liaison service is for.

1. Comorbid physical and psychiatric disorder where managing one complicates the other.
2. **Medically unexplained symptoms** presenting in clinical services, taught as an entity in the Somatic-symptom, sexual, impulse-control disorders and suicide notes.
3. Mental and behavioural disorders attributed to general medical conditions or to their management.
4. Psychiatric patients attending a medical setting for a diagnostic or therapeutic procedure.
5. Suicidal or self-harming behaviour arriving in an emergency or medical unit.
6. Health behaviour, personality traits, cognitive function or social circumstances that influence management of the medical condition.

What arrives is narrower than that spread. Writing about the emergency setting, Ghosal and Ray name **confusion with behavioural abnormality** as the commonest cause of referral in Indian liaison settings, and note that in intensive care it is often called intensive-care psychosis. The first

discrimination the consult owes is therefore between a neurocognitive disorder and a primary psychiatric condition presenting with behavioural disorganisation. The entity, its criteria, its screens and its treatment belong to the Stroke, TBI, delirium and focal brain syndromes notes; what belongs here is that the commonest thing you are called for is the thing most easily misfiled as psychiatric.

The Indian account also sets out what the caller should convey: who is calling, the patient's demographic details including hospital number, any anticipated language difficulty, the location in the hospital, the primary diagnosis and reason for admission, the psychiatric concern for which the opinion is sought, and the urgency. Two parallel instructions written for referring physicians are sharper still: do not initiate a call without examining the patient, and do not initiate a consultation without informing the patient or the caregiver.

IN INDIA

The Indian chapters describe the referral call not as it ought to be but as it is. Grover and Singh record that in practice it is limited to informing the psychiatrist to come and see the patient on a given bed number. There is no referral question in it, and a psychiatrist who walks to the ward on it has accepted the whole diagnostic problem without knowing what was asked. Two questions turn it back into a consult before you leave your chair: what has changed in this patient today, and what do you want from me.

2.5 Receiving the call, and the patient's right to decline

The Indian account gives the psychiatrist a checklist for the call itself, and it is not a courtesy list. Respond politely and seek clarification of the issue. Establish when the patient will actually be available, and what will obstruct communication: language, a tracheostomy, other medical devices. Ask whether the referral was discussed with the patient and the caregiver and whether consent to be seen was obtained; whether the referral is an outcome of the treating team's frustration rather than of a change in the patient; and how urgent it is.

One clause outweighs the rest and is the most examinable sentence in the procedure: the patient has the right to refuse psychiatric assessment, and this should be respected if possible. It is easy to miss, because a medical admission has already normalised examination by strangers. A patient who declines has obstructed nothing: record the refusal, tell the consultee, and leave the door open rather than persisting on the team's authority. Capacity and treatment refusal proper are taught separately; this is an operational rule that applies before any capacity question arises.

GOOD TO REMEMBER

Before writing your own note, ask the person who telephoned to write theirs: the Indian account makes it an explicit step to ask the consultee to document the reason for the call in the file. It fixes the referral question in the record rather than in your recollection, so your answer can be read against what was asked; it commits the team to having wanted something, which is what makes a later review meaningful; and where the call arose from exasperation rather than from a change in the patient, this is usually where that becomes visible.

2.6 Urgency: how it is graded, and where the grading belongs

Ghosal and Ray present the **Mental Health Triage Scale** with five colour-coded urgency bands and explicit response windows. The scope is the examinable part: it is an emergency-room instrument, offered as something emergency and primary-care personnel may be trained to use, and it is not a standard for answering a ward call.

BAND	RESPONSE WINDOW	PRESENTATION THE BAND IS WRITTEN FOR
Immediate (red)	Immediate response, with referral to security or police	Violent aggression, possession of a weapon, an attempt at self-destruction
Emergency (orange)	Usually within **four hours**	Clear intent, plan and arrangement to harm self or others; very high-risk behaviour with confusion and disorganised behaviour
Urgent (yellow)	Within twenty-four hours	Suicidal intent without a clear plan, rapidly increasing confusion, psychotic behaviour
Semi-urgent (green)	Within seventy-two hours	Mood disorder or apparent psychosis without suicidal intent, uncooperative behaviour on the ward
Nonurgent (blue)	Within four weeks	Known stable psychiatric disorder requiring follow-up

The scale's own primary publication is not available to quote, so the windows are attributed to the chapter that prints them rather than to the instrument's authors. In a recent Indian tertiary-hospital study using the scale the yellow zone was the commonest zone of referral: the modal emergency referral is genuinely urgent without being immediate, and a service configured only for the red band mishandles most of its work.

For the ordinary inpatient call there is no equivalent figure. No comparable standard is available to quote, and none is invented here. What exists is a behavioural rule rather than an interval: respond in a timely way, and tell the team the time frame in which the referral will be attended. Naming your own time frame is what converts an open-ended promise into something a ward can plan around, and it is the honest answer to an examiner.

2.7 The preparatory phase, and the consult at the bedside

Ghosal and Ray draw the sharpest structural contrast in the topic: in individual practice there is no interval between the appointment and contact with the patient, whereas the liaison setting has a compulsory **preparatory phase** the psychiatrist must complete first. Skipping it is how a competent psychiatrist produces an incompetent consult.

- The current medical diagnosis and the treatment being given.
- A review of all available papers in the chart, not the summary handed to you.
- Any past or ongoing psychiatric illness, and how it was treated.

- Direct communication with the treating or referring consultant to understand their conceptualisation of the case, what they need, and where they want the focus.
- For an inpatient, the observations of the nursing staff or the duty doctor.
- For an inpatient, word sent to a family member to be present at the interview.

The bedside sequence is a psychiatric assessment with additions that only make sense in a hospital. Review the treatment record first, including the sleep chart and the nursing observation record. Introduce yourself and take verbal consent, with caregiver consent where the patient is not competent to give it. Find a private area or quiet side-room, which on an open ward takes effort. Take the history keyed to onset, symptom type, fluctuation, and relation to events in treatment. Examine physically, then perform a detailed mental status examination; the interview and the examination themselves are taught in the Psychotherapies, clinical assessment, MSE and nosology notes. Cover, without exception, cognitive functioning, catatonic features, substance use with quantity and time of last intake, overdose and withdrawal, suicidality, sexual behaviour, poisoning, trauma, nutrition and infection.

What distinguishes this from an outpatient interview is the step candidates omit: having established the phenomenology, look deliberately for links to medications, surgery, the fact of hospitalisation, the disclosure of the diagnosis, the behaviour of the team, a mismatch between what the patient expected and what is happening, and the physical environment: lights, sound, indwelling tubes and neighbouring patients. Each is a candidate cause absent from outpatient practice, each is potentially reversible, and several are reversible by the ward rather than by the psychiatrist.

2.8 The note, and the three-way aetiological question

The Indian account itemises the liaison note, and the list is the consult's intellectual content rather than its paperwork.

- The provisional or differential diagnoses, stated by current nosology.
- The probable aetiology of the psychiatric condition against the background of the medical illness: whether there is **mutual causation, comorbidity or coincidence**.
- The probable interaction of the psychiatric treatment proposed with the ongoing medical treatment and the treatment milieu.
- A comment on the biopsychosocial background relevant to management, including developmental issues, current personal stressors and personality.
- Any evidence of immediate risk to self or others, with the need for or the decision about transfer to a psychiatric ward.
- Any adjustment needed from the treating team itself to manage uncooperative behaviour.

Build the answer around the second of those. The question is not taxonomy: each answer sends the consult somewhere different. Mutual causation makes the psychiatric problem part of the medical plan, and it is the finding that most often changes what the ward does next. Comorbidity means two conditions treated concurrently, which puts the weight on interaction and sequencing.

Coincidence means the illness would be present in this patient anywhere, so the honest recommendation may be continuity of existing treatment. A candidate who writes a diagnosis and a drug has skipped the only question that required a psychiatrist to attend.

> The consult ends when the consultant who called has been spoken to, not when the note has been written.

2.9 Feeding back, and the etiquette that keeps you invited

Writing in the file is explicitly not sufficient. Ghosal and Ray say that beyond notes on paper certain further things are advisable: the psychiatrist should communicate directly with the treating consultant, at least by telephone, resolve the team's doubts from a mental health perspective, give the overall formulation, and suggest a comprehensive treatment plan. The verbs are advisable and should rather than must, and are worth quoting as written. A note transfers information; a conversation is what lets the team say your recommendation is impossible on their ward, which is how good psychiatric advice ends up never implemented.

The same chapter reproduces ten commandments for the liaison psychiatrist, attributed to Pasnau, and they should be attributed that way, as a framework reproduced inside the Indian account, because the original is not available to quote.

MNEMONIC

Be concrete; do not obfuscate, procrastinate, preach or steal

The commandments **Pasnau** sets for the consultant, in the order a consult uses them. **Concrete:** recommendations written clearly enough for the physician to implement without translation. **Obfuscate:** no jargon and no irrelevant psychiatric detail, in simple language any physician can understand. **Procrastinate:** do not leave a call unanswered. **Preach:** do not teach or offer unnecessary advice to the physicians. **Steal:** discuss with the consultee who will be the patient's primary physician in the long term.

The last reads as manners and is not. Settling openly who holds the patient prevents two failures: a patient followed by nobody because each side assumed the other, and a team that stops referring because referral feels like losing patients.

2.10 Who keeps the patient, and who owns the decision

The request to move the patient to the psychiatry ward is the standing point of friction in liaison work, and the Indian account answers it with criteria rather than with a rule.

PRESENTATION	WHERE IT IS MANAGED	WHEN TRANSFER BECOMES APPROPRIATE
Delirium	Continues in the medical ward, with regular psychiatric observation	Not on the ground of the behavioural disturbance itself
Substance use disorder	Medical ward while medical complications are stabilised	After initial stabilisation of the medical complications
Depression, suicidality or psychosis with serious medical morbidity, where a medical emergency may emerge	Medical ward, under regular psychiatric supervision	Only in stable medical conditions, such as a patient not on any ports and not requiring oxygen therapy, and then with regular observation by the medical team

The reasoning under the first row is what an examiner tests. The transfer is requested because the behaviour is unmanageable on a medical ward; the answer is that the behaviour is the presentation of an acute medical problem: physicians and surgeons need to understand that this is a medical emergency due to an underlying medical cause, with psychiatric manifestations. Moving the patient moves them away from the investigation and treatment that will resolve it. The entity belongs to the Stroke, TBI, delirium and focal brain syndromes notes. What this topic owns is the negotiation, and the fact that the psychiatrist's job here is to decline the transfer while accepting the work.

On formal responsibility, be careful. What is stated is operational: the primary team must be told what is required before a transfer, delirium stays where it is, the consultee records the reason for the call, and the long-term primary physician is settled by explicit discussion. Whether the recommendation is formally advisory, and where clinical and legal responsibility rests once it is made, is not stated in terms by any available Indian source. No comparable statement is available to quote, and none is invented here. Describe the decision as negotiated with the primary team, and do not convert the transfer criteria into a claim about liability.

2.11 What happens after the consult

Documentation is deliberately duplicated: the consultation is documented in the primary treating team's medical records and in separate treatment records kept by the psychiatrist. The reason is structural: the team's file is where a recommendation must live if it is to be acted on, and it travels with the patient to whoever is on duty tonight, while the psychiatrist's own record is the only place a longitudinal psychiatric account survives once the chart is closed.

Two obligations follow the note. The patient is reviewed from time to time during the admission and followed up even after discharge from the inpatient unit; no review frequency is specified and none should be inferred. One interval is: where a major psychiatric diagnosis is confirmed and pharmacological treatment started, follow-up should be **within a week** at the latest, with regular psychiatry outpatient follow-up after discharge stated as obligatory. Where no definitive diagnosis was reached, the recommendation is regular follow-up with psychometric evaluation and symptomatic management rather than a diagnosis asserted to close the episode. That

distinguishes a liaison service from an opinion service: the honest output of a single ward visit is often an unfinished formulation.

2.12 Models of the service, and the case for building one

The principles and models of consultation-liaison psychiatry are set out in the Indian overview along three axes rather than one list, by focus of consultation, by function and by focus of work, with fourteen named models distributed across them. The axes matter more than the names, because they say what a service has chosen: whether the unit of attention is the patient, the crisis, the consultee or the situation; whether the psychiatrist consults, liaises, bridges or works autonomously; and whether the work is organised around critical care, biological treatment, the ward milieu or an integrated model. Competing classifications exist and are not interchangeable, so name the axis and the source rather than merging two schemes into one table.

The distinction that does most clinical work cuts across all three axes. **Reactive** practice means the patient is seen only after the primary team refers. **Proactive** practice puts the mental health professional inside a **behavioural intervention team**, a multidisciplinary consultation service attached to the medical or surgical unit itself. Its stated benefits are easy access to mental health services, reduced length of stay, early detection and treatment, education of colleagues in behavioural problems and better relationships with other specialties; the same chapter notes that in patients with combined physical and mental disorders, earlier referral to liaison psychiatry is linked to a shorter length of stay.

A service answered on call cannot detect early, so the referral rate measures the model as much as the ward's awareness. One worked Indian example exists. For psychodermatological work the preferred set-up is a clinic comprising a psychiatrist, a dermatologist and a clinical psychologist, as followed at Kasturba Medical College, Manipal, with the source's hedge preserved: because of a dearth of specialists such a composite set-up may not be possible across the country.

The economic argument, used when a service has to be funded, must be quoted with its provenance intact. The Indian overview reports that psychiatric consultation brought the average stay at Denver General Hospital down from 28 days to 16 days, as Billings reported in 1937, and that strategies training primary-care physicians to manage outpatients with hypochondriasis, reported by Smith in 1986, decreased medical costs by 49 to 53 per cent without affecting patients' health or satisfaction. Both are historical United States findings reported at second hand, and neither is an Indian cost-effectiveness result; the chapter's own position is that Indian cost-effectiveness research is what is missing. Quote them as the classic economic argument, and say so.

3 · Psychiatric aspects of medical and surgical illness

Why the marks are here. Almost every other topic in the syllabus begins with a syndrome and works outward to its causes. This one begins with a body that is already ill and works inward. The psychiatric aspects of medical and surgical illness are set as one wide question, and the answer that scores is not a catalogue of organs with a syndrome hung on each. It is an account of what recurs on every ward whatever the specialty, of the several different routes by which an ill body

generates a psychiatric presentation, and of the reading habits that stop a psychiatrist mistaking one route for another. An examiner can usually tell within two sentences whether a candidate has stood on a medical ward or only read about one.

Four neighbouring subjects are named here and deliberately not taught. The patient's own psychological work of being ill, the adaptations and reactions a serious or chronic diagnosis sets going, is taken up separately in this chapter, as are the high-stakes settings of transplantation, dialysis and intensive care, the specific cross-links between psychiatry and cardiology, dermatology and nephrology, and the psychiatric care of people with cancer. What belongs here is the general case: the signature that does not change when the ward does, read in both directions, and what it obliges you to do about it.

3.1 What a psychiatric signature is, and the four routes that produce one

A **psychiatric signature** is the recurring pattern of psychiatric presentation that a class of physical illness produces, taken across many patients rather than in one. It is a probabilistic statement and not a diagnostic one: it tells you what to look for and how high your prior should be, never what this patient has. Candidates lose marks by treating a signature as a criterion set, and lose them again by treating it as though every organ owned a private syndrome.

Four different things are folded into that single phrase, and prising them apart is most of the clinical work.

- **What the disease does.** The illness acts on the brain directly, through metabolic, inflammatory, endocrine, vascular or hypoxic mechanisms, and the psychiatric presentation is a part of the disease rather than a response to it.
- **What you gave it.** The treatment rather than the illness produces the picture: a drug, a procedure, the ward environment, or a withdrawal state manufactured by stopping something the patient was taking at home.
- **What it means.** The patient's own reading of the diagnosis, the prognosis and the lost function, which is where a great deal of the distress on a general ward actually lives, and which is taken up separately in this chapter.
- **What it hides.** The reverse case, in which what presents as a primary psychiatric disorder is the first visible sign of an undiagnosed medical disease.

MNEMONIC

What it does, what you gave it, what it means, and what it hides

The four routes in the order a ward consult meets them. **What it does:** the disease acting on the brain. **What you gave it:** the drug chart, the procedure, the environment, the withdrawal state. **What it means:** the patient's reading of what has happened. **What it hides:** a medical disease presenting psychiatrically. The first two are the ones you can establish from documents before you reach the bedside, the third is the commonest, and the fourth is the one whose miss is least forgivable.

Deciding which route is operating in a particular patient, and committing that decision to the record, belongs to the consult itself and is taught with it. What this topic supplies is the material out of which that decision is made.

3.2 The constant across specialties

The most useful single fact in this topic is that the presentations vary far less than the syllabus implies. The consultation-liaison guidance published in the Indian Journal of Psychiatry in 2022 states it without qualification: across all medical specialties and all ages, the commonest psychiatric symptoms and morbidities are stress, anxiety, depression and **somatic distress**. Not an organ-specific list. The same handful, on the cardiology ward, in the burns unit, in the renal clinic and the surgical side-room.

Two consequences are worth building an answer around. The first is procedural. If the presentations are constant, the opening move on any referral is constant too, and a candidate who cannot state that move has no method, only a memory of organ lists. The second is that the specialty is informative about mechanism and not about presentation. Knowing which ward telephoned tells you which drugs are likely to be on the chart, which metabolic derangements are plausible, what the operation did, and what the illness probably means to this patient and this family. It does not tell you what you will see when you pull the curtain back.

RULE **The specialty predicts the mechanism, not the presentation.** Whichever unit calls, you will meet stress, anxiety, depression or distress expressed in the body. What changes across the corridor is why it is there and what you may safely do about it: the disease process available to act on the brain, the drugs on that unit's chart, the procedures it performs and the meanings its diagnoses carry. An answer opening with a per-organ catalogue has inverted the subject and will run out of time before it reaches what is actually examined.

Somatic distress deserves separate attention because it is the presentation most likely to be misread by everyone in the room, by the medical team as a failure to find the lesion and by the psychiatrist as an absence of psychiatric illness. The disorders themselves are taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. What belongs here is simply that a medical ward will hand you this presentation as often as it hands you low mood, and that it arrives labelled as a diagnostic failure rather than as a referral question.

3.3 The step from the community to the ward

The second grounded fact is the size of the step between a general population and a hospital population. The same Indian guidance measures that step for depression and gives a band for anxiety, and both are worth carrying into the examination hall.

about 10%	up to 30%	20 to 30%
PREVALENCE OF DEPRESSION IN THE COMMUNITY, THE GUIDANCE'S BASELINE	PREVALENCE OF DEPRESSION REPORTED IN DIFFERENT MEDICAL UNITS	PATIENTS IN MEDICAL SETTINGS PRESENTING WITH ANXIETY DISORDERS

Read those as figures for depression and anxiety specifically, not for psychiatric morbidity in general, which is a wider quantity with its own literature. The step itself is a prevalence

observation and carries no causal claim on its own: more than one of the routes above is operating simultaneously in any medical unit, and none of them is measured by a prevalence figure. Illness acts on the brain, treatment acts on the brain, and being ill means something to the person; the count cannot say in what proportion. For stress and for somatic distress the same guidance gives no comparable figure. No comparable standard is available to quote, and none is invented here.

What the step does change is your threshold for asking. If the prior probability of depression on a medical ward is several times the community figure, a negative has to be earned rather than assumed, and screening only the patients who look sad will systematically miss those whose presentation has been absorbed into the medical picture. That, and not the arithmetic, is what the figure is for.

3.4 Which way the fraction runs

The current Indian clinical practice guideline for the assessment and management of depression, published in the Indian Journal of Psychiatry in 2026 by Tripathi and colleagues, tabulates how often other conditions accompany major depressive disorder. The table is headed as the prevalence of comorbidities in major depressive disorder, and that heading fixes the direction of every fraction in it: the denominator is the depressed population, not the medically ill one.

COMORBIDITY	SHARE OF PATIENTS WITH MAJOR DEPRESSIVE DISORDER	WHAT IT CHANGES FOR YOU
Anxiety disorder	**67 per cent**	The commonest travelling companion. A management answer for depression that never mentions anxiety has left out most of the patients it is about; the disorders themselves belong to the Anxiety, OCD and trauma-related disorders notes.
Obsessive-compulsive disorder	40 to 80 per cent	Quote it as the range it is. A band this wide is a statement about the spread of the underlying studies, not a point estimate waiting to be averaged.
Attention-deficit hyperactivity disorder	53 per cent	Inattention and restlessness in a depressed inpatient are not automatically depressive symptoms.
Substance use disorder	25 per cent	Withdrawal risk and interaction risk both change before a single dose is written up.
Irritable bowel syndrome	37 per cent	Abdominal symptoms in a depressed patient may be a comorbid disorder rather than distress expressed through the gut.
Parkinson's disease	40 to 50 per cent	The highest figure among the physical illnesses listed. The pairing is expected, not incidental, and it should never be explained to a family as a reaction to the diagnosis.
Metabolic syndrome	25 to 44 per cent	Weight and glycaemic consequences of the agent you choose are part of the treatment decision rather than an afterthought at review.
Hypertension	**27 per cent**	Blood pressure is a routine prescribing consideration in this population; the choice of agent belongs to the Mood disorders: pharmacotherapy notes.

Six further rows sit in the same table without a rate that can be quoted against them with confidence: autoimmune disease, eating disorders, epilepsy, multiple sclerosis, Alzheimer's disease and coronary artery disease. Their presence is itself the teaching point, because it tells you the pairing was thought worth tabulating. No dependable figure is available to quote for those rows, and none is invented here. Each of those conditions is taught elsewhere: epilepsy in

the Epilepsy and psychiatry notes, the degenerative dementias in the Dementias and neurocognitive disorders notes, eating disorders in the Eating and sleep-wake disorders notes.

TRAP **Quoting a comorbidity figure with the fraction inverted.** Because the table counts comorbidities within depression, its hypertension row states the share of depressed patients who also carry hypertension. It does not state the share of hypertensive patients who are depressed. Those are two quantities over two denominators, not interchangeable in either direction, and no arithmetic converts one into the other. An examiner who asks how common depression is in cardiac disease is asking for the reverse fraction, which this table does not contain; a candidate who supplies it from here has misread the title rather than the number.

3.5 The drug chart as a differential diagnosis

The most reversible cause of a psychiatric presentation on a medical ward is usually the one written on the chart at the foot of the bed. The same Indian depression guideline tabulates the drug classes reported to induce or exacerbate depression, and the practical value of that table is not that it should be memorised molecule by molecule but that it converts **medication-induced depression** from an afterthought into a standing item on the differential. The categories, as the guideline groups them, are these.

- Cardiovascular drugs and chemotherapeutics, the two classes most likely to be running when a specialty ward refers.
- Antiparkinsonian drugs, and antipsychotics, which is the row candidates forget because it names their own prescribing.
- Stimulants, where the guideline is explicit that the depressive picture usually belongs to **withdrawal** rather than to continued use, so the relevant date is the stop date and not the start date.
- Anti-microbial agents, antiretrovirals and central nervous system depressants.
- Hormonal agents, the row that names adrenocorticotropin, anabolic steroids, glucocorticoids and oral contraceptives, so that both an inflammatory prescription and a contraceptive one land in the same differential.
- A residual category holding agents that belong to no single specialty, among them cimetidine, disulfiram, phenytoin, tamoxifen and the non-steroidal anti-inflammatory drugs.

Note what the taxonomy is doing. It is organised by the ward that prescribes rather than by pharmacological mechanism, which is exactly right for a liaison psychiatrist: you are not asked to predict which receptor produced the low mood, but to read a chart written by somebody else and say which lines on it are candidate causes. The residual category matters most for that reason, since it collects the agent nobody thinks of as psychotropic, started for an unrelated indication by a team that will not connect it to the referral.

IN INDIA

The anti-microbial row is the one that changes most between a Western text and an Indian ward. It names chloroquine, cycloserine, dapsone, ethambutol, ethionamide, isoniazid and metronidazole. Those are not rarities on an Indian general ward; several are ordinary continuing treatment that arrives with the patient rather than being started in front of you, and the referring team may not list them when it telephones because it does not regard them as new. The antiretroviral row raises exactly the same issue. The obligation here is narrow and worth stating in exactly these terms: obtain the full treatment list, including what the family carries in a bag from home, before you accept that a low mood on this ward is primary.

3.6 Running the signature backwards

The fourth route turns a routine consult into a diagnostic emergency, and it is also the most reliably examinable content here, because it can be asked as a short list and marked without ambiguity. The Indian guidance sets out a small set of pairings that run from the psychiatric presentation towards an occult medical cause. Learn them as pairings and not as diseases: what earns the mark is the recognition that a particular combination of psychiatric picture and accompanying feature should send you back to the body.

PSYCHIATRIC PRESENTATION	THE FEATURE THAT SHOULD STOP YOU	CONSIDER, AND WHERE THE CONDITION ITSELF IS TAUGHT
Psychosis	Confusion, seizure, **subacute onset**	Autoimmune encephalitis, taught in the Neuropsychiatry of systemic and neurological disease notes
Depression	Weight loss with severe pain	Multiple myeloma. Not a psychiatric entity; the finding goes back to the treating team
Depression	Anorexia, nausea and abdominal pain	Gastric or pancreatic carcinoma
Depression or anxiety	Panic-like autonomic features with flushing	Paraneoplastic lung carcinoma in an older patient, phaeochromocytoma in a young one
Late-onset mood disorder	**Neuroleptic sensitivity** with a subtle movement disorder	Degenerative brain disease, taught in the Dementias and neurocognitive disorders notes
An apparently dissociative presentation	The label itself, when the psychiatric account behind it is thin	Localisation-related epilepsy, or non-motor vascular lesions including Balint, Gerstmann and Anton syndrome, taught in the Stroke, TBI, delirium and focal brain syndromes notes

Several of those rows share a structure worth naming. In each, the psychiatric diagnosis is entirely plausible on its own and the tell-tale is a feature that is out of proportion to it: weight loss too great for the mood state, pain too severe, autonomic arousal too paroxysmal, drug

sensitivity too marked for the dose given. Disproportion, rather than atypicality, is the signal. A patient whose depression is textbook except that the weight loss is extreme has a more suspicious presentation than one whose depression is merely odd.

The last two rows each carry a further lesson. Age itself narrows the differential, and the assessment of a first mood episode in later life has its own section here. An apparently dissociative presentation, meanwhile, is the psychiatric label most often applied without a positive account of why, and therefore the label under which a neurological diagnosis most easily survives untested.

GOOD TO REMEMBER

Run the reverse check at the end of the first assessment, not after the first treatment has failed. The common version of this failure is not a psychiatrist who cannot recognise an occult malignancy; it is a patient treated for depression for several weeks before anybody asks why the weight loss was out of proportion to the mood, by which time the case has acquired a history of non-response that is then read as treatment resistance. The check costs one question and belongs in the first note.

3.7 Where the per-system detail lives, and the table that is not here

A deliberate omission, and why. There is no single table in this chapter setting out the psychiatric signature organ system by organ system, and that is a decision rather than an oversight. No source consulted here carries such a table. The Indian consultation-liaison guidance distributes the material across **ten** separate organ-system chapters, each carrying its own prevalence figures, its own mechanisms and its own prescribing cautions. A single table assembled across those specialties from recollection would look authoritative and be unverifiable, so none is offered here.

What can usefully be given is the map. The organ systems treated separately in that guidance are cardiovascular, respiratory, hepatic and gastrointestinal, chronic kidney disease, endocrine, stroke and traumatic brain injury, Parkinson's disease, epilepsy, cancer, and human immunodeficiency virus infection with dermatology. The same body of guidance adds settings rather than systems: solid-organ transplantation, intensive care, bariatric surgery, the perinatal period, medication-induced psychiatric disorder and coronavirus disease. That last group is where the surgical half of this topic mostly lives, and it is the reason the subject is titled for medical and surgical illness rather than for medicine alone: an operation is an exposure in its own right, with its own environment, its own drugs and its own meanings.

Most of those are owned elsewhere and should be answered from there rather than from here. Epilepsy is taught in the Epilepsy and psychiatry notes. Stroke and traumatic brain injury are taught in the Stroke, TBI, delirium and focal brain syndromes notes, and the wider systemic and neurological diseases, endocrine disease among them, in the Neuropsychiatry of systemic and neurological disease notes. The localising and lesional groundwork behind all of those sits in the Neurology foundations for psychiatrists notes. Transplantation, dialysis and intensive care, the cardiological, dermatological and renal cross-links, infection with the human immunodeficiency virus, and cancer are each taken up separately in this chapter. What is genuinely owned at this

address is the cross-system pattern, the two directions of reading, the drug chart, and the referral habit that recurs whichever door the patient came through.

3.8 The habit that survives the specialty

Everything above collapses into a short sequence that holds whichever unit called, and it is what an examiner listens for when the question is set broadly. It is deliberately not a screening instrument; the instruments and their scoring belong to the assessment and bedside-testing material taught elsewhere. This is the order of thought.

- Establish the date on which the psychiatric change began, from somebody who saw it, and date every drug on the chart against that date rather than against the admission.
- Ask the treating team what changed in the medical illness itself inside the same window: a result, a complication, a procedure, an escalation of care.
- Ask what the patient has been told, and separately what the patient believes it means, because the two are routinely different and the second is what generates the distress.
- Before closing, run the presentation past the reverse list and satisfy yourself that nothing in front of you is out of proportion to the psychiatric diagnosis you are about to offer.

The first and second steps together are what distinguish a liaison assessment from an outpatient one. In a clinic the psychiatric history is the primary record; on a ward it competes with an obviously more urgent medical narrative, and the temporal relationship between the two is the single piece of information nobody else in the building is collecting. The clinical interview and mental state examination themselves are taught in the Psychotherapies, clinical assessment, MSE and nosology notes; what is added here is the discipline of laying two timelines side by side before interpreting either.

> Every specialty produces the same short list of presentations, so the ward tells you the mechanism and the prescribing, never the syndrome you are about to meet.

Answer the wide version of this question in that order and it holds together, and close it by conceding that the per-system detail is distributed across the specialties and should be answered from the relevant one. That concession is worth more marks than an invented table, because it is what a working liaison psychiatrist would actually say.

4 · Psychological reactions to physical illness and chronic disease

Why the marks are here. A question on the psychological reactions to physical illness is not a question about a disorder, and a candidate who answers it with a criterion set has answered something else. Almost every other topic in this area begins with a syndrome and works back to what produced it. This one begins with a person who has been told something about their body, and asks what they are now doing with that information: what the illness means to them, what it has cost them, and how much of that is visible on a ward round. The patient at the centre of it may carry no psychiatric diagnosis at the end of your assessment and still be the reason the referral was made.

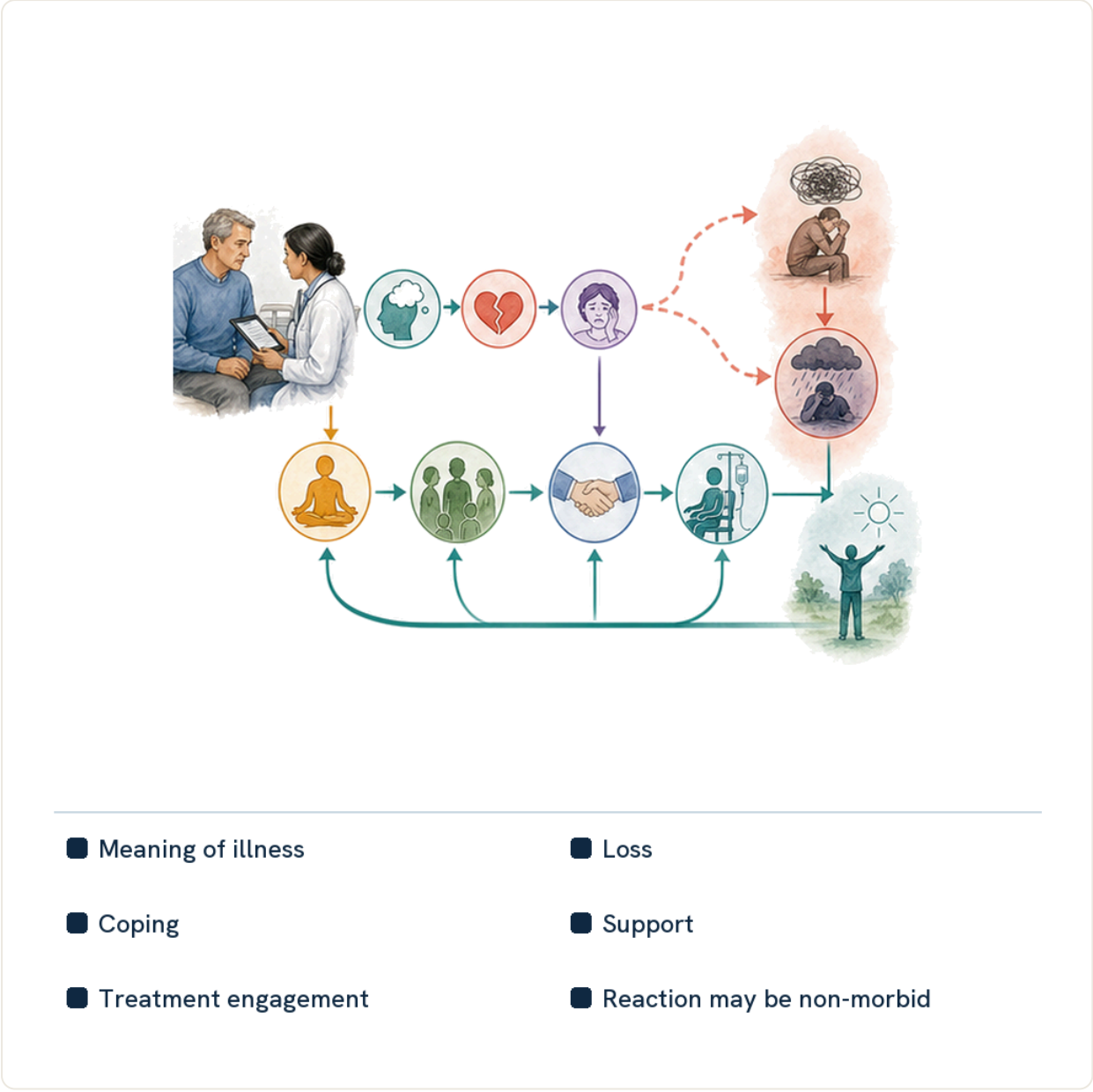


Fig 29.3 Every physical illness evokes a psychological reaction, but that reaction may or may not become morbid. Consultation explores the illness's meaning, losses, coping resources and effect on treatment engagement rather than assuming a psychiatric diagnosis.

Two boundaries keep the answer clean. Adjustment disorder as a diagnostic category, and the psychosomatic concept behind the two-way relation between mind and body, are taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. The psychiatric presentations a physical illness generates through the disease, through its treatment, or by concealing itself behind a psychiatric label, are taken up separately in this chapter. What is owned here is the patient's own work: the reaction, its trajectory across a long illness, and what both of them do to treatment.

4.1 The reaction is universal, the morbidity is not

The consultation-liaison guidance published in the Indian Journal of Psychiatry in **2022** opens this subject with a sentence worth carrying into the hall intact: all physical illnesses and their management cause a psychological reaction, and that reaction may or may not reach **morbid level**. The second half does the clinical work. Because the reaction is universal, its presence is not

a finding, and a patient who appears to feel nothing has told you something about how they are managing the news rather than that no reaction occurred. What varies between patients is how far it goes, and that variation, not the reaction itself, decides whether anything needs to be done.

The same guidance runs the relation in both directions in one sentence: mental illness and stress in their turn predispose to a wide variety of physical illnesses. The consequence for a consult is that the patient's psychological state is never purely downstream of the medical one. It is also an input to the illness in front of you, which is why it is assessed rather than noted in passing.

That is why the same source lists the discrimination among the tasks of the consultation-liaison psychiatrist: the opportunity to assess the reaction to physical illness, and to differentiate it from psychiatric illness presenting in medical and surgical units. Recognising a depressive episode on a surgical ward is one skill. Recognising that the distressed man in the next bed does not have one, and saying so in terms the team can use, is another, and the guidance is explicit about where that leaves him: people referred in this setting may not fulfil the diagnostic criteria for any particular mental disorder, and may nonetheless need support for their psychological difficulties.

RULE **The reaction is universal, so the question is never whether the patient has one, but how far it has gone and what it is costing the treatment.** An assessment that concludes "no psychiatric illness" and stops has answered a question nobody asked. The referring team did not enquire whether criteria were met; it asked what to do about the patient in front of it. A reaction well below any diagnostic threshold can still be the reason a man will not sit up after his operation, and a consult that names it and says what would help has discharged its task.

4.2 Moving or stuck: the judgment the guideline actually asks for

If the threshold is not a criterion count, what is it? The current Indian clinical practice guideline for the assessment and management of depression, published in the same journal in **2026**, supplies the working rule for a response to loss, and it transfers directly to the losses a physical illness inflicts. Enquire whether the person is moving toward acceptance, or has been stuck in one place for a prolonged period. And because there are no universal ways of coping with or dealing with stress, the comparator is not other patients: it is the **premorbid history**, and the question is whether the current response is normal or out of character for this individual patient.

Three consequences follow. The judgment is about direction rather than content, so the intensity of what you see at the bedside settles little on its own: grief that looks severe but is moving is a different clinical object from a flatter picture that has not shifted in weeks. It needs two points in time, which makes a review appointment part of the assessment. And it makes the patient their own control, which is the only comparator the guideline leaves standing.

A second decision sits behind the first: whether pharmacological help is needed, or whether psychotherapy or a support group will suffice. Notice the order. The intensity decision comes after the normality decision and not instead of it, and a candidate who reaches for an antidepressant before establishing direction and character has skipped the step the question was set to test. The choice of agent belongs to the Mood disorders: pharmacotherapy notes.

TRAP **Judging the reaction against how people are supposed to cope, rather than against how this person has always coped.** Candidates make it because a sequence of named phases reads like a timetable, and a patient who is not where the timetable says they should be looks abnormal by arithmetic alone. The guideline forecloses that reading, and what it leaves standing is the premorbid account. The practical form of the error is a diagnosis made on a stranger: a lifelong undemonstrative man recorded as flat and withdrawn by a clinician who never asked anybody who knew him beforehand.

GOOD TO REMEMBER

The comparator has to be collected, and it is not in the medical file. Before recording a reaction as abnormal, get from a relative what this person was like the last time something went badly wrong: how they took bad news, whether they talked or went quiet, whom they told. Then ask the patient what they expected to hear before they were told, because the size of a reaction usually tracks the gap between what was expected and what was said.

4.3 What the reaction costs the treatment

Why it is a treatment variable. The case for assessing any of this rests on outcome, not on sympathy. The same consultation-liaison guidance states that psychiatric morbidity in people with medical illness is associated with a set of negative outcomes:

- higher utilisation of health-care services;
- prolonged hospital stay;
- frequent hospitalisations;
- poor **adherence** with medication;
- higher and earlier mortality.

Read that as a chain rather than as five separate associations. Adherence is the hinge in the middle: a patient not taking the treatment accumulates complications, complications generate admissions, and admissions generate cost and risk. The other entries are largely what adherence failure looks like once it has been running a while. That is what makes the psychological reaction a modifiable determinant of a medical outcome rather than a comment on the patient's mood.

The renal chapter of the same body of guidance states the mechanism in one disease with more precision. Comorbid depression adversely affects the attitude toward medication compliance and compromises sleep quality, and psychiatric comorbidity in chronic kidney disease worsens help-seeking, lifestyle and medication adherence, and so worsens the renal outcome itself. Note the phrasing: attitude toward compliance. What is affected first is not the ability to take a tablet but the reason for bothering, which is the ground the psychological reaction occupies. The direction is stated and the magnitude is not: no effect size, hazard ratio or adherence figure is attached to any of it in that guidance, and none is supplied here.

So the question you are answering is not really whether the patient is depressed. It is why this patient is not getting better, and the psychological reaction is one of the few answers to that question anybody in the building can act on.

4.4 The long illness: biographical disruption and biographical repair

A reaction to an acute illness resolves as the illness resolves. A chronic disease offers no such ending, and the reaction to it is better understood as a trajectory than as a state. The most useful frame treats chronic illness as **biographical disruption**: the illness interrupts the life a person was in the middle of living, and everything after is the work of assembling a life around it. Bury's model, as applied in a 2025 systematic review and thematic synthesis of the qualitative literature on people receiving maintenance dialysis, published in BMC Nephrology, gives that trajectory a usable shape.

59	30	2000-2024
QUALITATIVE STUDIES SYNTHESISED IN THE REVIEW THAT SUPPLIES THIS TRAJECTORY	COUNTRIES FROM WHICH THOSE INCLUDED STUDIES WERE DRAWN	PUBLICATION WINDOW OF THE STUDIES THE REVIEW INCLUDED

Two cautions. The review sits in one disease because that is where the qualitative literature is thickest, and its subject is the patient's experience rather than the psychiatry of the dialysis unit, which is taken up separately in this chapter. It is an international synthesis and not Indian guidance, so no statement about Indian practice rests on it. What travels is the sequence:

- the diagnosis itself, and the initiation of a treatment that cannot afterwards be stopped, as the point at which the biography breaks;
- disabling physical symptoms and functional limitations;
- impaired socio-occupational functioning, which is where the loss stops being private;
- uncertainty and psychological distress;
- changes in self-image and identity.

The order carries the teaching. The early losses are of function and the late one is of self, so two patients with identical results can sit at very different places on it. One still contending with symptoms and limitation is asking what can be done. One who has arrived at a changed sense of who they are is asking something else, and answering the first question when the second was asked is how a well-meant consultation lands badly.

What the review describes next is **biographical repair**, the half candidates leave out. Repair is carried by **coping styles**, meaning the characteristic stance a person takes toward the illness, and by **coping strategies**, meaning the particular things they do. Both are modifiable, which is why naming them matters, and the factors that help or obstruct them divide into what the person brings and what the setting supplies.

FACTOR	WHERE THE REVIEW PLACES IT	WHAT IT GIVES YOU TO WORK WITH
Age and gender	Internal	Fixed, but it predicts which losses matter most: earning, marriage, caring for others, independence.

FACTOR	WHERE THE REVIEW PLACES IT	WHAT IT GIVES YOU TO WORK WITH
Personal beliefs and misconceptions	Internal	Separate the misconception, which is correctable, before anything is called irrational.
Feelings of shame and guilt	Internal	Ask what the patient thinks caused the illness. Self-blame is rarely volunteered and drives concealment.
Financial constraints	Internal	Placed with what the person brings, and often the largest determinant of whether a plan is followed.
Religion and spirituality	Internal	A resource in this model, not a complication. Record what the patient draws on, not only what they suffer from.
Social support	External	Establish who is actually doing it. It is usually one exhausted person, whose state predicts the patient's.
Stigma	External	Governs disclosure at work and at home, and so how much help the patient can accept.
Role of the clinical team	External	The one external factor you control. How the illness was explained is either equipment or obstacle.
Health system factors and the wider context	External	Named as the type of dialysis, the availability and quality of services, and the provision of health insurance. Read generally: what the treatment demands, what is reachable, who pays.

The table puts two entries where a candidate does not expect them. Financial constraint sits among the internal factors rather than among external circumstances, and religion and spirituality sit there too, with what the person brings.

4.5 Coping and resilience as things you assess

The companion assessment chapter in that same Indian guidance states the loop plainly. Chronic and serious medical morbidity, together with hospitalisation, increases the stress on the individual, which in a vicious cycle further worsens the outcome of the illness. To cope with that stress a person needs **resilience**, which in turn predicts a good outcome. So **perceived stress** and resilience are themselves assessed, rather than inferred from whether a diagnosis was reached. The guidance names the settings where this matters most:

- oncology;
- trauma;
- burns;
- patients waiting for transplant.

What those four share is what lets the principle travel to a ward not on the list. In each the outcome is uncertain, the waiting is long, the treatment is itself an ordeal, and the patient has time to think about all three. Those are the conditions under which coping capacity, rather than disease severity, begins to account for how a patient does. Standardised measures exist for both constructs, and the instruments and their scoring are taught in the Psychotherapies, clinical assessment, MSE and nosology notes.

An assessment recording only the presence or absence of a disorder has not examined the thing that predicts the outcome. Asking what this patient has to cope with, and what they cope by, yields something to write down even when no diagnosis is made.

4.6 The classical frameworks, and the vocabulary this section will not invent

Indian guidance points to two classical sources for the psychological reaction to illness. In a 1956 paper titled "Psychiatry and Medical Practice in a General Hospital", Bibring and Kahana classified patients into personality categories, deliberately avoiding psychiatric jargon in favour of language that would help practitioners recognise these patients in their day-to-day work, and explained what disease meant to each patient type and how doctors might best handle their predictable behaviours. The second is Groves, in two essays: one on taking care of the hateful patient, and one on the management of the borderline patient on a medical or surgical ward.

The pairing tells you what the field found it needed. The first framework answers what the illness means to a particular kind of person. The second answers what to do when the reaction has become a problem for the staff rather than a complaint from the patient, and that referral is common and rarely phrased as a psychiatric question. The call reports that the patient is refusing, or demanding, or has upset the nursing staff, and the skill lies in hearing a reaction to illness inside a complaint about behaviour.

The categories themselves are not reproduced here. The guidance pointing to these works does not carry their content in a quotable form, and a personality typology written out from recollection would look authoritative and be unverifiable. Anyone wanting to use either framework should go to the primary work.

The same discipline applies to a vocabulary this topic is often expected to produce. Three words recur in ward teaching and in model answers: denial, regression and dependency. No sourced definition, list or clinical description of them as reactions to physical illness is available at this address. No comparable standard is available to quote, and none is invented here. The better answer is available anyway: describe what the patient is doing, in their own words and the family's. What they have been told, what they say about it, what they are and are not doing about

the treatment, and what has changed since the diagnosis. A behavioural description survives an examiner's follow-up question; a label attached without a source does not.

4.7 Coping in the patient's own frame

A patient's account of what has happened to them rarely arrives in the vocabulary of a textbook. It arrives as something about fate, or duty, or what the family will now have to do. A clinician who waits for it to be restated in clinical language will wait a long time, and will meanwhile record the patient as having no insight into the illness.

An Indian communication published in the Indian Journal of Endocrinology and Metabolism in 2018 demonstrates what working inside that frame looks like. It presents a curated and abridged selection of verses from the Bhagavad Gita, setting out the reactions of Arjuna to stress alongside the way Lord Krishna encourages him to develop and use positive coping skills. Diabetes is the exemplar, but the authors state that the selection is intended to be useful in any illness, and offer the verses to health-care professionals for encouraging healthy coping in people seeking medical care. It is a communication and a teaching resource; no claim about the frequency, classification or outcome of psychological reactions rests on it.

What it demonstrates is a move rather than a content. A patient's own tradition frequently contains a worked account of bearing what cannot be changed while acting where action is possible, and it will be more persuasive to them than anything constructed in a side room. The task is to find out what it is for this patient and work with it, rather than translate it into a mechanism and file it.

The clinical question about any such account is about consequence rather than content: is this belief carrying the patient toward continued treatment or away from it? The same sentence from two patients means two different things. That it is in God's hands can be what makes a decade of treatment bearable, and it can be why a man stops attending for review. Nothing in the sentence tells you which, so ask, and ask again at the next visit.

IN INDIA

Three questions belong in this assessment on an Indian ward, and none is about symptoms. Ask who is deciding about the treatment, because the answer is frequently a family group rather than the patient alone, and the reaction obstructing the plan may not be the patient's. Ask what the patient and the family are already doing that they feel is helping, and record it in the coping assessment: a practice the patient's community sanctions is not a finding, and treating it as one costs you the alliance. Ask what would make the next appointment difficult to keep, because where a chronic treatment is paid for from the family's own pocket, an interrupted course is often an economic event rather than a psychological one, and recording it as poor motivation puts the wrong problem in the notes.

4.8 What changes because of the answer

An assessment of this kind has to end in something the treating team can act on, and it resolves into three dispositions rather than a diagnosis.

Where the reaction is within character and moving, the output is a statement and not a prescription. Say plainly that this is a reaction within this person's range, name what it is a reaction to, and say what would help: information the team can supply, a change to what the patient is being asked to tolerate without explanation, contact with somebody at the same point in the same illness. Saying it clearly stops the team hunting for a disorder and starts them addressing what the patient is reacting to.

Where it is stuck, or out of character, the second decision becomes live and the intensity question is answered on its own terms. Where adherence has already been affected, name that outcome to the team in those words, because it converts an observation about mood into a statement about the medical result they are responsible for, and it is the sentence most likely to get your recommendation followed.

An examiner setting this question is testing whether you can hold two propositions in one answer: that this patient may have no psychiatric diagnosis, and that this patient needs psychiatric input. Assert only the first and you sound dismissive; assert only the second and every unhappy inpatient becomes a case. The space between them is why a general hospital keeps a liaison service.

> A psychological reaction to physical illness is universal and only sometimes morbid: judge it by whether the person is moving or stuck against their own premorbid character rather than against any norm, and report it in terms of what it is costing adherence and outcome.

What arrives on the ward

5 · Delirium in the medically ill (CL perspective)

Why the marks are here. Delirium in the medically ill is examined twice over, and the two questions are not one question asked differently. The first asks what the syndrome is: its definition, subtypes, screening instruments, causes, treatment and prevention are set out in the Stroke, TBI, delirium and focal brain syndromes notes. The second asks what a psychiatrist does when a medical team telephones about a patient who has become difficult overnight. That is the question taken up here, answered in acts rather than criteria: what the call is reporting, what can honestly be established in a single bedside visit, what the note must make happen after you leave, and who holds the decision when you go.

Two boundaries keep it honest. What ageing contributes is taken up where delirium in the elderly is dealt with in these notes; the referral pathway, the negotiation about moving a patient between wards and the models a service can be built on are taken up where the principles and models of consultation-liaison psychiatry are dealt with in these notes. What remains is narrow and heavily examined: consultation work on a condition medical in origin, psychiatric in presentation, and visible mainly to people who are not psychiatrists.

5.1 The call, and what its wording is actually reporting

A ward telephones about **disturbance**, and disturbance is not a diagnosis. The vocabulary of a referral is set by what can be seen from a nursing station across a bay: a patient who has climbed over the cot side, pulled at a cannula, refused a dressing, or simply cannot be settled. That reports an observed act and somebody's difficulty with it. Nothing in it commits the ward to a view about cause, and a candidate who reads the request as a diagnostic proposal has accepted the wrong problem before reaching the bed.

Three things are recoverable from the wording. What changed and when: a referral saying a patient has become uncooperative carries a hidden claim about a before and an after that the ward has usually not examined. Whose distress generated the call: a request from an exhausted night nurse and one from a consultant on a round differ even when the words match. And what is being asked for, which here is generally an act rather than an opinion: sedate, shift, certify, or take over. Answering the act without answering the question is how a consult becomes a prescription.

HOW THE CALL ARRIVES	WHAT THE WORDING IS REPORTING	WHAT THE CONSULT SETTLES FIRST
Not cooperating, pulling at the lines	An observed act and an interference with treatment, seen from the bedside	When it began, against what previous state, and who noticed first
Acute psychosis, please start something	A lay diagnostic label attached to disorganised behaviour by a team with no psychiatric training	That the label is the referrer's inference, and what was observed underneath it
Please sedate for the scan, or for the night	A request for an act, framed so that a refusal reads as unhelpfulness	Whether it is for the investigation, for the ward to cope, or for the patient's safety
Please shift to psychiatry, we cannot manage this	The team's judgement about its own capacity, not about the patient's diagnosis	What specifically cannot be managed, by whom, on which shift
Very quiet since yesterday, probably depressed	A change noticed only because somebody knew the patient before it	Whether the quietness is new, and what else changed the same day

RULE **The referral tells you what the ward can see from the corridor; the consult exists to convert that into something the ward can act on tonight.** Everything procedural here follows: why the wording is examined rather than obeyed, why the change over time is reconstructed from the people who were present rather than inferred from the patient before you, and why the output is instructions to a team rather than a formulation for a psychiatrist. A consult that reaches an accurate diagnosis and changes nothing the ward does overnight has failed at the one thing it was called for.

5.2 The patient who generates no call

Because a referral is generated by disturbance, the **referral filter** selects against the patient who causes no trouble. Someone withdrawn, slowed, staring at the ceiling and accepting every procedure without protest interferes with nothing, and a busy ward records that patient as tired,

low, or comfortable. The consequence is structural: a service that only answers calls sees the population its callers can notice, defined by nuisance rather than by severity.

This is the difference between responding to referrals and **case-finding**, and it costs little on an Indian ward round. While on the unit for one patient, ask the nurse in charge a general question rather than a specific one: has anyone else on this bay changed since yesterday. Treat an answer such as has been very quiet since the operation as a referral, because clinically it is one and administratively it is not, and record what prompted you to look.

5.3 A screen at a bedside you will visit once

You attend once, usually in working hours, for a few minutes of a patient's week. The **observation record** kept by the nursing staff, with whatever the family attendant noticed, covers the rest. Any screen worth leaving behind must therefore be usable by those people rather than by you, because the observations that matter will be made when you are not in the building.

A screen here has a different job from a diagnostic interview: detection, and fixing a time point in the record, rather than closing a question. Which instrument is used, how it is scored and what it is validated against belong to the Stroke, TBI, delirium and focal brain syndromes notes; administering one in front of an examiner is taken up where the demonstration of clinical scales and bedside tests is dealt with in these notes. What belongs here is the choice as a service decision: an instrument only a psychiatrist can administer solves nothing on a ward the psychiatrist visits once a day.

So what is handed to the ward matters more than what is performed at the bed. **Serial observation** means a small number of items, repeated by whoever is on duty, entered in the chart with a time against them. Three properties make such an instruction survive a handover:

- it can be completed by a nurse or duty doctor with no psychiatric training, inside a routine observation round;
- it is timed and written in the ward's own record rather than reported verbally, so a pattern across a day and a night becomes visible to someone who was present for neither;
- it names in advance what result should bring the psychiatrist back, so the ward is not left choosing between doing nothing and declaring an emergency.

TRAP **Reporting one lucid interview as an exclusion.** The candidate sees the patient at midday, finds them oriented and cooperative, and writes that there is no evidence of a cognitive disturbance. That reports one time point as a conclusion and overstates its own instrument: what was observed at a stated hour is a finding, while nothing is present is a claim about hours nobody sampled. It is compounded because a reassuring note stops the ward looking. Write what you saw, when you saw it, and what would change the answer.

5.4 The note as an allocation, not an opinion

What a consultation note must contain in general, and the aetiological reasoning it is built around, are set out where the principles and models of consultation-liaison psychiatry are dealt with in these notes. What is distinctive here is that almost nothing the note asks for will be done

by the psychiatrist. The search for the cause belongs to the admitting team, the ward environment to the nursing staff, the drug chart to whoever prescribes on it, the investigation to the specialty that ordered it. A note written as advice, in the register of a formulation, distributes none of that. A note written as an allocation does.

MNEMONIC

Owner, act, time, trigger

The test to apply to each line before closing the file. **Owner:** the person or role, named, not the team in the abstract. **Act:** what is to be done, in terms the owner can execute without translation. **Time:** when, or by when, since a recommendation with no time attaches to nobody's shift. **Trigger:** what change should bring the psychiatrist back, in observable terms rather than a judgement about severity. A line failing any of the four is an opinion wearing the clothes of a plan.

Two further entries earn their place specifically here:

- an explicit statement of what the psychiatrist is *not* doing, since the commonest misunderstanding here is that a psychiatric opinion transfers the problem. Recording that the cause is being sought by the admitting team, and that psychiatric input runs concurrently rather than in sequence, stops the investigation stalling while each service waits for the other;
- a record of what was not concluded, because a single visit often ends without a settled answer, and naming which possibilities remain open and what would separate them is safer than a label chosen to make the page look finished.

GOOD TO REMEMBER

Write for the person who will read this at three in the morning, not for the consultant who requested it. The reader who acts on it is the night duty doctor or nurse in charge, working alone, without the conversation you had on the round. Put the acts and their owners first, the formulation beneath, in plain language. A recommendation that must be interpreted before it can be carried out will not be carried out.

5.5 Who holds the decision, and what nothing here settles

The maxim is that the consultant advises and the treating team decides, repeated widely enough that candidates state it as a rule of law. Handle it carefully. Whether a liaison recommendation is formally **advisory**, and where responsibility for accepting or declining it rests, is not stated in terms by any source available for this section. No comparable standard is available to quote, and none is invented here. What can be reasoned from the structure of the situation is examinable, and it is most of what a candidate needs.

Begin from what the psychiatrist demonstrably does not control: not the bed, not the drug chart, not the investigation list, not the discharge. Every recommendation therefore needs an act by somebody else before it becomes treatment, which makes the practical task the reduction of friction between advice and execution. Three positions follow without depending on any contested rule about responsibility:

- put the recommendation where the acting team will find it, in the record they use, not in a document only psychiatry reads;
- make disagreement visible instead of repeating yourself, since a recorded exchange protects the patient and the discussion where a second note in identical terms protects nobody;
- where the disagreement concerns risk, state it in the currency of the specialty that must act on it, because a ward moves on what it recognises as danger.

Whether the patient moves to a psychiatric bed is a separate negotiation with its own criteria, settled where the consultation-liaison service and its models are dealt with in these notes; a patient refusing assessment or treatment raises a different question again, taken up where capacity assessment and refusal of treatment in the general hospital are dealt with in these notes. The referral settles neither.

5.6 The statutory floor under the ward consult

One thing is settled, and by statute rather than custom. The service you provide on somebody else's ward is not a favour between departments; it is local delivery of an obligation placed on the state.

IN INDIA

The Mental Healthcare Act, 2017 makes the availability of mental health services a duty of the appropriate Government rather than a matter for each institution to arrange. Under section **18(6)** that duty runs to all general hospitals the Government runs or funds, with basic and emergency mental healthcare available at all community health centres and upwards in the public health system it runs or funds. The ward consult is therefore a **statutory entitlement** of the patient in that bed rather than a courtesy between colleagues, and a general hospital without psychiatric cover is a shortfall against a duty, not a local misfortune. Quote it by number and duty-holder; the range of services required is specified elsewhere in the same section.

Read the provision for what it does and does not do, because an examiner will push on that edge. It establishes that a service must exist and how far down the system it must reach. It does not create a referral pathway, staff a rota, set a response time, or tell a physician when to telephone, and it is silent on the question the previous section left open: who owns the decision once the psychiatrist has attended. It answers availability completely and authority not at all, and a candidate who says precisely that has understood it better than one who recites it.

5.7 What this section hands on

The call reports behaviour	One visit is one sample	The note allocates
THE WORDING NAMES WHAT WAS SEEN AND WHOSE DIFFICULTY IT IS, NEVER A DIAGNOSIS	A SETTLED INTERVIEW AT MIDDAY RECORDS A TIME POINT AND EXCLUDES NOTHING OUTSIDE THAT HOUR	EVERY LINE NAMES WHO ACTS, WHAT THEY DO, BY WHEN, AND WHAT BRINGS THE PSYCHIATRIST BACK

What an examiner is testing. Given a medical inpatient disturbed overnight, the discriminating answer does not begin with a definition. It begins with the call: who telephoned, what they said,

what they wanted, what the wording concealed. It moves to the bedside as a sampled observation rather than a verdict, and to the instruction left for the people present when you are not. It ends with a note allocating acts to owners with times against them. Answer in that order and the entity looks after itself; answer with the entity and the question has not been addressed.

> You are called about behaviour, can sample only an hour of it, and leave holding none of the levers: so the output is not a diagnosis but a set of acts, each with a named owner, a time, and a trigger to call you back.

6 · Somatic symptom and related disorders in CL settings

Why the marks are here. The heading reads like a request for a taxonomy, and answered as one it loses almost everything on offer. What these conditions are, what each diagnosis requires, how the instruments are scored and what is prescribed all belong to the Somatic-symptom, sexual, impulse-control disorders and suicide notes, which open on this group because it carries the largest reclassification in this part of the syllabus. None of it is repeated here.

What is owed instead is the part no taxonomy answers. **Somatic symptom and related disorders** reach the psychiatrist through another doctor's exhausted enquiry rather than through anything the patient, the family or the ward has called psychiatric. That fact governs the consent, the timing, the first sentence of the interview and most of what one visit can achieve.

6.1 The referral nobody in the room asked for

Most consults on a medical ward begin with a change in the patient: new confusion, a refusal, a collapse of mood. This one begins with a change in the referring team, which has run out of investigations it can justify. The patient is usually no different that day, and often does not know the call is being made. That makes it an **unrequested referral**.

The referral is itself an event in the illness. Before you are called, somebody has told the patient something about his results, and whatever was said is the ground you will be standing on. **The handover sentence**, the actual words in which the physician explained the referral, decides whether you meet a man offered another opinion or one told his symptoms are not real. It is not in the file, and will not be volunteered.

RULE **Find out what the patient was told, and by whom, before you ask the patient anything.** The referral has already made a statement about his body and his credibility, and your interview begins as a reply to it. Treat the distance between the referring doctor's words and the patient's account of the same conversation as a clinical finding, not a misunderstanding to correct.

6.2 When the call comes, and what the timing tells you

Timing carries information the referral text does not. The point at which psychiatry is called indicates what it is being asked to absorb.

WHEN THE CALL IS MADE	WHAT THE REFERRING TEAM HAS CONCLUDED	WHAT THE CONSULT DOES FIRST
Early, with investigation still running	That a psychological contribution sits alongside an enquiry that remains open	Take the history without waiting for the work-up, and tell the team so
At the point results come back normal	That nothing has been found, and the absence is itself the answer	Establish what was said to the patient then, and in whose words
After repeated presentations across several departments	That the pattern belongs to the patient rather than any one organ	Assemble the sequence of contacts before going to the bedside
After an intervention has caused harm	That the enquiry must stop, and psychiatry will be the brake	Record by name who still holds the physical questions, so the brake is not read as closure

A referral in the last row is not a delayed version of one in the first. Each asks for a different opening act, and the wrong one spends the only visit many of these patients attend.

6.3 What the patient is being asked to accept

The referral asks two things at once and they are refused together: that the search for a physical cause is finished, and that another kind of doctor now takes it over. A patient described as unwilling to see psychiatry is more often unwilling to accept the first, so opening by explaining what psychiatrists do loses the consult in its first minute.

Two features of the setting make the position harder than in an outpatient clinic. **Investigative momentum** is the tendency of a work-up to continue because it has begun: each further negative raises the cost of stopping for the team that ordered it, so by the time psychiatry is called somebody has usually already lost an argument. And the **contact history**, the ordered account of who was seen, for what, with what result and what each said afterwards, is held by nobody; every department holds its own segment. Assembling it is the most useful thing this consult contributes.

Establish before you reach the bedside:

- whether the physical enquiry is being closed or held open, and who holds it;
- what the family was told separately, and whether the two accounts agree.

> **GOOD TO REMEMBER**
>
> Where the physician is willing, be introduced by him at the bedside instead of arriving alone. It presents the consult as something the medical team has added to its own care rather than the handover that ends it.

Where the team's difficulty is not that the enquiry is finished but that it doubts the patient's account, the question and the method have both changed. That situation is taken up where factitious presentations and malingering in the general hospital are dealt with here.

IN INDIA

Three features of the general hospital press on this referral. Much of the investigation is paid for from the family's own pocket, so a normal work-up is a financial loss as well as a clinical dead end. The contact history is usually long and crosses systems of medicine as well as departments, and is not offered unless asked for without disapproval. And the patient is frequently sent on without being told which speciality, so your arrival at the bedside is the disclosure, made by a stranger. No figure is attached to any of the three: no comparable standard is available to quote, and none is invented here.

6.4 How the heading is asked

Set as a short note it wants the route and the address: who refers, at what point in the medical career, why then, and where the diagnostic account belongs. Set as a long case or bedside station it arrives as a patient with a thick file and normal results, and what is watched is the opening: whether you found out what he had been told before you began, and whether your first question was about his symptoms or his tests.

TRAP **Answering the ward's question with the classification.** Candidates do it because the taxonomy is freshly learnt and feels safe. It fails structurally: the correct diagnostic label was never the thing the referring physician could not produce, so a candidate who supplies it has answered a question nobody asked and left the patient exactly where the referral put him.

Another doctor's exhausted enquiry
HOW THIS GROUP REACHES THE PSYCHIATRIST

Taught in full elsewhere
WHERE THE DIAGNOSES, THEIR CRITERIA AND THEIR INSTRUMENTS SIT

The words already spoken
WHAT MUST BE ESTABLISHED BEFORE THE INTERVIEW OPENS

This group reaches psychiatry when a physician runs out of investigations, not when anyone identifies a psychiatric symptom, so the consult begins by establishing what the patient was already told and by whom; the diagnoses themselves, their criteria and their instruments are read in the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

7 · Capacity assessment and refusal of treatment in general hospital

Why the marks are here. The referral reads: patient refusing amputation, please assess capacity. It is one of the few consults in which a psychiatrist is asked not to describe a mental state but to underwrite or to block somebody else's surgical decision. It is also the consult on which Indian candidates most reliably reproduce a foreign answer, because the schema printed in most textbooks is not the test Indian law supplies. The marks are for knowing which law is in the room, what it actually asks, who else must be brought into the decision, what has to be written in the notes, and what follows when the patient may lawfully refuse.

Capacity assessment and refusal of treatment in the general hospital is two problems wearing one name. The first is a patient with mental illness whose treatment decision falls under a statute that states how capacity is to be judged and what may be done when it is absent. The second is a

physically ill adult with no mental illness who has heard the surgeon out and said no, and for whom Indian law is far less complete than examination answers pretend. Capacity, consent and confidentiality as general clinical doctrine are taught in the Psychotherapies, clinical assessment, MSE and nosology notes, and the admission pathways of the mental health legislation are not re-taught here.

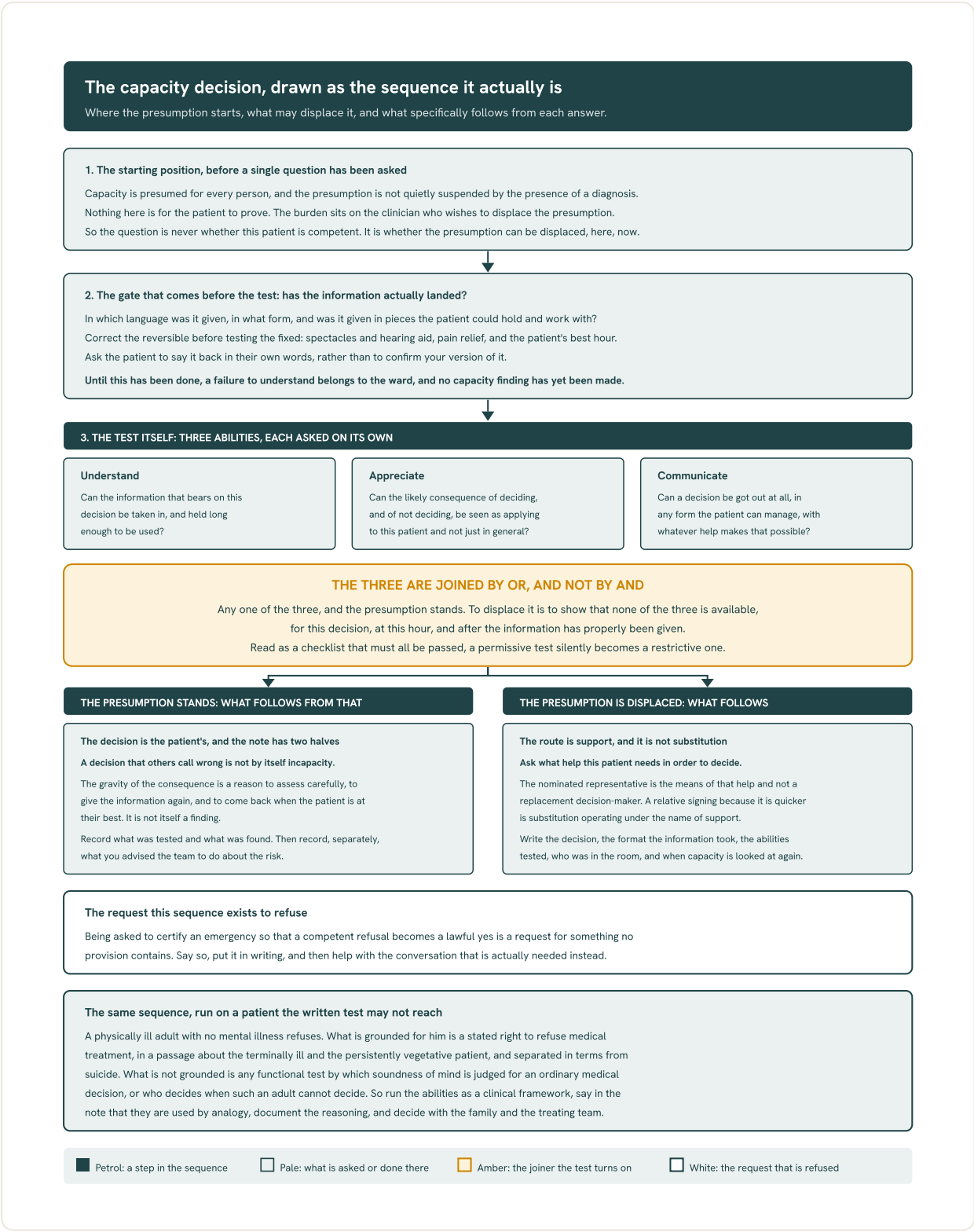


Fig 29.4. The capacity decision drawn as a sequence rather than as a checklist, opening at the presumption that puts nothing on the patient to prove, passing through the gate at which the information has to be given in a form that could land before any ability is tested at all, then the three abilities asked separately and joined at a disjunction that lets any one of them carry the case, and forking into what follows when the presumption stands, where a decision others call wrong is not by itself incapacity and the note has two separate halves, and what follows when it is displaced, where the route is supported decision-making and not a relative signing in the patient's place, with the request to certify an emergency so that a competent refusal becomes a lawful yes marked as the thing the sequence refuses, and the physically ill adult whom the written test may not reach given the same sequence by an analogy that is written down as an analogy.

7.1 Which law reaches the bedside, and how far

Two hinges decide whether the mental health legislation is in the room at all, and they point in opposite directions. The first is territorial and generous. The Mental Healthcare Act, 2017 defines a **mental health establishment** in words that expressly include any general hospital or general nursing home, whether established or maintained by government, a local authority, a trust, a corporation, a society or a private person, and expressly exclude the family residential place in which a person with mental illness lives with relatives or friends. A surgical ward in a district hospital is therefore inside the Act's reach. The ward assumption that the Act begins at the door of the psychiatry unit is simply wrong.

The second hinge is subject-matter and narrow. The statutory capacity test is written for decisions a person makes regarding his own mental healthcare or treatment, and the section names the decision domain three separate times as the treatment or admission or personal assistance. So the Act follows the psychiatrist onto the medical ward, but the test it carries there is scoped to a particular kind of decision. Whether it stretches over a decision about a laparotomy in a patient who also has schizophrenia is the question every real consult turns on, and the section does not answer it. A careful answer says only what is grounded: the establishment is covered, the test is written for mental healthcare decisions, and extending it to a purely medical decision is an argument rather than a citation.

7.2 The statutory test: a presumption, then three abilities

The section gives away the answer in most cases before it states the test. Capacity is **presumed** for every person, and the Act adds the words "including a person with mental illness" so that the presumption cannot be quietly suspended by a diagnosis. A person is deemed to have capacity to make decisions regarding mental healthcare or treatment if that person has the ability to:

- understand the information that is relevant to taking the decision;
- appreciate any reasonably foreseeable consequence of the decision, or of the absence of a decision; or
- communicate the decision, by speech, expression, gesture or any other means.

Now the point that carries the mark. The abilities are **disjunctive**: the section prints **three** abilities and joins them with "or", not with "and". Read as it is written, any one of them makes capacity out. That is a markedly lower threshold than the functional schemas taught in much of the international literature, in which understanding, appreciation, the ability to reason with the information and the expression of a choice are separate hurdles and a patient who fails one has failed the test. The Indian drafting is not careless; it is aimed. The same statute asserts that persons with mental illness have capacity to make treatment decisions and may require varying levels of support in order to exercise it, so a permissive test is consistent with the instrument it sits inside.

MNEMONIC

Understand, Appreciate, Communicate, and the joiner is OR

The three abilities in the order the section prints them, with the conjunction that decides the case. A candidate who memorises the abilities and forgets the conjunction converts a permissive Indian test into a restrictive foreign one, and loses the answer where the difference mattered.

RULE **The Indian statutory test is a presumption plus three abilities joined by "or", not a checklist that has to be passed in full.** The burden sits not on the patient to demonstrate competence but on the clinician who wishes to displace the presumption, and it is discharged only by showing that none of the three abilities is available to this patient, for this decision, at this time, after the information has properly been given.

7.3 The assessment is not finished until the information has landed

A capacity assessment tests what a patient can do with information, so it is only as good as the information given. The Act makes that a duty rather than a courtesy. The information referred to in the capacity test must be given in **simple language which the person understands**, or in sign language, or through visual aids, or by any other means that enables understanding. On a medical ward this is the step most often skipped before a team records that a patient lacks capacity. The surgeon explains the operation in English at the foot of the bed, the patient nods at everything, the nurse writes that the patient seems confused, and a consult is raised. Nothing in that sequence has yet tested capacity, because the first ability was never given a fair chance to operate.

The practical translation is a short sequence the psychiatrist controls. Establish which language the patient is comfortable in, and use it or find somebody who can. Correct the reversible before testing the fixed: spectacles and hearing aids left at home, an assessment timed for the patient's best hours rather than the team's convenience, analgesia before the conversation rather than after it. Give the information in pieces, and ask the patient to say back what has been understood rather than to confirm your version. Only then does a failure to understand belong to the patient rather than to the ward.

The Act also intends the procedure to be standardised rather than left to individual style. It requires the central authority to appoint an expert committee to prepare a guidance document for medical practitioners and mental health professionals containing procedures for assessing capacity, and it obliges every medical practitioner and every mental health professional, when assessing capacity, to comply with that document and to follow the procedure specified in it. Note the reach: it binds the physician and the surgeon who assess capacity, not only the psychiatrist called to confirm it. Whether the guidance document has in fact been prepared and published is a separate question, and it is one this account does not answer in either direction: no comparable standard is available to quote, and none is invented here. State the duty, then say plainly that its implementation is unresolved: the distance between an Act and its machinery is itself an examinable point.

7.4 Refusal is not the evidence of incapacity

Almost no capacity consult is generated by a patient who cannot decide. Almost all of them are generated by a patient who has decided something the team disagrees with. The Act closes that door explicitly. Where a person makes a decision about mental healthcare or treatment that others perceive as inappropriate or wrong, that **unwise decision** does not by itself mean the person lacks capacity, so long as the abilities in the test are present. That is not a legal nicety. A test that treated disagreement as evidence would be circular, and would make capacity a function of how strongly the team feels about the recommended treatment. That is precisely how capacity assessments are misused.

What legitimately raises the question is a change in the machinery of deciding rather than in the content of the decision:

- a fluctuating level of consciousness, or an acute confusional state that waxes across the afternoon;
- an inability to hold the information long enough to do anything with it, or to communicate any decision at all;
- a psychotic belief that bears directly on this decision, such as a conviction that the operating team intends harm.

Delirium is much the commonest of these on a medical ward, and it is taught with the ward delirium material in this chapter, and in older patients with the late-life delirium material.

TRAP **Answering that the patient lacks capacity because the refusal is dangerous.** The gravity of the consequence is a reason to assess carefully, to give the information again, and to come back when the patient is at their best. It is not itself a finding. Candidates slide into it because the alternative feels like abandoning the patient, and because the team asked the question in a form that presupposes the answer. Record the finding about the abilities you tested, then record separately what you advised the team to do about the risk.

7.5 The physically ill adult who says no, and the hole in the law

Now the harder half. A man of sixty with a gangrenous foot and no psychiatric history refuses amputation. He is not a person with mental illness, so the statute discussed above is not obviously his. The highest Indian authority on his position comes from a five-judge Constitution Bench of the Supreme Court of India, whose 2018 judgment states that a person who has come of age and is of sound mind has a **right to refuse medical treatment**, and separates that right in terms from suicide, from physician-assisted suicide and from euthanasia.

Quote it with its context or you will over-claim it. The passage sits inside the Court's discussion of the terminally ill patient and the patient in a persistent vegetative state, so it is not, on its face, a rule for every refusal on every ward. It is nonetheless the sentence to cite, and the separation it draws is clinically load-bearing: a competent refusal that ends in death is not a suicide, so a patient who declines dialysis is not thereby a psychiatric emergency, and does not become one because the physician finds the decision intolerable.

Where the law runs out. The phrase "of sound mind" describes a status, not a functional test: it names the condition the person must be in without saying how to establish it for this decision on this afternoon. That is the gap at the centre of this topic, and it is a gap in the law rather than in the reading. No Indian statute or binding authority is set out here that supplies a functional capacity test for an ordinary physical-treatment decision by a patient who has no mental illness, and none that settles who decides for an adult who lacks capacity and is not a person with mental illness. No comparable standard is available to quote, and none is invented here. The examinable discipline is to say so, and not to import a foreign capacity statute or schema and present it as Indian law, or to assert an Indian best-interests doctrine you cannot cite. What a good answer does instead is reason by analogy and admit it: apply the abilities the Indian statute names as a clinical framework, record in the note that they are used by analogy because this is not a mental healthcare decision, document the reasoning and not only the conclusion, and involve the family and the treating team in a determination no single clinician has been authorised to make alone.

THE SITUATION ON THE WARD	WHAT IS REALLY BEING ASKED	WHAT INDIAN LAW SUPPLIES	WHAT IT LEAVES UNSETTLED
A patient with mental illness refusing psychiatric treatment or admission	Is the statutory test made out for this decision?	A presumption of capacity, and three abilities joined by "or"	How long a finding holds outside a supported admission
A patient with mental illness whose medical treatment cannot wait	May treatment be given now, and on whose consent?	An emergency route open to any registered medical practitioner, on three defined triggers	What happens if the ceiling expires before any establishment has assessed the person
A physically ill adult of sound mind refusing medical treatment	Must the refusal be respected?	A stated right to refuse medical treatment, in a passage about the terminally ill or persistently vegetative patient	The functional test by which soundness of mind is to be judged for an ordinary medical decision
A physically ill adult who cannot decide and has no mental illness	Who decides, and against what standard?	Nothing that can be grounded here	Who the lawful decision-maker is, and the standard the decision must satisfy

7.6 Who else is in the decision

The Indian model is not the solitary competent patient of the Western textbook, and the Act is explicit. The **nominated representative** is a person the patient may appoint, and where none has been appointed the Act supplies a default order of precedence, which is worth reading in the bare Act itself. Two rules about the appointment carry the marks. Appointing a representative, or being unable to appoint one, is expressly not to be construed as a lack of capacity. And persons with mental illness are asserted to have capacity to make mental healthcare or treatment decisions, while requiring varying levels of support from their representative.

Read together, those provisions install **supported decision-making** in place of the substituted decision-making that Indian wards mostly practise, and the distinction is the thing to show an

examiner. Substituted decision-making asks the relative what should be done. Supported decision-making asks what help this patient needs in order to decide, and treats the relative as the means of providing that help. A son who signs the consent form because it is quicker is the substituted model operating under the name of the supported one, and the Act does not authorise it merely because obtaining the patient's own decision would be laborious.

IN INDIA

Before recording that a patient lacks capacity, ask three questions and write the answers into the note: in which language was the information actually given, who was in the room when it was given, and whom has the ward been treating as the decision-maker up to now. Where an accompanying relative countersigns consent as a matter of routine, the format duty is the step that gets skipped, and the capacity opinion then rests on a conversation the patient was never properly part of. Asking the patient to explain the operation back, in their own language, is a bedside test and a legal safeguard in one act.

7.7 What must be written down, and when capacity is looked at again

Capacity is specific to a decision and to a moment, so a finding has a shelf life. The Act fixes that shelf life in one place only, and knowing where is the discrimination. Where a patient needs nearly total support and the nominated representative therefore consents on the patient's behalf during a supported admission, the officer in charge must record that consent in the medical records and review the patient's capacity to consent every **seven days**. Where the admission has run beyond thirty days, the counterpart provision requires the same recording and a review of capacity on the expiry of every fortnight. Two intervals, two admission provisions, and a question that asks which is which.

Then the absence, which is the more useful half. Both duties sit inside supported admission. The Act imposes no equivalent express recording interval on a one-off capacity opinion given as a liaison consult on a medical ward, which is the situation this topic is actually about. That silence is not permission to write once and walk away. It means the review interval is a matter of clinical judgement rather than of statute, and that the judgement has to be justified in the note. A patient found to lack capacity during an acute confusional state and never reassessed has lost a decision to an administrative accident rather than to an illness.

GOOD TO REMEMBER

A capacity note that will survive scrutiny records the specific decision it is about, the information that was given and in what language and format, what the patient could do with that information tested against each of the abilities the statute names, the conclusion for that decision at that time, who else was involved and on what footing, and when capacity will be looked at again and by whom. A note reading only "not competent, family to decide" records none of them, and it is the note that actually gets written.

7.8 When treatment cannot wait

The emergency provision is what makes the Act usable in a general hospital. Its scope is wider than most candidates expect and narrower than most wards assume. Notwithstanding anything else in the Act, any medical treatment, including treatment for mental illness, may be provided by any registered medical practitioner to a person with mental illness, either at a health establishment or in the community, subject to the informed consent of the nominated representative where one is available, and only where it is immediately necessary to prevent death or irreversible harm to the person's health, or the person inflicting serious harm on himself or on others, or the person causing serious damage to property where that behaviour is believed to flow directly from the mental illness. The Act's own explanation extends **emergency treatment** to transporting the person to the nearest mental health establishment for assessment, which is what makes a lawful transfer out of a medical ward possible.

Three limits follow immediately, and they are what a question on this section usually turns on. Nothing in the provision allows treatment that is not directly related to the emergency itself. Nothing in it allows electro-convulsive therapy to be used as a form of treatment under this power. And the authority is limited to **seventy-two hours**, or until the person has been assessed at a mental health establishment, whichever is earlier, extending to a maximum of seven days only during a disaster or emergency declared by the appropriate government.

3	Seventy-two hours	Seven days	Seven days
STATUTORY ABILITIES IN THE CAPACITY TEST, JOINED BY "OR", ANY ONE OF THEM SUFFICING	CEILING ON EMERGENCY TREATMENT, OR UNTIL ASSESSMENT AT A MENTAL HEALTH ESTABLISHMENT, WHICHEVER IS EARLIER	EXTENDED EMERGENCY CEILING DURING A DISASTER OR EMERGENCY DECLARED BY THE APPROPRIATE GOVERNMENT	INTERVAL FOR REVIEWING CAPACITY WHERE THE REPRESENTATIVE CONSENTS IN A SUPPORTED ADMISSION OF UP TO THIRTY DAYS

Now the scope limit on which a whole answer can founder. The emergency provision operates on a person with mental illness. It is not authority to treat a physically ill patient who has no mental illness and refuses, however grave the consequence of that refusal, and it is not a mechanism for converting a competent no into a lawful yes. A surgical team asking the psychiatrist to certify an emergency so that a competent refusal can be overridden is asking for something the section does not contain. The correct reply is to say so, to put it in writing, and then to help the team with the conversation that is actually needed: what the patient believes will happen to them, and who they want in the room when the decision is made.

> Capacity is presumed, the statutory abilities are joined by "or", and a decision that others regard as wrong is not by itself incapacity.

The examiner is testing whether a candidate can hold two situations apart: a statute deliberately generous to the patient and a ward that is not, and a second situation the statute does not reach, where the honest answer names the limit rather than filling it with borrowed law. Both halves are marked, and the second more often than candidates expect.

8 · Factitious disorder and malingering in the general hospital

Why the marks are here. Factitious disorder and malingering in the general hospital are examined as a sequence of acts, not as a pair of definitions. What the two conditions are, how each is separated from the other and from the unconsciously produced somatic disorders, and what the criteria require, are set out in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. The question here is narrower and much harder to answer well. A medical or surgical team has begun to believe that its own patient is producing the illness, has said so aloud on the ward, and has telephoned psychiatry. Everything that follows happens on a ward the psychiatrist does not run, inside a record several services write in, in front of a family, and almost always before anything has been established.

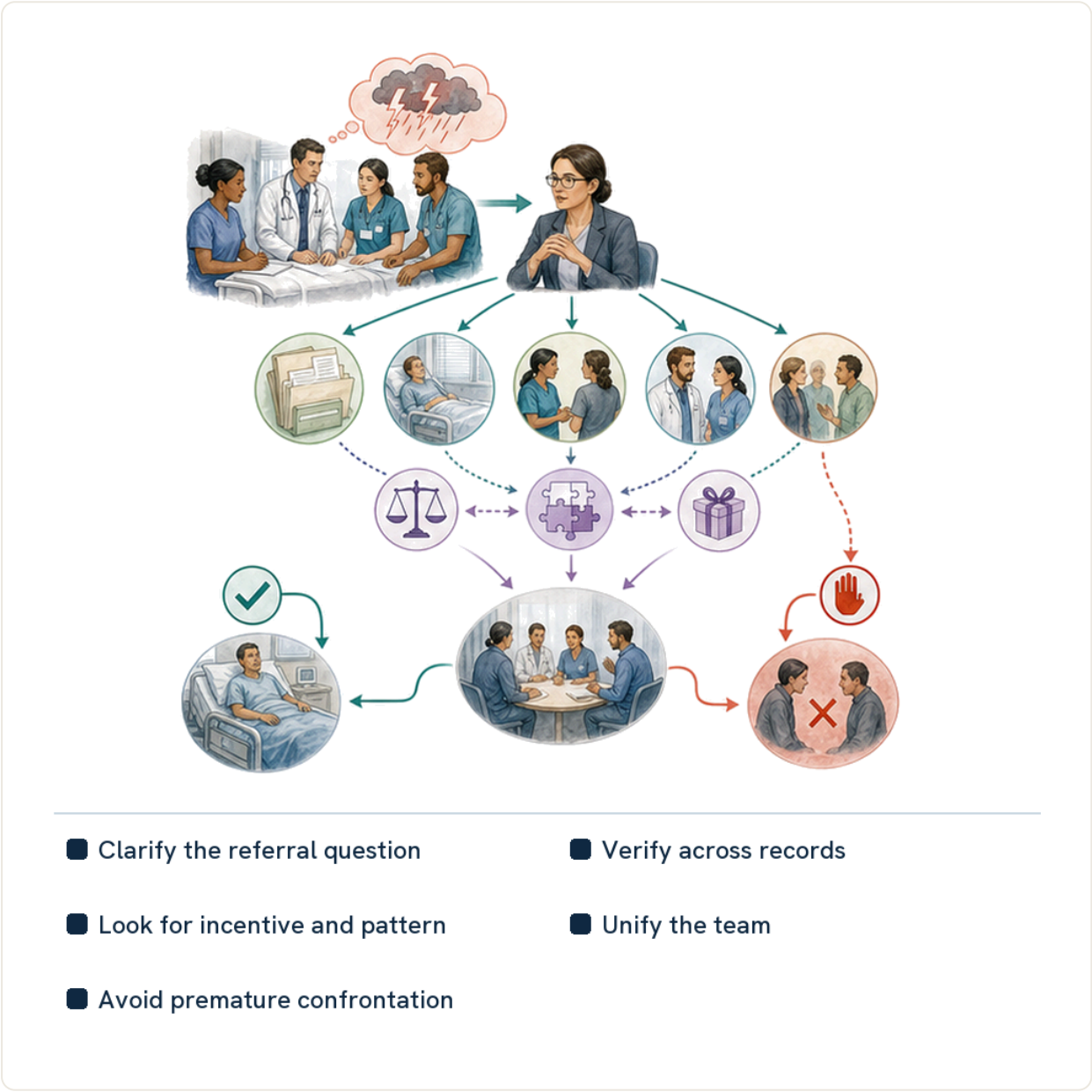


Fig 29.5 When factitious disorder or malingering is suspected in a general hospital, the liaison task begins by clarifying the referral, verifying observations across records and teams, and assessing pattern and incentive. Premature confrontation can harden error and fracture care.

The hinge is a fact of geography. These presentations do not begin in a psychiatric clinic. They arrive carrying a physical complaint, first to the general physician, so the psychiatric question is raised late, by a team that has already committed a long run of investigation to a different explanation, at the point where withdrawing it costs somebody something. Where the same suspicion arises in a medico-legal assessment there is an instructing party, a documented incentive, a defined report and an established method of assessing feigning. On a ward there is none of that: only a round tomorrow morning, a bed that is needed, and a team that has already used the word.

8.1 The request, and the three different things it can mean

Wards do not refer this question in clinical language. What arrives is that the patient is putting it on, that the story keeps changing, that nothing fits, or, from the more careful units, a request to rule out malingering. Read as a clinical question, that request cannot be answered at a bedside. Read as a report of where the team has arrived, it is highly informative: something has changed on that ward, and finding out what is the first act of the consult.

Three quite different requests hide inside the same sentence, each needing a different answer.

- **A request for certainty.** The team holds an inconsistency it cannot resolve and wants it converted into a finding by a speciality thought to deal in motives. No such conversion exists at a single visit, and supplying one is where the harm begins.
- **A request for permission.** The team wants to stop investigating, stop escalating, or discharge, and is asking psychiatry to authorise that so it does not have to own it. This is the commonest of the three and the best disguised.
- **A request for relief.** The ward is angry, exhausted, or feels it has been made a fool of, and the referral puts that somewhere. It tends to arrive out of hours and in strong language.

Deciding which is actually in front of you, early and out loud, reorganises the consult, because the second and third are addressed to the team and cannot be answered by anything found at the bedside. Left unnamed, what forms instead is a **corridor diagnosis**: a word that passes between staff, hardens with each retelling, acquires the authority of repetition, and is in the notes before anybody has decided whether it is true.

8.2 What a general ward can and cannot establish about its own patient

The working method of a medical ward is **exclusion**: candidate explanations are removed one at a time until one survives. When the last has gone and none survives, the ward reads the empty result as though it were a positive finding, because every previous negative in that sequence functioned as one. Here it does not. A work-up that has explained nothing licenses the statement that the illness is not yet explained, and nothing further. The distance between not explained and deliberately produced is the entire subject, and it is crossed by evidence about production, never by exhausting the medical list.

Two further limits belong to this setting. First, inconsistency is not deception. An account that differs between the admitting doctor at night and the unit round next morning has differed;

whether it differed because it was invented, because the two sets of questions were not the same, because the patient was frightened, sedated, in pain or delirious, or because the second version came from a relative, is not settled by the change itself. Second, once the suspicion exists the ward's observation stops being neutral. Behaviour that passed without comment last week is now offered to you as evidence, and observations that do not fit quietly stop being reported. You are given a filtered account by people who do not know they are filtering it.

The honest position at the end of a first visit is nearly always that the question is not settled, and that is not a failure of the consult. Managing an **unresolved suspicion** is the clinical task; producing a verdict is not, and cannot be done from a bedside chair.

RULE **A suspicion of fabrication changes what the team must do long before it changes what the patient may be called.** Everything worth doing is justified by the suspicion being unresolved and none of it by its being confirmed: slowing an invasive work-up the suspicion has itself made hard to justify, keeping the medical differential formally open under a named clinician, dating and attributing every observation so that a pattern rather than an impression survives, and bringing the disagreement out of the corridor into a meeting. A candidate who spends the answer on how to prove the deception has taken up a question the bedside cannot settle and left undone every act that protects the patient.

8.3 The record, and what a single entry can carry

This is where the consult is most exposed. A record made while a suspicion is unresolved is read later by people who were not present, for purposes nobody in the room intended: the next admitting team, the discharge summary, a certification request, an insurer, occasionally a court. The writer controls the sentence and none of its readers.

What may lawfully and ethically be entered when deception is suspected but not established, whether anything may be sought about the patient from another institution and on whose authority, and how such a conclusion is or is not communicated to the referring team, are not settled by any source available for this section. No comparable standard is available to quote, and none is invented here. What can be reasoned, and what an examiner will accept, is that entries differ in kind, and that the kinds carry very different weight once they leave your hands.

KIND OF ENTRY	WHAT IT ACTUALLY ASSERTS	WHAT IT CAN SUPPORT LATER
Timed observation of something you saw yourself	That one thing was seen, by you, at a stated hour	A pattern, if enough accumulate with times against them; alone, almost nothing
Attributed observation, naming who reported it	That a named person stated something, and that you are not the witness	Provenance: a later reader can return to the source instead of inheriting your confidence
A discrepancy between two documents, both named	A finding about the records, not yet about the patient	A reason to look further, and a trail somebody else can check
An inference about intention	Your reasoning, only as far as its steps are written out	Little; an unreasoned inference is read downstream as a conclusion
A diagnostic label entered in a summary	A settled conclusion, to every reader who was not there	Everything, including consequences outside the hospital, so it is the entry to weigh hardest

The discipline that follows is small and entirely learnable:

- write what was seen, and when, and name who saw it;
- keep reasoning visible as reasoning, with its steps shown;
- let the **permanent record** carry a conclusion only once one has been reached.

A note built this way stays useful if the suspicion proves right and harmless if it proves wrong, which is the only test a record made under uncertainty can be asked to pass.

TRAP **Letting the suspicion enter the permanent record as a diagnosis.** Asked what would be written, the candidate puts the label into the discharge summary, and it is wrong for reasons that are examinable rather than merely cautious. The label is short and the observations are laborious, so the label is what gets copied forward; it then travels further than the evidence that produced it, to readers who cannot see how thin that evidence was, and it closes the medical differential behind it. Write the observations, name their sources, state what remains open, and record who is continuing to look.

IN INDIA

Three features of the general ward press directly on this. A family attendant is at the bedside for much of the admission and is usually the only continuous observer the team has, so the account that would most change the picture is already in the room and is rarely taken systematically. Much of the admission is paid from the family's own pocket, so a request for a certificate, a fitness statement or an early discharge is not administrative; it has money attached, and that pressure reaches the note. And the questions raised here about records, and about what may be sought from anywhere else, have answers a candidate must find in the institution's own governance rather than in anything quotable. The examinable move is to say so, and to name who in your hospital answers it, rather than to invent a national rule that does not exist.

8.4 What the suspicion does to the team

The most reliable clinical sign in this situation is not on the patient. It is that the ward has divided, and it divides along concrete lines rather than temperamental ones: the clinician who admitted the patient and argued for the diagnosis against those never persuaded, the night nursing staff who carry the behaviour against the day team who see a settled patient on the round, the junior now being told, with varying kindness, that they were taken in. Each group has staked something, and the split holds because conceding costs face.

What makes it worse than ordinary clinical disagreement is the shift of **moral register**. The question stops being what is wrong with this person and becomes whether this person is honest, and once it has moved there the two available positions are naive and cruel. Nobody wants either, so the argument leaves the open forum and continues in the corridor, in handovers and in the tone of the notes, where it cannot be corrected. The **ward split** is therefore not a curiosity to observe; it determines whether the patient is investigated, and it is the liaison psychiatrist's work.

MNEMONIC

Stop, hold, name, date

The four acts an unresolved suspicion requires, in order. **Stop:** pause the escalating invasive work-up, whose justification the suspicion has itself removed. **Hold:** keep the medical differential open under one named clinician, so nobody assumes somebody else is still looking. **Name:** put the split into a meeting with both positions stated. **Date:** attribute and time every observation entered from here on. Not one of the four requires the suspicion to be true.

GOOD TO REMEMBER

Ask the ward two questions before the consult ends, and ask the group rather than the referrer alone. What would change your mind, and who is still responsible for the medical differential. The first makes the belief testable and shows the team it currently has no answer; the second stops the most dangerous thing that happens here, every service quietly assuming some other service is still investigating.

8.5 What the suspicion does to the patient's care

Once a ward believes it is being deceived, the risk to that patient rises in two opposite directions at once and a good answer names both. In one direction the admission simply stops: investigation ceases the moment the suspicion is voiced, each new symptom is attributed to the old belief before it is examined, and concurrent disease is missed because it is now expected to be absent. Suspicion and organic illness are not alternatives, and a patient may be doing both at once. In the other direction sits **iatrogenic escalation**: a team that cannot let the question go, ordering the next scan and the next procedure to settle an argument rather than to answer a clinical question. Both flow from the same unresolved belief, and the same acts make both less likely.

The third outcome is that the admission ends before the question does. A patient who senses the change in how a ward speaks to them often leaves, and a consult called to settle a suspicion has instead ended the only relationship through which anything could have been settled. Hence one

more reason for the consult to stay in a clinical register: a bedside interview conducted as an interrogation reliably closes the admission and answers nothing.

8.6 How the question is asked, and the order to answer it in

The ward is reporting itself	Exclusion proves nothing	Kind before content
THE REFERRAL DESCRIBES WHAT THE TEAM HAS COME TO BELIEVE, NOT A PROPERTY OF THE PATIENT	A WORK-UP THAT HAS EXPLAINED NOTHING LICENSES ONLY NOT YET EXPLAINED, NEVER DELIBERATELY PRODUCED	WHAT AN ENTRY CAN SUPPORT LATER IS SET BY ITS KIND, BEFORE ANYTHING IT SAYS

What an examiner is testing. Given a medical inpatient whose team suspects fabrication, the discriminating answer does not open with definitions or with how feigning is detected: both belong elsewhere and are available to anyone who has read the taxonomy. It opens with the referral, with who called, what they said and which of the three requests they were making. It moves to what can honestly be established at that bedside and says plainly that the usual answer is not yet. It then gives the acts, each standing without the suspicion being confirmed, and states what will be written and what will not. Where it reaches a standard that does not exist, it says so rather than inventing one, which reads as maturity and not as ignorance.

> The ward asks you to settle whether it is being deceived; what you can actually settle is what it must do while that stays open, and every act of the consult is justified by the suspicion being unresolved, not by its being confirmed.

The high-stakes settings

9 · Transplant, dialysis and ICU psychiatry

Why the marks are here. Transplant, dialysis and ICU psychiatry reads like three settings and is really one problem stated three times. In each, the treatment keeping the patient alive is also what generates the psychiatric presentation, and the psychiatrist works inside another team's decision, on their premises and against their timetable. And in each, the referral is rarely a request for a diagnosis: it asks that a decision be underwritten, or that a patient be made easier to treat. A candidate who answers with a differential has answered a question nobody asked.

Clear the ground first, because most of what these wards generate belongs elsewhere. The acute confusional state that dominates critical care, the decisional-ability question behind a refusal, and the standing link between an organ system and psychiatric morbidity each have an owner of their own, named below at the point where each arrives; the neurological substrate of confusion sits in the Stroke, TBI, delirium and focal brain syndromes notes. What survives those subtractions is small, specific and almost unwritten elsewhere: the evaluation before an organ is allocated, the psychiatry of a treatment room a patient returns to for life, and the state a survivor of critical illness is discharged into.

9.1 The structure the three settings share

Side by side, these settings differ less in psychopathology than in who holds the decision and what psychiatry can genuinely add. Learn the row rather than the disease: an examiner can move you between settings and expect the reasoning to transfer.

THE SETTING	WHAT IS ACTUALLY BEING ASKED	WHO HOLDS THE DECISION	WHAT PSYCHIATRY ADDS THAT NOBODY ELSE CAN
Before a transplant	Whether this person should receive a scarce organ, or whether something about them can be changed first	The transplant team and its selection process, never the psychiatrist	A statement of what is modifiable and over what interval, in place of a verdict
After a transplant	Why a patient given exactly what they wanted is not well	The treating unit, indefinitely	Separating adjustment from drug effect from acute brain syndrome, and dating each against the operation
The dialysis unit	Usually nothing, because the referral is never made	The nephrology unit, and in practice its nursing and technical staff	A detection routine the unit runs itself, since this morbidity is invisible to a service that waits to be called
The intensive care unit	Behaviour that is obstructing treatment now	The intensivist, minute by minute	A formulation that survives sedation and restraint, and a plan that does not need cooperation to begin
After intensive care	Also nothing, because nobody is looking	Nobody, and that is the finding	The question about the admission that no later clinician will otherwise ask

RULE **In each of these settings the treatment is the stressor, and the treatment cannot be withdrawn to test the hypothesis.** The usual experiment of removing the exposure and watching symptoms resolve is unavailable, so attribution rests on timeline, previous function and informant report rather than on response. The aim is not relief from the stressor, which is not on offer, but the ability to keep receiving it. And because the treatment outlasts your consult, an opinion filed once is worth far less than an arrangement the unit is still running next month.

9.2 The pre-transplant evaluation: whose question, and what kind of answer

One thing about this evaluation is settled: it happens. Psychiatric and psychosocial assessment is treated as imperative in judging whether a candidate is **suitable** as a recipient, and evaluating that suitability is described as a defined part of the psychiatrist's role in solid-organ transplantation.

Its contents are another matter, and an honest answer beats a confident one. The domains such an evaluation should cover, any structured instrument for conducting it, what separates an absolute from a relative psychiatric contraindication, and whether Indian transplantation law

imposes any requirement of psychiatric or psychological evaluation on a recipient or a living donor: no comparable standard is available to quote, and none is invented here. Two consequences are examinable. Do not import a Western programme's eligibility rule and present it as an Indian legal duty, because a condition written into one country's transplant programme is not thereby a statutory obligation in another. And establish what your own institution's process requires and who signs it, because that is what you will be asked across a table.

Dual agency changes the interview, and candidates handle it worst. You are not this patient's treating psychiatrist here; you are producing an opinion for someone else, and the patient knows what they say may cost them an organ. Under-reporting of alcohol use, low mood or a difficult household is not deception but a rational response to an incentive you created by walking in. Two moves reduce it. Say at the outset what the assessment is for, who reads it and what it cannot decide alone. And take collateral history as routine rather than as a challenge, so that corroboration is procedure and not accusation.

The output should do work rather than close a door. An opinion reading "unsuitable" gives the team nothing to act on and nothing to argue with. A useful pre-transplant opinion instead specifies:

- the decision it is addressed to, since an opinion written to no question answers none;
- what is currently a problem and whether it is changeable, stated as a condition rather than a label;
- over what interval a change could be shown and by what observable sign, because a team allocating an organ needs a date more than a diagnosis;
- what would make you revise the opinion in either direction, which turns a verdict into an assessment that can be repeated.

Where the donor is living, a second person is being evaluated for an operation that will not benefit their own health, inside a family in which the pressure to agree may never be spoken aloud. That interview belongs away from the recipient's relatives and clinician, and the question is not only whether the donor consents but whether refusal is a real option. Consent given in front of those who would be disappointed by it has not been tested.

9.3 After the graft: the work that begins when the operation succeeds

A successful transplant is not the end of a chronic illness but the exchange of one for another: lifelong immunosuppression, indefinite surveillance, and a new class of fear in which any ordinary symptom may be the start of rejection. Function returns faster than identity does, and someone whose family, work and routine were organised around being ill must renegotiate all of it while everyone celebrates. Low mood after a technically perfect operation is therefore not paradoxical, and reading it as ingratitude is the commonest failure of the ward's response.

Where the organ came from a living relative, the donor stays in the psychological field permanently. The patient carries part of someone they will meet at every family gathering, sometimes someone they had conflict with, and a sense of unpayable debt can push adherence

either way: fierce compliance as repayment, or avoidance of a relationship impossible to be ordinary in. Ask about the donor by name, and ask what the patient believes they owe.

Two things arriving now are routed rather than guessed. The acute brain syndrome after major surgery belongs where delirium in the medically ill is dealt with in these notes. The neuropsychiatric effects of the immunosuppressive regimen, and the interactions constraining what may be added to it, are prescribing matters: the antidepressant agents are set out in the Mood disorders: pharmacotherapy notes, and nothing is started without the current regimen in front of you and the transplant team told what you added.

9.4 The dialysis unit, which nothing else in these notes owns

Maintenance haemodialysis is the only treatment in this chapter that is also a place. The patient returns on a fixed recurring schedule to a shared room, is connected through a **vascular access** that is itself a source of anxiety and of repeated medical incident, sits immobile for hours beside other patients whose deterioration they watch, and lives in between under restrictions on food and fluid that reorganise a household's cooking. But nobody is admitted, so nobody is referred, and psychiatric morbidity accumulates in a population that is technically outpatient and permanently supervised. The organ-system link itself is taken up where the psycho-cardiology, psycho-dermatology and psycho-nephrology cross-links are dealt with in these notes; what is owned here is the treatment room as a place.

IN INDIA

The firmest Indian anchor is a study of 282 patients on maintenance haemodialysis across four Mumbai centres, two public charitable and two private fee-for-service, reported in the Indian Journal of Nephrology in 2025. Some degree of depression was present in **76 per cent**, and **21.28 per cent** reached the moderate-or-above band on the screening instrument. Carry the population with the number: these are prevalent patients already established on dialysis at four urban centres, of median age 55, with more men than women in the sample. It is not an all-India prevalence and must never be quoted as one.

The associations matter more at the bedside than the headline proportion. Female sex, a catheter as the vascular access and the stress of dietary restriction were each positively associated with significant depression, while being employed was protective; public charitable and private fee-for-service centres did not differ. Two repay thought. Access type is a technical variable visible on the chart and sometimes changeable by the unit, so a psychiatric risk marker here can be read off a nephrology note and acted on by a surgeon rather than by you. And employment being protective turns a medical schedule into an economic one, since the hours the treatment consumes are hours of wages; whether work protects, or better health permits work, is not separable in a cross-sectional design. Women were depressed roughly twice as often as men, 29.13 per cent against 16.76 per cent, and the study cannot tell you why.

Depression is substantially commoner in dialysis populations than in the general population, and under-recognised in both. That much is safe to say, and it is why a screening routine is justified at all. No pooled prevalence from the international meta-analytic literature is quoted here and none

is invented in its place: carry the Mumbai figures with their population attached rather than promoting them into a world number.

9.5 Why the unit does not see it, and what to examine instead

The reason offered for that invisibility is diagnostic rather than attitudinal. On its authors' account, depression here remains under-evaluated and under-addressed because the symptoms of **uraemia** mimic depressive symptoms and can mask a true depressive illness. That is a mechanism they propose, not an effect they measured. Recognising depression when advanced physical disease confounds the somatic criteria is taken up where depression, anxiety and delirium in cancer and palliative care are dealt with in these notes; what is specific here is that the confounder is not the disease alone but the treatment and its timetable.

WHAT IS OBSERVED	WHAT THE URAEMIC STATE AND THE UNIT GENERATE ON THEIR OWN	WHAT STILL DISCRIMINATES
Fatigue and loss of energy	Anaemia, the metabolic state, and the hours the treatment consumes	Whether energy recovers after a good session or stays flat across the interval
Poor appetite and weight change	Prescribed dietary and fluid restriction, altered taste, and shifts that make weight uninterpretable	Whether food the patient is permitted and used to enjoy still gives pleasure
Disturbed sleep	Restless legs, itch, cramps, and a schedule that fragments the week	Early waking with dread, and what the patient does with the waking hour
Slowed thinking and poor concentration	The metabolic state, and fluctuation around each session	A stable deficit that does not track the session, which raises a different question
Withdrawal from family and social life	Immobility, transport cost, and a timetable nobody else's life is built around	Whether the patient wants contact they cannot get, or no longer wants it

What survives the correction is interpersonal and evaluative rather than bodily: guilt, self-blame framed as being a burden, hopelessness that is absolute rather than realistically bleak, loss of pleasure in what the illness does not prevent, and whether any of it fluctuates with the treatment cycle. That last is the practical discriminator this setting hands you, since the schedule supplies a repeated natural measurement.

TRAP **Subtracting the somatic features, then treating what is left as too little to diagnose.** The candidate who has learned that uraemia mimics depression applies the correction and stops: fatigue, appetite change and sleep disturbance are discounted because the treatment explains them, and the conclusion becomes that only low mood remains, falling short of a threshold. Subtraction is half a method and useless alone. The second half is substitution: having set aside what the setting can generate, examine what it cannot and weight it more heavily than in a physically well patient. Examiners watch for the substitution, because the subtraction is the part everybody remembers.

How detection is actually done. Not by referral, which is the whole point. That study used the **PHQ-9**, and the operationally important detail is not the instrument but the administration: it was read aloud to every patient in their native language regardless of literacy. A self-report form handed out in an Indian dialysis unit measures literacy, language and eyesight at least as much as mood, and those it silently excludes are least able to complain of it. A screen that runs is one unit staff administer aloud, at a fixed point in the session, to everybody rather than to whoever looks unwell.

9.6 The referrals from the unit that are not what they say

When a dialysis unit does telephone, the request has usually been generated by an act rather than a symptom: a patient leaving sessions early, abandoning the fluid restriction, missing appointments, or saying outright that they want to stop. All arrive labelled as depression or poor motivation, and all need the same first move: establish what stopping would actually solve for this person before deciding what it means.

The pressures the answer names are often not psychiatric. The same Indian source describes the burden on these patients as physical, financial, occupational, social and dietary, and any of those can produce the behaviour with no psychiatric illness present. A man whose sessions are consuming a household's income, whose employer will not hold his job, may be making an intelligible economic decision that presents as a wish to die. Medicalising that misses a problem with a different remedy; missing depression in the same presentation is equally serious. The discriminating question is whether the wish is to stop treatment or to stop existing, and it is asked in those terms rather than inferred.

Where the refusal stands and the team wants it overridden, the question has become one about decisional ability, settled where capacity assessment and refusal of treatment in the general hospital are dealt with in these notes. What belongs here is the step before: refusing to let a capacity assessment become a device for producing compliance, since establishing that a refusal is informed and stable is a different task from establishing that it is wrong.

> **GOOD TO REMEMBER**
>
> Before leaving the unit, put four things in the note that the next person to open it can act on. What was asked of you, in the referrer's own terms. What you established about the timeline, including what changed and against what previous state. What you have asked the unit to do, named to a role rather than to the team in general, and by when. And what brings you back, stated as an observable event, so the nurse seeing the patient next knows the threshold.

9.7 Intensive care, and the state the survivor is discharged into

Inside the unit, most psychiatric work is delirium, dealt with elsewhere in these notes, and most of the rest is a request to make a sedated or restrained patient tractable. Two things there are genuinely psychiatry's: a formulation built without a usable interview, from the pre-admission history taken off relatives, the substance history that explains withdrawal states and the timeline of what was given when; and documentation of what the patient appears to be experiencing while unable to report it, which becomes the only record of that period.

More clearly this chapter's, and what candidates rarely have, is the aftermath. **Post-intensive care syndrome** is the agreed term for the residue of critical illness, settled at a multidisciplinary stakeholders conference convened by the Society of Critical Care Medicine. It denotes impairment across three domains, physical, cognitive and mental health status, the physical typically exemplified by weakness acquired in the unit and the cognitive by thinking and judgment. The qualifier does the real work: the impairment must be **new or worsening**, so a deficit present before admission does not count, and the construct rests on a baseline somebody must have recorded or reconstructed.

MNEMONIC

Body, mind, mood, and new or worse

The three domains and the qualifier, in the order that keeps them straight. **Body:** the physical domain, weakness acquired during the admission. **Mind:** the cognitive domain, thinking and judgment. **Mood:** mental health status. **New or worse:** the qualifier, because impairment carried into the unit is not this construct, and an answer without it describes any survivor of any severe illness.

How common it is, how long it lasts, how it is best detected, whether it looks the same in Indian survivors, and whether any follow-up clinic model operates in Indian tertiary practice: on all of these, no comparable standard is available to quote, and none is invented here. Resist supplying a figure: this is exactly the construct where a confidently quoted percentage is likeliest to be wrong and likeliest to be repeated.

Missing data does not remove the clinical duty, and the duty is specific. Whoever sees this patient next is usually a physician who did not treat them in the unit, working from a discharge summary that records organ support and antibiotics and nothing about the mind. The patient will not raise it, partly because the memory of the admission is fragmentary and partly because they have been told repeatedly how lucky they are. So ask, at every later contact:

- what they remember of the admission, accepting that what is remembered may not match what happened;
- what they have not got back, in function rather than in symptoms;
- what frightens them now, which is where stress symptoms surface if they are going to.

Record the answer where the next clinician will find it. Where the psychiatrist has influence over the unit's own practice, the higher-value intervention is upstream: a discharge document stating what this person was like beforehand, so the word new can later mean something.

9.8 What this section hands on

The treatment cannot stop	Detection, not referral	Subtract, then substitute	New or worsening
ATTRIBUTION RESTS ON TIMELINE, BASELINE AND INFORMANT, NEVER ON REMOVING THE EXPOSURE AND WATCHING FOR RECOVERY	THE DIALYSIS UNIT GENERATES CASES THAT NEVER BECOME REFERRALS, SO THE DELIVERABLE IS A SCREENING ROUTINE THE UNIT ITSELF ADMINISTERS	SET ASIDE THE FEATURES THE SETTING GENERATES, THEN EXAMINE AND UP-WEIGHT THE ONES IT CANNOT	A SURVIVOR'S DEFICITS ARE INTERPRETABLE ONLY AGAINST A BASELINE RECORDED BEFORE THE ADMISSION

An examiner is testing whether a candidate stays on the axis of the act. Given a transplant candidate, the discriminating answer opens not with a checklist of what to assess but with whose question it is, what the opinion is for, and how dual agency distorts what is disclosed. Given a dialysis patient, it explains why the setting hides the features rather than reciting them, which observations survive the correction, and how a unit that never refers can be made to detect. Given a survivor of critical illness, it names what is new or worsening against a baseline, and who is going to ask.

> In these settings the treatment that sustains the patient is also what generates the presentation, so the psychiatric task is not to remove the stressor but to keep the person able to receive it: an opinion naming what can change before an organ is allocated, a detection routine the dialysis unit runs without being asked, and a question about the critical-care admission at every contact that follows it.

10 · Psychiatric aspects of HIV and chronic infection

Why the marks are here. Two questions travel under the heading psychiatric aspects of HIV and chronic infection, and the answer is lost if they are not separated. One is about the brain: what a neurotropic infection does to cognition, how it is staged and what imitates it, and which antiretroviral agents carry psychiatric effects or constrain psychotropic prescribing. All of it is set out in the Neuropsychiatry of systemic and neurological disease notes. The other is the consult: a person with a lifelong transmissible diagnosis has been referred, and that question is answered in acts, not features.

They are examinable because a psychiatric interview's ordinary assumptions fail at the door. The diagnosis may not be usable in the room you are in. The treatment cannot be left to the medical team, because the psychiatric state often decides whether it continues to be taken. And the consult cannot be closed: illness and treatment outlast every relationship in the building.

10.1 Four properties, not one organism

The lens comes from the shape of the illness and of its delivery, not from virology, which is why the topic pairs one named infection with chronic infection in general. Four properties do the work, and any condition carrying all four produces the same consult:

- treatment that is lifelong, so the outcome rests on a repeated daily behaviour and never on a completed course;

- transmissibility, which makes the diagnosis partly another person's information and brings law into a clinical conversation;
- social meaning strong enough that hiding the condition is a reasonable strategy rather than a symptom;
- care delivered through a **vertical programme** with its own clinic, counsellor, register and drug supply rather than through general services.

The fourth is the property candidates omit, and it most changes practice because it settles where the patient physically is and whose cooperation any plan needs. Little of this work happens on a ward: the medical home is an outpatient clinic attended for review and supply, so a service built on inpatient referrals meets these patients only after something has gone wrong.

MNEMONIC

Lifelong, catching, shaming, separately run

The four properties, in the order they change what you do. **Lifelong:** the target is a daily act sustained for decades. **Catching:** the information is not the patient's alone, so speech and documentation are constrained. **Shaming:** hiding is rational, so it is not evidence of illness. **Separately run:** the patient belongs to a programme clinic, where any durable arrangement is made.

Where a condition carries only some of the four the lens shortens predictably: a long treatment nobody can catch generates the adherence work without the disclosure work. Taking on a chronic diagnosis is dealt with where psychological reactions to physical illness and chronic disease are taken up in these notes; added here is what changes when the diagnosis is also a secret.

10.2 The disclosure map is drawn before the interview, not during it

Disclosure is not one event that has either happened or not. It is a set of separate permissions, each granted or withheld before you were called, each governing a different part of what you may say and write. Neither the referral nor the file records them reliably, because a file holds what was written down rather than what was understood.

WHO MAY HOLD IT	WHAT THEIR KNOWING DECIDES	THE ASSUMPTION THAT COSTS MARKS
The patient	Whether they can name their condition, and in which words, which fixes the interview's vocabulary	That an explanation recorded as given was understood
The accompanying relative	Whether a supervised dose or collected supply is possible, the attendant being the working unit of care on an Indian ward	That whoever brought the patient in knows why
The sexual partner	The one relationship where the patient's interest and another's can diverge, and the only one with a separate answer in law	That the clinical and the legal question are one
The employer and neighbourhood	Where loss of work, housing and standing is generated, and so what is protected	That secrecy outside the hospital signals shame rather than calculation
The record you are about to write	A note in a shared chart discloses to every later reader, many with no clinical role	That documentation is neutral because it is routine

RULE **Nothing in this consult is information about the patient alone, and nothing in it ends when you leave.** The first half governs speech and documentation: what may be said, in front of whom, and what may safely appear in a chart other people read. The second governs the output: an opinion filed once is worth little against a treatment measured in decades, so the deliverable is an arrangement somebody else runs.

10.3 Where the law enters, and the consult it generates

Candidates treat the serological test as an investigation like any other and are caught by the question that follows. The commonest consult on this axis is a consent question: a patient too unwell or too frightened to agree, and a team asking whether the agreement it holds is worth anything.

IN INDIA

Consent for this test and this treatment has a place of its own in central legislation. The HIV and AIDS (Prevention and Control) Act of **2017**, as recorded in the India Code maintained by the Legislative Department of the Ministry of Law and Justice, gives section **5** the heading informed consent for undertaking HIV test or treatment. What that section requires in operative terms, what conditions it attaches, and what national counselling guidance in turn requires of a clinic: on all of these, no comparable standard is available to quote, and none is invented here. The structural fact is the examinable one. A legislature that gives consent for one test a section to itself has taken it out of ordinary medical custom, so arranging that test for a patient who cannot presently agree is a governed act and not a courtesy.

The psychiatric half is **capacity**, and the bedside assessment is dealt with where capacity assessment and refusal of treatment in the general hospital are taken up in these notes. Two additions are specific here. A result, once it exists, must be given to somebody, somewhere its consequences can be absorbed, so an opinion answering only whether the patient can consent has answered half the referral. And whether anyone may be told without the patient's agreement is a separate statutory question, settled in Indian law and not at the bedside.

What belongs to psychiatry is the preparation preceding any disclosure, and it is concrete. Establish what the patient believes will follow, separating a realistic fear of violence or destitution from a catastrophic one. Rehearse the actual sentence, in their own language. Offer to be in the room. Let them fix the timing, because a disclosure made to a clinician's deadline is one they live beside afterwards without you.

10.4 Stigma predicts behaviour, it does not decorate the answer

Handled as sociology, stigma ornaments an answer and changes nothing at the bedside. Handled as a clinical variable, it predicts what this patient will do. Three forms do different work:

- what the patient has met: the refused tenancy, the relative who stopped visiting, the staff member whose manner changed, which is history and can usually be dated;
- **anticipated stigma**, a prediction rather than an experience, which governs behaviour whether or not events confirm it;
- **internalised stigma**, where the community's judgement has been accepted as accurate and turned inward.

The second reaches the medical outcome, because it produces **concealment**: where tablets are kept, whether they travel, whether a clinic visit can be explained at home. Concealment answers a real hazard, and recording it as denial costs you the next problem the patient would have brought.

The third is most often mistaken for a mood disorder, and the distinction changes what you do: one calls for treatment of an illness, the other for work on a belief taken from other people. Where advanced disease confounds the somatic features, recognising depressive illness is dealt with where depression, anxiety and delirium in cancer and palliative care are taken up in these notes.

10.5 Adherence has links, and the repair follows from which one broke

Asking whether a patient is adherent yields a proportion and no plan. **Adherence** to a lifelong regimen is a chain of separable behaviours: knowing why, obtaining the supply, remembering the hour, having somewhere unobserved, and doing it again tomorrow. Each psychiatric problem attacks a particular link, so the useful question is which link.

WHAT THE ASSESSMENT FINDS	THE LINK IT DISABLES	WHAT THE CONSULT ASKS FOR
Depressive illness	Valuing the future the treatment is taken for, so the tablet is remembered but stops feeling worth it	Treatment of the mood disorder itself, and a named person who asks about tablets next visit
Alcohol or other substance use	The regularity of the day, so the dose is not to hand at the same hour	Quantification without a moral frame, and a plan that works during continued use
Cognitive impairment	Remembering, sequencing and self-monitoring, so the failure is of machinery rather than will	External structure: a supervised dose, a box filled by someone else, a shorter review interval
Psychotic illness	The meaning of the tablet, absorbed into the patient's account of what is being done to them	Work on the meaning before any argument about compliance, and a supply not conditional on agreement
Concealment	Doing it where it could be seen, the link no motivation repairs	A dosing hour and place kept unobserved, and collection that does not announce itself

Two constraints govern prescribing. Cognitive impairment here may or may not be attributable to the infection: its classification, staging and detection are set out in the Neuropsychiatry of systemic and neurological disease notes, while the consult contributes the timeline and the functional consequence, taken from an informant against a stated previous level of function. And no psychotropic is started without the current antiretroviral regimen in front of you, since safe combination and those drugs' own psychiatric effects sit in the same place. **Attribution** settled before the history is taken is the error this topic punishes.

TRAP **Answering the referral as written instead of the referral as meant.** The note says assess for depression; the unstated request is usually make him take his tablets, or get her to tell her husband. Answer the written words and you produce a diagnosis nobody needed. Deliver the unstated request and you have accepted a job psychiatry cannot honestly do, because an outcome cannot be extracted from a patient on another team's behalf. The discriminating answer names the real question aloud, says which part is psychiatry's, and hands the remainder back with a reason.

10.6 The durable output is an arrangement with the treating clinic

Because these patients are mostly not inpatients, this is service design rather than bedside technique, and the unit of work is a standing arrangement that is renewed and audited. The clinic already holds a counsellor known to the patient and present at every visit, so supervision, shared triage and joint review of the difficult few use a psychiatrist far better than a parallel clinic nobody attends.

That role is governed centrally, and knowing so changes how you approach the clinic. The National AIDS Control Organisation, within the Ministry of Health and Family Welfare, is the source of the national reference set for this work: a handbook for HIV and STI counsellors, a handbook on the prevention and management of stigma and discrimination, and a guideline for

HIV counselling and testing services. Their contents are neither reproduced nor characterised here. What follows is practical: establish what the clinic is already mandated to do before proposing anything, because a plan duplicating a programme requirement is dropped and one cutting across it is ignored.

Four things a workable arrangement specifies, in order:

- who screens, with what, and at which point in the visit, since a screen offered after the drugs are collected is never completed;
- what result escalates, how fast and by which route, so whoever screens never chooses between doing nothing and declaring a crisis;
- where the psychiatric record will live, given what a shared chart discloses;
- who notices and who acts when a patient stops attending, since disengagement is invisible to a service that sees only attenders.

Where these arrangements fail. On geography and timing far more often than on clinical disagreement. A referral requiring a second journey, to another building on another date, is one a patient paid by the day will not make, and the non-attendance is then recorded as poor motivation. **Same-visit access** decides whether the arrangement functions, and it costs a room and a fixed hour rather than a new post.

GOOD TO REMEMBER

Settle the documentation before the note is written. Decide which facts must sit in the shared record for the team to treat safely, which belong somewhere with narrower access, and what the patient has been told about who reads each. Then write, and tell them what you wrote. Put the follow-up arrangement in the same note, named to a role and carrying a date.

10.7 What this section hands on

Map before you speak	Name the broken link	Stigma is a predictor	Contract, do not visit
WHO HOLDS THE DIAGNOSIS IS ESTABLISHED PERSON BY PERSON, BECAUSE NO RECORD CARRIES IT	EACH PROBLEM DISABLES A DIFFERENT STEP OF THE DAILY ACT, AND THE REPAIR FOLLOWS	ANTICIPATED STIGMA PRODUCES CONCEALMENT, WHICH IS WHAT REACHES THE MEDICAL OUTCOME	THE DELIVERABLE IS AN ARRANGEMENT THE CLINIC RUNS AND AUDITS AFTER YOU HAVE GONE

An examiner is watching whether the candidate keeps the consult and the entity apart. The answer does not open with the neurocognitive syndrome. It opens with who knows and who is in the room, moves to consent and to what the referral is really asking, treats stigma as a predictor rather than as sympathy, identifies which link in the daily act has broken, checks the medical prescription before writing a psychiatric one, and closes with an arrangement rather than an opinion.

Psychiatry is not called here for the infection but for what the infection generates: a disclosure map governing every word said and written, a daily act that must survive decades of psychiatric weather, and a working contract with the clinic that outlasts the consult.

11 · Psycho-cardiology, psycho-dermatology and psycho-nephrology cross-links

Why the marks are here. Three medical specialties send psychiatry a steady stream of referrals, and each sends them for a different reason. Cardiology refers because a mood state is altering a cardiac outcome. Dermatology refers because a substantial share of its clinic is carrying a psychiatric problem dressed as a skin complaint. Nephrology refers because a treatment that will not end has become intolerable to the person receiving it. A candidate who answers all three with one generic account of depression in the medically ill has not answered any of them, because what is examined here is the specific traffic between psychiatry and each organ: who refers and at what point in the illness, what the psychiatric finding does to the physical prognosis, and what the psychiatrist's own prescription does back to the organ.

Three boundaries first, because this topic sits between several others in this chapter. The general psychological work of adjusting to physical illness, including denial, adherence and the shifts in identity a chronic disease brings, belongs to the companion topic on psychological reactions to physical illness and chronic disease. How a consult is requested, negotiated, answered and recorded belongs to the companion topic on principles and models of consultation-liaison psychiatry. The dialysis unit, the transplant work-up and the intensive care bed considered as settings belong to the companion topic on transplant, dialysis and ICU psychiatry. What is taught here is the organ-specific link itself: the size of each interface, its prognostic weight, the classification the referring specialty actually uses, and the drug traffic running in both directions.

1.6 to 2.7 fold	Under 15%	30% to 40%	21.4%
INCREASE IN MORTALITY RISK REPORTED WHEN DEPRESSION FOLLOWS MYOCARDIAL INFARCTION	DEPRESSION IN CORONARY ARTERY DISEASE THAT IS ACTUALLY DIAGNOSED	DERMATOLOGY OUTPATIENTS WITH AN UNDERLYING PSYCHIATRIC ISSUE	DEPRESSION REPORTED ACROSS CHRONIC KIDNEY DISEASE STAGES ONE TO FIVE

11.1 What a cross-link is, and what to call it

An organ cross-link is not a disorder and not a service. It is a relationship between two specialties around one organ system, and it has four parts worth separating before any of the three is discussed: how much psychiatric morbidity that clinic carries, how much of it is recognised, what the psychiatric state does to the physical outcome, and what each specialty's drugs do to the other's territory. Every examinable point in this topic is one of those four.

The names themselves need a word of caution, because they are used with different degrees of authority. Of the three head terms psycho-cardiology, psycho-dermatology and psycho-nephrology, only the dermatological one is securely attested in Indian guidance: **psychodermatology**, with its cognates psychocutaneous and psychodermatological, is the language the Indian guideline uses for that field, including in the heading under which it teaches the subject. The corresponding cardiac and renal terms did not appear in the body text of the two

Indian chapters read for this account. That is a statement about two documents and not about the literature: the cardiac and renal chapters title themselves as the management of psychiatric disorders in patients with cardiovascular diseases and in patients with chronic kidney diseases respectively, which is descriptive rather than terminological. Use psycho-cardiology and psycho-nephrology as convenient labels for a field of work, keep confident terminological claims for the dermatological one, and do not assert in a viva that the other two are established technical terms.

RULE **The clinically important number at every one of these interfaces is not the prevalence but the gap between the prevalence and the proportion diagnosed.** A physician who is told that a fifth of their clinic is depressed will reasonably reply that they have not seen it, and they are usually right, because they have not. That is the argument for a proactive arrangement rather than a referral-only one: a service that waits to be asked is measuring the referring team's recognition, not the ward's morbidity, and on these three interfaces those two quantities are known to be far apart.

11.2 Psycho-cardiology: how much depression, and in which cardiac patient

The cardiac interface is the best quantified of the three, and the Indian guideline published in 2022 gives figures at each stage of coronary disease rather than a single global rate. Depression is present in fifteen to twenty per cent of patients with coronary artery disease, in fifteen per cent of patients after coronary artery bypass grafting, and in twenty per cent of patients with congestive heart failure. After myocardial infarction the figure depends entirely on what is being counted: at least sixty-five per cent report depressive symptoms while twenty per cent fulfil criteria for a major depressive episode. Those are not two estimates of one quantity but two different quantities, and the distinction is the most examinable thing here.

Two modifiers are worth carrying. Risk is roughly two-fold in women compared with men, and particularly so under the age of sixty, which matters because the younger woman with cardiac disease is precisely the patient a busy unit is least likely to think of as depressed. And device recipients carry an anxiety burden of their own: around thirty per cent of patients with an implanted cardioverter defibrillator have clinically relevant anxiety, which is intelligible once you consider what the device does when it fires and how little warning the patient has.

Course is the part candidates omit. Depression at a cardiac index event is not a transient reaction that resolves as the patient recovers. At follow-up, the illness was chronic or relapsing in almost half of those who had a major depression at the index episode, and forty per cent of those with only minor depressive symptoms had progressed to a major episode within one year. The second half of that sentence is the reason a cardiac unit cannot safely apply a watch-and-wait rule to subthreshold mood symptoms, and it is the justification for a follow-up appointment rather than a single consult note.

TRAP **Quoting a symptom prevalence as though it were a disorder prevalence.** The commonest version of this error is the flat assertion that most patients after myocardial infarction are depressed, which takes a symptom-report figure and reads it as a diagnosis rate that is more than three times the true one. Candidates make it because the larger number is more striking and because the source sentence carries both figures and only the first is remembered. Always state the denominator with the number: symptoms reported, or criteria met. An examiner who hears a bare percentage for post-infarction depression will ask which one it is, and that follow-up is the whole point of the question.

11.3 Psycho-cardiology: why it is a prognostic problem, and the one procedural constraint

What makes cardiology different from the other two interfaces is that the psychiatric finding is a prognostic variable in its own right. Depression is described as an independent risk factor for coronary artery disease carrying a **bidirectional** relationship with it, meaning that the association runs in both directions and cannot be dismissed as understandable distress in a sick population. The mortality multiplier reported for depression following myocardial infarction is set out above; it should be quoted as the guideline reports it, because no confidence interval, no source study and no follow-up period accompanies it, so it is a reported range and not a pooled estimate you can defend as such.

The prognostic weight is not confined to depression. Stress, anxiety, panic and post-traumatic states are reported to increase mortality in cardiovascular disorder with a relative risk of 2.0 to 4.0, and post-traumatic stress disorder following an acute coronary syndrome carries a relative risk of 2.0 for relapse of that syndrome over one to three years. Severe mental illness belongs in the same frame: cardiovascular mortality in bipolar disorder is described as roughly doubled, with a relative risk of 1.5 to 2. That last figure is the one to have ready when a viva turns from the general hospital to the psychiatric outpatient, because it converts routine cardiovascular monitoring in a long-term patient from good practice into a mortality intervention.

One procedural constraint belongs here and only here, because it is a cardiac fact rather than a technique question. There are no absolute contraindications to electroconvulsive therapy, and recent unstable angina or myocardial infarction within **30 days** is a relative contraindication, with procedural precautions specified alongside it. The reasoning to show is why a relative contraindication with a time window is the right form for this rule: the haemodynamic surge is brief and manageable, the vulnerable myocardium is not, and the window closes.

11.4 Psycho-dermatology: the size of the interface and the Indian evidence

The dermatological interface is the largest of the three by proportion of the clinic and the least served by psychiatry. The headline proportion of dermatology attenders with an underlying psychiatric issue is given above, and what turns that figure into teaching is the Indian evidence sitting behind it, which is unusually good for a subject this neglected. Psychiatric morbidity is reported in thirty-five per cent of patients with acne and in **fifty-two per cent** of patients with chronic dermatoses, and depression in around thirty per cent of those with alopecia areata. The chronicity gradient in those three figures is the finding: the longer the skin disease has been visible, the larger the psychiatric fraction.

Stress as a trigger is measured separately and the two measurements should not be merged. Stressful life events in the year before onset or exacerbation were recorded in twenty-six per cent of patients with psoriasis vulgaris and sixteen per cent of those with chronic urticaria. Patient-reported emotional triggers run far higher, at fifty per cent in acne and almost all patients with hyperhidrosis. The hedge on that last one is part of the claim and should be reproduced with it. The gap between a documented life event and a reported trigger is not evidence that patients are wrong: it reflects two different questions, one asked of a record and one of a person.

IN INDIA

These dermatological figures are Indian studies quoted in an Indian guideline, and that is what makes them usable in an Indian viva without an apology. The decision they support is a service decision. A dermatology outpatient in a general hospital sees very large numbers in a short clinic and has no time to open a psychiatric enquiry, so a psychiatric problem in that clinic is found only if someone has arranged for it to be looked for. The renal chapter states the same requirement in plainer words, closing with the statement that collaborative work between the nephrologist and the psychiatrist is required; it was itself co-authored with a nephrologist. Asked how you would set this up, describe an arrangement in which psychiatry attends the other specialty's clinic, because the alternative depends on a referral that the figures above show is mostly not made.

11.5 Classifying the psychocutaneous disorders

Dermatology is the one interface where the classification itself is examinable, because the referring question changes completely depending on which class the patient falls into. Indian guidance adopts the classification attributed to Koo and Lee, which sorts psychocutaneous disorders into **three** types and adds a separate group of sensory presentations.

CLASS	WHAT DEFINES IT	NAMED EXAMPLES
Psychophysiologic (type 1)	Dermatological disorders that flare during stress	Alopecia areata, atopic dermatitis, acne, psoriasis, psychogenic purpura, rosacea, seborrhoeic dermatitis, urticaria
Primary psychocutaneous (type 2)	A psychiatric disorder is the root of the dermatological condition	Skin picking disorder, trichotillomania, delusional parasitosis, body dysmorphic disorder, factitious dermatitis
Secondary psychocutaneous (type 3)	Psychological problems arising from chronic skin disease or disfigurement	Alopecia areata, cystic acne, haemangioma, psoriasis, vitiligo, ichthyosis, Kaposi's sarcoma
Cutaneous sensory disorders	Unpleasant skin sensations with no known dermatological cause	Commonest on the face, scalp and perineum; includes glossodynia and vulvodynia

MNEMONIC

Flares, Drives, Scars

The three types in order and in the direction each runs. Type 1 is the skin disease that **flares** under stress. Type 2 is the psychiatric disorder that **drives** the skin lesion, so the lesion is produced by behaviour or by belief. Type 3 is the skin disease that **scars** the person, the psychological problem arising from chronic disease or disfigurement.

Two features of the table are worth arguing rather than memorising. First, alopecia areata and psoriasis appear in two classes each, and that is in the source's own table rather than an error to be tidied away. It is the most useful thing in the classification, because it says that one disease can both flare with stress and disfigure the person who has it, and that the two mechanisms need separate management in the same patient. Second, the type 2 examples are entities other chapters own: delusional parasitosis is taught in the Other psychotic disorders, delusional syndromes and catatonia notes, and skin picking, trichotillomania and body dysmorphic disorder in the Anxiety, OCD and trauma-related disorders notes, while factitious presentations are taken up in the companion topic on factitious disorder and malingering. What belongs here is the referral logic: a type 2 patient reaches psychiatry through a dermatologist who has usually already been consulted several times. The **matchbox sign**, the patient bringing collected specimens of the supposed organism to the appointment, is named in that guidance and is a cross-link observation rather than a psychopathological one: the dermatologist sees it first.

11.6 The arm that runs back: drugs, skin and the psychiatrist's duty

The dermatological interface is the clearest illustration of traffic in both directions, and both directions carry drugs. Running from dermatology into psychiatry, the same Indian guidance sets out a further and more recent classification of psychodermatological disorders, cut differently from the one above and to be named separately rather than merged with it. That newer scheme includes a category the first does not: psychiatric complications of the drugs dermatologists prescribe.

- **Depersonalisation** is named with minocycline.
- **Mood disorders** are named with isotretinoin, methotrexate and systemic steroids.
- **Psychoses** are named with dapsone and hydroxychloroquine.

The use of that list is a habit rather than a fact. In any patient referred from a skin clinic with a new psychiatric presentation, the drug chart is part of the mental state examination, and the temporal relation between starting a dermatological agent and the onset of the symptom is the first thing to establish, because it is the one that will not be recoverable later.

Running the other way, psychotropics can produce **severe cutaneous adverse reactions**, which the Indian guidance describes as potentially lethal, rare and sudden in onset. This account deliberately prints no rates, no onset windows and no per-syndrome mortality figures for them, because the tabulated values available here disagree with the same document's own prose and one of the cells is corrupted, so no comparable standard is available to quote, and none is invented

here. What survives that caution is the part that changes behaviour, and the guidance states it explicitly: the prescriber must warn the patient and the attendants, so that a rash is brought back rather than watched. That instruction is the examinable content. A psychiatrist who has started a psychotropic on a medical ward is responsible for recognising a serious skin reaction to it and acting on it, and cannot make a rash the dermatologist's problem because it is on the skin.

11.7 Psycho-nephrology: the burden along the disease course

The renal interface differs from the other two in that the psychiatric burden is described stage by stage along a trajectory that ends in either lifelong dialysis or transplantation, and it does not fall after transplantation.

- **Depression** is reported in 22.8 per cent of patients with advanced chronic kidney disease and 25.7 per cent of kidney transplant recipients, the stage-wide figure being given above.
- **Anxiety** is reported in 24.8 to 34.3 per cent of patients in stages three to five, and 26.6 per cent of transplant patients.
- **Cognitive impairment** reaches **up to 60 per cent** in advanced disease and in patients on haemodialysis, with deficits described in attention, concentration, orientation and executive function, and low serum albumin associated with decline in delayed memory, visuospatial skills, language and general cognition.

Two points follow. That transplantation does not return these rates to the population baseline is the finding most often assumed away, and it is the argument for continuing psychiatric follow-up after a successful graft rather than discharging at that point. And the cognitive figure is large enough to change how the rest of the assessment is conducted: a patient with that degree of impairment cannot reliably give a history of mood over months, cannot be assumed to have understood a consent discussion about modality, and may be misread as depressed on the basis of psychomotor slowing that is cognitive in origin. Where that impairment needs to be worked up as a neurocognitive presentation in its own right, the substrate belongs to the Neuropsychiatry of systemic and neurological disease notes.

The distress in end-stage disease has named sources rather than a general miserableness, and the guideline lists them: compromised health, dependence on others, regular frequent dialysis, the continued cost of treatment, and uncertainty about transplant. Two of those five are structural rather than psychological, and in Indian practice they are the two that dominate, because a family financing dialysis indefinitely and waiting on an uncertain transplant is not experiencing a distorted cognition that can be restructured. Naming them accurately is what separates a formulation from a diagnosis here.

Treatment at this interface has one grounded drug signal and one grounded psychological one, and the rest is deliberately not given. Citalopram increases the risk of sudden cardiac arrest in patients undergoing haemodialysis, significantly more than other selective serotonin reuptake inhibitors, with no effect size stated and none supplied here. On the psychological side, a meta-analysis supports the efficacy of cognitive behavioural therapy for depression in patients with renal disease on dialysis, which is worth quoting because it is a positive treatment claim in a

population where most trials are small. What is not printed here is any dose, any clearance threshold and any drug-by-drug schedule for prescribing in renal impairment; that material has its own owner and no fragment of it is reproduced here, while the general principles of antidepressant selection belong to the Mood disorders: pharmacotherapy notes.

11.8 Reading the three together

The comparison an examiner is actually testing. Asked to compare these interfaces, most answers list three sets of prevalences and stop. The better answer compares them on what the referring team wants, which differs in each case, and on what the psychiatrist's own decisions do to the organ.

INTERFACE	WHAT THE REFERRING TEAM IS ACTUALLY ASKING	THE PSYCHIATRIC ARM	THE ARM RUNNING BACK INTO THE ORGAN
Cardiology	Will this mood state change the cardiac outcome, and can it be treated safely here	Depression at every stage of coronary disease, mostly undiagnosed, often chronic or relapsing	An independent risk factor with a bidirectional relationship, plus the time-limited constraint on electroconvulsive therapy after an acute coronary event
Dermatology	Is the skin disease the problem here, or is the patient	A large minority of the clinic carries psychiatric morbidity, and the class decides the pathway	Dermatological drugs producing psychiatric syndromes, and psychotropics producing severe cutaneous reactions the prescriber must warn about
Nephrology	Why is this patient not tolerating a treatment they cannot stop	Depression, anxiety and substantial cognitive impairment across stages, persisting after transplantation	One drug-specific arrhythmia signal on haemodialysis, and clearance questions belonging to prescribing in renal impairment

GOOD TO REMEMBER

Two lines that candidates routinely omit should be in the consult note before it is closed on any of these three wards. The first states what the finding means for the physical illness, not only its psychiatric label, because that is the sentence the referring team can act on. The second states what has been done about the drug traffic in both directions: what the existing physical medication may be contributing to the mental state, and what warning the patient and the attendants have been given about the psychotropic just started.

Every organ cross-link has two arms: what the physical illness and its drugs do to psychiatric morbidity, and what the psychiatric disorder and its drugs do back to the heart, the skin or the kidney, and an answer that travels in only one direction has answered half the question.

12 · Psychiatric aspects of epilepsy and neurological disorders

Why the referral arrives at all. The neurology team has finished its investigations, reached its own view, and written one line at the foot of the chart: please see, query psychiatric. Nothing in that request is a question, and a psychiatrist who treats it as one ratifies a decision somebody else has already made. The psychiatric aspects of epilepsy and neurological disorders are taught in full elsewhere: what epilepsy is, how seizures are classified, which psychiatric presentations cluster around them and how the drugs behave belong to the Epilepsy and psychiatry notes; the rest of the neurological interface is listed below. What is owed here is the neurological instance: how the request is generated, what must be established before it can honestly be answered, and who holds which decision afterwards.

The examination question has the same shape. It is rarely a request to list the psychiatric complications of a neurological disease; it is a station in which a neurological patient has a behavioural problem and a team that wants an answer today. A candidate who reaches for the syndrome list has answered a question about the disease. The question was about the consultation.

Observed	Attributed	Owned
WHAT THE CONSULTATION ADDS THAT THE CHART DOES NOT	THE DECISION MADE INSIDE THE REFERRAL BEFORE THE PSYCHIATRIST ARRIVES	WHICH TEAM CARRIES WHICH DECISION AFTERWARDS

12.1 The referral question is not the question in the referral

The written reason for referral is a compressed account of the referring team's reasoning, and it almost always carries an **attribution** already made: this behaviour belongs to the brain disease, or it does not, and therefore it is yours. The **referral question** is the clinical decision actually pending on the ward, and the two are frequently different. The gap widens where the presentation is **paroxysmal behavioural disturbance**, because a paroxysm invites several competing explanations at once and the referring team has usually settled on one. The psychiatrist's value is not a better guess at the mechanism; it is the obligation to return to what was seen before deciding what it was.

WHAT THE REFERRAL SAYS	WHAT IS ACTUALLY BEING ASKED	WHAT HAS TO BE SETTLED FIRST
Please see, query psychiatric, investigations normal	Confirm a negative the team has already reached	Whether anyone has yet described an episode to a psychiatrist
Please see, low mood since the diagnosis	Is this the illness, the treatment, or a disorder in its own right	The sequence in time and the drug record, from a source that watched rather than inferred
Please see before discharge	Share a risk the team will not carry alone	What decision is pending, who may make it, and what the family has been told

12.2 What has to be established before an opinion is worth having

None of it is a mental state finding. A **witness account** is worth more than the ward's account of the same episodes, because a team's summary is where the attribution gets smuggled in, and the sequence in time must be recorded as observation, not as a label, since that labelling is taught with the entity. The **drug record** earns its place because a recent change nobody has connected to the presentation is a common explanation on a neurology ward, and because that record is seldom complete.

MNEMONIC

Witness, timing, list, owner

Witness: who watched an episode, quoted in their own words. **Timing**: where the disturbance sat in relation to the episodes, as sequence and not category. **List**: the drug record with dates, including what was stopped. **Owner**: whoever makes the next decision on each problem, named. An opinion with no named decision-maker is a paragraph, not a consultation.

IN INDIA

Outside the medical colleges and the metropolitan private sector neurology is thinly distributed, and the patient with paroxysmal episodes often reaches a psychiatrist first. The drug history often arrives with no prescription and no record of who started it or when, so it has to be reconstructed rather than assumed. And referrals go unanswered in both directions, so the working relationship with the neurology or medical team is built, not inherited. A national standard would settle how quickly and in what form these consultations happen; no comparable standard is available to quote, and none is invented here.

12.3 Shared care, and the decisions the psychiatrist declines

This patient is the standing example of **shared care**, which fails in a specific way: both teams assume the other is holding a decision, and nobody is. By convention rather than by rule, the seizure diagnosis, the anticonvulsant regimen and the advice about driving and occupation that follows from the seizures stay with **the primary team**. The psychiatric diagnosis, the psychotropic decision, the risk formulation and the psychological plan are the psychiatrist's. Where the two collide, chiefly in prescribing, the decision is joint and is recorded as joint, with a named person on each side.

Declining is an active clinical act, not a retreat. A psychiatrist asked to adjudicate whether the episodes are seizures at all should record that the question belongs to the referring team, state what they observed that bears on it, and set a **review point**. Silence is read as agreement, and an undeclined question tends to be answered by default in whichever direction the ward was leaning.

RULE **Answer the psychiatric question, decline the neurological one, and write both down.** The consultation's authority comes from a visible boundary. An opinion that quietly extends into the seizure diagnosis invites the referring team to stop thinking about it; one that withholds the psychiatric decision leaves the patient with two clinicians and no plan. Neither is visible unless the note says which question was taken and which returned.

12.4 What the examiner tests, and where the rest is taught

How the marks are allocated. A neurological patient is set before a psychiatry candidate to see whether two illnesses and two teams can be held in mind without collapsing either into the other. What is scored is the sequence, the sourcing of the history, the explicit attribution and the handover. Entity knowledge is assumed and examined elsewhere, which is why fluent recitation earns less than a candidate expects.

- Seizure classification, the psychiatric presentations related to seizures, and the anticonvulsants: the Epilepsy and psychiatry notes.
- Examination, investigation and localisation: the Neurology foundations for psychiatrists notes.
- Stroke, head injury and focal brain syndromes: the Stroke, TBI, delirium and focal brain syndromes notes.
- The neurocognitive disorders: the Dementias and neurocognitive disorders notes.
- Systemic disease with neuropsychiatric presentations: the Neuropsychiatry of systemic and neurological disease notes.

TRAP **Answering the referral's attribution instead of testing it.** Candidates make it because the attribution is usually reasonable, comes from a specialist team, and is the only framing the request supplies. It is also the check a psychiatrist is well placed to make, having no stake in the conclusion already drawn. The correction is not scepticism about neurology; it is separating, in the note, what was observed from what was concluded.

A consultation on a neurological ward is discharged by naming what was observed and by whom, what is and is not attributed to the neurological illness, and who carries which decision from here.

What changes at seventy-eight

13 · Normal ageing and psychiatric assessment of the elderly

Why the marks are here. The examiner who turns to the older patient is rarely asking what dementia is, or what late-life depression looks like; those have their own questions and their own answers. This one asks something harder to prepare for. Here is a person of eighty: show me how you assess them, and then tell me which of your findings is the illness and which is simply the age. The second half is where answers collapse, because a candidate with no defensible account of what ageing normally does has nothing to measure abnormality against, and every finding in the

interview becomes uninterpretable in both directions at once. Slowness gets called depression. Forgetting a name gets called dementia. A genuine early deficit gets waved through as expected for age.

The topic has an awkward shape for a reader. Almost everything written about older people concerns their diseases, so the normal baseline is the least rehearsed part of the subject and simultaneously the part every diagnosis silently rests on. That is why normal ageing and psychiatric assessment of an older person belong in one answer rather than two: a procedure is only as good as the norms it is read against.

13.1 The instrument does not change; the weights inside it do

Begin where the guidance begins, because it is unusually blunt. A clinical practice guideline on older people presenting with psychiatric emergencies, published in the Indian Journal of Psychiatry in 2023, states that the basic principles of psychiatric assessment remain the same in old age, and then names them: thorough history taking, physical examination, mental state examination, and carrying out the investigations required. **Four** parts, in the order every candidate already knows. Nothing is deleted because the patient is old, nothing exotic is inserted, and there is no separate geriatric interview to name.

What changes sits inside the first part. The same guideline directs that in taking the history the clinician should not confine attention to the psychiatric history but must also cover **comorbid physical illness**. Read that as a statement about weight and not about coverage. An adult history asks about physical illness too, but handles it as background against which the psychiatric story is told. In later life it stops being background and becomes a second history of equal standing, taken with the same care, the same chronology and the same insistence on detail as the psychiatric one.

Four reasons make that shift defensible rather than merely dutiful, and a good answer gives at least two. The physical illness is more often the cause of the presentation than a context for it. It frequently dictates what treatment is available, so a plan written before the physical history is complete may have to be abandoned. It changes the reading of the mental state, since fatigue, poor appetite, disturbed sleep and slowing all have honest medical explanations in a patient with several active diagnoses. And it is the part the patient is least likely to volunteer, having normalised it over years and having come to see a psychiatrist.

RULE **The skeleton of the assessment is age-invariant; the weight distributed across it is not.** Anyone who answers this question by describing a special geriatric interview has misread it. The examinable content is which parts of a familiar structure grow, what gets added to the history because of the patient's age, and against what baseline the mental state findings are then read. Say the structure is unchanged in your first sentence, and spend the rest of the answer on the redistribution.

One qualification belongs in the answer. The document stating the principle most crisply is written for the emergency presentation, so its setting is the acutely disturbed older patient rather than the routine outpatient. That sentence about the structure is itself general and travels, but a candidate who names the source should name its scope too.

PART OF THE ASSESSMENT	WHAT IS UNCHANGED	WHAT THE PATIENT'S AGE ADDS
History	The same sequence, the same headings, the same discipline about chronology	Physical comorbidity taken as a full second history; three added domains an adult clerking omits; an informant account that is rarely optional
Physical examination	The examination itself	It cannot be deferred to another team, because its findings now enter the psychiatric formulation rather than sitting beside it
Mental state examination	The same structure, the same terminology, the same descriptive discipline	Every finding is read against a normal-ageing baseline before it is called abnormal, and correctable sensory deficit is dealt with before cognition is tested at all
Investigations	Those the assessment has shown to be required	The physical differential raised by the history is longer, so the list is driven by that differential rather than by a fixed panel

13.2 The premise underneath all of it: reduced reserve

A single line in the same guideline carries the physiology for the entire subject. Older people have a lower level of **physiological reserve**, and the consequence drawn from it is that any tiny change should be given due importance. The guideline says this while instructing the reader how to evaluate drug intoxication and withdrawal, which is where a small change is most easily dismissed, but the premise is not specific to drugs and the reasoning generalises across the assessment.

Reserve is the distance between what a system does at rest and the most it can produce under load. Ageing narrows that distance across several systems at once, and the corollary is worth memorising: a perturbation absorbed silently in a younger patient produces a disproportionate effect here. Two things follow for the assessment.

- The size of the trigger stops predicting the size of the effect, so a search that stops because nothing impressive has been found has stopped too early, and a small complaint is pursued rather than filed.
- A change in mental state becomes a system-level signal rather than a psychiatric one, and it earns a physical review before it earns a psychiatric label.

What is deliberately not supplied here is the arithmetic. How far renal clearance falls per decade, and what happens to hepatic metabolism, lean body mass, total body water, albumin and receptor sensitivity, are exactly the figures a candidate reaches for at this point. For each of them no comparable standard is available to quote, and none is invented here. Those numbers belong to prescribing rather than to assessment, and are taken up where the principles of

psychopharmacology in later life are dealt with in these notes. In an assessment answer the qualitative statement is what earns the mark.

13.3 Normal cognitive ageing is a pattern, not a slope

The most useful correction to make early is that normal ageing is not global decline. A review of normal cognitive ageing published in Clinics in Geriatric Medicine in 2013 frames it as a split. Some abilities are resilient to brain ageing and may even improve with age, vocabulary being the standing example. Others decline gradually across time, and the three the review names are conceptual reasoning, memory and processing speed. The rate at which any of this happens varies widely between individuals, which is the reason chronological age predicts a given person's performance so poorly and the reason a normative table can never replace a premorbid baseline.

The same review puts numbers on the two trajectories, and they are the only quantified ones offered here. The abilities it groups as fluid, naming executive function, processing speed, memory and psychomotor ability, peak in the third decade of life and thereafter decline at an estimated **0.02** standard deviations a year. The crystallised abilities remain stable or gradually improve, at a rate the review prints as **0.02 to 0.003** standard deviations a year, through the sixth and seventh decades of life. Notice what that pairing means: across middle and later adulthood the two curves move in opposite directions inside the same skull, so a single global impression of a patient as sharp or as failing is almost always wrong about one half of them.

The fluid and crystallised distinction itself, its origin, its lifespan trajectory and the hold versus no-hold logic of testing that follows from it belong with the psychology of intelligence and are not re-derived here. What this section owes is the clinical use of the split. Preserved crystallised performance is what allows an estimate of what the patient used to be, and the gap between that estimate and current fluid performance is the quantity a cognitive assessment is really trying to measure. A patient whose vocabulary and general knowledge have gone is not showing you an exaggerated version of ageing; they are showing you something ageing does not do.

DOMAIN	WHAT NORMAL AGEING DOES TO IT	HOW TO READ A POOR PERFORMANCE
Overall language	Remains intact	A genuine language deficit is a finding, not a concession to age
Vocabulary	Resilient, and may improve with age	Loss here is among the strongest arguments against normal ageing
Visual confrontation naming	About the same until age 70, declining in subsequent years	Interpret against age before calling it anomia in an older patient
Verbal fluency	Declines	Weak on its own, and confounded by slowing
Processing speed	Begins declining in the third decade and continues through life	The likeliest single explanation for a broad, shallow, timed-test deficit

DOMAIN	WHAT NORMAL AGEING DOES TO IT	HOW TO READ A POOR PERFORMANCE
Rate of acquisition	Declines across the lifespan	Slow learning of a word list is compatible with normal ageing
Retention of what was learned	Preserved where cognition is healthy	Failure to hold material that was demonstrably learned is not ageing
Delayed free recall, source and prospective memory, retrieval	Decline with normal age	Expected; weigh them lightly without a retention failure alongside
Recognition memory with cueing, temporal order memory, procedural memory	Stable with normal age	Deficits here carry more weight than an equivalent recall deficit
Simple auditory attention span	Falls only slightly, and late	A markedly reduced simple span deserves an explanation
Selective attention, divided attention, working memory	Decline more noticeably	Poor performance under distraction or dual demand is weak evidence of disease
Conceptual reasoning	Declines gradually	Expected, and heterogeneous enough that a single score means little

13.4 Slowing is the common cause, and it contaminates the rest

The point that changes how you read a score. **Processing speed** is not one deficit sitting alongside the others. The review is explicit that many of the cognitive changes reported in healthy older adults are the result of slowed speed, and that the slowing depresses performance on tests built to measure entirely different domains, verbal fluency among them. That single observation reorganises the whole of bedside cognitive interpretation.

The mechanism is not mysterious. Almost every cognitive instrument is timed, or carries an implicit time limit set by the examiner's patience, or asks the patient to hold material while operating on it. Each of those designs converts slowness into a lower score without any deficit in the domain being tested. The patient who produces fewer words in a minute may have intact semantic access and a slower retrieval engine. A profile of shallow deficits spread evenly across many domains is therefore the signature of a speed effect, and reads quite differently from a deep deficit in one domain with the rest preserved.

Two things follow at the bedside, and both are things the examiner can ask you to do rather than describe. Give time, and say in the note that you did, because a result obtained under time pressure and a result obtained without it are different measurements. And when a score comes out low, ask what proportion of that instrument's marks depended on producing something quickly before you record a domain deficit against the patient's name.

TRAP **Reading a low score as a domain deficit when it is a speed artefact.** Candidates learn cognitive testing as a map of domains and assume each subtest measures the domain it is named after. In an older person that assumption fails in a specific direction, because slowing pulls down scores across instruments that have nothing to do with speed. The answer that wins the mark names slowed processing speed as a competing explanation for the whole profile, rather than accepting the profile at face value and reporting a scattered multi-domain impairment.

13.5 Memory in normal ageing: slower to learn, not quicker to forget

The memory findings are the most examinable material in the topic, because they are the ones that separate an expected complaint from a diagnostic one. Normal ageing reduces the **rate of acquisition**: material takes more exposures and more time to get in. What it does not do is dissolve material that got in. Retention of information that has been successfully learned is preserved in cognitively healthy older adults, and that asymmetry is the baseline against which any complaint of memory failure has to be read.

The practical consequence is that the interesting question is never whether the patient forgot something. It is whether the item was ever learned. A patient who could not repeat a name back at the time of registration has not forgotten it thirty minutes later, and the examiner who watches a candidate record that as delayed recall failure has already found the mark. This is why an adequate registration step is not a formality, and why an examination that skips it produces a delayed recall figure that cannot be interpreted.

The direction of the normal changes is worth holding as two lists rather than one, because the second list is what makes a finding meaningful. Declining with normal age: delayed free recall, source memory, prospective memory, the rate of acquisition and retrieval. Stable with normal age: **recognition memory** when cueing is given, temporal order memory and procedural memory. A patient who cannot retrieve a word list freely but recognises every item when choices are offered is displaying a retrieval pattern, which is what ageing produces. One who does not recognise them even when offered has failed at something ageing does not touch.

Two boundaries belong here and are not crossed. What a rapidly failing memory in a patient with psychotic symptoms should push you towards is dealt with where late-onset psychosis is taken up in these notes, and the fine-grained cued-recall discriminators between the neurocognitive disorders belong to the Dementias and neurocognitive disorders notes. What this section supplies is the thing both of them stand on: the description of what memory does when nothing is wrong.

13.6 Language and attention: where candidates over-call and under-call

Language is the domain most often mishandled in both directions. Overall language ability remains intact with ageing, and vocabulary remains stable or improves, so a genuine language deficit in an older patient is a finding to be explained rather than a concession to be made. Against that, the review names two exceptions and both are common enough to trip an unwary examination. **Visual confrontation naming** stays about the same until the age of **70** and declines in the years after it, so naming failures in the eighties are read against a moving norm. And **verbal fluency** declines, which matters doubly because fluency tasks are also timed and therefore carry the speed confound described above.

Attention divides along a similar line. Simple auditory attention span shows only a slight decline in late life, whereas selective attention, divided attention and working memory decline more noticeably. That asymmetry is directly useful in a busy clinic. A patient who cannot hold a short span of digits at all has produced an abnormal finding worth pursuing; a patient who loses the thread when two things are asked at once, or when a corridor conversation intrudes, has produced an expected one. It also explains why the same patient looks impaired on a ward round and unimpaired in a quiet room, with no change in their brain between the two.

Sensory, frailty, abuse	3rd	0.02	2
THE HISTORY DOMAINS ADDED BECAUSE THE PATIENT IS OLD, THE LAST OF THEM NEEDING SUSPICION RATHER THAN ENQUIRY	DECADE OF LIFE IN WHICH FLUID ABILITIES PEAK, BEFORE THEIR LONG DECLINE	STANDARD DEVIATIONS A YEAR, THE ESTIMATED RATE OF THAT FLUID DECLINE	EXCEPTIONS TO OTHERWISE PRESERVED LANGUAGE: CONFRONTATION NAMING AFTER 70, AND VERBAL FLUENCY

13.7 The history items that exist only because the patient is old

Beyond the redistribution of weight, the geriatric history acquires domains an adult history does not routinely ask about. The same national guideline names them, and they are worth memorising as a set because a candidate who produces all three has demonstrated the point of the whole question. Due importance is to be given to the assessment of **sensory deprivation**, visual or auditory, and to a review of frailty; and the assessment of elder abuse requires a high index of suspicion.

Take the modal verbs seriously, because they differ. Sensory status and frailty are enquiries you make. Elder abuse is not an enquiry that succeeds by being made, since nobody volunteers it and the person who brought the patient may be the person concerned; what is asked for is active suspicion, the possibility raised by the clinician on the strength of discrepancy rather than of complaint. That topic's forms, its named instrument and what a clinician is then obliged to do are taken up where elder abuse and neglect are dealt with in these notes.

Sensory deprivation earns its place for two separate reasons and only one of them is about the patient's experience. Degraded hearing and vision impoverish the information reaching an older person, so more of the world has to be inferred and less of it is received. Independently of that, an uncorrected deficit invalidates the examination you are about to perform: a patient who cannot hear an instruction looks inattentive, and one who cannot see an object looks unable to name it. What that does at the bedside of a confused inpatient belongs to the section on delirium in later life. What belongs here is the history step and its order: establish what the patient normally uses, establish whether they have it, and correct it before the mental state examination rather than after.

On the sensory changes themselves, this section stops short deliberately. What normally happens to hearing and to vision with age, the pattern in which it happens, the age at which it becomes clinically material, and how many older adults in India are affected are all facts a complete answer would carry, and for each of them no comparable standard is available to quote, and none is invented here. Say what is defensible: that sensory decline is expected, that it is frequently

correctable, and that its uncorrected presence makes a cognitive result uninterpretable. Do not attach a prevalence or an age threshold you cannot source, because that is precisely the sentence an examiner will ask you to justify.

Frailty is named here as a review, not as a construct to be taught. Its definition, its scoring and the multidisciplinary assessment it triggers are dealt with where the comprehensive geriatric assessment is taken up in these notes; in the psychiatric history it is a question about reserve.

MNEMONIC

Hear it, Weigh it, Count it, Suspect it

The four acts that turn an adult history into a geriatric one. **Hear** it: establish and correct sensory deprivation before any cognitive item is administered. **Weigh** it: give the comorbid physical history the same weight as the psychiatric one, and review frailty as part of it. **Count** it: produce a cumulative anticholinergic total from the drug history rather than a list of drugs. **Suspect** it: raise elder abuse yourself, because it is not volunteered.

13.8 The medication history has to produce a total, not a list

Every candidate takes a drug history. The geriatric requirement is different in kind: the guideline treats assessment of the **total anticholinergic burden** of all ongoing medications as a critical part of evaluating the medication history, and gives the reason plainly, which is that a high burden is one of the crucial causes of delirium. The output of the history is therefore a quantity, not an inventory, and an answer that says the drug history was taken without saying what it produced has not met the requirement.

The word doing the work is total. The clinical problem is rarely one strongly anticholinergic agent prescribed in error, which anyone would spot. It is the sum of several mild contributors accumulated across years and across prescribers, each individually defensible, none individually alarming, and nobody holding the addition. Note what is owed here and what is not: the assessment step is to arrive at the total. How that total then constrains prescribing, and what scales exist for scoring it, belong to the section on psychopharmacology in later life.

IN INDIA

Whose drugs get counted is where an Indian history diverges from the textbook version. The same guideline explicitly extends the medication history to medications from other pathies, naming homeopathy and ayurvedic preparations, alongside what has been bought over the counter. In practice the older Indian patient arrives on a physician's prescription, something from a second system of medicine that the family regards as harmless and so does not mention, a sleeping tablet running for years on repeat, and a topical or ophthalmic preparation nobody counts as a drug at all. The question that recovers all of it is not what medicines are you taking. It is a request to bring in every strip, bottle, sachet and tube in the house, from every doctor and every shop.

13.9 What the assessment has to leave behind

Because none of this is a separate procedure with its own form, what marks a geriatric assessment as competently done is what appears in the record at the end of it. Four entries carry the topic,

and each of them is the written trace of something taught above.

- The premorbid cognitive and functional baseline, with its source named, since a current performance without a baseline is a number without a comparator.
- The physical history and examination findings placed inside the psychiatric formulation rather than appended after it, with the differential they raise made explicit.
- A reconciled drug list from every source, with its cumulative anticholinergic burden stated as a judgement.
- A sentence saying which of the findings you have read as ageing and which as illness, and on what grounds, because that is the reasoning the question was testing and it is invisible unless written.

Two habits of conduct make those entries possible and are worth naming in a viva. Interview at the patient's pace, which is not courtesy but measurement discipline, given how much of what looks like deficit is slowing. And take an informant history routinely rather than as a rescue when the patient proves a poor historian, because the baseline everything else is read against usually exists only in somebody else's memory.

GOOD TO REMEMBER

Before the words cognitive impairment go into an older patient's notes, two sentences have to precede them: what this person was like before, and who told you. If neither is there, what has been recorded is a performance and not a finding, and every clinician who reads the note afterwards will inherit the conclusion without the evidence that would let them revise it.

Whatever form the question takes, it asks whether you can hold two frames at once. A candidate with only the assessment produces a competent adult clerking of an old person; one with only the norms produces a lecture on gerontology. The mark is in the join.

In normal ageing the rate of acquisition falls while retention of what was successfully learned is preserved, and vocabulary holds or improves while processing speed has been falling since early adulthood: so slow learning and slow performance are age, and losing what was learned or losing words is not.

14 · Principles of psychopharmacology in the elderly

Why the marks sit here. A prescription for a woman of seventy-eight is not a smaller version of the prescription for a woman of thirty with the same syndrome. The drug may be identical and the arithmetic is still different, because the body it enters has changed in how much arrives, how long it stays and how hard it lands.

The principles of psychopharmacology in the elderly are prescribing logic rather than a drug list; the agents belong to the Mood disorders: pharmacotherapy notes and the Anxiety, OCD and trauma-related disorders notes. Four things change with age: the kinetics, the dynamics, the number of other drugs already in the patient, and the prescriber's willingness to stop one.

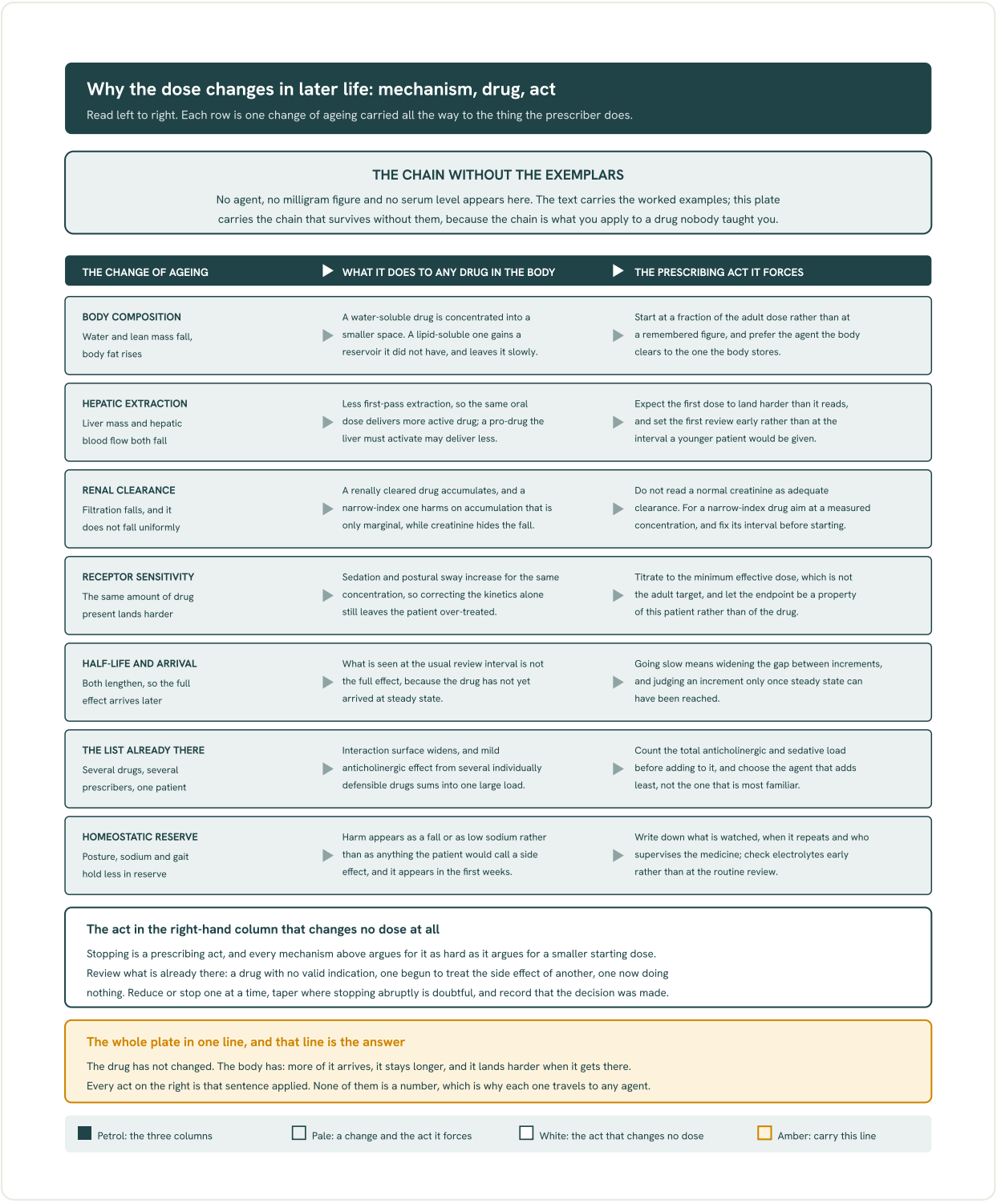


Fig 29.6. Why the prescription changes in later life, drawn as seven chains rather than as a list of changes, each beginning with one pharmacokinetic or pharmacodynamic shift of ageing, passing through what that shift does to any drug in the body, and ending in the act it forces on the prescriber, with no agent, milligram figure or serum concentration anywhere on the plate, and with the act that adjusts no dose at all, the review and withdrawal of what is already there, given its own panel because every mechanism above argues for it.

14.1 The kinetic shift

The whole kinetic change states in one line. Renal clearance falls, hepatic clearance falls, the **volume of distribution** rises for lipid-soluble drugs, and elimination half-life lengthens as a consequence. The review that states it this way also names psychotropic drugs, with anticoagulants and cardiovascular agents, as a class to which sensitivity is altered and usually

increased, which is why this is a psychiatric topic and not only a geriatric-medicine one. It hedges throughout, and a candidate who hardens its "probably" into a mechanism has overstated it.

WHAT CHANGES WITH AGE	CONSEQUENCE FOR THE PRESCRIPTION
Body water and lean mass fall, fat rises	Smaller volume of distribution for water-soluble agents; larger volume and longer half-life for lipid-soluble ones, diazepam the exemplar, so the sedative cleared by breakfast at forty still circulates at teatime at eighty
Liver mass and hepatic blood flow fall	First-pass metabolism reduced, so bioavailability can rise for a drug extensively cleared on first pass, while a pro-drug the liver must activate might be activated more slowly
Renal flow and filtration fall, not uniformly	Clearance falls for renally cleared agents, lithium among them, and marginal accumulation of a narrow-index drug harms
Sensitivity to several classes is altered upward	Sedation and postural sway increase with diazepam and postural sway with temazepam, so the same plasma level buys a bigger effect

PITFALL

A normal serum creatinine in an older patient is not evidence of adequate renal function. Filtration falls while plasma creatinine does not rise, because muscle mass falls in parallel, so creatinine is not a reliable indicator of glomerular filtration rate in the elderly subject, and serum cystatin C offers no significant advantage over it. The same source is explicit that the decline is not uniform or consistent, which warns against the familiar per-decade figure. No rate of decline is asserted here, and no percentage for the fall in body water, lean mass or liver blood flow: none of those magnitudes is available to quote, and none is invented here.

14.2 The pharmacodynamic shift

Kinetics can be reasoned from first principles. Dynamics cannot, and the honest source says so: because the effect of age on drug sensitivity varies with the drug studied and with the response measured, generalisations are often difficult. Quote that rather than paraphrase it. Within the caution the direction is loud for the benzodiazepines: one at seventy-eight is not merely longer-acting but intrinsically more destabilising at the same concentration. It is not loud everywhere: the same table's scopolamine row runs the other way, its effect on cognitive function decreasing with age.

MNEMONIC

Fewer litres, slower exit, sharper target

Fewer litres is the body-composition shift, **slower exit** the fall in clearance and the longer half-life, **sharper target** the rise in sensitivity that includes psychotropics.

14.3 Start low and go slow, as a quantity

Start low, go slow heads the Indian list of general prescribing principles for the elderly. Quoted alone it is nearly useless: it says nothing about how low or how slow. Current Indian guidelines do quantify it, and differently for different drug classes, which is the examinable point rather than an inconsistency to smooth away.

half OF THE ADULT STARTING AND TARGET DOSE FOR ANTIDEPRESSANTS IN THE ELDERLY, INDIAN DEPRESSION GUIDELINE	**25 to 50% lower** THAN THE ADULT ANTIPSYCHOTIC STARTING DOSE IN OLDER ADULTS, INDIAN SCHIZOPHRENIA GUIDELINE	**more than 5** MEDICATIONS, THE POLYPHARMACY COUNT TRIGGERING A DEPRESCRIBING REVIEW IN INDIA	**every 6 months** OR MORE FREQUENTLY, THE GENERAL FILTRATION AND THYROID SCHEDULE ON LITHIUM, OLDER AGE BEING A REASON TO GO MORE OFTEN

The first two figures are not the same rule. The antidepressant rule is a flat halving that moves the target dose as well as the start, so the destination itself moves; the antipsychotic rule is a range of reduction, stated for the starting dose only. Neither states an upper ceiling for older adults and neither states a milligram figure, so a correct answer attaches the class and the guideline to each figure.

Going slow has an endpoint as well as a rate, and the endpoint is what candidates drop. The Indian obsessive-compulsive disorder guideline states it plainly for older adults: start low, increase slowly, stabilise at the **minimum effective dose**, which is not the adult target. It also says clomipramine may be avoided on cardiac, sedative, constipating and falls grounds, and that high-dose selective serotonin reuptake inhibitors should be used cautiously because of falls and hyponatraemia, "high dose" meaning the supratherapeutic anti-obsessive range that guideline itself recommends.

The clearest quantified illustration of slowness is not a psychotropic. For digoxin, time to steady state rises from 7 days in the young to 12 days in the elderly, so digoxin loading doses should be **reduced by approximately 20 per cent**. The arithmetic transfers: such a drug cannot be titrated on a younger patient's schedule.

RULE **The age adjustment is a fraction, not a figure.** Every quantified dose rule for older adults in current Indian guidance is a proportion of the adult dose or a serum-concentration target, and none states an absolute milligram starting dose: the adult dose is the only fixed point guideline and prescriber share.

TRAP **Converting a relative instruction into a remembered absolute one.** Told the elderly antidepressant dose is half the adult dose, a candidate reaches for a milligram number. The instruction has no milligram content; the moment it acquires one, it came from the candidate and not the guideline.

In an older adult the starting dose is a fraction of the adult dose, the titration endpoint is the minimum effective dose rather than the adult target, and the monitoring that decides the outcome is sodium, renal function and the ability to stand up without falling.

14.4 Lithium, and a guideline that disagrees with itself

Lithium is where every strand of this topic meets. It is renally cleared, its clearance falls with age, and it is separately named with the aminoglycosides and digoxin as a drug of **narrow therapeutic index** likely to cause serious adverse effects if it accumulates only marginally more than intended. Those two properties together are the argument for a lower target in old age.

PHASE AND POPULATION	SERUM LITHIUM TARGET AS PRINTED	WHERE THE GUIDELINE STATES IT
Acute mania, medically healthy	0.8 to 1.0 meq/l	the acute-mania dosing table
Acute mania, older adults or relevant medical issues	0.6 to 0.8 meq/l	the same dosing table
Acute phase, general	0.6 to 1.2 meq/l	the lithium narrative of the same document
Acute phase, older adults	0.4 to 0.8 meq/l, which the guideline says "may suffice"	the same narrative
Maintenance, medically healthy	0.6 to 0.8 meq/l	the maintenance section
Maintenance, older adults or relevant medical issues	0.4 to 0.6 meq/l	the same section

Two things there need saying aloud. First, the current Indian bipolar disorder guideline states the older-adult acute target in two places and they do not agree: the dosing table sets the lower bound at 0.6 meq/l while the narrative of the same document sets it at 0.4 meq/l, both agreeing on an upper bound of 0.8 meq/l. Averaging them gains nothing: name the location you quote, or give both ranges. The narrative also carries the softer modal verb, that the lower range "may suffice" rather than that it should be aimed for.

Second, what the guideline does not say. The dosing table prints a milligram-per-day range for the adult and prints no milligram-per-day figure for the older adult at all, so the older-adult figure available to quote is a serum concentration and never a starting dose. A candidate asked for milligrams of lithium at seventy-eight should name the serum target and the monitoring, and say the dose is whatever achieves that level.

Monitoring is where the age effect refuses to become an interval, and the population is the trap. Six-monthly is the general schedule for filtration and thyroid function on lithium, with or more frequently attached, not an older adult's schedule. For the older adult the guideline says only that more frequent monitoring of urea and creatinine may be needed, in older adults and where a diuretic, a non-steroidal anti-inflammatory drug or an angiotensin converting enzyme inhibitor is co-prescribed or there is renal impairment. May be needed is the source's own modal, and how much more often is nowhere stated.

14.5 Anticholinergic burden: a mandate without an instrument

Indian guidance makes assessment of the total **anticholinergic burden** of all ongoing medications a critical part of the medication history in an older patient, and gives the reason as delirium: high anticholinergic burden is one of its crucial causes. The word total is load-bearing: the problem is rarely one strongly anticholinergic drug prescribed in error, but the cumulative effect of several mild ones from several prescribers, each defensible alone.

The same guidance names no scale, no score and no cut-off, and a candidate should say so. Instruments exist outside India: the **Anticholinergic Cognitive Burden scale**, the Anticholinergic Drug Scale and the Anticholinergic Risk Scale, the first the most frequently validated of the expert-based scales against adverse outcomes. No numeric threshold from any of them is asserted here: no comparable standard is available to quote, and none is invented here.

Two practical consequences follow even without a score. The Indian schizophrenia guideline makes lower anticholinergic burden and lower sedative property the selection criteria for a first-line antipsychotic in older adults, gives the purpose as preventing falls, tells the prescriber to avoid anticholinergic co-prescription so far as possible, and requires more frequent metabolic monitoring without saying how much more. Anticholinergics are also the one class Indian deprescribing guidance names as generally high risk in the elderly. The cognitive endpoint belongs to the Dementias and neurocognitive disorders notes.

14.6 Falls and hyponatraemia

When Indian guidance quantifies the elderly antidepressant rule it attaches two monitoring targets and only two: hyponatraemia and falls. They are the two adverse effects that turn a psychiatric improvement into a medical admission. On falls, the drug-side risks named are the need for a mobility aid, sedative medication, and drugs causing a postural fall in blood pressure; after a fall the history asked for is structured:

- where the fall happened, what the patient was doing, and the type of fall
- dizziness or fainting around it
- weakness on changing posture, such as standing from sitting or lying
- walking difficulty, recent previous falls, and visual or auditory impairment, each a checklist item in its own right

No falls instrument or score is named in the Indian sources, so naming a falls tool goes beyond them. On hyponatraemia the mechanism is stated: these drugs are associated with it through the **syndrome of inappropriate secretion of antidiuretic hormone**, and the risk factors begin with old age, then female sex, co-administration of drugs that themselves cause hyponatraemia, reduced filtration and comorbidity. Timing is as examinable as mechanism: in elderly and frail patients the risk sits especially in the first weeks of treatment, which is why electrolytes are checked early rather than at a later review. First weeks is not a number of weeks. Referral to a specialist is set at a serum sodium **below 125 mmol/L**, a laboratory threshold and not a dose.

A third harm needs a clause because its age relevance is inferential rather than stated. These agents may increase the risk of upper gastrointestinal bleeding, particularly with non-steroidal anti-inflammatory drugs or antiplatelet agents, and caution is advised where aspirin or oral anticoagulants are co-administered. The source does not stratify that risk by age; what makes it geriatric is that those co-prescriptions are commonplace at seventy-eight.

GOOD TO REMEMBER

Two answers must be in the note before an older patient leaves with a new prescription: who will supervise the medication, and which investigations repeat and when.

14.7 Interactions, class choice and the citalopram trade-off

Interaction matters here for an unglamorous reason, and Indian guidance names it: the elderly are likely to be on many medications for other medical conditions. All selective serotonin reuptake inhibitors are metabolised by the cytochrome P450 system, and they divide in two:

- fluoxetine, fluvoxamine and paroxetine also significantly inhibit P450 enzymes, so they may interfere with a wide variety of other medications
- citalopram, escitalopram and sertraline do not substantially inhibit those enzymes and are associated with fewer drug interactions

That reads as a clean recommendation until you turn to the same guideline's cardiac table. As a class these drugs are reported to have no effect on QTc and no association with arrhythmia, with one exception: citalopram and escitalopram show a dose-related increase in QTc and torsades de pointes in overdose and should be used with caution in those at risk for arrhythmia, while sertraline appears safest. Two of the three interaction-safer agents are therefore the conduction-riskier ones, and an answer naming one ground must carry the other.

What that guideline does not supply is a number: no millisecond QTc threshold and no age-specific dose cap appear in it, so Indian guidance cannot be cited for a QTc cut-off. The only age-triggered maximum available comes from elsewhere and it is a ceiling rather than a starting point. Secondary reports of a United States regulatory safety communication describe it as advising against citalopram above 40 mg per day generally, and as reducing the maximum to 20 mg per day in older patients, in hepatic impairment, in CYP2C19 poor metabolisers, and with a CYP2C19 inhibitor, the age threshold being sixty years in both reports, and neither report attaches that ceiling to any single indication, obsessive-compulsive disorder included. Three limits belong with that figure: it is a daily maximum and carries no starting dose; the reports are not the issuing regulator's own document but a journal article and a second country's medicines agency stating the same cap; and they disagree over whether a patient of exactly sixty falls inside the ceiling, so neither wording is adopted here. Which of these agents a given older patient is started on, and at what dose for which disorder, is settled in the notes that own the antidepressants; what belongs here is only that age by itself lowers a ceiling.

Class choice may itself shift with age. The current Indian depression guideline states that in older adults these agents may be less effective and that serotonin and noradrenaline reuptake

inhibitors such as duloxetine may be more suitable, while the obsessive-compulsive disorder guideline reports that in older adults they appear to be as effective as in the adult population. Between them they make the flat sentence that these drugs are first-line in the elderly unsafe to write: attach the disorder, and keep the modal verb.

14.8 Deprescribing: stopping as a prescribing act

Why stopping is the harder skill. Every incentive in a consultation favours addition, and stopping a drug someone else started means owning a decision you did not make. **Deprescribing** is defined in Indian guidance as a systematic process of recognising, dose-reducing, stopping or replacing medicines when the risks of continuing outweigh the benefits, judged against this patient's medical morbidity, functioning, values and preferences, its stated aim being not necessarily to stop medications entirely but their judicious use. The same principle appears independently in the current Indian bipolar disorder guideline, among its principles for polypharmacy generally rather than in any geriatric section: periodically reassess the need for multiple agents and taper the non-essential or non-effective ones through careful review of history and shared decision making, which may reduce adverse-effect burden and increase adherence. That statement names no branded framework and attributes its principles to non-Indian work, so a framework name offered as the Indian position would be an invention.

Operationally the guidance answers three questions. *When*: nine triggers are listed, the first numeric, receiving more than five medications, with older age and frailty each counting in their own right alongside multimorbidity, renal impairment, multiple prescribers and transient care, non-adherence, limited life expectancy and dementia. Read the operator: more than five, not five or more, and a threshold for review rather than a permitted maximum. *Which* drug: those with no valid indication, those contributing to the presentation, those generally high risk in the elderly, ineffective ones, preventive drugs in a patient now palliative, and those begun as a **prescribing cascade**, meaning a medication started to treat a side effect of another medication. *How*: stop first the drugs causing or most likely to cause harm and those of most concern to the patient; stop one drug at a time, unless an adverse reaction is suspected or withdrawal risk is minimal, when two or more may go together. Where there is any doubt about stopping abruptly it is safer to taper over weeks to months, the plan being shaped by severity of risk, duration of use with benzodiazepines flagged, dose and half-life, and the likelihood of an adverse withdrawal reaction.

Explicit lists naming drugs as **potentially inappropriate medication** in older adults sit alongside this reasoning rather than replacing it. One such list is the American Geriatrics Society Beers Criteria, whose 2023 update places the non-benzodiazepine benzodiazepine-receptor-agonist hypnotics at Avoid, because their adverse events in older adults resemble those of benzodiazepines, including delirium, falls and fractures, for minimal improvement in sleep latency and duration. Two caveats travel with it: the copy available was a third-party mirror rather than the issuing society's own document, so its strength-of-recommendation labels are not asserted here, and neither an Indian equivalent list nor any other explicit-criteria set is described here: no comparable standard is available to quote, and none is invented here.

14.9 The Indian frame, and what is not available to quote

Indian guidance on prescribing to older adults is explicit and entirely qualitative. The canonical statement is a table of **fifteen** general principles headed by start low and go slow, not one of which carries a number. Among them: mandatory baseline investigations; review of all prescriptions including over-the-counter medicines; review of the anticholinergic load before prescribing; evaluation for sensory deprivation as a determinant of adherence; the simplest possible prescription; identifying who will supervise it; avoiding polypharmacy; the shortest possible duration; and regular monitoring of investigations.

IN INDIA

Two scope facts change how that table is cited. It was written for the emergency setting and states that it can also be applied to elderly patients seen in a consultation-liaison setting, so calling it an outpatient prescribing guideline overstates it. And it is published in the Indian Journal of Psychiatry, the official publication of the Indian Psychiatric Society, which makes it the Indian answer rather than an imported one.

Indian guidelines do name Indian constraints in terms, though none of the examples is specific to older adults. One current guideline records an agent approved abroad for agitation in bipolar disorder as not yet introduced in India, and another states that selective serotonin reuptake inhibitors are preferred first-line for obsessive-compulsive disorder in the Indian context because resources for delivering cognitive behavioural therapy are limited. The second is the Indian formulary argument in miniature: what counts as first-line here is decided partly by what can be delivered here. For the older adult specifically, the facts a prescriber would most want, whether marketed strengths permit a clean halving, whether liquid or dispersible formulations exist, and what any of it costs out of pocket, are not established here and none is invented here.

The last piece of currency is the state of the evidence, which one guideline states without flattery for its own disorder. Specific management strategies for older adults with obsessive-compulsive disorder have not been evaluated; the pharmacological evidence comes primarily from open-label trials and case studies; and because of high rates of physical illness and multiple medications, psychological approaches are often recommended first-line in this age group. That is disorder-specific and must not be lifted into a general claim, but its logic is portable: where the evidence in old age is thin and the risk thick, the threshold for reaching for the prescription pad rises. One caution on currency: the kinetic and dynamic account rests on a review published in 2004, which should be qualified rather than assumed current.

15 · Elder abuse and neglect

Why the marks are here. Elder abuse and neglect is the geriatric topic where a candidate can know the clinical picture well and still lose the question, because what is examined is a sequence of acts: how the possibility is raised, how a history is taken when the person who brought the patient may be the person harming them, which instrument is named, and what the clinician is then obliged to do and on whose authority. The last of those is where most answers collapse,

because they are written by analogy with child protection, and that analogy does not hold in India.

The subject also carries an unusual split in its evidence. The clinical half is largely unlegislated and the legal half is largely unclinical, so the two parts of a complete answer come from different kinds of authority and carry different force. An answer that keeps them apart, and says which is which, is doing precisely what the question tests.

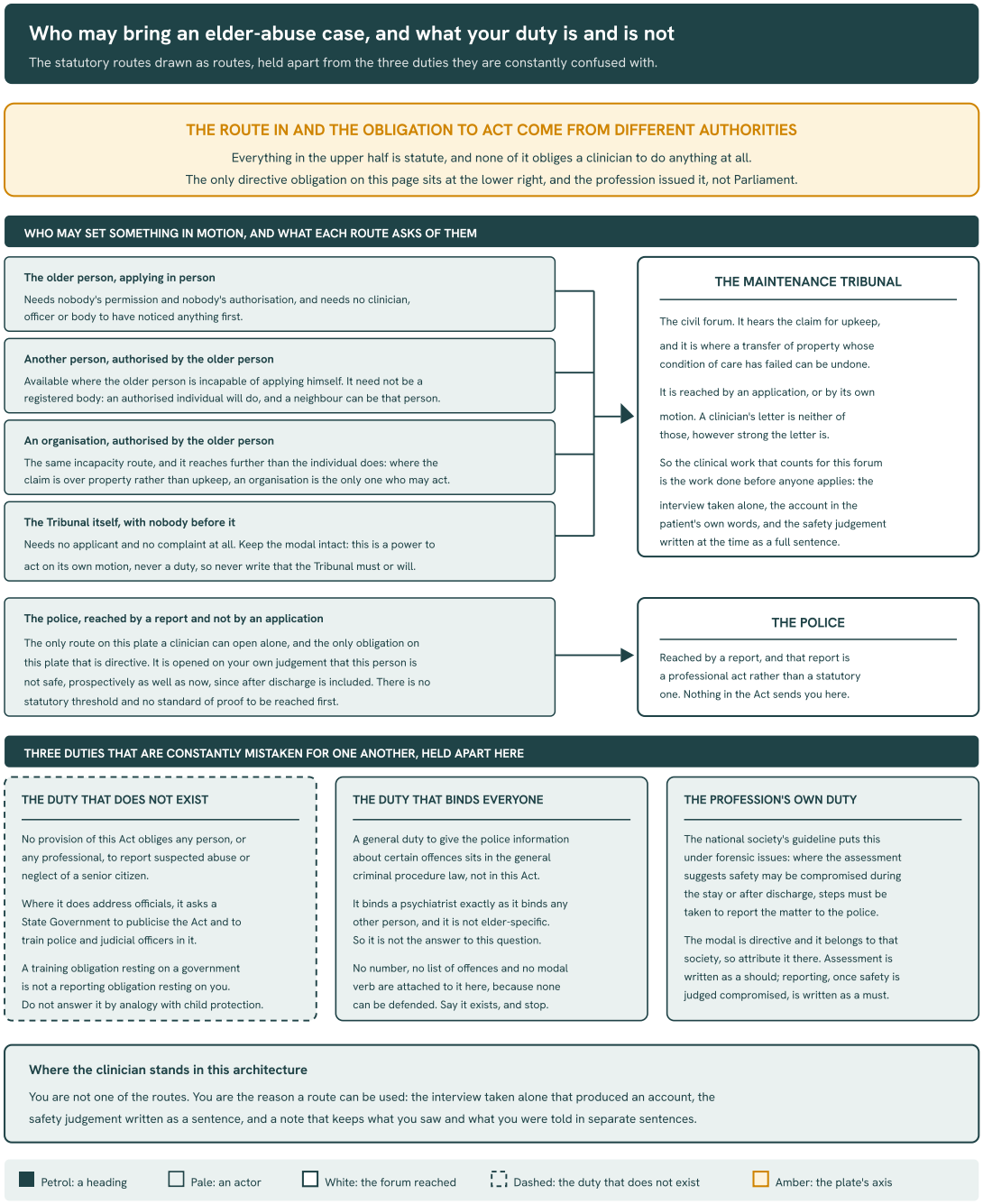


Fig 29.7. Who may set an elder-abuse matter in motion, drawn actor by actor rather than provision by provision: the older person applying in person, an authorised individual where he is incapable, an authorised organisation which alone reaches the property protections, and the Tribunal acting with nobody before it, all converging on the maintenance forum, with the police shown as a separate destination reached by a report rather than by an application, and the three duties that are constantly mistaken for one another set out beneath, the elder-specific reporting duty that does not exist, the general duty that binds every person and is not elder-specific, and the professional obligation whose trigger is the clinician's own judgement that safety is compromised.

15.1 The definition you will be asked for, and what it leaves out

The most quotable Indian definition sits inside a parenthesis in the 2023 clinical practice guideline on older patients presenting with psychiatric emergencies, issued by the Indian Psychiatric Society and published in the Indian Journal of Psychiatry. It treats **elder abuse** as

acts of omission that result in harm, or threatened harm, to the health or welfare of an older person.

Three phrases do the work. Threatened harm sets the threshold at risk rather than damage, so a clinician need not wait for an injury, and an arrangement that has not yet hurt anybody can still meet it. Health or welfare is wider than health alone, and welfare is where loss of money, of a home and of company enter a definition that would otherwise read as a purely medical one. And the harm is defined against the older person rather than against a relationship, so it does not depend on establishing who did it, which matters because attribution is usually the last thing to become clear.

Then say plainly what it does not cover, because a viva will push on exactly that. As printed, the parenthesis captures omission: the things not done. Elder abuse in ordinary clinical use also covers acts of commission, so offering that parenthesis as a complete definition narrows the subject in the act of defining it. Quote it, attribute it to the guideline it comes from, and add that acts of commission are conventionally included. For how common any of this is in India, no comparable standard is available to quote, and none is invented here; estimates move very widely with the definition and the instrument used.

15.2 The forms it takes, and the discrimination each one demands

Categories help only when each is paired with the thing it is actually confused with, and in Indian practice the confusable is rarely another form of abuse. It is a normal feature of family life, or a shortage of money. The grouping below is a working clinical frame rather than a quoted national standard.

FORM	HOW IT REACHES A PSYCHIATRIST	WHAT IT MUST BE DISCRIMINATED FROM
Physical	Injuries of different ages, marks of restraint, a mechanism that does not fit the injury, sedation used to keep someone manageable	Falls, fragile skin and anticoagulation. Not whether the sign is explicable, but whether the explanation is proportionate to it
Psychological	Threats, humiliation, being discussed in the third person while present, isolation from visitors, the telephone taken away	Ordinary family friction. Pattern, an intent to control and the effect on the person separate the two
Financial and material	Pension or bank account operated by another, an abrupt transfer or change of will, a patient who cannot afford drugs in a household that can	Pooled family income, normal in Indian households. Consent and benefit are the tests, not who holds the passbook
Sexual	Very rarely disclosed. May arrive as unexplained genital injury, or as changed behaviour around one particular person	Behavioural change attributed wholesale to a neurocognitive disorder
Neglect	Dehydration, pressure damage, untreated conditions, spectacles or a hearing aid never repaired, appointments missed	Poverty. The test is whether care available to the household is withheld from this member
Abandonment	Left at a hospital, an institution or a public place. Nobody collects the patient once discharge is ready	A genuine collapse of resources, which is a social problem and not an intention
Institutional	In residential care: rigid routines, restraint by drug or by rule, no privacy, no route to complain	Understaffing. Both need action; only one is answered by naming an individual

Two rows carry most of the difficulty in an Indian clinic. Financial control inside a joint household is not by itself abuse, and treating it as such will end the consultation; what makes it abuse is that the older person neither agreed to the arrangement nor benefits from it. And neglect cannot be diagnosed from the standard of care alone, because a household with nothing cannot care well for anyone. What identifies neglect is a gradient inside the household: food, medicine, warmth and attention reaching everybody except the oldest person there.

15.3 Recognition: it does not present as abuse

Nobody arrives complaining of elder abuse and neglect. It arrives as a fall, a confusional episode, weight loss, poor adherence, a request for admission the family is unusually keen on, or a discharge that keeps being deferred. Every one of those has an ageing explanation immediately available, and that is the diagnostic problem: an innocent alternative is always to hand, so the finding is never forced on the clinician and must be looked for.

What can be looked for is discrepancy, better taught as one discipline than as a list of signs. Between the injury and the mechanism described. Between the severity of a problem and the delay before help was sought. Between the family's resources and the patient's condition. Between the account given alone and the account given with relatives present. Between what the carer says the patient can do and what the patient is seen doing on the ward. None of these proves anything; each is a reason to take the history again, separately.

The interaction in the room is itself evidence. Watch who answers, whether the patient looks at the accompanying person before replying, whether that person declines to leave, whether the account becomes fuller once the door closes, and whether the minimising sounds rehearsed. Note too that the direction of harm is not fixed: the carer may be exhausted, unwell and unsupported, and may also be the one being struck, which happens in dementia care and is taken up with the behavioural and psychological symptoms in the Dementias and neurocognitive disorders notes. A formulation that identifies a villain and stops has missed how the household works.

PITFALL

Writing a suspicion into the record as a finding. What was observed and what was alleged belong in different sentences, with the source named for each: the bruise you saw is your observation, the explanation for it is somebody's account. Notes that fuse the two are useless as evidence and unfair to a family that may have done nothing.

15.4 Taking the history: the patient is seen alone

The procedural point that is actually marked. The same national guideline calls this a sensitive matter whose history should be carefully evaluated, and gives one instruction about technique: the patient should be interviewed separately and given time and reassurance to open up. Keep that modal in mind, because it changes later in the same document.

The separate interview carries such weight because this topic inverts the usual value of collateral history. Across geriatric psychiatry the accompanying relative is the safeguard, supplying what the patient cannot; here that same person may be the hazard, and the more dependent the patient, the more completely the account is theirs to shape. Time and reassurance are in the instruction for a reason too: someone who depends on that household for food, medicine and shelter is being asked to put all three at risk, and will not do it inside two minutes of brisk questioning.

Practically, separate the interview for a reason that is not about the family. An examination, a blood pressure, a walk to the ward toilet: any of these routinises the separation without announcing a suspicion to people you may still have to work with. Three things must come out of it.

- The patient's own account, in the patient's own words, of how the injury or the shortage or the arrangement came about.
- Whether the patient feels safe returning to where they came from, asked directly and answered before anyone else re-enters the room.

- What the patient wants done, which is frequently much less than the clinician wants done, and which is recorded even when it will not be followed.

Where cognitive impairment or acute illness prevents an account, the assessment does not stop; its source changes. The questions move to observable care, to informants outside the household, and to what the ward sees over a few nights. Whether the patient can make the decisions that follow is a capacity question, assessed as one, using the approach set out for the general hospital elsewhere in these notes.

> **GOOD TO REMEMBER**
>
> The step that gets skipped is the simplest. At some point in the encounter the patient has been alone with a clinician, and the note says so in as many words. If that sentence is missing, no conclusion about safety at home is defensible, because every account in the record was given in front of the people the question is about.

15.5 The named instrument, and the limits of what it gives you

The same guideline carries a table of suggested rating scales, and against the elder abuse domain it puts the **Caregiver Abuse Screen Evaluation**. The guideline names the instrument and gives nothing else about it: no item count, no cut-off and no validation data, and none are supplied here. Scales as a class, with their construction and psychometrics, belong to the Psychotherapies, clinical assessment, MSE and nosology notes.

Two things follow. The instrument's own title puts the caregiver, and not only the patient, inside the frame of the screen. And the guideline attaches a qualifier to that whole table: the selection of scales is influenced by the diagnosis and by the need of the individual patient. Read alongside the absence of any published threshold, that makes the screen a prompt to ask rather than a test to pass. Naming it earns the mark; treating it as though a score settled the question does not.

15.6 What Indian law does not provide

Here is the finding most answers get wrong. The Maintenance and Welfare of Parents and Senior Citizens Act, **2007**, the central Indian statute on this subject, creates no elder-abuse-specific mandatory reporting duty. It contains no provision of the kind familiar from child protection legislation obliging any person, or any professional, to report suspected abuse or neglect of a senior citizen.

Where the Act does address officials, at section 21, what it asks for is different in kind. The State Government is to ensure wide publicity for the Act, and to ensure that Central and State Government officers, including police officers and members of the judicial service, are given periodic sensitisation and awareness training on the issues relating to it. That is a training obligation resting on a government, not a reporting obligation resting on a clinician, and the distinction is worth having ready.

Scope the negative correctly, because it is easy to overstate. It concerns this Act. It is not the wider claim that no reporting obligation of any kind can reach a doctor in India: a general duty to give the police information about certain offences sits in the general criminal procedure law rather

than in this Act, and binds a psychiatrist as it binds any other person. For the text of that provision, its section number, the closed list of offences it is keyed to and its modal verb, no comparable standard is available to quote, and none is invented here. Say that a general duty exists and is not elder-abuse-specific, and attach no number to it you cannot defend.

RULE **The safeguarding answer for an older person has two halves, and only one of them is law.** The statute supplies remedies and names who may seek them; it does not tell a clinician when to act. Professional guidance supplies the trigger to act and carries no legal force. A complete answer gives both, says which is which, and never lets the modal verb of one migrate into the other.

TRAP **Answering by analogy with child protection.** Candidates have been drilled on a safeguarding architecture in which a named statute imposes a reporting duty on a named professional, with a penalty for failing. Transplanted onto an older person it produces a confident, well-organised answer that is factually wrong, and wrong in the direction that costs most: it invents an obligation and leaves the routes that do exist untaught.

15.7 The obligation that does exist, and where it comes from

The directive half of the answer comes from the profession rather than from Parliament. The 2023 national guideline places elder abuse under a heading of forensic issues, and states that where the assessment suggests the patient's safety may be compromised during the hospital stay or after discharge, appropriate steps must be taken to report the matter to the police to initiate legal action. The modal is directive, and it belongs to the society that issued the guidance. Attribute it there, not to a statute.

Three features repay attention. The trigger is the clinician's own judgement that safety may be compromised, not a statutory threshold and not a standard of proof, so what the note must answer is what made you think this person would not be safe. It is prospective as well as present, since after discharge is expressly included, so the assessment must reach into the household the patient is going back to. And no timeline, form or consequence for not reporting is specified, which cuts both ways: it leaves the judgement with the clinician, and leaves the clinician with nothing but the record to show it was exercised.

Notice the internal grading, examinable in itself. Assessment of abuse is written as a should; reporting to the police, once safety is judged compromised, is written as a must. That is a sensible hierarchy: asking is always appropriate, escalation is reserved for the point at which the answer is that the person is not safe.

IN INDIA

There is no adult protective service to refer to. Two doors exist in practice: the police, where the national guideline points once safety is in doubt, and the maintenance machinery of the senior citizens Act, which handles food, shelter, money and property. That Act is national legislation, assented in December 2007, and as enacted its extent excluded one State; it commences in a State on a date that State Government notifies, so the machinery a patient can reach is state machinery. The respondent is usually the relative who accompanied the patient and will take them home again, which is why the sequence of separate interview, record, safety judgement and only then escalation matters more here than the escalation itself.

15.8 How a case actually starts, when nobody is obliged to report

If there is no reporter, something else must begin the process, and this Act's answer is an application rather than a report. Under section 5(1), an application for maintenance may be made by the senior citizen or parent, or, where he is incapable, by any other person or organisation authorised by him. Read that second route carefully: it is not confined to registered bodies, and an authorised individual will do, though the condition of authorisation attaches to individual and organisation alike.

The widest route needs no applicant at all. The Tribunal may take cognizance **suo motu**, which is the honest answer to the follow-up about what happens when nobody complains. Keep the modal intact: this is a power and not a duty, so the correct sentence is that the Tribunal may act on its own motion, never that it must or will.

Where the Act uses the word **organisation**, the Explanation to that sub-section defines it, for the purposes of that section, as any voluntary association registered under the Societies Registration Act, 1860, or under any other law for the time being in force. Those closing words keep the definition open to bodies registered under other statutes rather than tying it to one register.

5	23	24	25
SECTION OF THE SENIOR CITIZENS MAINTENANCE AND WELFARE ACT SETTING OUT WHO MAY BRING THE APPLICATION	SECTION UNDER WHICH A PROPERTY TRANSFER IS VOIDED WHEN ITS CARE CONDITION FAILS	SECTION OF THAT SAME ACT PENALISING THE ABANDONING OF A SENIOR CITIZEN	SECTION MAKING EVERY OFFENCE UNDER IT COGNIZABLE, BAILABLE AND TRIABLE SUMMARILY

PROVISION	WHAT IT DOES	WHO MAY SET IT IN MOTION
Section 5(1)(a)	Brings the application for maintenance	The senior citizen or parent
Section 5(1)(b)	The same application where the senior citizen is incapable	Any other person or organisation authorised by him
Section 5(1)(c)	Starts the matter with no application before it	The Tribunal, on its own motion
Explanation to section 5(1)	Defines organisation for that section only	Any registered voluntary association, on the terms set out above
Section 23(1)	Voids a property transfer whose condition of care has been broken	The transferor, at whose option the Tribunal declares it void
Section 23(3)	Enforces those property protections where the senior citizen cannot	Organisations only, as defined in that Explanation
Section 24	Makes exposure and abandonment of a senior citizen an offence	Prosecution, on an intention of wholly abandoning
Section 25	Makes every offence under the Act cognizable and bailable, and triable summarily	A Magistrate

One sentence of your answer should carry the structural point. Under this Act there is no report and no reporter; there is an applicant, or a Tribunal acting on its own motion, and the clinician's contribution is to make that application possible and to document what would support it.

15.9 Property, and the provision that does the proving for you

The commonest financial abuse a psychiatrist meets in Indian practice has a specific legal answer. A parent transfers a house or land to a child on the understanding that they will be looked after, and then is not. Section 23(1) provides that where a senior citizen has transferred property after the commencement of the Act, by gift or otherwise, subject to the condition that the transferee provide the basic amenities and basic physical needs of the transferor, and that transferee then refuses or fails to provide them, the transfer is deemed to have been made by fraud or coercion or undue influence, and shall, at the option of the transferor, be declared void by the Tribunal.

Two points are examinable and both are commonly stated backwards. The first is the **deeming provision**: the older person does not have to prove fraud, coercion or undue influence as a matter of fact, because the Act deems it once the condition of care has been broken. That converts an almost unwinnable evidential problem into a simpler factual question about whether basic amenities and basic physical needs were provided. The second is that avoidance is at the transferor's option, so the transfer is not an automatic nullity; it is a right the older person may choose to exercise, and one who wants the relationship more than the property may decline to.

Where the senior citizen cannot enforce those property rights, action may be taken on his behalf by any of the organisations referred to in that Explanation. Set it against the maintenance route and get the difference the right way round: the incapacity route in the earlier section admits an authorised individual as well as a body, while this one admits organisations only and reaches only the property protections. A neighbour who could carry a maintenance application cannot, on this provision, carry the property one.

The psychiatric contribution here is evidential rather than therapeutic. Whether an older person understood a transfer, and whether they were free when they made it, arrive as capacity and undue-influence questions, and a contemporaneous note of the mental state and of the patient's own account is often the only usable evidence years afterwards.

15.10 Abandonment as an offence, and how it is tried

Section 24 carries the Act's penal provision, and its wording is narrow. Whoever, having the care or protection of a senior citizen, leaves that senior citizen in any place with the **intention of wholly abandoning** them is punishable with imprisonment of either description which may extend to **three months**, or with a fine which may extend to **five thousand rupees**, or with both.

The mental element is where answers fail, and they fail predictably. The offence requires an intention of wholly abandoning, so neglect falling short of that intention is not this offence, however grave it is clinically. A family whose care is poor, or whose care keeps failing, has not committed it; a family that leaves a parent at a hospital gate and does not come back has. That gap between what is clinically serious and what is criminally caught is why the professional and civil routes carry most of the weight in practice, and saying so is a better answer than implying the penal section covers the field.

How such an offence is handled sits in section 25, which operates notwithstanding the Code of Criminal Procedure, 1973. Every offence under the Act is **cognizable** and **bailable**, and is tried summarily by a Magistrate. In Indian criminal procedure those words describe a deliberately light route: the police may take the matter up directly, the accused is not held pending trial as a matter of course, and the trial is the short form. For a clinician a report to the police can therefore start something, and what it starts is quick and small rather than grave.

MNEMONIC

Start it, Undo it, Punish it, Try it

The four provisions of the senior citizens Act to be able to place without hesitating. **Start** it: section 5, who may apply, and the Tribunal's own motion. **Undo** it: section 23, the conditional property transfer set aside. **Punish** it: section 24, exposure and abandonment. **Try** it: section 25, cognizable, bailable and summary.

15.11 What the encounter has to leave behind

Because nothing here is triggered by a statutory form, the record is the only durable product of the encounter, and it is what a tribunal, a police officer or a colleague reading months later will work from. Three entries are not negotiable.

- That the patient was interviewed alone, with their own account in their own words.
- The safety judgement as a full sentence, saying what led to it and whether it concerns the admission, the discharge or both, since that judgement is what the obligation to report turns on.
- What was done next: whom you informed, what you told the patient and the family, what the patient wanted, and when the question will be reviewed.

None of that needs a service that does not exist, a statute that has not been passed, or an instrument with a threshold nobody has published. It needs what the whole topic needs: that the possibility was raised deliberately, asked about privately, judged explicitly and written down.

> There is no elder-abuse-specific mandatory reporting duty in the Indian senior citizens Act; the obligation to act is professional, its trigger is your own judgement that safety is compromised, and the statutory route is an application to the Maintenance Tribunal or the Tribunal taking cognizance on its own motion.

16 · Sleep disturbances in the elderly

Why the marks are here. A referral about an older patient's sleep usually arrives with its own answer attached: she is seventy-eight, she sleeps badly, and the age is offered as the explanation. That sentence is where the marks are lost. What is examined here is the reasoning a clinician runs when the complaint is made at seventy-eight: which features of this patient's sleep are the ordinary arithmetic of ageing, which belong to the diseases and the drugs that arrive alongside ageing, whether the complaint is overstated or quietly understated, and what to do about the hypnotic that is often already being taken.

The entity work is done elsewhere. Insomnia disorder and the primary sleep disorders, with their criteria, instruments and drug treatment, are taught in the Eating and sleep-wake disorders notes, and sleep physiology from the neurological side in the Neurology foundations for psychiatrists notes. Sleep disturbance as a feature of a neurodegenerative illness belongs with the Dementias and neurocognitive disorders notes, and a new nocturnal disturbance with fluctuating attention is a delirium question before it is a sleep question, taught with the delirium material in this chapter. What follows is the geriatric lens on sleep disturbances in the elderly: what changes, when it changed, what may be attributed to age, and what each answer obliges you to do at the bedside.

16.1 What changes with age, and when the change actually happened

The standard list names six changes, and it is not closed. Sleep timing advances, nocturnal sleep shortens, daytime naps become more frequent, awakenings within the night become more numerous, the total time spent awake during the night increases, and **slow-wave sleep** is reduced. Candidates reproduce that list and then stop, which is where its clinical value is thrown away, because the same work adds a second finding that reverses the meaning of the first: most of that change occurs between young and middle adulthood, and among healthy older adults the parameters are largely unchanged.

RULE **By the time a patient is old, the age-related change in sleep has mostly already happened.** Ageing rearranges sleep in the middle of life rather than in later life, so a change the patient dates to the last year or two is a change ageing does not account for. This is why "poor sleep at her age" is not a formulation: it invokes a process that had largely finished before the patient reached the age being blamed, and it makes the one informative feature of the history, the date of onset, disappear.

The parameters below are drawn from a 2017 review of sleep in normal ageing in Sleep Medicine Clinics. Read the location column before the direction column, because in the consultation the direction of a change matters far less than where in the lifespan it is located. Three parameters carry a quantified rate. The most quoted, **wake after sleep onset**, matters less for its rate than for its age window.

SLEEP PARAMETER	DIRECTION WITH AGE	WHERE THE CHANGE IS ACTUALLY LOCATED	WHAT THAT MEANS AT SEVENTY-EIGHT
Timing of the sleep period	Advances to earlier hours	Mostly before old age	Early evening sleepiness and early waking, not a new illness
Nocturnal sleep duration	Shortens	Mostly before old age	A short night is not by itself a disorder
Daytime naps	More frequent	Mostly before old age	Ask what the naps are costing the night
Wake after sleep onset	Rises	Quantified from 30 to 60 years, then mostly unchanged after 60	The rate does not reach a patient of seventy-eight
Proportions of NREM stage 1 and stage 2 in nocturnal sleep	Both rise	Not significant among healthy adults above 60	A fragmented hypnogram is not explained by age alone
Proportion of slow-wave sleep	Falls	1.7 per cent per decade in men, and no change with age in women in one cohort	The blanket claim needs a sex qualifier
Proportion of REM sleep	Falls, at 0.6 per cent per decade	From 19 to 75 years, with small increases between 75 and 85	The band that contains seventy-eight is not a band of decline
REM latency	Association with age is minimal	Reported without an age window	A shortened REM latency asks for another explanation

TRAP **Quoting the rate of increase in wake after sleep onset as though it applied to the patient in front of you.** It is the most quotable figure in this field, carrying the largest effect size of any sleep parameter studied, and it is **ten minutes per decade**. The sentence that supplies it also supplies its window, beyond which the parameter is reported as mostly unchanged. Carried forward to a patient of seventy-eight, a mid-life rate becomes an allowance for wakefulness that no measurement supports, and that allowance licenses precisely the reassurance the patient should not be given.

One caution belongs with this table rather than with the disorders. The loss of slow-wave sleep is not uniform between the sexes: one European cohort found no change at all in women against a measurable per-decade fall in men, and the review concludes only that men may be more prone to that decline. It also leaves a tension unresolved, since the meta-analysis it cites has women carrying a greater proportion of slow-wave sleep than age-matched men; levels compared at one age are not rates of change compared across ages, and the two must not be read as one. Knowing that a well-worn one-liner is contested is worth more than reciting it.

16.2 Why the patient is awake before dawn: the circadian account

The commonest presenting complaint in this age group is not difficulty getting to sleep but waking too early, and it has a candidate mechanism that is not a diagnosis. Older people commonly feel sleepy earlier in the evening and wake earlier than they wish. That earlier timing may be due to an age-related **phase advance** in the circadian rhythm, and the hedge is the source's own. The advance is **about one hour** across the markers together, and it is not confined to the sleep-wake cycle. The body temperature rhythm and the timing of melatonin and cortisol secretion are advanced with it, which marks it as a shift in the clock rather than in the bedroom.

Two refinements stop this becoming a lazy explanation for everything. The advance in sleep timing is larger than the advance in the other circadian markers, which is why **sleep homeostasis** is offered as an example of what else may be involved rather than as a settled answer. And overall melatonin secretion falls with ageing, with the nocturnal rise significantly reduced against young adults while daytime melatonin, already at a low base, may be unchanged. Be exact about what that second observation is: a mechanism, not a prescription. The therapeutic use of melatonin is taught in the Eating and sleep-wake disorders notes, and nothing in the physiology above licenses it at the bedside.

This account changes the target. A patient who falls asleep in the early evening and wakes long before dawn has slept a normal quantity at an abnormal hour, so the complaint is about the hour: a problem of timing and of what fills the evening, and not one answered by a drug that shortens sleep latency in a patient whose latency was never the problem.

16.3 Age, or what arrives with age: what the prevalence figures actually attribute

This is where the referral letter is answered, and the answer is an attribution rather than a number. Sleep complaints are genuinely common in later life, and the same literature says the excess does not belong to the age.

About 50%	Up to 50 to 60%	About 67%	About 90%
OF OLDER ADULTS HAVE INSOMNIA SYMPTOMS, A PREVALENCE ATTRIBUTED TO COMORBIDITY RATHER THAN TO AGE	REPORT POOR SLEEP QUALITY, A WIDER CONSTRUCT THAN INSOMNIA SYMPTOMS	OF OLDER ADULTS CARRY MULTIPLE COMORBIDITIES, IN UNITED STATES DATA	OF ADULTS AGED 65 AND OVER TAKE PRESCRIPTION DRUGS, AGAIN IN UNITED STATES DATA

The decisive sentence is the comparison, not the prevalence. Medical and psychological comorbidity is what the review holds responsible for the insomnia-symptom figure, and in older adults in excellent health the prevalence of insomnia is similar to that of younger adults. Age with

nothing else attached does not raise it. The two figures must not be collapsed into one: self-reported poor sleep quality and insomnia symptoms are different constructs, and averaging them loses the distinction.

The same review states in terms that poor sleep quality and sleep disturbance in older people are not necessarily due to ageing alone, even though schedule, quantity and architecture do change with age. What it lists alongside age is, in effect, the history you are obliged to take:

- medical conditions
- psychiatric conditions
- the environment the patient sleeps in
- social engagement and lifestyle change

One boundary keeps this honest: those architecture findings describe adults who are healthy and ageing well, so a frail multimorbid inpatient is not who they were measured in.

16.4 The reporting gap, and it runs in both directions

The consultation has a measurement problem before it has a treatment problem. Older adults are less likely, not more likely, than younger people to report poor sleep, especially once comorbidity and health are controlled for, and one offered explanation is that they may expect less consolidated sleep with age and may accept the change as normal. Set against that, among 150 healthy older adults who reported no sleep problem at all, **33 per cent** of the women and 16 per cent of the men had impaired **objectively measured sleep**.

So the discordance runs two ways, and each direction carries its own error:

- the complaint may be absent while measured sleep is impaired, so an unremarkable history does not establish unremarkable sleep
- the complaint may be understated when it is present, so sleep has to be asked about rather than waited for

Two provisos belong with that pair of proportions. The sample was healthy, selected because it reported no trouble, and not Indian, and the figures reach the review second-hand from work one of its own authors conducted, so they support a direction rather than a rate. The instruction survives both provisos: ask about sleep in the systems review, and do not let a patient's acceptance of her sleep stand as evidence that it is intact. Measured impairment in a patient who has no complaint is not by itself a reason to prescribe.

16.5 The drug chart is part of the sleep history

What this changes at the bedside. Medication burden in this age group is not a footnote to the sleep history, it is a substantial part of it. **More than a third** of older adults who take prescription drugs routinely take over five medications, and multiple medications can produce three separable outcomes: **excessive daytime sleepiness**, worsening of a primary sleep disorder already present, and **comorbid insomnia**. Three problems with three different next steps:

collapsing them into "the tablets are affecting her sleep" throws away the distinction that earns the mark.

The reasoning matters more than the figures, and it is circular. A drug that produces daytime sleepiness produces daytime sleep; daytime sleep shortens the following night; the shortened night is reported as insomnia; and the insomnia is treated with a further drug that produces daytime sleepiness. Somewhere in that loop a clinician has to read the chart rather than the complaint. The figures quoted are United States data, and the population is part of the number: they establish that the burden is large, not what proportion of your clinic carries it.

GOOD TO REMEMBER

Before "should she have something to help her sleep" is even reached, three things belong in the note: the medication list with the time each dose is actually taken, what the patient took last night as against what is prescribed, and how much she slept between waking and the evening. A sleep plan written without those three is a plan written about a night nobody has described.

16.6 The hypnotic that is already being taken

The reflex this topic exists to interrupt is the prescription, and in this age group the harder question is usually not whether to start a hypnotic but what to do about one taken for years. **Deprescribing** in an older person is a planned act rather than a decision taken at the door, and among the things Indian guidance requires such a plan to weigh is the **duration of use**, where benzodiazepines are named as the particular concern. Read that as a statement about which patient is difficult: the long-standing hypnotic is the hard case.

That is why the reflex is wrong twice over. Starting a hypnotic at seventy-eight creates, in one prescription, the patient the guidance warns about, in a person likely to be taking several other drugs and sleeping in the afternoon. And withdrawing one already established is not a matter of stopping it: the order in which drugs come off and how slowly is taught with the geriatric prescribing material in this chapter, while hypnotic doses belong to the Eating and sleep-wake disorders notes. What belongs here is the decision preceding both, that a sleep complaint at this age is an invitation to review the drugs already present before adding one.

IN INDIA

The Indian anchor here is the 2023 clinical practice guideline on the assessment and management of elderly patients presenting with psychiatric emergencies, published in the Indian Journal of Psychiatry, which is where the deprescribing plan and its benzodiazepine flag sit. Notice what it does not supply: no duration beyond which use counts as long, no taper rate, no dose. Since the flag turns on duration, the history must establish it explicitly, including who first prescribed the drug, when, and whether it has been continued from any source other than the prescription in front of you. The prevalence and architecture figures here are Western. For the Indian older population there are no normative polysomnographic values, no prevalence figure for the sleep complaint, no professional standard on sleep in old age, and nothing on whether customary Indian sleep-wake schedules and shared sleeping arrangements alter how the phase advance presents: no comparable standard is available to quote, and none is invented here.

A new sleep complaint at seventy-eight is a symptom to be explained, not an age to be accepted.

17 · Comprehensive geriatric assessment and cognitive screening (MMSE, MoCA, ACE)

Why the marks are here. Comprehensive geriatric assessment and cognitive screening is a question most candidates answer by reciting instruments, which is the smallest and least defensible part of the subject. What is examined is a procedure: which older patients enter it, who carries it out, across which domains, what document it produces, and what obliges anyone to open that document again. A cognitive screen is one line inside one of those domains, and a candidate who reaches for it first has answered a different question.

The instruments themselves belong to other chapters and are named here without being taught. Administration, scoring and interpretation of the Mini-Mental State Examination, the Montreal Cognitive Assessment and the Addenbrooke's Cognitive Examination, with the bedside batteries and formal neuropsychological testing, are taught with the dementia material and with the rating-scale and higher-mental-function material: the Dementias and neurocognitive disorders notes and the Psychotherapies, clinical assessment, MSE and nosology notes. What follows is the assessment they sit inside, which a psychiatrist is more often asked to contribute to than to lead.

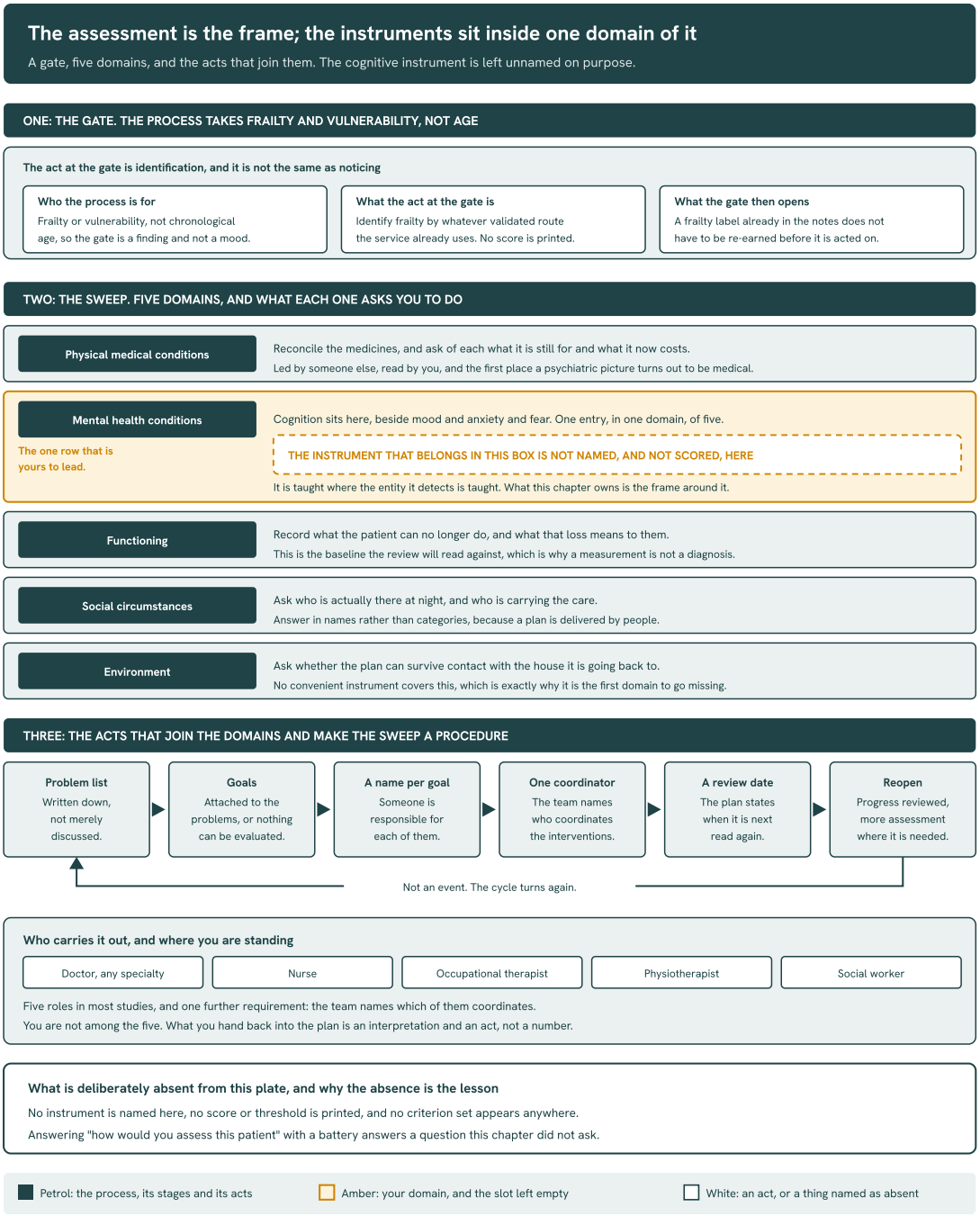


Fig 29.8. The comprehensive geriatric assessment drawn as a frame rather than as a battery: the gate that admits a patient to the process, the five domains swept across it with the act each one asks for rather than the contents each one holds, the chain of joining acts that turns a sweep into a procedure and then returns it to its own beginning, and the team that carries it, with the cognitive instrument shown as one deliberately unnamed and unscored box inside a single domain, because the instrument belongs to another chapter and the frame around it belongs to this one.

17.1 The definition, and the two adjectives that carry it

Comprehensive geriatric assessment is a process used to manage frail or vulnerable older people, and every word of that is load-bearing. A process is not an encounter, so it cannot be finished in an afternoon or written on a proforma. Its target is frailty or vulnerability rather than chronological age, so identifying frailty is the gate and not an incidental finding. And it manages

a patient rather than describing one, so an assessment that ends in a description has stopped short of the definition.

Two adjectives are given explicit meanings in that definition and both are examinable. **Interdisciplinary** means the assessment takes in what nurses and allied health professionals contribute and not only what doctors contribute. **Multidimensional** means it takes in functional impairment and the environmental and social circumstances bearing on wellbeing, and not only medical diagnoses. Candidates routinely use the two as synonyms: one is about who is in the room, the other about what is being asked.

A 2014 article for the non-specialist in the International Journal of Clinical Practice, the source of this definition, is blunt about one misreading. The term is often taken as a synonym for geriatric medicine, and it is not one. Geriatric medicine is a specialty; this is a method, and a method can be run by people who are not geriatricians in settings that have none. The same literature carries an older name for it, **geriatric evaluation and management**, worth recognising when it appears in trial titles.

RULE **A comprehensive geriatric assessment is defined by its product and its cycle, not by its content list.** Any clinician can generate a list of domains. What separates this from a thorough clerking is that it terminates in a written plan with named goals, named responsibility and a review date, and that the plan is then reopened. A candidate who can describe the domains but cannot say what document was produced, who owns it and when it is next read has not understood the procedure.

17.2 What it produces, and why that makes it a procedure

The output is where this topic earns its marks. The assessment generates a **problem list**, develops goal-driven interventions against those problems, and then provides and coordinates an integrated plan spanning treatment, rehabilitation, support and long-term care. Problems first, goals second, coordination last but not optional. A plan naming interventions without the goals they serve cannot be evaluated, and a plan nobody coordinates is a set of separate referrals under one heading.

It is explicitly not a one-off event but an iterative process. A **case manager** carries responsibility for ensuring a care plan exists at all, and that plan must state explicit goals, state who is responsible for each, and state a timeline for review. Progress is then reviewed, further assessment is done where needed, and the cycle turns again. This is what most distinguishes the method from the multidisciplinary meeting a candidate has actually attended, where a great deal is discussed and nothing is owned.

The settings in which it has been studied show it is not confined to a geriatric ward:

- in hospital, where it can start on admission, and where it has been evaluated in emergency departments, medical admissions units and trauma and orthopaedic wards
- in the community, in patients' own homes, in long-term care, in community hospitals and in intermediate care

On outcomes, be careful in the way the evidence requires. Hospital-based assessment of this kind has been reported in systematic review to reduce the combined outcome of death or functional decline, and to raise the chance that a patient is alive and living in their own home rather than in residential care. No effect estimate is printed here. The figures usually quoted reach the reader secondhand through review articles, and the systematic review behind them has been updated since the version those figures came from. Quoting a superseded odds ratio confidently is a worse error than saying the direction of effect is established and the current magnitude must be read at origin.

17.3 The five domains of health, and where a cognitive screen actually sits

The structure of the assessment is set out as domains of health, and the psychiatrist's contribution is confined to part of one of them. That is the answer this item is really asking for, and it is structural rather than psychometric.

5
DOMAINS OF HEALTH ACROSS WHICH A COMPREHENSIVE GERIATRIC ASSESSMENT IS ORGANISED

5
PROFESSIONAL ROLES NAMED AS THE CORE ASSESSMENT TEAM IN MOST STUDIES OF THE METHOD

18
DOMAINS ENUMERATED IN A MULTIFACTORIAL FALLS RISK ASSESSMENT FOR A HIGH-RISK OLDER ADULT

60
AGE IN YEARS FROM WHICH ANNUAL OPPORTUNISTIC FALLS SCREENING IS ADVISED IN LOW- AND MIDDLE-INCOME SETTINGS

DOMAIN	WHAT THE SOURCE PLACES INSIDE IT	WHAT THE PSYCHIATRIST READS OR SUPPLIES
Physical medical conditions	Comorbid conditions and disease severity, medication review, nutritional status, the problem list	The drug chart, and the medical contributions to a psychiatric presentation
Mental health conditions	Cognition, mood and anxiety, fears	The whole of this row, and it is the only row the psychiatrist owns
Functioning	Core functions such as mobility and balance, activities of daily living, life roles important to the patient	What the patient can no longer do, and what that loss means to them
Social circumstances	Social networks, meaning informal support from family, the wider network of friends and contacts, and statutory care; poverty	Who is available at night, and who is bearing the care
Environment	Housing including comfort, facilities and safety; use or potential use of telehealth technology; transport; accessibility to local resources	Whether the plan can survive contact with the home it is going to

Read the second row carefully, because it settles the relationship this item exists to teach. Cognition appears as one entry under mental health conditions, alongside mood and anxiety and

fears. A cognitive screen therefore samples a small fraction of the territory the assessment covers, and a normal screen closes almost none of it.

The same source warns against the opposite error. Standardised scales encourage consistent practice, but they can also be time consuming and clinically constraining. That caution names the failure mode of an instrument-led assessment: the domains with no convenient scale, chiefly the patient's own life roles and the environment they are returning to, quietly drop out.

TRAP **Answering "how would you perform a comprehensive geriatric assessment" with a list of scales.** Candidates make this error because the instruments are the part they have been drilled on. But a battery is not an assessment, and the method is explicitly not the specialty that popularised it. The answer that survives a follow-up names the domains, the team, the problem list and the plan, and places the cognitive screen inside one domain and downstream of the reason for asking.

17.4 Who is in the team, and where the psychiatrist stands in it

The method is by necessity multidisciplinary and cannot be practised by a geriatrician, a nurse or a therapist in isolation. Most studies report a core team of five roles, each with a defined remit: a doctor, who need not be a geriatrician, to ensure medical treatments are given safely; a nurse covering all aspects of care; an occupational therapist for activities, aids and appliances; a physiotherapist focused on transfers and mobility; and a social worker for social support mechanisms and the interventions that follow from them. One further requirement is easy to skip and is exactly what a viva turns on: the team identifies which member is in charge of coordinating the various interventions. Composition varies with the setting, and these five describe a well-resourced health system.

The psychiatrist is not in that list, and this is the teachable point rather than an oversight: on this model the psychiatrist contributes one domain to somebody else's process. Two consequences follow. An opinion asked for inside a geriatric assessment is being asked for cognition, mood, anxiety or fear, so it should be returned in a form the plan can use, meaning an interpretation and a recommended action rather than a score. And the occupational therapist's account of activities and the physiotherapist's account of transfers usually hold the functional evidence a psychiatrist needs; ignoring them repeats work already done better.

17.5 Measuring function: the instruments that are actually yours to use

What this changes at the bedside. The functional domain, unlike the cognitive one, has instruments a psychiatrist is expected to name and use without trespassing. Indian guidance on assessing older patients presenting with psychiatric emergencies, published in the Indian Journal of Psychiatry in 2023, names them by purpose: the **Katz Index of Independence in Activities of Daily Living** for basic activities of daily living, the **Lawton Instrumental Activities of Daily Living Scale** for instrumental activities, and a Frailty Index for frailty. The same guidance makes the wider point that structured scales apply not only to the mental state but to the history and the physical examination.

What is grounded is the mapping of instrument to purpose and nothing more: no item content, no scoring method and no cut-off for these three instruments is available to quote, and none is supplied from memory. That matters less than it looks: the mark is usually for choosing the right instrument for the right question, not for reciting its items.

One boundary needs stating plainly, because instrumental activities are used in two different ways. As a diagnostic hinge, the point at which a person needs help with complex instrumental tasks marks the step from a milder to a major neurocognitive disorder, and that use belongs to the Dementias and neurocognitive disorders notes. Inside this assessment the same construct is a measurement step: it establishes where the patient currently sits, so the plan has a baseline and the review has something to compare against. Treating the measurement as the diagnosis is the commonest way a functional assessment gets misreported.

17.6 Frailty: the entry criterion, defined and then scored

Since the assessment targets frail or vulnerable older people, frailty is the entry criterion and needs a definition rather than an impression. Indian guidance defines **frailty** as a biological syndrome characterised by lower reserve and lower resistance to stress, arising from cumulative functional decline across multiple physiological systems and leading to vulnerability to adverse outcomes. Two things repay attention. It is a syndrome of reserve, so the frail patient is not necessarily the sick patient but the one with nothing left over when something goes wrong; and it is multisystem by definition, so no single organ measurement identifies it. The same source names its consequences: frailty is associated with falls, hospitalisation and mortality.

Its characteristic features are unintentional weight loss, impaired grip strength, self-reported exhaustion, slow walking speed and reduced physical activity. The 2022 World guidelines for falls prevention and management for older adults, published in Age and Ageing, describe the same five as a frailty phenotype and attach a scoring rule: **three or more** of the five categorises a person as frail, one or two as prefrail, and none as not frail. That an Indian and a global guideline converge on the same five is worth knowing; neither text read here attributes them to a named author, so no eponym is attached to them.

MNEMONIC

Slow, Weak, Thin, Tired, Still

The five phenotype criteria as they present: **slow** walking speed, **weak** grip or muscle weakness, **thin** from unintentional weight loss, **tired** from self-reported exhaustion, **still** from low physical activity. Count them rather than impressing them: the count carries the threshold.

The alternative in routine use is the Clinical Frailty Scale, a semi-quantitative scale with pictograms running from very fit at one end to terminally ill at the other, on which a score of **4 or above** is considered frail. For risk stratification the falls guideline accepts either previously identified frailty or a positive result on a validated instrument used to detect it, a permission worth having: a frailty label already in the notes does not have to be re-earned before it can be acted on.

17.7 Falls: the single question, the definitions, and the triage before the assessment

Falls enter the assessment through one question, and the reason is a measurement problem rather than a clinical one. Falls are often not reported spontaneously, which is why asking about them routinely is a strong recommendation at GRADE 1A. Older adults in contact with healthcare for any reason should be asked at least once a year about a fall in the last 12 months, and about the frequency, characteristics, context, severity and consequences of any fall; conditionally, also about dizziness, loss of consciousness or disturbance of gait or balance, and about concerns regarding falling that limit usual activities. The asymmetry is examinable: asking at all is a strong recommendation, while the detail of what to ask carries only GRADE E, the expert-recommendation tier. Anyone answering yes should be offered an objective assessment of gait and balance, again at GRADE 1A.

Four definitions give that history a denominator. A fall is an unexpected event in which a person comes to rest on the ground, floor or a lower level. **Recurrent falls** means **two or more** falls reported in the previous 12 months. A severe fall is one with injuries needing a physician consultation, or leaving the person on the ground unable to get up for at least an hour, or prompting an emergency visit, or associated with loss of consciousness. An unexplained fall is one where a multifactorial risk assessment finds no apparent cause. Without these, "she has had a few falls" is an unusable history.

The objective test that follows carries the two printable numbers of this topic. Assessment of gait and balance is recommended at GRADE 1B. For stratification the guideline recommends gait speed, with a cut-off of **below 0.8 m/s**, at GRADE 1A, chosen for predictive ability and simplicity and measured over a 4-metre walking length. The Timed Up and Go test is the stated alternative, with a cut-off of **more than 15 seconds** at GRADE 1B, and the guideline says in the same breath that evidence for its use in fall risk stratification is mixed. Quote that cut-off with the qualification attached or not at all.

What those tests feed is a triage, not an assessment. Low risk is an older adult with no history of falling, or a single non-severe fall and no gait or balance problem; the response is education about falls prevention and exercise with annual reassessment, on the explicit ground that low risk does not mean no risk at all. Intermediate risk is a single non-severe fall together with gait or balance problems, answered by strength and balance exercise or physiotherapy referral. High risk is a fall plus any of five features: accompanying injury, two or more falls in the previous 12 months, known frailty, inability to get up unaided for at least an hour, or suspected transient loss of consciousness. Only the high-risk tier is offered the full multifactorial assessment, and suspicion of a syncopal fall triggers syncope evaluation and management instead.

GOOD TO REMEMBER

Before an older patient leaves any clinical encounter, one question and its answer belong in the note: has there been a fall in the last 12 months. It costs nothing, it is a strong recommendation, and it is the only step here a solo psychiatrist without a team can complete unaided. If the answer is yes, the obligation that follows is equally single: an objective look at gait and balance, before any conclusion about why the patient fell.

17.8 Inside the multifactorial assessment, and why its components are not equal

The **multifactorial falls risk assessment** is offered to community-dwelling older adults identified as high risk, as a multiprofessional assessment intended to guide tailored interventions, at GRADE 1B. Its domains are enumerated in a single sentence, and the list is long: gait and balance; muscle strength; medications; cardiovascular disorders including orthostatic hypotension; dizziness; functional ability and walking aids; vision and hearing; musculoskeletal disorders; foot problems and footwear; neurocognitive disorders, glossed as including delirium, depression, dementia and behavioural issues such as impulsiveness and agitation; neurological disorders; underlying acute and chronic disease; concerns about falling; environmental hazards; nutritional status including protein intake and vitamin D; alcohol consumption; urinary incontinence; and pain.

The most important sentence here is the disclaimer following that list: the strength of the evidence differs per component. The grade attaches to the recommendation to offer the assessment, not to each domain, and reading the enumeration as a set of equally strong recommendations misstates the source. The component recommendations span the full width of the grading scheme.

COMPONENT	WHAT THE GUIDELINE ASKS TO BE DONE	GRADE OF THAT COMPONENT'S OWN RECOMMENDATION
Concerns about falling	Use a standardised instrument	1A
Gait and balance	Assess; use gait speed for stratification	1B for assessment, with the stratifying cut-off at 1A
Cognition	Assess as a component of the falls workup	1B
Cardiovascular	Cardiac history, auscultation, lying and standing orthostatic blood pressure, and a surface electrocardiogram	1B
Environmental hazards	Identify the hazards where the person lives and assess their capacities and behaviours in relation to those hazards, by a clinician trained to do it	1B
Fall-risk-increasing drugs	Use a validated tool	1C

COMPONENT	WHAT THE GUIDELINE ASKS TO BE DONE	GRADE OF THAT COMPONENT'S OWN RECOMMENDATION
Vision, and hearing separately	Enquire about impairment, measure visual acuity, examine for hemianopia and neglect where appropriate; enquire about hearing, measure, examine and refer where appropriate	E
Urinary symptoms and incontinence	Enquire, with no instrument, threshold or referral trigger specified	E
Dizziness, pain, depression and nutrition	Assess, each under its own component recommendation	E
Footwear and environment in low- and middle-income settings	Prioritise these as risk factors; screen for inappropriate footwear including bare-footedness, assess foot problems, consider podiatry referral	2C, a conditional recommendation

Two things follow that a careful candidate can use. Vision, hearing, dizziness, urinary symptoms, pain, depression and nutrition rest on expert recommendation rather than trial evidence, so presenting them as strongly evidenced is wrong about the source even when it is right about the practice. And the cardiovascular component, where an unexplained fall most often turns out to have its answer, is not merely a blood pressure reading: if the initial cardiovascular assessment is normal no further cardiovascular assessment is required unless syncope is suspected, and further assessment of an unexplained fall should be the same as for syncope, at GRADE 1A.

Bone health is the one thing candidates expect here and do not find, and its absence is deliberate. The guideline states that managing fall-related injury is beyond its scope and treats bone health as a separate, reciprocal assessment: adults with low-trauma fractures or osteoporosis should have a falls risk assessment, and conversely those at moderate to high falls risk should have a bone health assessment using local protocols. The named fracture-risk tools are FRAX, Garvan and QFracture, with bone densitometry to confirm osteoporosis. So do not list bone health as a domain of the multifactorial assessment, and attach no grade to that reciprocal pairing, which is given as justification and not as a graded recommendation.

Falls work is joined to the wider assessment explicitly. The falls guideline describes its own product as identifying and measuring risk factors across multiple domains to indicate potentially modifiable areas for intervention, and states that this combines with the other components of a comprehensive geriatric assessment to enable a person-centred approach, while declining to cover the rest of that assessment. It also supplies the sentence that makes falls a psychiatric concern rather than an orthopaedic one: a fall in an older adult, particularly one living with frailty, should be treated as a warning sign of potentially unidentified underlying conditions, and may be the presenting feature of an acute medical illness.

17.9 The Indian and low-resource reading, and what is missing from it

Two of these sources speak directly to practice in a resource-constrained system. The falls guideline carries recommendations written for low- and middle-income countries, a class that includes India on the classification the guideline itself uses. Community-dwelling adults aged 60 years and over should be screened opportunistically for fall risk during any clinical encounter, at least once a year, by asking about falls in the past 12 months, and a strong recommendation at GRADE 1B requires local context to be considered when falls-prevention programmes are implemented in such settings. Alongside it sits the conditional recommendation at GRADE 2C to prioritise cognitive impairment, obesity including sarcopenic obesity, diabetes, lack of appropriate footwear and environmental hazards as risk factors. Footwear is the component most directly transferable to an Indian clinic, and the guideline's own word for the exposure, bare-footedness, is the one to carry; it also notes that footwear practices and environmental safety differ culturally and that assessment and education should account for that difference.

The Indian guidance contributes the history rather than the triage, and the two are complementary rather than competing. When an older patient presents with a fall, it asks for the place of the fall, the activity the patient was engaged in, the type of fall, and symptoms such as dizziness, fainting and weakness on change of posture. It also names who is predisposed: older people who need mobility aids to walk, who take sedative medication, or who take drugs that can produce a postural fall in blood pressure, with substance intoxication and psychotropic-induced postural hypotension named alongside. That last clause is the uncomfortable one, because the prescriber of the drug producing the postural drop is frequently the person taking the falls history.

IN INDIA

The assessment process, its team and its falls component are taught above from a 2014 explanatory article in a British journal and a 2022 global consensus guideline. The Indian contribution is the 2023 clinical practice guidance in the Indian Journal of Psychiatry, supplying the falls history, the frailty definition and the functional instruments, plus the global guideline's low- and middle-income-country recommendations, which are internationally recommended practice applicable to Indian settings and are not an Indian standard. For an Indian national statement that this assessment is expected practice, for an Indian multidisciplinary staffing norm, and for an Indian falls-screening cadence, no comparable standard is available to quote, and none is invented here. Say that in a viva rather than inventing a programme requirement.

The practical consequence is for the ward rather than the examination. Where the five-role team does not exist, the method does not become unavailable; the division of labour does. The domains still have to be covered, the problem list written, someone named as coordinating it, and the plan given a review date. A clinician running the process alone is doing something harder than the model describes, not something different, and the first thing to slip is the review, which is the feature the definition insists on.

A comprehensive geriatric assessment is a process with a named coordinator, a written goal-driven plan and a review date; the cognitive screen is one line inside one of its domains.

The late-life presentations

18 · Dementia in the elderly (overview, behavioural and psychological symptoms)

Why the bracket is the instruction. The heading is set as dementia in the elderly (overview, behavioural and psychological symptoms), and a candidate who reads it as a request for an account of the disease has read past the only unusual part of it. What the condition is, how it is classified, how it is investigated and staged, and what is prescribed for it and for the behavioural disturbance belong to the Dementias and neurocognitive disorders notes, which carry all of it, the work with families included. A compressed second version of an account that exists in full is a rival, not a summary, so none of it is repeated here.

What is left over is what these notes owe. Most headings in psychiatry name something a patient is referred for; this one names something a patient usually already has when they are referred for something else, and that difference organises everything below.

18.1 Where the condition sits once the question is about later life

These notes are built around who is asking, in whose ward, and what changes when the patient is old. Read that way, this is seldom the question asked and almost always the **background condition** it is asked against. The acute confusion arriving on a brain already changing is taken up where delirium in later life is dealt with here; the flat, slowed presentation read as decline, and the decline read as depression, where late-onset depression and the depressive presentation that mimics it are dealt with. The suspiciousness in a person living alone, the prescribing decision for a patient who cannot report an adverse effect, the nocturnal disturbance that is an evening behavioural pattern, and the neglect unreported because the only witness cannot describe it each have their own place here. In every one the answer moves when this condition is in the background, and that is why the subject belongs here at all.

RULE **Treat it as the context of the consultation, not as its subject.** A geriatric station rarely opens with a request to diagnose the condition; it opens with a behaviour, a family, a fall, a drug or a crisis, in a person who has it. A candidate who begins by establishing the diagnosis is answering a question settled before anyone was called, and runs out of time before the one that was not.

18.2 What actually generates the consultation

Who decides that today is the day. The **referral threshold** is set by what the household can absorb, not by how impaired the patient is. People equally affected reach a clinic years apart, one living with a daughter who has given up paid work, the other with a spouse who is himself unwell. The corollary is examinable: a referral carries as much information about **carer capacity** as about the patient's brain, and a request arriving abruptly after years of stability usually records a change in the household rather than in the illness.

So why now is answered by asking about the house, and answering it badly is why a consultation yields a prescription and no plan. Establish these before the cognitive examination, not after:

- what changed recently, in the patient, in the household or on the drug chart, and in what order;
- who is present by day, who is present at night, and who has lately stopped being present;
- which behaviour the household has decided it cannot absorb, in their own words rather than as a symptom list.

IN INDIA

The family is the service. Most districts have no old-age psychiatric provision to refer on to, so the request reaches a general psychiatrist and the plan must be one the household can run. **Diagnostic delay** is built in: presentation comes by way of a crisis, a wandering episode or a bodily complaint rather than a memory complaint, because forgetfulness in an old person is heard as ordinary and the diagnostic word carries the weight of madness in everyday speech. Neither the provision nor the delay is given a figure here: no comparable standard is available to quote, and none is invented here. That inverts **disclosure**, which is asked for upward, to relatives, before the person it concerns, and families often ask that nothing be named at all; how that conversation is conducted is taken up where breaking bad news is dealt with in these notes. The work is usually done unpaid by a woman in the same house, so asking what the household can sustain is an enquiry into her, and it is where the protection question first appears, dealt with where elder abuse and neglect are taken up.

18.3 Where each part of the subject is taught

A reader wanting the disease is sent, not served a thinner copy, including the **behavioural and psychological symptoms** in the bracket, whose description and pharmacology are the owner's.

WHAT IS BEING ASKED FOR	WHERE THE FULL ACCOUNT SITS	WHAT THESE NOTES ADD
Definition, criteria, subtypes, investigation, staging, and the behavioural symptoms with their pharmacology	**the Dementias and neurocognitive disorders notes**	Nothing but the reason the referral came when it did
Cognitive instruments and neuropsychological testing	**the Psychotherapies, clinical assessment, MSE and nosology notes**	The assessment they sit inside, taken up with geriatric assessment here
Telling it from an acute confusional state	**the Stroke, TBI, delirium and focal brain syndromes notes**	What ageing contributes, taken up with delirium in later life
Telling it from a depressive presentation	**the Mood disorders: pharmacotherapy notes**	The discrimination as examined, with the depressive mimic here

18.4 How the heading is asked

Set as a short note it wants breadth held briefly, and the marks go missing when a candidate spends the answer on classification and never reaches the bracket. Set as a long case or a viva it is

never asked alone: it arrives attached to an old patient with a behaviour, and the condition is the frame the case is read through rather than the thing to be diagnosed. Either way:

- name the condition and where its account belongs, in a sentence, without lingering;
- say what its presence changes about the question actually asked;
- finish on **the pending decision** and on who carries it.

TRAP **Examining the patient thoroughly and never examining the household.** Candidates make it because the patient is in front of them, the cognitive examination is rehearsed and scoreable, and the family is treated as a source of history rather than as a subject of assessment. The result is an immaculate account of impairment that explains none of the timing, and a plan that could have been written before the patient arrived.

Context, not subject	The household, not the stage	Named and handed on
WHAT THE CONDITION IS IN A CONSULTATION FRAMED BY THE ENCOUNTER	WHAT DECIDES WHEN THE REFERRAL IS ACTUALLY MADE	WHAT THESE NOTES DO WITH THE ENTITY ITSELF

Dementia enters here as the condition an older patient already has when the consultation is called: the entity, its criteria, its instruments and its drugs are read in the Dementias and neurocognitive disorders notes, and what is answered here is why the referral came now, what changes because it is there, and who decides.

19 · Late-onset depression and its features

Why it matters clinically. An older patient with depression is a common presentation and the syndrome is well described, so the marks here are not for describing it. They are for the question that follows: is this the first time in this person's life it has happened, and if it is, what does that oblige you to do that a recurrence would not? The syndrome, its criteria, the screening instruments and their scoring, and the agent-by-agent geriatric prescribing caveats are set out in the Mood disorders: pharmacotherapy notes. What is taken up here is the part candidates skip: onset.

19.1 Onset, not age, is the variable

Two patients of the same age sit in the same clinic with the same complaints. One has had episodes since her twenties and is having another. The other has never been depressed in his life and is depressed now. They may be indistinguishable on the mental state examination, and only the history separates them. **Late-onset depression** means a first episode arising in later life; a long-standing illness whose current episode merely falls in later life is **early-onset recurrent depression** in an older person, a different clinical problem wearing the same face. What makes late-onset depression and its features examinable is not the symptom list but the fact that the timing of the first episode changes the workup, what the family is told, and what follow-up is for.

The age at which an episode counts as late-onset is a matter of convention and the conventions differ: no cut-off is available to quote here, and none is invented. Nothing below depends on a

number, only on whether an episode has happened before, which is a historical fact rather than a threshold.

RULE **Establish whether this is a first episode before you decide anything else about the case.** Onset is not a descriptive detail collected for completeness. It is the variable on which the direction of the assessment, the weight given to the medical enquiry, what the family is told about recovery and the content of follow-up all turn. Every later decision inherits the answer, so an onset settled late is settled after the plan was written.

WHAT IS BEING DECIDED	FIRST EPISODE, ARISING NOW	OLD ILLNESS, RECURRING NOW
What the history must establish	That no earlier episode occurred at any age, checked with someone who knew the patient young	When the episodes fell, what was given, and how well the patient was between them
Where the diagnostic effort goes	Into why this brain and body have produced the syndrome now, never having done so before	Into why it has recurred, and what was lost from whatever had been holding it
What the family is asked for	The patient as they were decades ago, which nobody has asked them to describe	The pattern they have already watched, usually given in a sentence
What the treatment decision rests on	Published guidance and physiology, there being no record of what worked	The agent and dose that produced remission before, if tolerability allows
What follow-up is for	Resolving the question the first episode raised, which the treatment response does not	Preventing the next recurrence of an illness whose course is known

TRAP **Recording a first episode on the patient's word alone.** Candidates make this error because the patient is often the only informant in the room and answers confidently. An episode decades earlier that was never named as an illness, that a physician treated as weakness or a stomach complaint, or that was simply endured at home, leaves no record and no memory the patient recognises as psychiatric. Everything above rests on that one fact, which makes it worth a telephone call to a sibling or an old neighbour, and the note should say who supplied it.

19.2 The presentation that misleads, and who it misleads

Why the mask works better the first time. That older patients present with bodily and cognitive complaints rather than with a complaint of sadness, and the rule of recognition built on it, belong to the Mood disorders: pharmacotherapy notes. What onset adds is why the same mask defeats everybody in a first episode and almost nobody in a recurrence. In a long-standing illness the family has watched this before; they often make the diagnosis themselves and say so in the first minute. In a first episode nobody has seen them like this, so nobody holds a template, and everyone in the room has a non-psychiatric explanation that fits the facts: the physical illness that began around the same time, a bereavement, a move into a child's household, the end of working life, or simply age. The patient offers one first, because it is the only account they have, and the presentation is filed under the explanation rather than examined.

This is why the referral, when it comes, arrives from a physician rather than the family, often after an investigation for weight loss, pain, giddiness or forgetfulness returned nothing. Read that sequence as information: the complaints were taken seriously by someone competent and were not explained, and the illness is older than the date on the letter.

An **informant history** settles onset, and a general enquiry about past psychiatric illness will not get it, because the informant is being asked about labels when what you need is behaviour. Ask instead:

- whether there was ever a stretch of adult life, however explained then, when the patient stopped working, stopped going out or stayed in bed for weeks;
- whether they were taken to a doctor for sleep, nerves, weakness or a stomach nobody could account for, and what was given;
- whether anything of the kind followed a childbirth, a bereavement or a surgical illness decades ago;
- what the patient was like as a young adult, since a first episode is measured against a person and not a norm.

19.3 Why a first episode reframes the assessment

A syndrome that has never occurred across a long life and occurs now is, on its face, a statement that something is different now. That does not make the depression secondary to anything, and it does not license leaving the mood alone while the physicians work. It changes where the diagnostic effort goes, and when. In a recurrent illness the medical and drug review is a safety check run alongside treatment; in an **index episode** it is the main line of the assessment, done now rather than after an antidepressant has failed, because a contribution found late has cost the patient a trial.

The mimics, the drugs that lower mood and the investigations that exclude them sit in the Mood disorders: pharmacotherapy notes, and systemic and neurological contributions in the Neuropsychiatry of systemic and neurological disease notes. Two asymmetries belong here. A positive finding does not close the case: an untreated endocrine abnormality or a recently started drug may contribute to an episode without accounting for it, so the mood disorder is still treated on its own terms. A negative panel does not close it either, because the contribution that matters most here may be cerebral rather than systemic, and nothing routine reports on it.

19.4 The vascular contribution as a question about substrate

The proposal that cerebrovascular disease predisposes to, precipitates or perpetuates some late-life depressive syndromes, the phenotype that goes with it and the treatment expectations that follow all belong to the Mood disorders: pharmacotherapy notes; cerebrovascular disease itself to the Stroke, TBI, delirium and focal brain syndromes notes. **Vascular depression** is named at this address for one reason: it is an argument about onset and not about age, and the two are routinely conflated.

Consider the same finding in two patients. In a woman depressed since her twenties, cerebrovascular disease and long-standing hypertension found now are comorbidity: real, worth treating, and no explanation of an illness that predates them by decades. In a man depressed for the first time in old age the identical findings are a candidate explanation. The difference lies wholly in the history, which is why a substrate hypothesis is never raised or dismissed from a scan report.

Treating that hypothesis as live has three consequences, and each is an act rather than a conclusion:

- vascular risk factors become part of the psychiatric plan rather than another team's business, because you are the one who has just made them relevant to the mood;
- what the family is told about the shape of recovery is worded carefully, since a slower or more partial course is possible and neither promising nor excluding it is defensible;
- the cognitive picture is reviewed once the mood has moved rather than settled during the episode, because the treatment response alone does not answer the question the first episode raised.

The opposite error shadows all of this. Executive slowing and poor test performance get read as an early degenerative process, the mood is treated half-heartedly, and the patient is followed as a dementia. Telling those apart is taken up where pseudodementia and dementia are compared in these notes. What belongs here is that a first episode is where both mistakes are available at once, because no earlier episode exists to argue against either.

19.5 The frailty-aware decision, and a position that has moved

In a first late-life episode the treatment decision is made without the information that usually makes it easy. In a recurrent illness the agent that produced remission before, and the dose at which it did so, are most of the plan. Here there is no such record, so the decision rests on published guidance and this patient's physiology alone.

The Indian clinical practice guideline for the assessment and management of depression, published in the Indian Journal of Psychiatry in January 2026, gives the older patient a rule of its own and attaches a quantity to it: a low start, slow titration, and a dose usually **half** the adult figure at the start and at the intended destination alike, with hyponatraemia and falls named as what to monitor. The rate, the endpoint and that monitoring are worked through where the principles of psychopharmacology in the elderly are set out in these notes. What belongs here is what a moved destination does to the judgement of a trial in a patient with no treatment history.

It does this. A patient sitting at a reduced **target dose** who has not improved, and a patient quietly under-treated out of caution, generate identical entries in a record, and the next clinician cannot tell a deliberate ceiling from an abandoned titration. The remedy is administrative: before titration starts, write down the dose you intend to reach and the date the trial will be judged. That is the only way a failed trial is later told apart from an untried one.

IN INDIA

The same guideline also states that age influences the choice of agent, and here the expected answer is no longer the safe one. In older adults an SSRI may be less effective, and an SNRI such as duloxetine may be more suitable. Both clauses are hedged and the hedge is the content: this is not an instruction to prefer an SNRI in older patients, and an answer that converts it into one asserts what the guideline declined to assert. An earlier Indian position places the SSRIs first-line in late-life depression with a reduced start and slow titration, and is recorded in the Mood disorders: pharmacotherapy notes. Both are set out here and neither is adjudicated: whether the later document displaces the earlier or simply differs from it is not established, the earlier document is not examined at this address, and no supersession is asserted. State both, name the hedge, then say which you would follow for this patient and why.

GOOD TO REMEMBER

Three lines in the record of a first depressive episode in an older patient do more work than the rest: that this is a first episode, and who established it; that a medical, drug and cerebral contribution was considered, what was done and what came back; and the dose you intend to reach, with the date you will judge the trial. The third is routinely left out, and without it nobody reading the file afterwards, including you, can tell a cautious plan from an abandoned one.

19.6 What this section decides, and what it hands on

Two boundaries were not named above. The structured functional and frailty workup this reasoning sits inside belongs where the comprehensive geriatric assessment is dealt with in these notes, and formal risk assessment in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. Everything else routed above stays routed: nothing here describes the syndrome, scores an instrument or names a milligram.

What is left is the reasoning, and it runs in one direction. An examiner presenting an older patient with depression is testing whether you settle onset first and from whom; what a first episode obliges you to look for that a recurrence does not, and why that enquiry precedes the trial; whether you grasp that a substrate question changes the follow-up and not merely the workup; and whether you can state the current Indian dose position and its hedged statement on agent choice without over-reading either. Answer from onset to substrate to dose to follow-up, and the description of the syndrome becomes the least of what you say.

Onset before anything else

WHETHER THIS IS A FIRST EPISODE IS A HISTORICAL FACT TAKEN FROM AN INFORMANT, NOT A JUDGEMENT MADE FROM THE MENTAL STATE

A first episode is a question

A SYNDROME NEVER SEEN BEFORE IN A LONG LIFE ASKS WHY NOW, AND THE MEDICAL, DRUG AND CEREBRAL ENQUIRY ANSWERS THAT

The ground has moved

THE CURRENT INDIAN DEPRESSION GUIDELINE HEDGES RATHER THAN ASSERTS THE CHOICE OF AGENT IN OLDER ADULTS

In an older patient with depression, settle first whether this is the first episode of their life: a first episode makes the medical, drug and cerebral enquiry the main line of the assessment rather than a safety check, keeps the substrate question open into follow-up instead of closing it on the treatment response, and is treated on published guidance alone, so the intended target dose and the date of judgement are written down before titration starts.

20 · Late-onset psychosis and paraphrenia

Why it matters clinically. When a psychosis declares itself for the first time in someone who has lived seven decades without one, the diagnostic label is the smallest part of the work and the last part of it. The entity itself, meaning the onset bands, the delusional content, the sex ratio and the sensory and social background, is set out in the Other psychotic disorders, delusional syndromes and catatonia notes and is not repeated here. What is taken up under late-onset psychosis and paraphrenia in this chapter is the act: the order a clinician works in on the day this patient arrives, what an Indian guideline requires to be excluded before anything is called primary, when imaging is owed, and what the patient's age does to every treatment decision that follows.

The examined version of this topic is procedural far more often than descriptive. A candidate who can recite the onset bands but cannot say what they would reconcile, request and arrange before writing a diagnosis has answered the smaller half of the question. The half that carries the marks is a sequence, it has an Indian source, and it is short enough to hold.

20.1 The word, and what is left for the clinician to do with it

Paraphrenia reaches a modern answer as an inheritance rather than as a working category. Its coinage, the reason the syndrome it named was separated from the deteriorating psychosis of youth, its later revival as a late-life term, and the modern onset bands that absorbed it all belong to the Other psychotic disorders, delusional syndromes and catatonia notes. Retelling that history is not what earns credit here.

What the word still does is prime recognition. It carries a clinical stereotype, and a stereotype earns its place at the door of a clinic, because it makes a clinician look properly at a patient who might otherwise be sent home as eccentric. What it must never do is close the assessment. That is the hazard of an old and vivid label: it feels like a conclusion, it is easy to write, and once it is in the file every later reader treats the question as settled. The word describes; it excludes nothing.

Where the label sits, or sat, inside a formal classification is a separate question, and this section deliberately leaves it unstated rather than guessed at: no code and no inclusion term is named here. What a classification does with the presentation, as against with the word, belongs with the nosology in the notes named above. In an answer, give the lineage a clause, say plainly that the term is historical, and spend the remaining time on the workup.

20.2 The exclusion list runs first, and it is a sequence rather than a differential

Current Indian guidance on schizophrenia in older adults does not open with treatment. It opens by requiring a thorough evaluation for a defined set of alternatives before the presentation is

treated as primary, and that set is best learnt as a sequence of acts rather than as conditions to bear in mind. A differential is something a clinician holds; a sequence is something a clinician completes and records. The enumeration is an affective psychosis, delirium, a dementia, a psychosis caused by medication, and a psychosis caused by a psychoactive substance, and its value lies in how specific it becomes at the two ends candidates skip.

At the dementia end it does not stop at the word: Alzheimer's disease, the frontotemporal group, Parkinson's disease, Lewy body disease, vascular disease and mixed pathology are each named. That granularity matters because these are not one exclusion but several, with different tempos and different first clues, and the differentiation itself is taught in the Dementias and neurocognitive disorders notes. At the pharmacological end, **medication-induced psychosis** is given as named drug classes rather than as a gesture at polypharmacy, and this is the part almost nobody has ready.

WHAT MUST BE EXCLUDED BEFORE THE WORD PRIMARY IS USED	WHY IT STAYS LIVE IN AN OLDER PATIENT	THE ACT THAT SETTLES IT, AND WHERE THE ENTITY IS TAUGHT
An affective psychosis	Mood is under-elicited in older patients, and psychotic content is louder than the affective change underneath it	Take a mood history from patient and informant across the whole episode, not the current week; the disorders belong to the Mood disorders: pharmacotherapy notes
Delirium	The referral arrives worded as psychosis, which describes content and says nothing about attention or fluctuation	Get a timed account of onset and of variation across the day from someone present; the syndrome is taught in the Stroke, TBI, delirium and focal brain syndromes notes
A dementia: Alzheimer's, frontotemporal, Parkinson's, Lewy body, vascular or mixed	Several can produce psychotic features before the cognitive complaint is what brings the family in	Establish the premorbid baseline and trajectory from an informant, then assess cognition formally; the differentiation is in the Dementias and neurocognitive disorders notes
Medication-induced psychosis: antihistaminergics or anticholinergics at higher doses, steroids, dopamine agonists, antimalarials, antiretrovirals, opioid analgesics, fluoroquinolones, ACE inhibitors and beta-blockers	Every class here is in ordinary use in older Indian patients, and several are bought without a prescription or continued from another prescriber	Reconcile the full drug chart yourself, including whatever the family brings in a bag, and date every start and stop against the onset of symptoms
Psychoactive substance-induced psychosis	Substance use is under-asked at this age because the clinician does not expect it, and withdrawal states are missed for the same reason	Ask patient and informant separately, about current use and about anything recently stopped

TRAP **Treating the exclusion list as a differential to consider rather than a sequence to complete, so the drug chart is never actually reconciled.** The mark is lost predictably: the referral says psychosis, the assessment therefore runs as a psychosis assessment, and the medication list is read as background rather than as evidence. It is the one item on the list that is fully reversible, and the one the Indian source makes specific by naming classes. Saying the word iatrogenic does not answer it; naming which agents you would look for, and dating each start against the onset, does.

Four places on an older patient's drug history repay being asked about by name, because none reliably appears on a chart:

- anything started or increased in the weeks before symptoms began, including by another treating team;
- anything stopped abruptly in the same window, since a withdrawal state presents as readily as an addition;
- anything bought over the counter or continued from an old prescription, which is where the sedating antihistamines and the anticholinergics usually sit;
- anything taken alongside the prescribed list, whether traditional, complementary or given by a relative, which is not volunteered unless it is asked for without judgement.

20.3 The imaging instruction, and what it converts

From an imperative to an instruction. Every textbook tells a clinician to exclude an organic cause in a late-life psychosis, which is a sentiment rather than an order, because it says neither what to do nor when. The Indian guideline is more useful. It states that neuroimaging is indicated, and attaches the emphasis to a specific situation: a first episode presenting at an elderly age, which it puts at **after 60**. That age is being used as an investigation trigger and not as a nosological boundary; where the onset bands come from is a separate matter, taught with the entity.

A trigger survives contact with a busy service in a way a sentiment does not. An instruction to consider organic causes is discharged by a clinician who considered them; an instruction that imaging is indicated at this age either happened or did not, and the note shows which.

IN INDIA

The exclusion list, the imaging trigger and the treatment changes in this section are taken from the current Indian clinical practice guideline for the management of schizophrenia, published in the Indian Journal of Psychiatry in 2025, in the row of its special-populations table dealing with older adults. Naming a national source is worth a mark in a viva, where a recalled Western habit is not. Two local frictions recur, and neither justifies skipping a step. Imaging is an out-of-pocket cost a family may defer or decline, so record the indication, the explanation given and the refusal, then arrange it again at review. And the drug history arrives as strips, folded prescriptions and several prescribers rather than as a chart, so it must be assembled by the assessing clinician and cannot be delegated to the referral letter.

20.4 What changes because the patient is seventy-eight

Once the exclusions are worked and the presentation is being treated as a primary psychosis, the age changes the treatment decision at its first step rather than its last. In a younger adult a drug is chosen for what it is expected to do, and its adverse effects are then managed. Here the order inverts: **selection is driven by the side-effect profile**, because comorbidity is the rule at this age and the adverse event being avoided is the one that ends a person's independence.

RULE **In a late-life psychosis the agent is chosen by what it must not do.** The first-line preference is for agents with **lower anticholinergic burden** and lower sedative property, and the guideline states the purpose rather than leaving it to be inferred: to prevent falls. Read that reason forward and the rest follows from it. Sedation and anticholinergic load are the two properties that produce a fall, so the same logic bars **anticholinergic co-prescription** so far as it can be avoided, which matters because that is precisely the reflex a prescriber reaches for when extrapyramidal effects appear.

Two further changes complete the picture. The starting dose is set lower than in an adult, and monitoring for metabolic adverse effects is more frequent. The quantified dose reduction, the anticholinergic burden scales, the falls evaluation and what more frequent monitoring means in practice all sit where the principles of psychopharmacology in later life are dealt with in these notes; the agents themselves belong with the entity. What belongs here is the reasoning that ties them together: one stated purpose, the prevention of falls, generates the selection rule, the co-prescription rule and the dose rule at once. That is what an examiner is listening for, and it is one sentence.

20.5 Who brought the patient, and where the treatment actually happens

The guideline does not stop at the drug. It records that the psychosocial challenges of this group are distinctive and often need psychosocial intervention in their own right, and here that clause carries more weight than it appears to, because of who is standing in the room. The patient has usually not referred themselves. The complaint has been made by a family member, a neighbour or a landlord, and the person best placed to supervise medication is frequently the person the patient's complaint is about. A plan written without noticing that is a plan for a household which does not exist.

Three consequences follow, each an act rather than an attitude. The alliance is built with the patient about something the patient wants changed, which is rarely the belief and is often sleep, safety or being left alone; arguing the belief costs the alliance and buys nothing. **Supervised administration** then has to be arranged by name, because an older person living alone with a persecutory belief will not reliably take a drug handed over by someone they distrust, and recording who holds the medication, and where, is part of the prescription. And the isolation and sensory deficits that so often accompany this presentation are targets rather than context: a hearing aid obtained is an intervention.

GOOD TO REMEMBER

Four things should exist before this first consultation ends, and none will exist unless you make it. A reconciled medication list with dates, assembled by you rather than copied from the referral. A named informant with a telephone number, recorded as the source of the premorbid baseline. A written statement of whether imaging was requested, obtained, deferred or refused, with the reason. And a named person who will actually give the medication, with the arrangement written down. Each is what the next clinician will need, and none can be recovered later.

20.6 The diagnosis is made over time, so the note has to be re-openable

What finally separates this presentation from a first psychosis in a young adult is that the exclusion list contains conditions which do not all declare themselves at once. A dementia early enough to produce psychotic features before a cognitive complaint need not be visible at a first assessment, and a medication effect becomes obvious only once the agent is withdrawn and the picture watched. The workup therefore has a component running after the consultation, and a diagnosis recorded as settled at first contact quietly removes it.

How often a late-life psychosis is later reclassified, and how long a clinician should watch before treating the diagnosis as stable, are questions this section cannot put a figure or an interval on: no comparable standard is available to quote, and none is invented here. What can be taught is the consequence for the record. Write the diagnosis with its grounds visible: what was excluded and how, what was not yet excluded and why, and what would cause it to be revisited. A colleague reading that in six months can re-open it; a colleague reading a bare label cannot, and will not.

The list before the label

THE INDIAN GUIDELINE PUTS A THOROUGH EXCLUSION EVALUATION AHEAD OF CALLING A LATE-LIFE PSYCHOSIS PRIMARY

Imaging has a trigger

A FIRST PRESENTATION IN OLD AGE CONVERTS THE EXCLUDE-AN-ORGANIC-CAUSE SENTIMENT INTO AN INVESTIGATION THAT EITHER HAPPENED OR DID NOT

Chosen by what it must not do

LOW ANTICHOLINERGIC AND LOW SEDATIVE SELECTION, NO ANTICHOLINERGIC CO-PRESCRIPTION AND A LOWER START, ALL GENERATED BY ONE STATED PURPOSE

In a first psychosis of late life the examinable work is a sequence and not a label: complete the guideline's exclusions with the drug classes named and the drug chart reconciled by you, treat a first episode at an elderly age as an indication for neuroimaging, then choose the antipsychotic by its side-effect profile and start it low, because the fall is the outcome that ends independence.

21 · Delirium in the elderly

Why it matters clinically. Delirium was the commonest psychiatric disorder in one Indian study of elderly patients screened at emergency medical outpatient settings, present in **34.1%**, and the examinable question about the confused older inpatient is almost never what delirium is. It is why this patient, why now, and what follows. The entity, its criteria, its subtypes and its treatment belong to the Stroke, TBI, delirium and focal brain syndromes notes, and telling it apart from dementia and from depression belongs to the Dementias and neurocognitive disorders notes.

What is taken up here is narrower: what ageing itself contributes, so that the same syndrome in an older person has a lower threshold, a different set of precipitants, a harder point of comparison and a longer tail.

Keep this apart from the ward referral. The call that arrives as behavioural disturbance on somebody else's service, the bedside screen, the consult note and the ownership of the decision afterwards are taken up where delirium in the medically ill is dealt with in these notes. That section answers what a liaison psychiatrist does when called; this one answers why the call is so often about the oldest patient on the ward.

21.1 What ageing brings to the bedside

Delirium in later life turns on how much insult the brain could absorb before this illness began, and on how large the insult is. The first quantity is **physiological reserve**, and its progressive loss across several organ systems at once is what **frailty** names. Frailty is not chronological age and not a long problem list: one older person can carry several diagnoses and retain reserve, another few and have almost none. Its clinical content is that homeostatic responses have narrowed, so a perturbation a younger patient corrects silently is corrected slowly or not at all. The brain sits downstream of all of them, which is why cerebral dysfunction is so often the first system to declare a failure that began elsewhere.

RULE **The frailer the brain, the smaller the precipitant needed, and the less the precipitant tells you.** In a frail older patient the trigger may be trivial by the standards of a younger ward, so a search that stops when nothing impressive is found has stopped too early. The corollary is the more examinable part: when delirium appears in a robust older person with no cognitive history, the insult was probably not trivial, and the response is to look harder, not to be reassured.

Reasoning in late life therefore runs from trajectory to trigger. The Indian Psychiatric Society's 2023 guidelines on psychiatric emergencies in the elderly list advanced age over **70 years**, cognitive impairment, a previous episode and sensory impairment among the risk factors and weight none of them, so what follows are mechanisms rather than weights, and what each earns is an act that must precede the examination.

WHAT AGEING BRINGS	WHY IT LOWERS THE THRESHOLD	WHAT IT CHANGES AT THE BEDSIDE
Loss of reserve, expressed as frailty	Correction is slower and less complete, so a modest insult is not absorbed	Search wide for a small precipitant; do not stop because nothing dramatic is found
Uncorrected hearing and vision loss	Input is impoverished and ambiguous, so more must be inferred from less	Restore the aid and spectacles before testing, and record that you did
A long and layered drug chart	Altered handling and cumulative central load make the precipitant often iatrogenic	Reconcile every agent, including whatever the family brings in
Cognitive impairment already present, recognised or not	The vulnerable substrate is there already, so less is needed to decompensate it	Get the premorbid baseline before interpreting the state in front of you

21.2 The unaided ear, and the test that is not valid

Uncorrected sensory loss acts in separate ways, and it is the second that catches candidates. The first is a contribution to vulnerability: when hearing and vision are degraded, the information reaching the patient is sparse and ambiguous, and more of their experience must be inferred than received. Ask that of someone in an unfamiliar room, with unfamiliar voices and no visual anchors, and **sensory deprivation** of this ordinary, correctable kind becomes a condition under which misinterpretation is likely. It explains why the same patient is settled with a daughter present in daylight and disorganised in a dim side room at night, with no change in the underlying illness.

The second effect is diagnostic, and it invalidates assessments rather than causing disease. A patient who cannot hear the instruction appears not to attend to it; one who cannot see the object appears not to name it. Each failure is indistinguishable from the failures that matter, and each gets recorded as a cognitive finding by whoever tested without checking. An unaided examination yields a result that cannot be interpreted in either direction. Which ward measures prevent delirium is the owning chapter's; assessing an older person generally is taken up where normal ageing and psychiatric assessment are dealt with in these notes.

> **GOOD TO REMEMBER**
>
> Before a single cognitive item is administered to an older inpatient: ask what they normally use, get it on, and get the light on. Then write that the hearing aid was in place and the spectacles worn, or that they were unavailable and the examination is limited for that reason. An unqualified cognitive result on an unaided patient is not a finding, and it follows the patient through every later team.

21.3 The drug chart as part of the physical examination

Polypharmacy earns its place for reasons that call for different acts. It is a marker: a long chart usually indicates multimorbidity, therefore reduced reserve, and the same guidelines put multiple physical illnesses and polypharmacy among the things that raise the risk. It is also the most reversible precipitant on the ward. Older patients accumulate centrally acting agents across years

and across prescribers, and the cumulative anticholinergic and sedative load of a chart assembled that way is often greater than any single entry suggests. How ageing changes the handling of each agent is taken up where the principles of psychopharmacology in later life are dealt with in these notes. Read the chart before accepting anybody's account of what precipitated this.

These places on a chart repay specific attention, because each is easy to miss on a ward round:

- the agent started most recently, including one added by another team during this admission;
- the agent stopped most recently, since abrupt withdrawal of something long established precipitates as readily as an addition;
- the agent being taken but absent from the chart, whether over the counter, traditional, or brought from home in a strip;
- the agent continued unchanged at a dose set years ago, when the patient handled it differently.

IN INDIA

The ordinary Indian bedside changes how this is done. A family attendant is almost always present, and is usually the only source of the premorbid baseline and the only person who will notice a change at night: name them in the note and ask them directly, not through the ward staff. The drug history sits across more than one prescriber and arrives as strips and folded prescriptions rather than a chart, so ask for all of it and reconcile it yourself. Glasses, hearing aids and dentures live at home: ask whether they came in with the patient at all. Each closes a diagnostic gap that nothing later in the admission will close for you.

21.4 Delirium on a brain that was already changing

An episode in a person who already has a dementia is to be expected rather than treated as a special case, and **delirium superimposed on dementia** generates most of the diagnostic difficulty in geriatric practice. The reason is structural: the diagnosis rests on an acute change from a previous state, and when that state was already abnormal, the change is invisible unless someone can describe what the patient was like beforehand. On a busy ward the enquiry stops at a sentence to the effect that the patient has been confused for a while, which is equally compatible with a stable dementia, a slow decline and an acute deterioration on top of either. It separates none of them, and it is usually the only history taken. Which of delirium, dementia and depression best explains a presentation is taught in the Dementias and neurocognitive disorders notes; what belongs here is that in an older patient the answer is often more than one of them at once, and that the **baseline** is the instrument for that judgement.

A **collateral history** taken for this purpose has to establish particular things, and a general enquiry about memory establishes none of them:

- what the person could do without help before this admission, in concrete terms rather than impressions;
- whether memory, orientation or self-care were already impaired, and for how long;
- whether the current change came on over hours or days rather than over months;

- who first noticed it and what they noticed, since the earliest observation is the most diagnostic and is rarely in the notes.

TRAP **Reading a confused older patient as the natural course of their dementia.** Candidates make this error because it is available: the label is already in the file, it accounts for the findings, and it requires no telephone call. The failure is one of history-taking, not of phenomenology, and examining the patient more carefully does not repair it, because the acute change is not in the current mental state. It is in somebody's memory of last week. The error runs in reverse when a first episode in an older person is treated as evidence of a dementia nobody has assessed.

21.5 Sundowning is a word about the clock

Why the term misleads. **Sundowning** is a ward word for agitation, disorientation or restlessness that appears or worsens as the evening comes on. It carries no agreed definition that can be quoted, and none is invented here; what it describes is timing, not a mechanism, a diagnosis or an explanation. Its usefulness lies in what it prompts you to ask, because several different situations get recorded under it: the evening exacerbation of a delirium present all day that becomes visible once structure and staffing thin out; evening behavioural disturbance in an established dementia with no delirium, which belongs with the behavioural and psychological symptoms taken up where dementia is placed in the geriatric frame in these notes; and an artefact of the ward evening itself: handover, reduced supervision, dim light, and the withdrawal of the attendant who had been orienting the patient all day.

Because the pattern is temporal, it is established by documentation across the whole cycle rather than by an impression formed on one evening: timed observations across the day and night discriminate between those situations, while a note recording that a patient was disturbed at night discriminates nothing. And because the evening presentation invites a sedating response at the hour when supervision is lowest, the reflex to prescribe rather than to look is strongest exactly when the diagnostic information is thinnest. What changes about sleep with age, and what to do with the reflex to prescribe at night, are taken up where sleep in later life is dealt with in these notes.

21.6 The tail: what happens after the ward

The assumption that quietly governs discharge planning is that the episode ends when the illness that triggered it ends. In an older person that assumption is not safe to make, and what rests on it is what the family is told, when cognition can fairly be re-examined, and what the next clinician gets from your note. Features still present on the day of discharge are easily recorded as the patient's new normal, particularly when the discharging team never knew the old one. Whether recovery tracks the medical problem, and how much of the later functional and cognitive trajectory belongs to the episode rather than to the frailty that permitted it, is exactly where a candidate is tempted to supply a proportion: no comparable standard is available to quote, and none is invented here, so the consequence for practice is taught instead.

A frail brain needs a small insult	The baseline is the instrument	Discharge is not the day to certify recovery
WHY AN INFECTION A YOUNGER PATIENT ABSORBS SILENTLY DECLARES ITSELF AS CONFUSION IN AN OLDER ONE	THE ACUTE CHANGE IS ESTABLISHED FROM SOMEONE WHO KNEW THE PATIENT, NOT FROM THE STATE IN FRONT OF YOU	THE NOTE CARRIES THE PREMORBID BASELINE AND AN ARRANGED REVIEW, NOT A JUDGEMENT MADE ON THE DAY

What the discharge summary carries decides whether any of this survives the admission. These entries are worth insisting on, and none is standard:

- that an episode occurred, named as such, with its dates and precipitant, because a summary recording only the treated infection loses the cognitive event;
- the premorbid baseline established, and from whom, so the next clinician has the comparison you had;
- whether cognition at discharge had returned to that baseline, was short of it, or could not be assessed, with an arranged review rather than a reassurance.

21.7 What this section decides, and what it hands on

The boundaries are worth stating plainly. The syndrome itself, with its criteria, subtypes, instruments, causes, treatment and prevention measures, is set out in the Stroke, TBI, delirium and focal brain syndromes notes. Prescribing belongs where psychopharmacology in later life is dealt with, and the structured assessment these vulnerabilities are measured inside belongs where the comprehensive geriatric assessment is dealt with.

What is left is the reasoning: an examiner who gives you an older patient with new confusion is testing whether you can say what made this brain vulnerable before the illness arrived, what small thing was enough to tip it, how you would establish that anything had changed, and what you would arrange for afterwards. Answer in that order, from reserve to precipitant to baseline to outcome, and the entity looks after itself.

> Delirium in the elderly is a statement about reserve as much as about the illness that triggered it: establish the baseline from someone who knew it, read the drug chart as part of the examination, restore the hearing aid and spectacles before testing, and hand the episode on in the discharge note rather than closing it on the day.

22 · Pseudodementia versus dementia (depression in the elderly)

Why a comparison settled elsewhere still needs an address. The heading is set as pseudodementia versus dementia (depression in the elderly), and it names a discrimination made at the bedside, quickly, before any specialist service has seen the patient. The construct is **depressive pseudodementia**: a depressive illness in an older person whose presenting complaint is of failing memory, concentration and intellect, set beside a degenerative process capable of the same appearance. Its features, the formal differentiation from a true dementia, and the discriminators laid out side by side are given in the Dementias and neurocognitive disorders

notes and in the Mood disorders: pharmacotherapy notes. Neither is condensed here: a shortened comparison competes with the full one.



Fig 29.9 Cognitive symptoms in late-life depression and early dementia may not be resolved in one assessment. The consultation treats reversible contributors, documents uncertainty, reviews the trajectory and addresses safety while the diagnosis is clarified.

Those accounts do not use the same name for it, and no preferred term is adopted here; the label is settled where the construct is taught. What is owed at this address is what no comparison table carries: who makes the call and in what setting, what the error costs in each direction, and what the consultation must produce when it cannot answer on the day.

22.1 Both errors are available, and they do not cost the same

Reading a depressive illness as a degenerative one withholds a treatment that could return the person to their previous level, and it does more: the household is told to expect decline, the plan turns custodial, and the **provisional label** in the first case sheet is seldom reopened by whoever reads it later. The opposite error, reading an early degenerative process as depression alone, is not

harmless either: the safety review, the driving and financial conversations and the family's preparation are all deferred while a treatment is given time to work.

The pair is not symmetrical, and the asymmetry is the examinable point: the depressive possibility must be actively excluded rather than hoped for, because it is the only member in which the deficit may lift. That is about the order of the work, not the odds.

RULE **Where the two cannot be separated at the first sitting, treat the reversible possibility and name the date on which the answer will be read.** The discrimination is often completed by what happens over a treated interval, not by anything a single examination yields, so a consultation closing with a verdict and no review point has answered a question nobody asked.

22.2 How the question reaches you, and whose account decides it

The request almost never uses the word. It arrives as a son saying his father has become forgetful since the mother died, or as a medical unit wanting an opinion before a discharge the family is resisting. What is tested is whether you notice the question is available at all: the referral names a deficit, and the referrer has already decided which of the two it is. A third possibility is easily lost between them: an **acute confusional state** gives a similar appearance, and it is taken up where delirium in later life is dealt with here.

Whose account settles it is decided before the examination, not during it. An older patient's own report of their memory cannot close the question alone, so the household's version is not corroboration but a second history, separately sourced and recorded. Where the family has already named the illness, that naming is itself clinical material: it tells you what they will agree to. Three things belong in the note before the cognitive examination begins.

- Who gave each part of the history, and which parts rest on the patient alone.
- What has already been named to the family, by whom, and what they have stopped expecting.
- Who will bring the patient back for review, and whether they are able to.

IN INDIA

Most districts have no memory service to refer to, so the discrimination is made, and then owned, by whoever the family reached first. The provisional label travels onward in a case sheet the family carries, and the next consultation is often with a different clinician in a different hospital, so nobody is placed to revise it: **diagnostic inertia** here is a property of how care is delivered, not of anybody's carelessness. The two words also land differently in a family's hearing, one as a terminal sentence and the other as weakness of character, so the review appointment must be explained as part of the diagnosis, not offered as an optional return. What proportion proves reversible, and how much old-age provision exists to refer to, are not quantified: no comparable standard is available to quote, and none is invented here.

22.3 Where each part is taught, and how the heading is set

WHAT IS BEING ASKED FOR	WHERE THE FULL ACCOUNT SITS	WHAT THESE NOTES ADD
The construct, its features, and the formal differentiation from a true dementia	**the Dementias and neurocognitive disorders notes**	Nothing; the reader is sent
The discriminators side by side, inside the depressive illness they belong to	**the Mood disorders: pharmacotherapy notes**	Nothing; the reader is sent
Cognitive instruments and their scoring	**the Psychotherapies, clinical assessment, MSE and nosology notes**	The workup they sit inside, with geriatric assessment here
The acute confusional state as the third possibility	**the Stroke, TBI, delirium and focal brain syndromes notes**	What age contributes, with delirium in later life

As a short note the marks sit in the comparison, so answer it from the owning account rather than improvising at the desk. As a viva or long case it is never asked in the abstract: an older patient with a cognitive complaint and a mood history is put before you, and the examiner watches whether both possibilities survive to the end. What scores is a fixed order.

- Name both possibilities, and the third one, before examining for either.
- Say whose history you took for each, and what you could not obtain.
- Close on the treatment you are starting and the date the label will be tested.

TRAP **Reproducing the comparison and stopping there.** Candidates make it because the side-by-side account is compact, memorable and the part that was revised, so it feels like the answer. What it produces is an answer with no decision in it: no treatment begun, no informant named, no date at which the label is tested.

GOOD TO REMEMBER

Write the review date in the same sentence as the provisional diagnosis, in the case sheet the family carries. A label with a date invites the next clinician to test it; without one it reads as settled, and where that clinician is a stranger, this is the difference between a diagnosis and a verdict.

Named and handed on
WHAT THESE NOTES DO WITH THE COMPARISON ITSELF

Excluded, not hoped away
HOW THE TREATABLE MEMBER OF THE PAIR IS HANDLED

A date, not a verdict
WHAT THE CONSULTATION IS OBLIGED TO PRODUCE

The comparison is read in the Dementias and neurocognitive disorders notes and in the Mood disorders: pharmacotherapy notes; what is decided here is that the treatable possibility is excluded rather than hoped away, and that the provisional label leaves the room with a date on which it will be tested.

Culture and the explanatory model

23 · Concepts of culture, illness and culture-bound syndromes

Why a heading whose framework is taught elsewhere still carries marks. This heading asks for a vocabulary before it asks for anything clinical, and the vocabulary was rebuilt once already. DSM-5 moved from **culture-bound syndromes** to **cultural concepts of distress**, an umbrella that holds **three** distinct ways culture shapes suffering rather than only the syndrome-shaped one. That framework is taught in full, with its definitions, its worked examples and the assessment instrument built on it, in the Psychotherapies, clinical assessment, MSE and nosology notes. Nothing here repeats it, and an answer that stops at the framework has recited a vocabulary and left the clinical question untouched.

What is left over is what these notes owe. A concept of illness is not general knowledge sitting beside the diagnosis: it decides what counts as a symptom, who is entitled to describe it, and which account of the cause a clinician has to work with before any treatment is accepted. That is a consultation problem, and it is examined as one.

23.1 Where the framework is taught, and what is deliberately not repeated

The umbrella's parts are a **cultural syndrome**, a **cultural idiom of distress** and a **cultural explanation** or perceived cause. Each is defined, discriminated from its neighbours and illustrated in those notes, alongside the classic named syndromes as a definitions list and the structured formulation that elicits all of it. This section names the parts and stops there, because a compressed definition is a worse version of a definition that already exists, and because the reader who needs the definitions needs them in one place rather than in competing versions. The argument the classification made for the change is set out with the framework and is not restated here, in any shortened form.

RULE **Name the umbrella before you name an example.** An examiner who asks about concepts of culture, illness and culture-bound syndromes is asking whether you hold a framework, and the exotic examples are the part of the answer that needs no help. A candidate who opens with a roster of syndromes has answered a question about content with a question about geography, and has to be led back to the framework by the examiner, which is the only part of the exchange that is ever remembered.

WHAT THE READER IS LOOKING FOR	WHERE THE FULL ACCOUNT SITS	WHAT THESE NOTES ADD
The terminology shift, and the parts of the umbrella	**the Psychotherapies, clinical assessment, MSE and nosology notes**	Nothing. It is named here and handed on
The classic named syndromes, as definitions	**the Psychotherapies, clinical assessment, MSE and nosology notes**	How such a presentation actually arrives, and the negotiation that follows it
Dhat syndrome, at length	**the Somatic-symptom, sexual, impulse-control disorders and suicide notes**	Named here only as the one most likely to arrive in an Indian clinic
The cultural formulation and the interview built for it	**the Psychotherapies, clinical assessment, MSE and nosology notes**	Where it belongs inside an assessment done in a general hospital
Migration, ethnicity and acculturation	**These notes, in full**	The whole of it, since it sits with the encounter and not with the taxonomy

23.2 What a chapter that owns the encounter does with culture instead

The organising question. Every other heading in psychiatry teaches what a thing is. These notes teach who asks, in whose ward, what changes with age, whose account of the cause is already in the room, and how an examiner asks for all of it. Culture enters that scheme not as a topic but as a seam that runs through the rest of it, which is why the concept is named here and then reappears, in clinical form, wherever it does work. It reappears in these notes as:

- the encounter with the classic presentations, meaning how such a presentation actually walks into a clinic and how the negotiation with a family that has already settled on an explanation is conducted;
- the structured formulation and its interview, placed where an assessment would reach for them rather than taught again;
- the patient's vocabulary for suffering, and the account of cause that vocabulary carries;
- migration, ethnicity and acculturation, which these notes carry in full;
- religion, spirituality and the healing that happens before the clinic is ever reached.

GOOD TO REMEMBER

Before writing a cultural label into the record, ask what the label changes. If it changes nothing about the plan, it is a description and not a diagnosis, and the note still has to name the disorder being treated and the account of cause being worked with. A record that says only that the presentation was cultural has documented the clinician's impression of the patient's background and no decision at all.

23.3 How the heading is asked, and the order the answer takes

Asked as a short note or a viva opener, this heading rewards a sequence rather than a store of examples: the current umbrella and why it replaced the older term, the parts it holds, the address of the definitions if a definition is wanted, and then the move to the encounter, where the marks for judgement sit. Asked as a long question, it is almost never asked alone. It arrives attached to a case, and the concept is the frame the case is read through, so the candidate who has treated the framework as a glossary has nothing to say when the case turns out to be a treatable disorder wearing an unfamiliar explanation.

TRAP **Answering a question about concepts with a catalogue of syndromes.** The catalogue is memorable, regionally exotic and easy to revise, while the framework is abstract and easy to skip, so the catalogue is what surfaces under pressure. The same error runs the other way in the clinic: a name is attached, everyone relaxes, and the assessment stops at the point where it should have begun.

IN INDIA

The older vocabulary is still the working vocabulary here. It survives in teaching, in ward usage and in the wording of examination questions, so a candidate meets the superseded label and the current umbrella in the same viva and needs fluency in the relationship between them rather than loyalty to one. Expect the examples to be Indian and the expectation to be that you move from the term to the clinic, since a roster recited to an Indian examiner invites the follow-up question of what you would do with the patient in front of you.

Named and handed on	Definitions elsewhere	The encounter
WHAT THIS SECTION DOES WITH THE FRAMEWORK	WHERE A DEFINITION IS TO BE READ	WHAT THESE NOTES ADD IN ITS PLACE

Cultural concepts of distress is the current umbrella and it replaced culture-bound syndromes, which covered only the syndrome-shaped part of it; the definitions and examples belong to the Psychotherapies, clinical assessment, MSE and nosology notes, and what these notes add is the encounter the concept is used in.

24 · Culture-bound syndromes (dhat, koro, amok, latah and others)

Why the encounter is examined here and the definitions are not. No group of headings is memorised as reliably, or handled as badly, as the culture-bound syndromes (dhat, koro, amok, latah and others). A candidate can produce the roster on demand and then have nothing to say when one of them is sitting across the table, because a name is worth little in a clinic: it tells you what the patient calls his trouble, not what he has, what he has already swallowed for it, or who sent him. The definitions, the umbrella term that replaced the older one, the classic list and the placement of these presentations in the classifications are taught in the Psychotherapies, clinical assessment, MSE and nosology notes, and dhat syndrome at length, with its figures and its

management, in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. None of that is rebuilt here.

What is left over is the clinical encounter, and it holds both the marks and the mistakes: which door such a presentation comes through in India, what the man and his household already believe by the time a psychiatrist meets them, how a negotiation between two accounts of one complaint is conducted, and what arrives that the classic list never mentions. One discipline runs through all of it. The Indian evidence here is a few single-centre clinic series and individual case reports, so every figure in this field is a proportion of the people who attended one clinic, and the honest answer teaches a method rather than a set of rates.

24.1 Which door it comes through, and why the psychiatrist is not the first clinician

Begin where the patient begins, because the **help-seeking pathway** explains most of what looks puzzling about these presentations. The Indian phenomenological description this section leans on studied **100** men, and it did not recruit them from a psychiatry outpatient department at all: they were attending a sex and marriage counselling clinic run from a community medicine department at a single tertiary centre in New Delhi, and the work was published in the Indian Journal of Psychiatry in 2016. Its method is as instructive as its findings. The investigators ran focus groups with specialists in dermatology, community medicine, medicine, surgery and endocrinology, and when focus groups with traditional practitioners proved impossible to assemble, interviewed three ayurvedic and two homeopathic practitioners individually. Read that as a map of the doors this complaint knocks on before it reaches you.

The other two Indian reports say the same thing from different directions. A pair of cases of **anthropophobia** reached an obsessive-compulsive disorder clinic rather than a general psychiatry clinic, and a man with a koro-like presentation and dhat was assessed, and re-assessed, before the treatable disorder underneath was identified. By the time a psychiatrist sees such a patient, several other people have already explained it to him, so the psychiatric account is not the first one offered but a competing one arriving late.

One methodological detail of the clinic series has to travel with it, because it is a trap in both directions. Psychotic illness was an exclusion criterion, so anyone whose conviction might have reached delusional intensity was screened out before the study began. That bounds what the series describes, and it also means this sample cannot be used to settle the argument about whether such an attribution is a belief or a delusion. That argument belongs with the definitions and is taken up there.

24.2 What he has already been told, and what he has already taken

Where the belief was learned is a clinical fact, not an anthropological one, because it tells you who else has to be persuaded. The same clinic series records that this knowledge is acquired from friends, relatives and colleagues, from roadside advertisements and lay magazines, and from Hakims and Vaids. Not one of those is a clinician in the sense a hospital uses the word, and every one is more available, cheaper and less humiliating to consult than an outpatient department.

The **Hakims and Vaids** in that list are practitioners with their own coherent systems, their own diagnostic vocabulary, and a treatment they will hand over at the first visit.

The second half of that record is what patients themselves count as cures, and it is the more useful half. Reported **perceived cures** run from desi medicines and herbs, and the advice of Hakims and Vaids, through dietary correction with protein-rich and iron-rich food, B-complex tablets or injections, antibiotics, anti-anxiety drugs and aphrodisiacs, to marriage itself. Look at the two ends of it. An injection is the most concrete thing a patient can be given. Marriage is not a prescription a clinician can write and is very often one the family has already written. So he arrives with a settled expectation that something energising will be supplied, and with a household committed to a plan of its own.

How commonly that expectation is held, and in what proportion of such patients, is a figure this account will not give you: no comparable standard is available to quote, and none is invented here. The qualitative fact is enough to work with, and it is the part that changes the consultation.

IN INDIA

The parallel market is not a curiosity at the edge of the case, it is the referral pathway. A roadside advertisement, a lay magazine and a neighbouring practitioner have between them supplied a diagnosis, a mechanism and a treatment before you are consulted, at a price already paid. Two questions belong in the first interview and are almost never asked: who did you consult before coming here, and what did they give you. The answers name what has already failed, what the family counts as a real treatment, and whatever is currently being swallowed. A record stating that the patient is on no medication, when he is taking a tonic and tablets bought over a counter, is inaccurate in a way that matters.

24.3 The family's account, and why you ask for it rather than assume it

The family is not an accompanying party in these presentations, it is usually the referrer. In the Delhi report of anthropophobia, the man managed the problem himself by avoidance, and the change that produced a consultation was functional: he stopped going to work, and it was his family who noticed and who brought him to the clinic. That is the ordinary Indian route into psychiatric care in one sentence. Distress alone does not generate a referral; loss of role does, and the person who converts it into an appointment is a relative.

It follows that the household arrives with an account of the illness already formed, and that the account is a clinical object rather than background colour. What is not available is any measurement of it. Nothing here establishes what proportion of Indian families holds a biomedical explanation, whether families commonly hold several explanations at once, whether a non-medical account predicts a worse outcome, or whether it predicts that the tablets get taken. Those are exactly the propositions a clinician feels certain about. So the instruction below is argued as good practice, from the structure of the encounter, and must not be dressed up as an evidence-based intervention in an answer.

MNEMONIC

Where did you hear it? What have you taken? What do you want me to do?

Three questions, asked in that order, before any explanation is offered. The first locates the source of the belief and therefore who else holds it. The second uncovers the treatments already tried, which is both a history of failure and a current drug history. The third surfaces the expectation you are about to disappoint, which is the single most useful thing to know before you speak, because an expectation that is named can be negotiated and one that is not simply ends the consultation at the door.

24.4 Conducting the negotiation

The consultation is a meeting of two accounts of one complaint, and the psychiatric account has the less authority in the room. The patient and the practitioners he has already seen understand the trouble as a bodily disorder; the **allopathic** clinician he has now reached understands it as a psychological one. Neither party is unreasonable, and the encounter fails when the difference is treated as ignorance to be corrected first and treated afterwards. A workable sequence looks like this.

- Examine him. The complaint is bodily, and a physical examination that is skipped tells the patient more clearly than any sentence that you did not take it seriously.
- Take the history of what has already been consulted and consumed before you offer any account of your own, so that your explanation lands after his rather than instead of it.
- Do not open by correcting the belief. Correction at the first meeting costs the follow-up and buys nothing, because the belief is held by people who are not in the room.
- Say what you will do and, explicitly, what you will not do. A tonic or an injection given to satisfy the model purchases this consultation and sells the next one, since it confirms that the complaint was the kind of thing an injection treats.
- Name in the record the disorder you are actually treating, and treat it. Where the pathway has already passed through a temple, a shrine or a healer, the negotiation with that part of it is taken up in these notes under religion, spirituality and faith healing.

RULE **The name tells you what he calls it, not what he has.** A culture-named presentation is a presentation and not a diagnosis, so attaching the name completes nothing. The task after the name is the ordinary one: identify the treatable disorder, if there is one, and the expectation that will decide whether treatment is accepted. An answer, or a note, that stops at the name has recorded the patient's vocabulary and made no decision. This is also the axis the long essay is marked on, because the roster is the part that needs no help.

GOOD TO REMEMBER

Four things belong in the note and are usually missing from it: the patient's own words for the complaint, his account of what caused it, what he has already taken and from whom, and the sentence in which you told him what you would and would not prescribe. The last matters most at the next visit, because a patient who does not return has usually been refused something without being told what he was offered instead, and the clinician who sees him next cannot know that unless it was written down.

24.5 The long tail: what walks in that the roster does not list

The classic list is a list of names collected historically, not a census of what presents. The clearest Indian demonstration is a case series from Delhi, published in the Indian Journal of Psychological Medicine in 2021, reporting **two** cases of anthropophobia, a presentation classically indexed to Japan. Its authors state that to their knowledge no such case had previously been reported in the Indian context, and that hedge is theirs and should survive into any use you make of it: it is a statement about the reported literature, not about how often this occurs. Two cases license an existence claim and a narrative of how they reached care. They license nothing epidemiological whatever.

The teaching point carries into any question on this heading. The name records where a presentation was first described and described often, which is a fact about the history of psychiatry rather than about the distribution of human distress. Presentations cross those boundaries, and an Indian clinic meets what the roster does not list.

The Indian literature also carries its own named presentations outside that roster, and the Psychotherapies, clinical assessment, MSE and nosology notes name suchi-bai, the ascetic syndrome, nuptial psychosis and jhinjhinia. They are named here and nothing more is said about them. No phenomenology, no region, no sex distribution and no frequency is offered for any of the four: no dependable account of them is available to quote, and none is invented here. This is precisely the material that gets written from memory, with great confidence and no basis.

THE INDIAN REPORT	WHERE IT PRESENTED	HOW HE REACHED IT	WHAT IT CAN CARRY, AND WHAT IT CANNOT
A clinic series of 100 men, tertiary centre, New Delhi	A sex and marriage counselling clinic run from a community medicine department, not a psychiatry clinic	**Attending a non-psychiatric clinic; psychotic illness was an exclusion criterion**	The information ecology and the expected remedy. Not a population rate, and not the question of delusional conviction, since those patients were excluded
A case series of two, Delhi	An obsessive-compulsive disorder clinic	**Managed alone by avoidance, then noticed by relatives, then brought in by the family once he stopped working**	That a presentation crosses the boundary it is named for, and the Indian route into care. Nothing epidemiological
A single case letter, rural West Bengal	Assessed with two culture-named presentations at once	**Comorbid obsessive-compulsive disorder emerged only on an unscheduled review**	That these presentations ride on ordinary disorders. Not a description of the epidemic itself, which reaches this account second-hand

24.6 They ride on ordinary disorders, and the first assessment can miss it

The most useful single Indian case in this area is a letter from rural West Bengal, published in the Indian Journal of Psychiatry in 2020, describing one man who presented with two culture-named complaints together and in whom obsessive-compulsive disorder was camouflaged at the initial examination by those complaints and detected only on a later, unscheduled review. Two things in that sentence are worth more than the diagnosis itself: the comorbidity was present from the start and was not visible, and what made it visible was a second look rather than a better first one.

The authors also record that what the man showed was **koro-like** rather than classical, which is the ordinary situation and not the exception. Textbook descriptions are drawn from the clearest published cases; clinics see partial, mixed and attenuated versions, and a presentation that fails to match the description is not thereby excluded from being one. They set the case against an epidemic background they date to 2010 and describe as involving several Indian states. That background is stated here as their attribution: the epidemic report itself is not available to this account, so the epidemic is not asserted as a free-standing fact and its extent is not quantified.

Their recommendation follows, and its authority has to be carried with it. The authors of that letter state their belief that all koro and especially koro-like cases with a subacute or chronic presentation should be screened for the obsessive-compulsive spectrum. That is the opinion of a case report, carrying the modal verb its authors chose. It is worth acting on and it is not a guideline, and the difference is examinable. Obsessive-compulsive disorder itself, its assessment and its treatment, belongs to the Anxiety, OCD and trauma-related disorders notes.

TRAP **Treating the culture-named presentation as the whole diagnosis and stopping the assessment there.** The name is satisfying, it explains the striking part of the history, and once it is attached everyone in the room relaxes, including the clinician. Meanwhile the treatable disorder sits underneath it and can be invisible at a first assessment. In the exam this is an answer that describes a syndrome beautifully and never mentions screening for comorbidity; in the clinic it is a patient who was labelled, reassured and not treated.

24.7 What a number in this literature can bear

The discipline that separates a safe answer from a confident one. Every figure available in this field is bound to the group it was counted in, and the **denominator** is part of the number rather than a footnote to it. The clinic series above is 100 men attending one clinic at one tertiary hospital, so what it describes is that clinic's attenders and no wider group. The boundary-crossing report is two cases. The comorbidity report is a single letter. Where a proportion for dhat is quoted in the Somatic-symptom, sexual, impulse-control disorders and suicide notes, it is a proportion of men attending clinics and not a rate in any population.

Say that plainly in a viva. A candidate who states that a figure describes clinic attenders rather than a population, and then declines to convert it into a prevalence, has shown exactly the judgement the question is testing.

100 men, one clinic	Two cases	One case letter	No population rate
THE INDIAN PHENOMENOLOGY SERIES THIS ACCOUNT RESTS ON, AND ITS WHOLE DENOMINATOR	THE INDIAN REPORTED EXPERIENCE OF ANTHROPOPHOBIA AT THE TIME OF THAT REPORT	THE EVIDENCE FOR CULTURE-NAMED PRESENTATIONS RIDING ON A COMORBID DISORDER	WHAT NONE OF THOSE DENOMINATORS CAN BE CONVERTED INTO

PITFALL

Do not print a prevalence for a culture-named presentation, in an answer or in a note. Nothing available here samples a population: the sources are clinic attenders, a pair of cases and a single letter, and a number from any of them describes the people who walked through one door. The error is attractive because a percentage looks like scholarship, and because the figure quoted is usually a real number lifted out of its denominator. Asked where it comes from, you will produce either the denominator or silence, and silence costs more than quoting nothing.

24.8 How the heading is asked, and what an essay needs from here

This heading is asked in three recurring forms, and they want different things. As a full essay it appears as a bare instruction to discuss the culture-bound syndromes, which a western-India state health-sciences university has set in that bare form in 2011, 2015 and 2017. As a shorter question it appears as an instruction to enumerate them and then describe dhat syndrome in detail, set that way by the same university in 2013 and 2018. And it appears as a short note on the heading alone, set in 2017.

The enumeration and the detailed account of dhat are the parts that come from elsewhere. The list of classic syndromes with their definitions is in the Psychotherapies, clinical assessment, MSE

and nosology notes, and dhat in full, including its figures, its classification and its management, is in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. Those two chapters will carry the first half of a short question by themselves.

What they will not carry is the essay, because an essay answered entirely from them is a glossary with an introduction and is marked as one. This section is the second half of that answer and the part that separates candidates: the doors these presentations come through in India, the information ecology behind the belief and the remedies already tried, the family as referrer and its own account, the negotiation and what is put in the record, the comorbid disorder that must be looked for a second time, the presentations that cross the boundaries they are named for, and the denominator discipline that stops an answer ending on an invented rate. Let the definitions occupy the essay's opening rather than its body, and spend the body here.

Expect two follow-ups. Asked what you would actually do with such a patient, do not answer with a classification: answer with the sequence, examination first, elicitation of what has been consulted and consumed second, explanation third. Asked what is contested, say that the boundaries the names imply do not hold, that those who report these cases recommend screening for comorbidity, and that the Indian evidence is too thin for any prevalence to be quoted from it.

> These presentations reach an Indian psychiatrist late and through non-psychiatric doors, with a belief learned from family, advertisements and traditional practitioners, a course of energising remedies already taken, and a family that referred him when he stopped working; the name is his word for the complaint and not a diagnosis, the treatable disorder underneath it must be looked for a second time, and every figure in this literature is a proportion of one clinic's attenders rather than a rate in any population.

25 · Cultural formulation and DSM-5 cultural formulation interview

Why an instrument taught in full elsewhere still has to be placed here. The heading cultural formulation and DSM-5 cultural formulation interview names two things, and candidates routinely merge them into one. The **Outline for Cultural Formulation** is the organising outline that tells an assessment what it must account for; the **Cultural Formulation Interview** is the instrument built to gather that material from the patient at the bedside. Their domains, the core question set and the additional modules that extend it for particular populations are set out in full in the Psychotherapies, clinical assessment, MSE and nosology notes, and no part of that account is repeated here.

What is owed here is the part no instrument manual supplies. A structured formulation is worth only what its placement in a real consultation is worth: who is actually asked, what survives when the clinic offers far less time than the full instrument assumes, and what has to reach the record for the exercise to have changed anything. That is also where the marks sit: a memorised roster of domains takes one sentence to deliver and demonstrates nothing.

Outline, then interview
THE TWO SEPARATE THINGS THIS HEADING NAMES

Taught in full elsewhere
WHERE THE DOMAINS AND THE QUESTION SET ARE SET OUT

Placement and use
WHAT THESE NOTES ADD IN THEIR PLACE

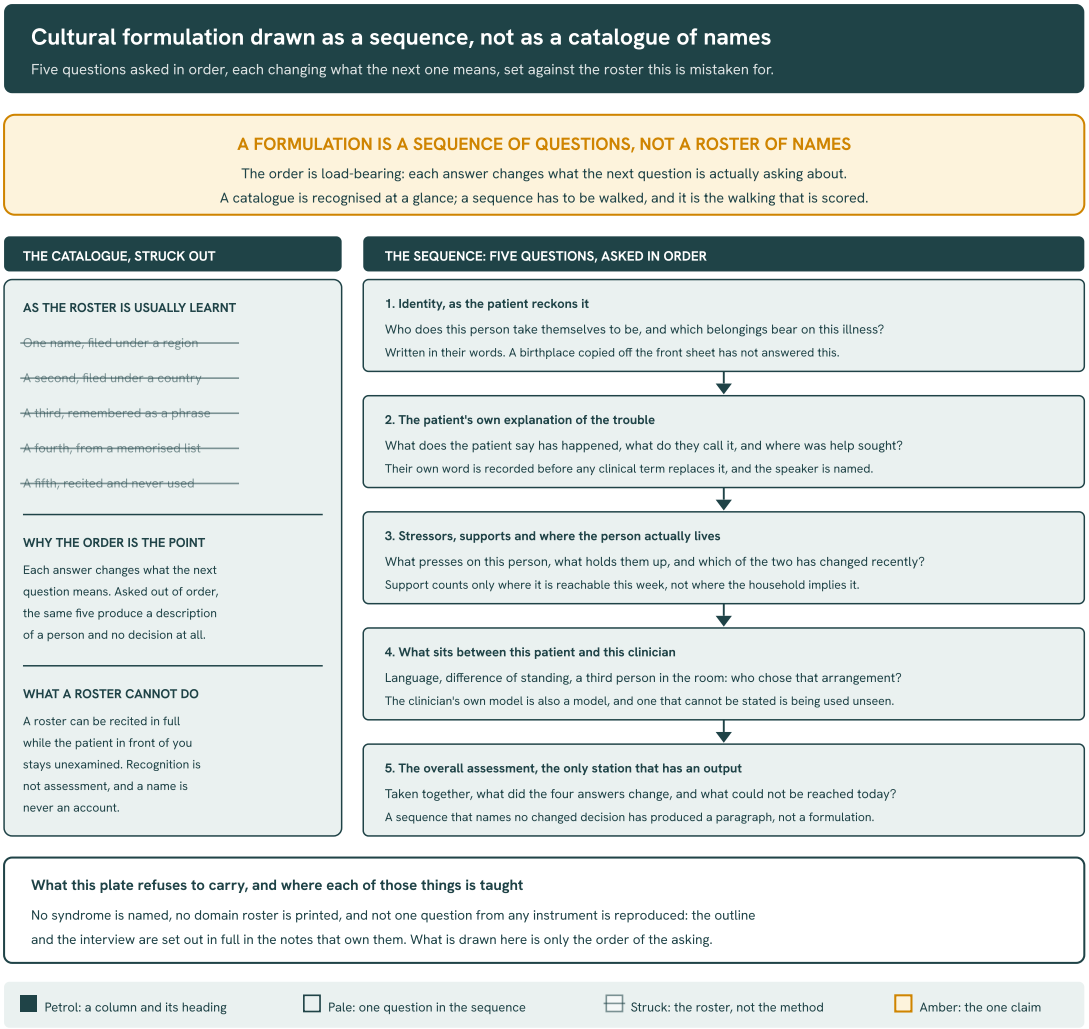


Fig 29.10. The cultural formulation drawn as five questions asked in a fixed order, from who the patient takes themselves to be, through their own account of what has happened, the pressures and the supports that are actually reachable, and what stands between this patient and this clinician, to an overall assessment that is the only station obliged to produce a changed decision, the whole set against a struck-out roster of names to show that a catalogue is recognised while a sequence has to be walked, with no syndrome named and no question from any instrument reproduced.

25.1 The outline, the interview, and the address of the full account

The outline and the interview are one construct in two forms, and the division between them decides where each belongs in a working assessment. The outline is the shape the written formulation takes, which puts it beside the **diagnostic formulation** rather than inside the history. The interview is the means of obtaining what the outline asks for, which puts it inside the assessment, before any formulation can be written. Everything that follows from that division is taught once and in one place; a compressed copy carried here would be the dangerous version,

not the convenient one. A half-remembered outline reliably produces the same failed assessment: the clinician asks the patient where they are from, records the answer, and files it as a cultural assessment.

25.2 Where the formulation belongs inside a working assessment

The placement is the whole of the difficulty. Two errors sit at opposite ends of it. The first treats the formulation as a supplement written after the plan is settled, so it is decorative and everybody knows it. The second treats it as a substitute for diagnosis, so a treatable disorder is admired as a cultural presentation and left untreated. The instrument is neutral between them; the clinician's placement of it is not.

RULE **The cultural formulation is appended to the diagnostic formulation, never substituted for it, and it must name the one thing in the plan that it changed.** Without a named consequence the exercise cannot be audited, by an examiner or by the clinician who inherits the patient. If the account genuinely changed nothing, write that too: a recorded negative tells the next reader the question was put, and a silence tells them nothing.

Whose account is being taken is the second decision, and it is settled before the first question, not during the interview. The patient's own account and the family's are frequently different, and the difference is often the clinical material. Where the interview passes through a relative, that relative is at once informant, interpreter and a stakeholder in the explanation, so the **collateral account** and the patient's cannot be recorded as one voice. Time forces the third decision. When the full instrument cannot be administered, the honest compromise is not to shorten every part equally but to take the questions whose answers could change what you do, and to record what was left undone.

POINT IN THE ENCOUNTER	WHAT THE CULTURAL ACCOUNT CHANGES THERE	WHAT THE NOTE MUST CARRY
Before the first question	Who will speak, in which language, and who chose that arrangement	Who interpreted, and their relationship to the patient
The complaint	Whether the patient's word for the trouble and the clinician's word mean the same thing	The complaint quoted, before it is translated into a symptom
The account of cause	What the patient and the family believe has happened, and where help was sought before this clinic	The **explanatory model** as given, and who in the room holds it
The plan	Whether an agreed plan can survive contact with the explanation the family already holds	What was negotiated, what was declined, and the review point

IN INDIA

The instrument assumes a patient who speaks for himself, in his own language, to a clinician who shares it. In a general hospital clinic here the family commonly speaks first and speaks most, the interview is often conducted in a second or third language for one or both parties, and a healer or a shrine has often been reached before the outpatient department was. None of that makes the formulation less usable; it makes the sourcing of each account the thing that must be written down, because a record that merges patient, relative and interpreter into one narrator cannot afterwards be untangled. A national protocol setting out how these instruments are to be used, translated and validated in Indian practice would settle several of these questions; no comparable standard is available to quote, and none is invented here.

25.3 What the examiner is actually scoring

As a short note it is a definition question with a practical tail, and the tail is where the discrimination shows. As a long case or a bedside station it is never asked in the abstract: a patient whose account of the illness is not biomedical is put in front of you, and the examiner watches whether the assessment bends around that account or ignores it. The answer that scores runs in a fixed order.

- Name both, and say which is the outline and which the interview.
- Place the formulation beside the diagnostic formulation, and say what it is for.
- Name whose account you obtained, and whose you did not.
- State what the account changed in the plan.
- Say what you could not complete, and when it will be finished.

GOOD TO REMEMBER

Record the parts of the formulation you did not reach, by name. A partial formulation that says so is usable by the next clinician; one that does not is indistinguishable from a completed one with negative findings, and the missing questions are then never asked at all.

TRAP **Reserving the formulation for the visibly different patient.** Candidates make this error because the instrument is introduced with unfamiliar examples, so it is filed as a tool for other people's patients. The consequence is that the majority-culture patient's account of cause is never examined, and the clinician's own model is treated as though it were not a model at all. Every patient arrives with an explanation; the only variable is whether the clinician noticed that it differed from his own.

Name the outline and the interview separately, obtain the account before the plan rather than after it, source it to the person who gave it, and write down the one decision it changed.

26 · Migration, ethnicity and mental health

Why this sits in a transcultural chapter and not in an aetiology one. Migrant status is one of the most reproducible social signals in psychiatric epidemiology, and one of the most abused. The

figures are quoted as though they described a mechanism, and attached to patients whose move bears no resemblance to the moves that generated them. The cultural concepts of distress themselves, and the cultural formulation built to elicit them, are taught in the Psychotherapies, clinical assessment, MSE and nosology notes; what belongs here is the frame around them, the epidemiology of the transcultural axis, migration and acculturation, which is to say who moves, why they move, what the population figures license, and what changes in the room when the person in front of you has had their social world reorganised by a move. Migration, ethnicity and mental health sit in one section and not three, because the literature that raises the question uses the three words almost interchangeably and the clinic has to take them apart again.

One seam runs through the whole topic and decides most of the marks: the epidemiology that makes migration famous is host-country epidemiology, and the Indian answer is not inside it. So this account teaches the reasoning and the frame, and it does not put a risk multiple on the page in either direction: no dependable figure for the risk of psychotic illness in migrants is available to quote, and none is invented here.

26.1 What the migration question is actually asking

Migration is not a state a person is in, it is a process a person has been through, and the psychiatric question separates into parts a history has to answer independently. Who left, and what were they like before they left. What the leaving and the journey consisted of, including whether it was chosen. And what the arrival is like now, which is usually where the illness sits. Collapsing them is the commonest error in a formulation, because each supports a different causal story and only the third is modifiable by anything a clinician does.

The word also covers movements with almost nothing in common. A doctor who takes a post in another country, a woman who moves into her husband's household in the next district at marriage, a seasonal labourer who spends most of the year on a construction site in another state, and a person who has fled and cannot return are all migrants. They differ in whether the move was chosen, whether it can be reversed, whether the family moved with them, whether language and food and worship changed, and whether they are legally secure where they now live. Any of those differences can plausibly matter more than the fact of movement, which is why "migration" on its own is a poor formulation term and a good screening question.

RULE **Migrant status is an epidemiological signal, not a mechanism and not an explanation.** A raised rate in a migrant group tells you where to look and nothing about what to look for. The clinical work is to name which of the many things bundled inside the word applies to this patient: a selection effect operating before departure, a loss sustained during the move, a social position occupied after arrival, or a diagnostic process happening in front of you. A formulation that stops at "migrant, therefore at risk" has taken an epidemiological label and used it as a substitute for the history.

26.2 What the international literature establishes, and what it does not

Migration has been treated in the international psychiatric literature as a risk factor for psychotic illness for decades, and the claim is made in two places at once: for people who moved, and for

people born in the host country to parents who moved. That is the shape of the finding, and no magnitude is attached to it here for either generation.

That is a more useful position than it looks, because it lets the frame be taught instead of the digits. Four things bound any such figure and none is optional: which diagnosis was counted, since an estimate for schizophrenia and one for all non-organic psychotic disorders are different quantities; which host countries the studies were done in; which generation it belongs to; and how wide the interval was, since an estimate resting on a handful of studies can be compatible with a risk barely above the population and with one many times it. A multiple recited without those four is a decoration.

The argument that changed the field concerns **second-generation migrants**. Those people did not migrate: their exposure is being the child of migrants rather than the act of moving. A purely selective account predicts that the signal belongs to the generation that left and fades in the children who never did. Raised risk is discussed in that second generation as well, which is why the field moved from arguing about who migrates to arguing about what happens after arrival. The reasoning is what an examiner listens for: a signal in people who never moved is not explained by selection at departure. What it cannot do is size that risk, and an answer that makes the second generation the higher one has gone past what can be shown.

One feature of the sampling frame belongs with the claim wherever you meet it. Those studies concern international migration into predominantly Western, high-income host countries, so what is counted is the crossing of an international border into a society in which the arriving group is a visible minority. That bounds what they are estimates of, and it is what decides the Indian question.

26.3 Ethnicity: what the second word is doing, and what it marks

The second word in the title does different work from the first, and candidates treat the two as synonyms. Migration is an event and it has a date. **Ethnicity** here is a position a person occupies in the society they are currently in, meaningful only relative to that society: the same person is majority in one place and minority in another. So when a host-country literature reports higher rates in some migrant or minority groups than in others, the comparison is not between kinds of people. It is between kinds of position.

Two disciplines follow. A subgroup contrast inside a pooled literature is the weakest thing that literature produces: groups were not randomised into their origins, studies differ in how cases were found, and the diagnostic habits of host-country services differ by the ethnicity of the patient in front of them, so a subgroup difference can be manufactured by the measuring instrument rather than found in the risk. No subgroup magnitudes appear here, for that reason and because none is available to quote. The second discipline is that the careless reading of any such gradient is racial where the careful reading is social: what it marks is the position of the arriving group in the receiving society, not a property of the people who arrived.

For Indian practice the useful move is to ask what the local analogue of that position is, because it is not usually skin colour. Caste, language group, tribal status, religion and the rural origin of an

urban worker all mark a family out in an Indian city, and any of them can place a household in the position host-country studies describe. No Indian figure of that kind is available to quote along those axes, and none is invented here, so they are asked about in a history rather than scored.

26.4 Treated incidence, and what a rate from a host country is a rate of

The modern replacement for that older literature is the multinational first-episode incidence study, in which psychosis is counted prospectively across catchment areas in several countries at once. Treated incidence varies markedly from one catchment area to another, and within those areas rates are reported as raised in racial or ethnic minority groups. Whether the variation between places is larger than the difference within them is not settled here: no dependable figures are available to quote, and none are invented here. What a large between-place variation does establish is a direction for thinking. Whatever raises the rate is partly something about places and about positions within them, so minority status reads better as a marker of occupying a bad position than as a cause in its own right.

Then there is the word treated. These are **treated incidence** rates, counted from people who reached services, so any difference in how easily a group reaches care sits inside the estimate alongside any difference in how often the disorder occurs. A group arriving late, by way of the police rather than a first-contact clinician, can generate a higher treated rate without a higher true incidence. Treated incidence cannot separate the two, which is why an answer that ignores the point is incomplete. And there is no Indian catchment area anywhere in this literature, so the ethnicity axis is grounded entirely in host-country settings.

AXIS OF COMPARISON	THE MIGRATION QUESTION	THE MINORITY QUESTION
What the estimate is of	Risk of psychotic illness in people who moved and in their children, against the population they settled among	Treated incidence of psychotic disorders, against the majority of the same catchment area
Exposure that defines the group	Having migrated, or being the child of migrants	Belonging to a racial or ethnic minority group where one lives
Where the evidence was gathered	Incidence studies of migration into predominantly Western, high-income host countries	Catchment areas in several countries, not one of them Indian
What it can support	That raised risk in the generation that never moved is not explained by selection at departure alone	That variation between places is large, so place and social position belong in any explanation
What it cannot support	Any statement about internal migration, and any magnitude this account can print	Any separation of true incidence from access to care, and anything at all about India

26.5 Arguing the mechanisms without overclaiming

How to structure the answer when asked why the rate is raised. Three families of explanation compete, and a good answer names all three, says what each predicts, and then says which

prediction the data have already tested.

- **Selection.** The people who migrate differ from those who stay, whether by illness already present, by early prodromal drift, or by traits associated with risk. This predicts that the signal belongs to the generation that left and fades in their children, and the second-generation discussion is the reason it cannot be the whole story.
- **Post-migration adversity.** Something about occupying a disadvantaged, visibly different position after arrival raises risk: chronic exclusion, insecure work and housing, and the accumulated experience of being treated as an outsider. This predicts a gradient by visible difference and disadvantage rather than by distance moved, and by place rather than by person, which is the direction the host-country literature points in.
- **The diagnostic encounter.** Some of the excess is made in the clinic, by unfamiliarity with how distress is expressed, by interpreting culturally normative belief or behaviour as psychotic, and by differences in the route through which a group reaches care. Treated incidence cannot exclude this, which is why an answer that ignores it is incomplete.

What the evidence cannot yet adjudicate is worth stating as plainly as what it can. Whether living among many others of the same background protects a person is a real question, and it is not answered here: no dependable estimate of it is available to quote, and none is invented here. An answer that names the question and leaves it open is stronger than one asserting a protective effect it cannot cite.

26.6 Cultural bereavement: naming what the move actually cost

The concept that links the move to the illness at the level of one person is **cultural bereavement**, a term worth having because nothing else in the psychiatric lexicon names what it names. The idea is grief for a way of life rather than for a person. What a move takes from someone is the ordinary machinery of a life: the norms that told them how to behave, the religious observance that organised the year, the people consulted when a household member fell ill, the language spoken around them, and the standing they held in a community that already knew them. It is not the bereavement that follows a death, which belongs with grief and end-of-life care rather than here.

Two disciplines matter when using it. The first is modal. That cultural bereavement is what converts a move into an illness is a hypothesis, it is written here as one, and it is not an established causal pathway; write it the same way in an answer and in a formulation, because no dependable account of the pathway is available to quote, and none is invented here. The second is that there is no uniform migrant effect to claim. Where raised rates are discussed they are discussed for some migrant groups rather than as a property of migration itself, and a candidate who flattens that into a single migrant risk has strengthened the claim past anything that can be shown.

Clinically the concept earns its place because it converts a demographic fact into questions. What did this person do on a given day of the week that they can no longer do. Who did they consult when a child was ill, and is that person reachable now. What did they eat, what did they hear

spoken around them, and at what point in the year did the household do something together. These are not pleasantries. They locate what has been lost with enough precision that it can be named in front of the patient, and often they explain the timing of a presentation better than any life event on a checklist.

GOOD TO REMEMBER

Two sentences change the quality of a migrant patient's record. Write which move you are talking about, dated, with who moved and who did not. And write what has not been replaced since: the person consulted first about illness, the place of worship, the language spoken at home, the work that matches the training. A note that says "migrant" and stops has recorded a category. A note that records the move and the unreplaced losses has recorded an exposure, and the next clinician can act on it.

26.7 Acculturation: two questions, four strategies, and the limits of the typology

What happens after arrival is usually taught through **acculturation**, and specifically through the two-dimensional model associated with Berry. It rests on two independent questions rather than one continuum running from foreign to assimilated. The first asks whether the person places value on holding on to their own culture and identity. The second asks whether they place value on relationships with the wider society they now live in. Because the two answers are independent, they generate four positions rather than a scale, and the four are positions a person can occupy rather than stages a person passes through.

VALUES MAINTAINING OWN CULTURE	VALUES RELATIONSHIPS WITH THE LARGER SOCIETY	STRATEGY	WHAT IT LOOKS LIKE IN THE ROOM
Yes	Yes	Integration, or biculturalism	The host culture is adopted while the culture of origin is maintained; the patient moves between two settings without treating either as a betrayal of the other
No	Yes	Assimilation	The host culture is adopted in place of the culture of origin; distress often surfaces around the family left behind, or around a child being raised differently
Yes	No	Separation	The host culture is rejected in favour of the culture of origin; the practical cost is usually access, to services and to work, rather than identity
No	No	Marginalisation	Both are rejected; the person belongs to neither reference group, which is the position that most often warrants a closer look in an assessment

MNEMONIC

Keep mine? Join theirs?

Two questions, answered yes or no, give the four positions and their names. Yes and yes is integration. No and yes is assimilation. Yes and no is separation. No and no is marginalisation. Answer the two questions in that order and the names follow, which is safer than carrying them as a list.

Now the qualifications, which are as examinable as the model. The same person can use different strategies in private and in public life, so a man who is entirely separated at home and functionally assimilated at work has not contradicted himself and is not a diagnostic puzzle. A model borrowed from cross-cultural psychology also carries its own frame: it was built around individuals moving between two identifiable cultures, which is a poor description of a household in which three generations are moving at different rates and in different directions, and a poorer

one still of a woman who has moved between two districts of the same state and two versions of the same religion.

TRAP **Presenting the four strategies as a validated typology, or as a single scale.** The two questions are independent, so what they generate is a two-by-two and not a continuum running from foreign to assimilated, and a candidate who recites the four as an ordered list loses the discrimination between separation and marginalisation. The heavier error is predictive: the scheme has been criticised for having very little predictive validity, because people do not always fall neatly into those categories. Use it to say precisely where a person stands, never as an instrument that tells you what will happen to them.

26.8 Migration in India: the scale, the reasons, and the outcome evidence that does not exist

India is not a footnote on this topic, it is a different topic. The **migration rate** at the all-India level from the Periodic Labour Force Survey of 2020 to 2021 was **28.9 per cent**, and the reasons split sharply by sex. Marriage accounted for about **86.8 per cent** of all female migrants. Migration in search of employment or better employment was the largest single reason among male migrants, at **22.8 per cent**. Read those last two carefully, because their denominator is migrants and not the population: they say what the people who moved moved for, not what proportion of women or of men has moved.

28.9%	86.8%	22.8%
ALL-INDIA MIGRATION RATE FROM THE NATIONAL LABOUR-FORCE SURVEY OF 2020 TO 2021	SHARE OF ALL FEMALE MIGRANTS WHOSE REASON FOR MOVING WAS MARRIAGE	SHARE OF MALE MIGRANTS MOVING FOR EMPLOYMENT OR BETTER EMPLOYMENT

Sit with what that does to the picture. Migration in India is predominantly the marriage migration of women, and the **labour migration** that the word "migrant" summons in a Western clinic is not the dominant pattern here and is mostly a male one. So the commonest migrant in an Indian outpatient clinic is a young woman who has moved at marriage into a household not her own, frequently into a different language area, having left the people she would previously have consulted when unwell, and with no legal or administrative marker of having migrated at all. Nobody labels her a migrant. Every element of cultural bereavement is nonetheless available to be asked about, and the reason for her move is precisely the relationship inside which her distress is now occurring.

Then the hard part, which is what the epidemiology does not give us. All of the incidence evidence discussed above concerns international migration into high-income host countries. What is established for India is the scale of internal movement, with no comparable Indian outcome estimate to quote, and none is invented here. No national picture of internal migrants, of rural-to-urban migrants or of interstate labour migrants is available to cite, in incidence, prevalence or morbidity, so this topic carries Indian scale without Indian outcome. The honest examination answer states that gap rather than filling it, and notes that what is missing concerns the commonest kind of movement in the country.

PITFALL

Do not carry a host-country risk figure across to an Indian internal migrant. Every risk estimate in this literature comes from host-country studies where the exposure was crossing an international border, being the child of someone who did, or being counted as a racial or ethnic minority there. An interstate labour migrant from Bihar working in Karnataka, or a woman who moved two districts at marriage, is not that exposure, and no Indian study licenses the transfer. Quoting a remembered ratio and then applying it to the patient in front of you is the single most likely way to be wrong in this topic, and it is wrong in the direction of pathologising ordinary Indian mobility.

IN INDIA

There is no Indian guideline cover for this topic. The Indian Psychiatric Society clinical practice guidelines of 2025 for schizophrenia, depression, bipolar disorder and obsessive-compulsive disorder carry no recommendation on migration or acculturation, so no transcultural position can be attributed to them and every India-specific figure in this topic comes from official statistics rather than from clinical guidance. Nor is there a dedicated national migration survey: the rate above comes from a labour-force survey, and the Ministry of Statistics and Programme Implementation has proposed a Survey on Migration for July 2026 to June 2027. The consequence for practice is direct. If the guideline does not prompt the question and the record does not code the move, the migration history exists only if the clinician takes it.

26.9 What the examiner is testing, and the answer that survives a follow-up

Questions on this topic are marked on whether the candidate can hold a reproducible finding and a weak inference in the same hand. Three moves earn most of the marks, in this order.

- **Give the finding with its frame, and let the frame do the work.** Raised rates of psychotic illness are reported in migrants and in the children of migrants, from population-based incidence studies of migration into mostly Western, high-income host countries. If you quote a multiple you have met elsewhere, be ready to bound it on the four axes set out earlier; if you cannot, give the direction and decline the magnitude.
- **Use the second generation as an argument, not a decoration.** Say what it excludes and why it excludes it, because the examiner is listening for the inference rather than for a number.
- **Move from person to place.** Incidence varies markedly between catchment areas, so ethnicity is best read as a marker of social position in a particular place rather than as a property of a group, and treated incidence keeps access to care inside every one of these estimates.

Then land the Indian answer, because that is where most candidates stop and repeat the Western figure. Give the national migration rate, give the split by sex between marriage and employment as reasons, and say that no Indian outcome estimate exists onto which the risk figures could be transferred. An examiner who hears the gap named accurately learns more about the candidate's reasoning than any recalled ratio can show.

Two further follow-ups are common enough to prepare. Asked for a mechanism, give cultural bereavement, name the losses, and keep the modal verb hypothesised. Asked what you would do

differently, do not answer with a scale. Answer with the history: which move, who moved, what has not been replaced, and where this person now sits on the two acculturation questions. That answer is clinical, it is defensible, and it does not require a number that has not been measured in this country.

Migrant status is an epidemiological signal and not a mechanism: raised rates are reported in migrants and in their host-country-born children, so selection at departure cannot be a sufficient explanation; the mechanism is offered as the hypothesis of cultural bereavement, the aftermath is described by two acculturation questions with four positions, and in India the scale of internal migration is known while its mental-health outcomes are not.

27 · Idioms of distress and explanatory models of illness

Why two definitions taught elsewhere still have to be placed inside the encounter. The heading idioms of distress and explanatory models of illness names two constructs that stand side by side and are routinely collapsed into one. An **idiom of distress** is the vocabulary a patient and those around him use for suffering, a way of saying. An **explanatory model** is his own theory of what has gone wrong and why, a claimed cause, and it is the construct Kleinman attached to that third kind of cultural concept. Eliciting it is not a courtesy at the end of the history; it is the engine of the cultural assessment. Both constructs, the family of cultural concepts they belong to, and the questions that draw the model out are set out in full in the Psychotherapies, clinical assessment, MSE and nosology notes, and none of that is reproduced here.

What is owed in a chapter about the consultation is what a definition cannot carry. An idiom governs how you listen and how you record. A model governs what the patient will accept, what he does next, and when he decides he is well. Different levers, and marks are lost by pulling one and calling it the other.

A way of saying	A claimed cause	Defined in full elsewhere
WHAT AN IDIOM OF DISTRESS IS	WHAT AN EXPLANATORY MODEL IS	WHERE THE DEFINITIONS AND ELICITING QUESTIONS SIT

27.1 The division, and where the definitions sit

The two travel differently, which is why they must be kept apart. An idiom is usually shared: a language community may use one bodily phrase for everything from ordinary demoralisation to psychosis, so hearing it tells you little about severity and a good deal about how the complaint will be worded. A model is particular. Two patients using the same phrase may hold different accounts of its cause, and the household may hold a third. Collapse the two and you get the classic incomplete assessment: the clinician has learned the family's word for the trouble, assumed he therefore knows what they believe caused it, and never asked.

27.2 The idiom in the room: two wrong translations

An idiom fails clinically in two opposite ways, both examined. In **over-translation** the clinician hears a bodily or metaphorical phrase, converts it at once into the nearest symptom term, and

records only the conversion. Lost are the severity gradient the phrase carried and any later ability to check the translation; where the idiom is somatic, the same reflex converts a way of speaking into a somatic disorder. In **under-translation** the phrase is recognised as culturally shaped, the presentation is filed as a cultural matter rather than a clinical one, and a treatable disorder is admired instead of treated. Opposite mechanics, identical result: the assessment stops at the vocabulary.

RULE **An idiom is a form of words, so its presence neither establishes a disorder nor excludes one.** Record the complaint verbatim in the patient's own phrase before you translate it, keep both lines in the note, and decide the diagnosis on phenomenology as for any patient. Translate without leaving the original and you destroy the only thing that would let the next clinician find your error.

27.3 What the explanatory model predicts

The payoff is prediction, not description. Each part of a model forecasts a behaviour you will otherwise meet as an unexplained non-attendance. Ask for the parts separately: patients rarely volunteer them as a set.

WHAT THE MODEL ANSWERS	WHAT IT FORECASTS	WHAT THE CLINICIAN DOES WITH IT
What the trouble is, and its name	Which complaints get reported and which are thought irrelevant	Ask directly for what is not being mentioned
Why it began, and why now	Whether treatment must address a cause or a consequence	Say openly which of the two the plan offers
What it does to the body or the life	The course and severity expected, often not yours	Set the trajectory before the first prescription
Who can treat it, and who was consulted already	Whether treatment runs alongside another form of help	Ask what else is being done, without requiring it to stop
What counts as cured, and when treatment may stop	The point of unilateral discontinuation	Negotiate review against the patient's stopping rule

GOOD TO REMEMBER

Ask what the patient believes is wrong and what he believes will help before you offer the plan, never after. Asked afterwards it reads as an audit of a decision already taken and earns a polite answer. Asked before, it tells you which part of the plan will be quietly dropped, while there is still time to negotiate it.

What must reach the record, and rarely does:

- the untranslated complaint, quoted;
- the account of cause, and who in the room holds it;
- help sought earlier, and whether it continues;
- his own criterion for being well again;

- the single point where his account and yours disagree.

IN INDIA

Three features of ordinary practice make this heading unusually practical. The model is commonly held by the family rather than the patient alone, so the account you elicit may not be the one deciding whether tablets are given at home. The route to an outpatient department has usually passed through other forms of help, so the useful question is what runs alongside your treatment, not what was given up for it. And the idiom is generally spoken in a language the record is not written in, with a relative translating, so the phrase is lost at the first hop unless somebody preserves it. A measured national figure for how often help is sought elsewhere first would sharpen all three; no comparable standard is available to quote, and none is invented here.

27.4 How the heading is asked

As a short note it is a discrimination question: define both, keep them apart, attribute the model correctly, and close with what eliciting it changes. As a long case or a bedside station it is never asked as a definition. A patient whose account of his illness is not biomedical is put in front of you, and the examiner watches whether you obtained that account before proposing a plan, whether you can state it back in his own words, and whether you can name the one place the two accounts diverge. Revise only the definitions and you can name the constructs and say nothing about the divergence, which is the whole question.

TRAP **Eliciting the model and then correcting it.** The sequence feels like thoroughness and is its opposite: having asked for the belief, the clinician explains why it is mistaken, and it goes underground rather than changing. It survives, stops being reported, and now acts on adherence invisibly. The aim is a plan that can coexist with the account already in the room, not a conversion.

An idiom of distress is how the trouble is said and an explanatory model is what the patient holds to have caused it; their definitions belong to the Psychotherapies, clinical assessment, MSE and nosology notes, and what these notes add is that the model forecasts help-seeking, adherence and when the patient decides he is cured.

28 · Religion, spirituality, faith healing and mental health in India

Why the route a patient took before reaching you is a clinical fact and never a verdict on them. Of every heading in this chapter, religion, spirituality, faith healing and mental health in India is the one where the Indian answer is not a local variation of a Western one but the whole of the subject. A great deal of psychiatric help-seeking in this country begins at a religious site, and not at one kind of site: the single sustained piece of Indian research in this area opens by observing that people troubled by emotional distress or by more serious mental illness go to Hindu, Muslim, Christian and other religious centres, and that the healing power identified with these institutions may reside in the site itself rather than in the religious leader or in any medicines provided at the site. Keep that modal verb where the authors put it. It is a proposition

they advance about where a tradition locates its own power, not a finding they went on to establish.

Two failures of register are available here and both are penalised. The first is dismissal, in which the healing pathway is recorded as ignorance or delay, and the family, having heard the tone, stops mentioning it. The second is romanticisation, in which a practice is admired rather than assessed and a treatable psychotic illness is left untreated somewhere that has no doctor. What makes the topic examinable is that the evidence bearing on it is mixed, thin and almost entirely Indian, and that the boundary between a **sanctioned religious practice** and a disorder has to be drawn somewhere. It is drawn here, in the patient's words and the family's account, and not in a list of features.

28.1 Religion in the history: four different things wearing one word

Religion enters a psychiatric history in at least four ways that behave differently, and a candidate who runs them together will give one answer where four were wanted. It can be a source of structure and support, a daily and weekly scaffolding that survives when everything else has stopped. It can be the vocabulary in which suffering is spoken, the words a family reaches for before any clinical term is available to them. It can be the explanation held for the illness, the account of what has gone wrong and why. And it can be the pathway, the sequence of places help was actually sought, of which your outpatient department is usually not the first.

Only the last two change a management plan, and only the last two are commonly missing from the record. The explanatory model as a construct, and the structured way of eliciting it, belong to the cultural assessment set out in the Psychotherapies, clinical assessment, MSE and nosology notes, and none of that is reproduced here.

- Where has help been sought already, in what order, and who in the family chose each place.
- What is still going on alongside this consultation, because the commonest situation is concurrent rather than sequential use.
- What the family understood from what was done there, since that account, and not yours, is the one operating at home.
- Whether anything is currently being restricted: food, fluids, movement, sleep, or medication already prescribed.
- What would count as being well, in their terms, because that is the point at which treatment will be stopped without telling you.

GOOD TO REMEMBER

Ask these before you offer a plan, not after it. Asked afterwards, the pathway question reads as an audit of a decision already taken and earns a courteous denial. Two lines in the record change what the next clinician can do: the sequence of places help was sought, dated, and what is still running alongside. A note that records only that the patient "went to a temple first" has recorded a stereotype. A note that records who took him, what was done, what is continuing and what is being restricted has recorded an exposure and a risk.

28.2 The boundary between a sanctioned practice and a disorder

This is the discrimination the rest of the syllabus hands to this chapter, and it is easier to state than to perform. The question is never whether the belief is true, and it is never whether the practice is rational. Those are not clinical questions and no examiner is asking them. The question is whether what you are being shown is a form the person's own community recognises and sanctions, occurring in its proper setting, or whether something has broken out of that frame.

The method follows from that. You do not settle it against a textbook description, which was written from published cases and not from this community. You settle it by asking the people who would know. Does the family recognise what they are seeing as the thing their tradition does, or as something that frightened them because it was not that. Does it begin and end with the occasion, or has it stopped ending. Is the person able to do what they were doing before, outside the setting, or has role function fallen away. And, most simply, is the person themselves distressed by it, and unable to stop it when they wish to. Those four questions are asked of the family and of the patient in their own words, and their answers are recorded in those words before any translation into clinical terminology.

RULE **Whether a practice is sanctioned is a question for the patient's community; whether this person is ill is a question for you; and the two are answered separately.** The error in both directions is to let one answer settle the other. A sanctioned practice does not exclude a disorder in the person performing it, and an unfamiliar practice does not establish one. Take the community's answer on the first question as authoritative, because on that question it is, then do the diagnostic work on phenomenology exactly as you would for any other patient.

PITFALL

The compression failure. A religious practice summarised into a list of features has, in the act of summarising, been converted into a symptom cluster, and the reader who learns it that way will recognise the practice and diagnose it. The same reflex reaches backwards: it is a short step from an ethnographic account of a revered figure to naming a disorder in that figure, and it is a step with no clinical purpose and a real cost to the relationship with the family sitting in front of you. Describe the practice in the community's terms, quote the patient, and keep the diagnostic reasoning in the phenomenology where it belongs.

28.3 The one measured Indian study: the site, and what the temple actually does

Almost everything quoted about faith healing in Indian psychiatry traces to a single report published in the BMJ in 2002 by Raguram, Venkateswaran, Ramakrishna and Weiss. It is worth reading at origin rather than recalling, because what it says is more interesting and more careful than what it is usually made to say. The setting was a Hindu **healing temple** in South India: the temple of Muthusamy in the village of Velayuthampalayampudur, Dindugal District, Tamil Nadu, in the foothills of the Palani range of the Western Ghats, built more than 60 years before the study, on the outskirts of the village in the middle of a graveyard, over the tomb of Muthuswamy. One site.

The tradition's account of its own origin is that towards the end of his life a mere touch of Muthuswamy's hand was noticed to cure many ailments, especially mental illnesses, and stories spread about his healing powers; the temple was built over his tomb after his death. That is recorded as ethnography, as the community's memory of a revered figure, and it carries no diagnostic content of any kind.

What the temple does is unusually well described, and two of its features matter clinically. People may stay without charge, and a close relative stays with them and takes care of their daily needs: the family is not relieved of the person, it moves in with them. And the paper records something in both directions at once, which is the reason it can be trusted on this point. Physical restraints for agitated people are used at many other healing temples, and are not used at this one. Neither half may be quoted alone. Taken together they say that a healing site is a particular institution with particular practices, not a category with uniform standards, and that where a patient stayed is a question with an answer.

28.4 Who was studied, and what they had already tried

Read the denominator before the result, because it governs everything the study can be used for. Thirty-one people sought help and stayed at the temple over the course of the study. Twenty-three were diagnosed with paranoid schizophrenia, six with delusional disorders and two with bipolar disorder with a current manic episode. Twenty-one were male farm labourers from rural areas, and all were Hindu. There is no non-psychotic presentation in the group at all, so this work says nothing about common mental disorders, distress states or possession presentations at religious sites.

The exposure history is the second half of the picture. The average duration of illness was 71 weeks, the mean duration of stay in the temple six weeks with a range of 1 to 24 weeks, and only one of the group had ever received any prior medical care, that being from a general practitioner rather than a psychiatrist. This is therefore a largely **treatment-naive** group with illnesses of well over a year's standing, observed across a stay of a few weeks. That is what makes the group informative and it is also precisely what limits it, because natural course and regression towards the mean are left entirely uncontrolled.

31	29	6 weeks	1
PEOPLE STUDIED AT THE HEALING TEMPLE, THE DENOMINATOR FOR EVERY RESULT THE STUDY REPORTS	OF THAT GROUP CARRYING A NON-AFFECTIVE PSYCHOTIC DIAGNOSIS, PARANOID SCHIZOPHRENIA OR DELUSIONAL DISORDER	MEAN DURATION OF STAY IN THE TEMPLE ACROSS THE WHOLE GROUP STUDIED	NUMBER IN THAT GROUP WHO HAD EVER RECEIVED ANY PRIOR MEDICAL CARE, AND THAT FROM A GENERAL PRACTITIONER

28.5 What changed, and the spread that cannot be taught

The same rater assessed everyone on arrival and again at departure using the **brief psychiatric rating scale**. The mean total fell from **52.9** on arrival to **42.9** at departure, $P < 0.001$, a relative reduction of **18.9 per cent**, which the paper itself describes as nearly 20 per cent. Two standard deviations are printed in the same sentence, and they cannot be reconciled with the paper's own subscale table, so the dispersion of the total score is not established and no figure for it is asserted

here. That is not a quibble: a pre-post mean difference whose spread is unknown cannot be turned into an effect size, and much of what this study is used to argue depends on one nobody can compute from it.

SUBSCALE	ON ARRIVAL, MEAN (SD)	AT DEPARTURE, MEAN (SD)	T	P
Thinking disturbance	12.45 (3.21)	9.81 (4.42)	3.701	0.001
Hostile suspiciousness	12.26 (4.30)	9.39 (4.90)	4.631	< 0.001
Withdrawal retardation	8.32 (5.31)	7.16 (5.03)	3.574	0.001
Anxious depression	7.32 (5.09)	6.58 (4.74)	2.101	0.044

Values are as the paper prints them. All four factors fell, which is the honest headline, and the internal pattern repays a second look. The largest absolute movement is in thinking disturbance, from 12.45 to 9.81, and the strongest test is hostile suspiciousness at t 4.631. The one nobody should lean on is anxious depression, at P 0.044, which would not survive any correction for four comparisons. Note also, so that you do not file it as an error, that the four factor subscales do not cover all 18 items of the scale, which is why the subscale means do not add up to the printed totals.

There is a second outcome, and it needs its denominator kept in view. According to the evaluation by family caregivers, 22 of the group had improved and three had recovered fully, which accounts for 25 of the 31. The rating offered four options: recovered, improved, no change and worsened. Two categories existed for people who did not do well, neither is ever reported, and the remaining six are not accounted for in the printed result. This rating is also unblinded and made by the same relatives who brought the person and lived with them throughout, so it is not independent of the scale change and is not a second confirmation of it.

28.6 The exposure under study, and where the authors locate the healing

Here the paper becomes genuinely surprising, and this is the part most often lost when it is quoted. The people studied received no psychopharmacological or other somatic intervention during their stay in the temple. And no specific ceremonies were performed to promote anyone's recovery: residents merely attended the simple morning prayers, the puja, at the shrine for about **15 minutes**, and spent the rest of the time in light maintenance routines of the temple. So the exposure under study was not a healing rite and was not a drug. It was residence in a valued place, with a relative present, a short daily prayer, and something useful to do.

That is also, remarkably, what the tradition itself says. The community's own account, in the technical sense of an internal view of illness held by patients and by the local population as against the external view of doctors and epidemiologists, is that it is the experience of residing in the temple for a period of time, rather than therapy provided by a healer, that brings relief from

mental illnesses. The tradition and the researchers point at the same thing from opposite directions, and neither points at a procedure performed on a person.

MNEMONIC

Residence, Relative, Routine; no Rite, no Restraint

The five features of the exposure that was actually measured, and the reason a candidate should never describe this study as an evaluation of a healing ritual. Residence over a period of weeks; a close relative living alongside; light daily routines of the temple; no ceremony performed for anyone's recovery; and no physical restraint at this particular site, though the paper is explicit that restraint is used at many others.

The authors' own conclusion is hedged, and the hedges are the most examinable words in the paper. Their summary is that the research shows that a brief stay at one healing temple in South India improved objective measures of clinical psychopathology; that, in the absence of any specific healing rituals, the observed benefits appeared to result from a **supportive non-threatening environment**; and that this may indicate the value of a **culturally valued refuge** for people with severe mental illness. Not shows that a supportive environment causes recovery. Not demonstrates the value of refuge. An answer that strengthens those verbs has misreported the source, and an examiner who knows the paper will hear it.

28.7 The comparability claim, and the authors' own bar on their findings

The sentence that made this paper famous is the authors' interpretation, not their finding: that the observed reduction of nearly 20 per cent represents a level of clinical improvement matching that achieved by many psychotropic agents, including the newer atypical agents. Two things must be said whenever it is used. It is attributed to the authors, and its entire support is a single citation, Umbricht and Kane's 1995 review of the efficacy and safety of risperidone, Schizophrenia Bulletin 1995;21:593 to 606: one atypical agent, reviewed seven years earlier, in a different population under a different design. There was no drug arm in the temple study, so what is being compared is a milieu against a medicine, across two literatures, and not one against the other in the same patients.

TRAP **Quoting the twenty per cent as evidence that temple healing works as well as antipsychotic medication.** Candidates do this in good faith, because that is how the study circulates. Three facts dismantle it in one sentence each: the design is an **uncontrolled pre-post comparison** at a single site with the same rater at both time points; the group was largely treatment-naive with illness of over a year's standing, so natural course and regression to the mean are untested alternatives; and the comparison with medication is the authors' interpretation resting on one review of one drug. Say instead that a real and statistically significant pre-post change was observed under a design that cannot attribute it, which is also what the authors say.

Because they do say it. Theirs is the first study to use a standard clinical assessment to evaluate the effectiveness of temple healing, and their own verdict on their findings is that they are only suggestive owing to the limitations of their methods: there were no comparison groups, and although they endeavoured to keep the second assessment by the same rater independent of the

first, standards fell clearly short of rigorous double blind research methods. A candidate who reports the finding and the authors' own caveat in the same breath is doing better history of the paper than most published citations of it.

Two further disciplines belong here. The first is the authors' bar on generalising: because temples operate in different ways, they hold that it would be inappropriate to generalise findings from the study of one site to other regions or to other healing temples in the same region. The study is therefore expressly not about temple healing as a class, which is the one thing it is habitually used to talk about. Their further argument, that comparison groups and randomisation would be difficult to incorporate and would add little to the generalisability of findings, deserves careful reading rather than agreement or dismissal. It is an argument about external validity, reasonable on its own terms, and it does not answer the internal validity problem that a comparison group would have addressed and that they concede separately. The second discipline is arithmetical vigilance: the paper's Discussion refers to a stay of five weeks and to a mean duration of illness of one year, neither of which matches its own Findings, and the paper never reconciles them. Teach the Findings values.

28.8 Acceptability rather than access, and what a service does about it

The most consequential sentence in the whole report is one that gets quoted least. Set against those illness durations, only one of the people studied had ever consulted a doctor in the government primary health centre, which is located in the same village as the temple. The biomedical alternative was not distant. It was adjacent, and it was unused.

That single fact moves the question from access to **acceptability**, and the distinction is the examinable one. An access problem is solved by putting a service somewhere. An acceptability problem is not, because the service is already there and is not what people found usable, intelligible or trustworthy for this kind of trouble. Nothing in that observation implies error on anyone's part: a family choosing a place where a relative may stay free of charge, where they may stay alongside, and where the trouble is described in words they already use has made a defensible choice about a real problem. The service-development question that follows is what a primary health centre would have to change to become a place that family would use, and it is a question about explanation, continuity, cost and welcome rather than about siting.

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Three practical consequences follow for Indian practice. First, ask the pathway question of every patient and record the answer, because there is no register, no coding field and no guideline prompt that will do it for you. Second, treat concurrent religious help as the normal case rather than as non-compliance: a plan that requires the family to abandon the shrine before treatment begins is usually the plan that gets abandoned. Third, the safety line is not the belief and not the site, it is what is being done to the person. Restriction of food, prolonged restraint, restriction of prescribed medication or confinement is a safeguarding matter wherever it occurs, and where the pathway has passed through such a setting the clinician asks about it directly. How commonly Indians seek religious healing first, how long it delays psychiatric contact, and how common custodial practice is at religious healing institutions are all questions a service planner needs answered; no comparable standard is available to quote, and none is invented here.

28.9 Working alongside the pathway, and how the topic is asked

How to answer when this comes up, in a long note or across a viva table. The examiner is testing whether you can hold reverence and rigour in the same hand, and the answer that fails is the one that picks a side. Open with the position rather than the study: religious help-seeking is a fact about the route to care and a legitimate question in every history, never in itself a finding about pathology. State the boundary and how you draw it, in the community's terms. Then give the evidence, and give it accurately, which means naming it as one uncontrolled study at one site, giving the direction and the significance of the change, giving the authors' own hedged attribution to a supportive environment and their own refusal to generalise from it, and saying that no comparable measured evaluation exists for a shrine of any other faith.

Clinically, the working posture is collaboration without endorsement and without confrontation. You do not have to agree with an explanation to work alongside it, and you do not have to displace it to treat. What you must do is make your part of the plan compatible with the rest of the person's life: name what your treatment addresses and what it does not, agree what would count as improvement and by when, and keep the door open so that when a family returns from a shrine they return to you rather than to nobody. Where the religious setting is providing what the study describes, a place to stay, a family alongside, and something useful to do, the honest clinical judgement is that these are not the enemies of treatment; the enemy of treatment is untreated psychosis, and the two can occupy the same weeks.

Finally, be exact about what is not known, because on this heading the gaps are large and stating them is not weakness. There is no measured Indian evaluation of a dargah, a church or any non-Hindu healing site with a standard clinical instrument. There is no outcome evidence at all for the non-psychotic presentations that make up most of a real clinic. There is no Indian guideline position on collaboration with religious healers to attribute to anyone. And there is no quantified national picture of how often, or for how long, the religious pathway is travelled before psychiatric contact. A candidate who names those gaps precisely has shown the examiner something no recalled percentage can show.

Religious help-seeking is a fact about the pathway to care and never in itself a finding about pathology: the only measured Indian evaluation is an uncontrolled single-site study of a South Indian healing temple in which the mean brief psychiatric rating scale total fell from 52.9 to 42.9 in 31 largely treatment-naive people who received no drug and attended no healing ceremony, whose authors attribute the change, hedged, to a supportive non-threatening environment and expressly forbid generalising it to other temples.

Cancer, dying and grief

29 · Psychological reactions to cancer diagnosis and treatment

Why the marks are here. A candidate is asked about the psychological reaction to cancer because it is the commonest situation in which a psychiatrist is called to see a patient who is not, in the ordinary sense, mentally ill. The referral says distress. The task is to decide whether what you are looking at is a person adjusting to catastrophic news or a disorder that has grown out of it, and then to do something about the conversation in which the news was delivered, or was not delivered at all. In an Indian oncology ward the second half of that task usually arrives first, because the person who knows the diagnosis is often not the person who has it.

Psycho-oncology is the mental health of the patient with cancer and of the family around them: adjustment reactions, depression and demoralisation, anxiety about procedures and about prognosis, delirium in advanced disease, and the communication and palliative-care skills that carry all of it. What this topic owns is the psychological reactions to cancer diagnosis and treatment, and the conversation in which those reactions begin. The recognition and treatment of depression, anxiety and delirium in a patient with advanced disease, grief and end-of-life care, and demoralisation and the wish for death are each taught in companion topics of this chapter, and the adjustment disorders as a diagnostic category belong to the Anxiety, OCD and trauma-related disorders notes.

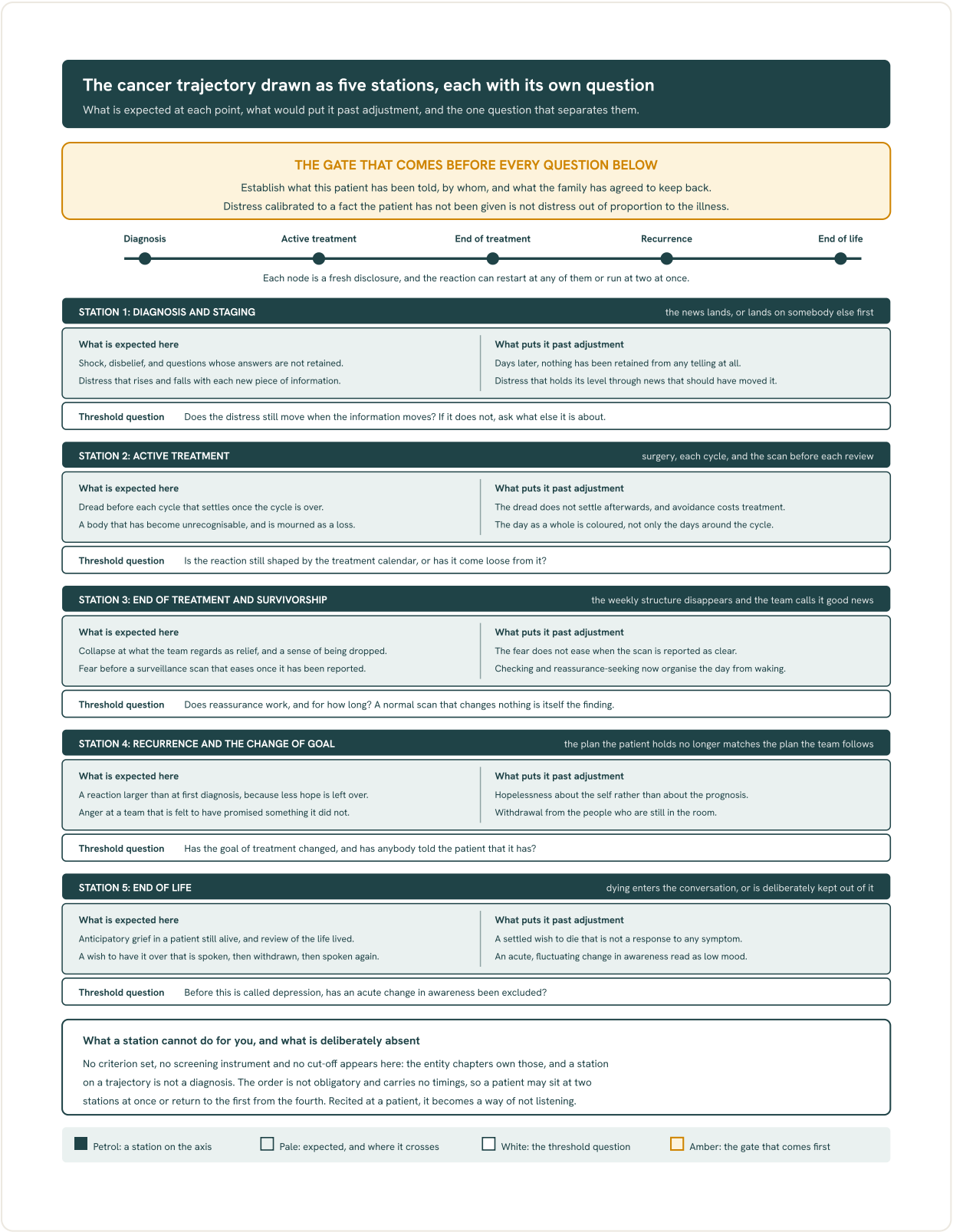


Fig 29.11. The reaction to cancer drawn along one axis as five stations, from diagnosis and staging through active treatment, the end of treatment and survivorship, recurrence and the change of goal, to the end of life, with each station carrying what is expected there set against what would put the reaction past adjustment, and one threshold question stated for each rather than a list of diagnoses, the whole gated by the prior question of what this patient has been permitted to know, and with criteria, instruments and cut-offs named as absent because they belong to the chapters that own the entities.

29.1 The reaction as a trajectory, and what a trajectory is not

The reaction to hearing that one has cancer is conventionally described as a sequence: shock and disbelief, then anger, depression, loss and grief. The description is clinically useful and worth

being able to reproduce, but be careful what you claim for it. It is a textbook account of what is commonly seen rather than a staged model with evidence behind it, so it carries no timings, no obligatory order, and no implication that a patient who has arrived at anger has finished with disbelief. Patients move back and forth across it and many never look angry at all. Recited as a schedule it becomes a way of not listening, because the clinician then checks the patient against the stage instead of asking what the patient has actually understood.

What the sequence is genuinely good for is vocabulary. It tells you that the affect in front of you at the second visit is not necessarily the affect that will be there at the fourth, that anger directed at the treating team is usually part of the reaction rather than a complaint about the team, and that loss and grief begin long before anyone dies. The anticipatory grief of a patient still under active treatment, and the grief of the family afterwards, are taught with the grief and end-of-life material in this chapter.

RULE **The reaction is normal until it is not, and in Indian practice you cannot judge which until you know what the patient has been permitted to know.** Distress that is exactly calibrated to a fact the patient has not been told is not distress out of proportion to the illness; it is distress about something else, and it will not respond to reassurance about the illness. Establish what has been disclosed, and by whom, before you decide whether the reaction in front of you is disordered.

29.2 Adjustment or disorder, which is the discrimination that carries the marks

The most useful single thing to know about psychiatric morbidity in cancer is which diagnosis sits at the top of it, and it is adjustment disorder and not depression. An Indian cross-sectional survey of consecutively admitted adult cancer inpatients in the radiotherapy department of a tertiary teaching hospital in Kerala, over 2011 and 2012, found a substantial minority carrying a psychiatric diagnosis, and the largest single group within that minority was the adjustment disorders, a clearly bigger group than major depressive disorder in the same sample.

384	41.7%	22.6%	10.9%
ADULT CANCER INPATIENTS ASSESSED, INDIAN TERTIARY RADIOTHERAPY SERVICE	CARRIED ANY PSYCHIATRIC DISORDER, SAME INPATIENT SAMPLE	ADJUSTMENT DISORDERS, THE LARGEST SINGLE DIAGNOSTIC GROUP	MAJOR DEPRESSIVE DISORDER IN THAT SAME SAMPLE

What the setting does to the number. These are inpatients on a radiotherapy service in one tertiary centre. They are not a community sample, not an all-India figure, and not an advanced-disease or hospice population, and a palliative inpatient unit would not be expected to look like this. Quote the proportion with its setting attached or do not quote it at all, because a figure from a treatment ward asserted about the dying is a different claim. Two further features are worth carrying into a viva. Diagnoses were made by structured diagnostic interview, using the MINI International Neuropsychiatric Interview rather than a distress screen, which matters because screening instruments in oncology count symptoms while diagnostic interviews count disorders, and the space between those two operations is where inflated prevalence claims are manufactured. And the sample was consecutive rather than referred, so it is not the enriched population a liaison psychiatrist meets on a consult list.

Conceptually the **adjustment disorders** are emotional and behavioural symptoms arising in response to an identifiable stressor, and in an oncology clinic the stressor is never in doubt. That is what makes the category both easy to reach for and easy to misuse. The examinable discrimination is not between sadness and depression as lists of symptoms, which the mood and anxiety chapters own; it is between a reaction that tracks the illness and a syndrome that has acquired its own autonomy. The reaction moves with events, remits when the news improves, leaves the capacity for pleasure intact between episodes of distress, and responds to information, time and company. The syndrome persists when the news improves, colours the day as a whole, holds a fixed view of the self rather than of the situation, and does not lift when the family arrives.

The practical consequence of adjustment being the commonest finding is that the commonest correct action is not a prescription. It is time, accurate information at a pace the patient sets, a named person to contact, and a review appointment that actually exists. The two errors that follow from getting this wrong are symmetrical and both are common: medicating every appropriate reaction, which teaches the oncology team that the psychiatrist is a source of sedation, and dismissing every reaction as understandable, which is how a treatable depression in a patient with cancer goes untreated on the grounds that anyone would be sad.

29.3 What the treatment itself does to the reaction

The reaction is not one event at one interview. Diagnosis, staging, surgery, each cycle of chemotherapy, the scan taken before a review appointment, the end of treatment when the structure of weekly attendance disappears, and any suggestion of recurrence are each a fresh disclosure, and each can reopen the whole sequence. This is why a patient who coped well at diagnosis can present in crisis at what the team regards as good news, and why the end of treatment can be a point of collapse rather than of relief.

One transition reorganises the psychological work more than the others, and it is the one where the goal of treatment changes. The Indian review that names the communication problem in this setting singles out two moments at which it surfaces: **the curative-to-palliative transition**, and the point at which death and dying enter the conversation at all. Both are moments when what the patient has been told stops being sufficient, because the plan the patient was given no longer matches the plan the team is following.

Some of the treatment-related material a full account would want is not settled enough to quote here. Body image after mastectomy or head and neck surgery, sexual function, fear of recurrence as a persisting preoccupation, distress at the end of treatment and in survivorship, and the financial catastrophe that treatment inflicts on an Indian family are all real clinical themes and all belong in a history, but no comparable Indian standard is available to quote for their magnitude, and none is invented here. Procedural and prognostic anxiety, and delirium arising in the course of advanced disease and its treatment, are taught in the companion topic of this chapter on depression, anxiety and delirium in cancer and palliative care.

29.4 Collusion, which is the name for what is actually happening

Collusion is the name for information about diagnosis, prognosis or medical detail being withheld, or shared selectively, within the triangle of patient, family and treating team. Its most important property is that it is graded rather than binary. The family may allow the physician to tell the patient about the recommended treatment while asking that the diagnosis not be revealed, or the physician may disclose the diagnosis to the patient and withhold what is known about the prognosis. So describing a case requires three answers and not one: who is being kept in the dark, what exactly is being withheld, and how complete the withholding is. The review that names the construct puts the point memorably: "Collusion is not always a conspiracy of silence, it may be a conspiracy of lopsided communication as well!"

Two patterns are named in the same source and both are worth recognising by name in a viva, because both look like coping and neither is. In **the recovery plot**, patient and relatives together focus on treatment and recovery and do not address prognosis, disability, relapse or death; the conversation is busy, hopeful and entirely about the next appointment. In **medical activism**, the doctor does exactly the same thing, offering the next investigation and the next line of treatment in place of the conversation that is due. The second is the more dangerous, because it is the one the team mistakes for professionalism.

WHAT IS WITHHELD	WHO IS KEPT IN THE DARK	HOW IT LOOKS AT THE BEDSIDE	THE CLINICIAN'S FIRST MOVE
The diagnosis, while treatment is openly discussed	The patient	Consent is given for radiotherapy without the word cancer being used; the patient asks the nurse what the machine is for	Establish what the patient already believes is wrong, before answering anything
The prognosis, after the diagnosis has been given	The patient	The patient plans as though cure were certain; the relatives already know it is not	Ask what the patient understands this treatment is trying to achieve
Everything, completely	The patient	Relatives answer for the patient throughout the consultation; the patient stays silent and watchful	Interview the family first by agreement, then see the patient alone
The patient's own knowledge and fear	The family	The patient knows, protects the relatives from knowing that they know, and each side performs hope for the other	Offer to be present when the two of them speak openly for the first time

Note what the last row does to the standard teaching. **Partial collusion** is not always the family protecting the patient. It runs in the other direction often enough that assuming the patient is the ignorant party is itself a clinical error, and the family is not the only possible party in the dark:

the treating team can be the one that has not been told, when the patient and relatives have agreed between themselves what the doctor will be allowed to hear.

29.5 The Indian family-disclosure reality, in numbers

Two structural facts make collusion the ordinary case in Indian oncology rather than the exception. An Indian palliative-care review reports that nearly one half of patients seeking cancer treatment in India are unaware of their diagnosis or their treatment, and that most patients attend accompanied by a close relative. That proportion is the review's own summary of the literature it surveyed rather than something it measured, so it should be quoted as a magnitude and in its own words; it does not convert into a percentage, and converting it would be inventing a measurement. The second fact does more work than the first, because the accompanying relative is not merely present. In the Indian family scenario a responsible family member is the decision-maker who directs and discusses most treatment matters, and collusion with the healthcare team follows from that structural position rather than from any wish to deceive.

The figures that make this examinable come from a prospective Indian study by Gautam and Nijhawan, which assessed 100 cancer patients, as reported in the Indian Psychiatric Society's clinical practice guideline on breaking bad news, published in the Indian Journal of Psychiatry in 2023. Among the patients who already knew about their condition, **71 per cent** wanted to be told the truth. Among relatives, **81 per cent** wanted the diagnosis disclosed to them, while **77 per cent** did not want it disclosed to the patient. Hold those three together and the shape of the problem becomes visible. The patients who know want the truth; the relatives want the truth for themselves; and the same relatives do not want the patient to have it. The contradiction is not between the doctor and the family. It sits inside the family's own position, which is why arguing with the family rarely resolves it and why naming the contradiction gently sometimes does.

TRAP **Quoting the patients' figure as though its denominator were all the patients in the study.** It is not. It is the proportion of those who already knew about their condition who wanted to be told the truth, a narrower group and one already selected for having found out somehow. The figure therefore says nothing at all about what the unaware want, and used the other way round it becomes an argument for universal disclosure that the study never made. Candidates lose the mark by dropping the denominator, and clinicians lose the argument at a family meeting for the same reason: a relative told that most patients want to know can correctly reply that their patient is not among those patients.

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Before any decision about disclosure, establish three things and write them down: who accompanied the patient today, who in this family actually makes treatment decisions, and what has already been said to whom. In a service where the accompanying relative is usually also the decision-maker, a clinician who opens with the diagnosis has not been brave; they have walked into a conversation whose terms were set before they arrived, and have often ended the family's willingness to leave the patient alone with the team again. The order in which you interview the patient and the relatives is a clinical decision in its own right, and it deserves to be taken deliberately rather than by whoever reaches the chair first.

29.6 The ethics, which cut both ways

The defensible position is not that family-first disclosure is simply bad practice awaiting correction. The Indian source that grounds this picture argues both sides of it, and a candidate who argues only one side has answered half the question.

What collusion costs the patient:

- It obstructs the patient's autonomy, because decisions are then made about a person by people who are better informed than that person is.
- It can deprive them of health services and care they would have accepted had they understood what was wrong.
- Trust can break when the truth is discovered later, and the discovery may be followed by fear, depression and anger directed at everyone who kept it.

What the family is protecting, and it is not nothing:

- Collusion may defend the person from potential maleficence, as this family judges what this particular person can carry.
- It may minimise the patient's concerns about the future, which is precisely what the relatives believe they are being asked to do.
- It expresses an idiom of care in which relatives are involved in making the patient get better rather than in making the patient feel better.

The two sides do not cancel out, and the source's own resolution is about timing rather than principle. What it argues is that breaking the collusion in good time matters, because a patient left unchecked is the more likely to end up distressed, morbidly anxious and depressed. That reframes the clinician's question into something answerable at the bedside. It is not whether a family may ever withhold, it is how long this particular silence can hold before it costs the patient more than it protects them, and who will be sitting with the patient when it fails.

One thing this topic deliberately does not assert. Whether any Indian regulatory instrument imposes a duty to disclose a diagnosis to the patient rather than to the family, and with what exceptions such as therapeutic privilege, is not established here: no comparable standard is available to quote, and none is invented here. Argue the ethics and the clinical consequence, keep the argument about autonomy and harm, and do not attribute to an Indian doctor a legal obligation you cannot cite.

29.7 Working through collusion, which is the clinician's actual task

The source that names collusion also describes how it is dismantled, and the description is a way of working rather than a validated protocol: it carries no acronym, no step count and no trial behind it, and it should not be recited as though it did. The reasons for the collusion are established early, because a family withholding out of terror needs something quite different from a family withholding because of a promise made at a bedside years ago. The relatives are then given an explicit undertaking that nothing will be told to the patient without their consent, and a contract to that effect. Only after that is the patient's own level of awareness assessed,

through direct questions and by following the cues the patient offers about what they think is happening to them. The observation that makes the whole sequence work is that patients usually show considerably more awareness of their condition than their relatives believe they do, which means the conversation the family is dreading has frequently already taken place inside the patient's own mind.

What follows is pacing rather than revelation. The clinician is physically present when the patient and the relative first speak openly, so that neither of them is left alone afterwards with what was said. The pace is set by what all parties can tolerate rather than by the clinician's timetable, which in practice means that a single conversation is rarely the unit of work. And the feelings of both parties are reassessed periodically, because a family that agreed to disclosure at one meeting may need the agreement rebuilt at the next, particularly after a scan.

GOOD TO REMEMBER

The undertaking to the relatives is the act that makes everything after it possible, and it is the easiest step to skip. Said aloud it sounds like this: nothing will be said to your father that you have not agreed to, and I will tell you before I say it. It costs nothing, it removes the family's reason to keep the patient away from the team, and it converts an adversarial negotiation into a shared one. Record what was agreed and with whom, so that the next clinician on the ward does not undo it by accident in the first minute of a ward round.

Before deciding what to disclose, establish what the patient already knows and what the family has agreed to keep, because in Indian practice the disclosure decision has usually been taken before the psychiatrist arrives.

The structure of a breaking-bad-news interview as an examined station, and the way such a station is marked, is taught with the practical-examination material in this chapter. What belongs here is the substance that station is testing, which is the ability to work out which of two quite different problems is in the room.

30 · Depression, anxiety and delirium in cancer and palliative care

Why the marks are here. A question about the patient with advanced cancer who has stopped eating, cannot sleep and says there is no point is not asking for a criterion set. It asks whether you can still reach a diagnosis once the illness has taken away most of the evidence diagnosis rests on, and whether you will still treat when the prognosis is short and the drug chart is crowded. Candidates fail in two opposite directions: one records a diagnosis the body has manufactured, the other declines to diagnose at all, because in a dying patient everything is attributable to the disease.

What follows is the recognition and treatment of depression, anxiety and delirium in cancer and palliative care, on the assumption that each entity has been learned elsewhere. Delirium itself, with its subtypes, instruments, causes and treatment, belongs to the Stroke, TBI, delirium and focal brain syndromes notes; the anxiety disorders as diagnostic categories to the Anxiety, OCD

and trauma-related disorders notes; antidepressant choice, dose and schedule to the Mood disorders: pharmacotherapy notes. The reaction to the diagnosis, grief and bereavement, and the wish for a hastened death are taken up in companion topics of this chapter.

30.1 The evidence the illness takes away

Ordinarily much of the case for depression is carried by the body: appetite gone, weight falling, sleep broken, energy absent, movement and speech slowed. In advanced malignancy each of those is also produced by the tumour, by cytotoxic and radiation treatment, by opioid analgesia, by anaemia, by unrelieved pain and by the metabolic disturbance of the illness. The problem this **somatic confound** creates is not that the features are hard to read in one patient. It is that they lose their discriminating power across the whole ward, and a feature everybody has separates nobody.

Two symmetrical errors follow and an examiner is usually probing for one. Count the somatic features at face value and the apparent prevalence of depression on a palliative unit approaches its census; attribute them all to the disease and nobody there is ever diagnosed. Both are failures to notice that a decision about **attribution** is being taken silently, and that whichever way it goes it fixes the answer before the interview begins. How the criteria should be handled here, whether the somatic items are discounted, replaced by affective and cognitive substitutes, or counted regardless of cause, is not settled on this page. No comparable standard is available to quote, and none is invented here.

RULE **In advanced disease the diagnosis of depression is carried by what the patient believes about themselves, not by what the body is doing, because the body is answering to the illness.** That relocation drives everything practical here: the interview turns early to self-attitude, guilt and the capacity for pleasure rather than to sleep and appetite, and the attribution reasoning goes into the note rather than staying in the clinician's head.

30.2 What still discriminates, and the order in which to look

Move the weight of the assessment onto content the disease does not manufacture. Advanced cancer explains fatigue, but not a settled belief that one is a burden who deserves what is happening; poor appetite, but not guilt about matters unconnected with the illness; withdrawal, but not **anhedonia** in the strict sense, the loss of any capacity to be pleased, including by a grandchild arriving or a scan better than expected. Hopelessness about the prognosis may be an accurate reading of the facts; hopelessness about oneself is not something a tumour produces.

The second discriminator is sequence rather than content. Distress driven by an unrelieved physical symptom generally moves when that symptom moves, so pain, breathlessness, nausea and constipation are treated first and the mood re-examined afterwards, both examinations timed and recorded. Where no investigation settles the question this is the only experiment available, and it turns an argument about attribution into an observation somebody else can check.

Which screening question or brief instrument is defensible in a patient too breathless or too exhausted for a full interview is not answerable here: no comparable standard is available to

quote, and none is invented here. What can be said is what such a screen has to survive:

- it must be answerable by someone whose concentration fails quickly, since an instrument the patient cannot finish returns nothing;
- it must stay interpretable when the patient stops because of the illness rather than the mood, a distinction almost no instrument draws for you;
- it needs somewhere to hold what the person at the bedside overnight has noticed, since that person holds most of the observation.

30.3 Whether to treat at all, and what the national guideline settles

The commonest reason depression goes untreated in advanced disease is not that it was missed but that it was recognised and judged not worth treating, on two grounds rarely said aloud:

- the prognosis is too short for an antidepressant to work, so nothing is started and the question is never revisited;
- the drug chart is already full and the oncology team will not welcome another agent on it.

The Indian position on the first is explicit. The clinical practice guideline for the assessment and management of depression in India, prepared for the Indian Psychiatric Society and published in the Indian Journal of Psychiatry in 2026, states that where depression sits alongside medical illness pharmacotherapy remains indicated. Name what that rests on as well as what it says. It cites an umbrella systematic review and meta-analysis of randomised controlled trials in major depressive disorder, spanning **27** comorbid medical conditions, in which antidepressants were more effective than placebo across a range of illnesses including myocardial infarction, coronary artery disease, stroke, inflammatory bowel disease, diabetes mellitus and cancer.

One qualification travels with that recommendation wherever it is quoted: patients with psychiatric and medical comorbidities tend to have a poorer response to antidepressants than those without. Read the wording exactly. It gives a direction and not a magnitude, and a poorer response is not an absent one. It is a reason to be honest about what to expect and to plan the review, not a reason to withhold.

The psychological arm carries its own limits and they are examinable. Despite study heterogeneity, which the guideline names in the same sentence, meta-analyses are said to support cognitive behavioural therapy and behavioural activation for patients with medical comorbidities such as coronary heart disease and neurological disorders. Those illnesses are examples, not a closed set. But cancer, named among the illnesses on the drug side, is absent from the examples on the psychological side, so offering structured psychological treatment in advanced cancer on this evidence is an extrapolation and is better presented as one.

None of this licenses the prescription itself, which belongs to the Mood disorders: pharmacotherapy notes. The constraints that actually decide the choice appear here only as questions, with no answer asserted for any: how fast an agent can act against a prognosis that may be short, impaired hepatic and renal clearance, interaction with opioids and with anti-emetics,

and anticholinergic load in a patient already close to delirium. No comparable standard is available to quote, and none is invented here.

TRAP **Carrying a treatment finding across from the population that produced it to the patient in front of you.** The trials gathered into that umbrella review recruited people with major depressive disorder and a comorbid physical illness, and such a participant is generally well enough to consent, attend and complete ratings across the study period. That is not the patient in the final phase of the illness. The direction stands and should still be quoted, but presenting the evidence as though it came from a hospice overstates it.

30.4 Anxiety, which has several sources and one appearance

Anxiety on a cancer ward looks much the same whatever generates it, and the task is to work out which process is running. Sorting it by what the fear tracks is more useful at the bedside than sorting it by severity, because the tracking tells you what will answer it. **Procedural anxiety** attaches to an event and **prognostic anxiety** to a question the patient has not been able to ask, and both are often present in the same patient at different hours.

WHERE THE FEAR COMES FROM	WHAT IT TRACKS	WHAT ANSWERS IT	WHAT IT GETS MISTAKEN FOR
An event	The cannula, the mask that immobilises the head for radiotherapy, the scan and the wait for its report; it settles once the event is over	Changing how the procedure is done and who is present	A pervasive anxiety needing regular medication
A question	Review appointments and changes of plan; it does not settle when the procedure ends, because the procedure was never what it was about	Establishing what the patient has understood and what they have not been able to ask	Poor coping, or a patient the team starts to call demanding
The body	Breathlessness, hypoxia, unrelieved pain, sepsis, and the fear that opens a delirium before anything else about it is visible	Finding and treating the physical cause, after which the fear commonly goes too	An understandable reaction to being ill, which nobody looks past
The drug chart	What was started and what was stopped; the onset dates from a dose rather than a conversation	Reviewing the chart with whoever prescribes on it, before adding to it	Worsening anxiety, answered with a further prescription

The bottom row is the one candidates leave out, and a patient who locates the fear in the legs rather than the mind points straight at it. The discrimination that carries marks, though, is the third. Fear accompanied by a fluctuating level of alertness, or by attention that slides off the

question, is managed as delirium until shown otherwise, and the anxiolytic reasonable in the first two rows is the wrong instrument there.

30.5 Delirium once the goal of treatment has changed

The decision belonging to this setting and to no other is how far to look for a cause once the illness is no longer being treated for cure. Earlier in the disease that is not in doubt. Late in it the search carries its own costs: venepuncture, a transfer for imaging, a catheter, a move back to a ward from the home the patient wanted to stay in. Its extent becomes a clinical judgement rather than a protocol.

The failure to guard against is not that too little was done but that nobody decided. The search quietly stops, no reason is entered anywhere, and afterwards the team cannot say whether a reversible cause was excluded or never sought. A recorded decision to limit investigation, carrying its reasoning and whoever took it, is defensible to a family and to an examiner; an absence of decision is defensible to neither.

Indian data are thin and must be quoted with the setting attached. A hospital-based cross-sectional survey published in the Indian Journal of Psychiatry in 2016 found delirium in **6.5 per cent** of adult cancer inpatients on a tertiary radiotherapy service in Kerala. Those patients were admitted for active treatment, so the proportion describes an oncology treatment ward and nothing beyond it. What it is in advanced or terminal disease in India is not established here: no comparable standard is available to quote, and none is invented here. The instrument is not named either, the report identifying it only in general terms.

The restlessness of the final hours is spoken of at the bedside as **terminal restlessness**. Whether it is properly a distinct entity, how it should be described, and how antipsychotic choice differs there are not settled on this page: no comparable standard is available to quote, and none is asserted. What is safe to teach is the explanation given to the family. A relative who understands that a frightened, confused patient is ill in the brain, rather than possessed or being punished, stops restraining, stops arguing with the content, and begins supplying the observations the search depends on.

IN INDIA

The continuous observer at an Indian bedside is **the family attendant**, present through the whole of a night the clinical team samples once. Two consequences follow. The history of fluctuation, of what the patient was like earlier and whether anything changed, comes in a detail no observation chart will match, provided the attendant is asked in their own language and asked about changes rather than symptoms. And the attendant usually decides whether the tablet is given after discharge, so a treatment decision explained only to the patient, or only to the referring team, may never be carried out.

30.6 What has to be settled before the interview ends

What an examiner is checking. Three questions are open in every one of these consultations and all three can be answered in a single visit. Which presenting features are being counted towards a

psychiatric diagnosis and which attributed to the disease. Whether treatment is being started, and if not, on what ground and who will look again. And whether this is a disturbance of mood, of anxiety or of consciousness, since the third rewrites the management of the other two.

The body cannot testify
APPETITE, WEIGHT, SLEEP AND ENERGY ARE ALL CLAIMED BY THE DISEASE, WHICH IS WHY THE INTERVIEW MOVES TO GUILT, WORTHLESSNESS AND THE CAPACITY FOR PLEASURE

Poorer, not absent
RESPONSE TO ANTIDEPRESSANTS TENDS TO BE POORER WHERE MEDICAL COMORBIDITY IS PRESENT, WHICH IS A REASON TO PLAN THE REVIEW AND NOT TO WITHHOLD

A decision, not a drift
LIMITING THE SEARCH FOR A CAUSE OF DELIRIUM LATE IN ILLNESS IS DEFENSIBLE WHEN IT IS RECORDED WITH ITS REASONING

GOOD TO REMEMBER

Write the decision not to treat as carefully as the decision to treat, with a reason and a review attached. An unwritten decision cannot be told apart from an oversight. The sentence that does the work is short: the low mood is judged to be driven by unrelieved pain, analgesia has been optimised, and the mood will be reassessed at the next review by the clinician named as doing it.

In advanced disease the somatic evidence belongs to the illness, so the diagnosis rests on the patient's view of themselves, and a short prognosis with an attenuated expected response is an argument for planning the review rather than for withholding treatment.

31 · Grief, bereavement and end-of-life psychiatric care

Why the marks are here. Nobody is called to see a bereaved person because bereavement is a disease. The psychiatrist is called because a team, or a family, has run out of ways of being with someone, and the examinable skill is deciding which of two very different requests has arrived: company through something ordinary and terrible, or assessment of something that has stopped being ordinary. Err towards treatment and you medicalise a family's worst month. Err towards reassurance and you leave a treatable illness inside a story everyone finds sufficient.

What follows is grief, bereavement and end-of-life psychiatric care written as a set of acts: what the clinician does before a death, in the conversation where the news is given, and in the months that follow. The entity belongs elsewhere: prolonged grief disorder as a diagnosis, the criteria and the duration written into them, and the point on which the two classification systems disagree, are taught in the Anxiety, OCD and trauma-related disorders notes. Depression, anxiety and delirium in advanced disease, and demoralisation and the wish for an earlier death, belong to the companion topics of this chapter on those subjects, and the ethics of withdrawing treatment are argued in their own place.

31.1 Grief is not the referral question

Normal grief is what most of this work consists of, and the default posture towards it is **accompaniment**: presence, accurate information, a named person to contact, and a review that actually exists. That is not a lesser intervention held in reserve. It is the intervention, and for the great majority of bereaved people it is the whole of it.

The referral is hard to read because it is rarely generated by the bereaved person. It is generated by somebody watching them: a ward sister who has run out of things to say, an adult child who wants a sedative for a parent so the household can function again. Establish who is asking, what they want changed, and what they believe happens if it is not. Many then resolve without a psychiatric formulation, because the problem was never located in the person referred.

RULE **Intensity is not the axis on which this decision is made.** Grief that looks unbearable to a watching team may be exactly proportionate to what was lost, and grief that looks restrained may conceal someone who has stopped eating and stopped speaking. The axes that carry the decision are function, safety, and whether the picture is qualitatively different from sorrow rather than merely larger than expected. A candidate who answers with adjectives about how sad the patient looked has answered a different question.

Mourning as a set of observances, and the boundary between a sanctioned religious practice and a disorder, are drawn where culture and the explanatory model are taken up in this chapter. What carries into the interview is procedural: establish what this family expects to be doing at this stage, and who is expected to do it, before deciding anything is unusual. A relative who has not left the house is obeying an instruction in one family and withdrawing in another.

31.2 Anticipatory grief, and the loss that starts before the death

Anticipatory grief is the mourning that begins while the person is still alive, once it is clear to patient or family that the illness will end in death. It is not a rehearsal and should not be sold to a family as one. What it does is redistribute the psychological work across time, so that some reorganising of roles and plans happens while the dying person can still take part. Whether it reduces the intensity or duration of what follows the death is the question this literature is built around, and no comparable standard is available to quote, and none is invented here.

Two consequences carry the marks. It is readily mistaken for coldness at the deathbed by staff who arrive late and see only the calm. The second is the hinge of this topic: a family cannot grieve in advance for a death nobody has told them is coming, and neither can the patient. Where the prognosis is held back, the work anticipatory grief would have done early and slowly is deferred whole to the hour of the death and the months after it.

31.3 Breaking the news to a family rather than to a patient

Every framework for delivering serious news that a candidate has read was designed for two people in a room, a clinician and a patient. That assumption does not hold in most Indian consulting rooms, and the Indian palliative-care literature says so directly: in filial cultures the patient is almost always accompanied, relatives are reluctant to leave when asked, and an instruction that the patient is not to be told is routine. A dyadic protocol applied unmodified there fails by putting the clinician into a negotiation with people it does not acknowledge.

The adaptation is small to state and hard to do. A cross-cultural analysis published in the Indian Journal of Palliative Care in 2009 by Chaturvedi, Loiselle and Chandra recommends conducting the disclosure with **more than one** family member present alongside the patient, because more than one relative is already involved in the care and all will want the clinical detail. The second

half is the part candidates omit. Where several relatives are in the room, the clinician identifies **the key relative** by asking whom the patient regards as the key relative or head of the family. Not the loudest voice, not whoever booked the appointment, and not the clinician's guess from the seating.

> **IN INDIA**
>
> Three questions before the news is given do most of the work. Who does the patient want in the room for this. Who does the patient regard as the one who speaks for the family. What has already been said, by whom, and to whom. In that order the third is usually answered without a struggle, because the family has heard they are not about to be excluded. A clinician who reaches for the diagnosis first has not been braver, only faster, and has often ended the family's willingness to leave the patient alone with the team.

There is a named hazard on the clinician's own side. The same source warns that the doctor may be quite comfortable with the recovery plot and enter this conspiracy too readily, because the conversation about the next investigation is easier than the one that is due and the family will reward it. That pattern, and the method for dismantling it, belong to the companion topic of this chapter on psychological reactions to cancer diagnosis and treatment. What belongs here is that the multi-party meeting is where a clinician joins it, invisibly to themselves.

The stepwise conduct of the interview, the order of delivery and the criticism made of that order are taught with the communication and risk-assessment station material in this chapter. No step count, expansion or sequence appears here, deliberately: what this section owns is the shape of the room, not the script.

31.4 What a silence held to the end leaves behind

Concealment has a near-term cost and a long-term one, and the second is why grief and disclosure sit in one topic. Near-term, an unaddressed silence leaves the patient morbidly anxious and depressed, and lowers the threshold for physical symptoms such as nausea and pain, so symptom relief becomes harder to achieve. That is the argument a palliative team accepts when the ethical one has failed: the concealment is interfering with the analgesia.

The long-term cost falls on the survivors. Where the silence holds to the death, what is left is **unfinished business**: practical and emotional matters never attended to, because attending to them would have meant admitting what was happening. The arrangements only the dying person could make, and the things each of them meant to say and could not without conceding the diagnosis. The source states the consequence plainly: this failure makes it harder for relatives to work toward resolving their own grief. Withholding intended as protection is therefore not neutral for the protectors. It is a debt falling due after the funeral, on the people who took it on.

TRAP **Arguing disclosure purely as the patient's right, in front of a family whose motive is love.** Candidates lose this exchange because the family is not making a claim about autonomy and cannot be defeated on one. What moves an Indian family is the consequences they already care about: symptoms harder to control while the silence holds, the things their father will not get to arrange, and the grief they will themselves be doing with all of it undone. Argue the ethics in the viva, but recognise that in the room it is the second argument that works.

31.5 The hours after a death, and what is honestly known about them

A boundary worth stating aloud. What a clinician does at a death and just afterwards, meaning how the news of the death is given, how the meeting that follows is conducted, what enters the record, whether a condolence contact is made, and which relatives are offered **bereavement follow-up** and on what basis, is not settled here. No comparable standard is available to quote, and none is invented here. That matters because it is the part of the work most often improvised.

What can be reasoned rather than quoted is a priority, and it follows from the mechanism above. If unfinished business is what makes the survivors' work harder, the families to look for afterwards are those in which the silence held: the prognosis never discussed, one relative carrying the decision to withhold alone, or disclosure too late for anything to be arranged. That is reasoning in the absence of a standard, offered as such.

Ask who is asking
THE BEREAVEMENT REFERRAL IS USUALLY RAISED BY THE OBSERVER, NOT BY THE PERSON NAMED ON IT

The room holds more than two people
DISCLOSURE IN INDIAN PRACTICE IS MULTI-PARTY BY DEFAULT, AND THE PATIENT NAMES WHO LEADS IT

Unfinished business is the debt
A SILENCE HELD TO THE DEATH MAKES THE SURVIVORS' OWN GRIEF HARDER TO RESOLVE AFTERWARDS

31.6 When accompaniment becomes assessment

This is the discrimination the examiner is testing, and it is made without the diagnostic apparatus, because in most of these encounters reaching for it is itself the error. The table is written the way a referral arrives, not the way a criterion set is.

WHAT THE REFERRAL SAYS	WHY THAT ALONE DOES NOT SETTLE IT	THE ACT THAT DOES
She cries all the time and cannot be consoled	Intensity tracks what was lost and how recently, and consolability describes the visitor as much as the patient	Ask what she has managed to do since: eating, washing, sleeping, caring for whoever depends on her
He talks to his dead wife and hears her	Such experiences occur in ordinary bereavement, and in many families are expected rather than alarming	Ask whether it is sought or intrusive, whether it is held to be real, and what the family makes of it
She says she wants to go with him	A wish to have died alongside is not an intention to act, and neither is inferred from the other	Ask the suicide question directly; the assessment is taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes
He was fine at the funeral and fell apart weeks later	The ritual period supplies structure, company and a role, so its ending is a predictable collapse point	Locate it in the trajectory: ask what changed when it began, not what is wrong now
The family wants something to help her sleep	A solution has been offered before any problem was stated, and it is often the household's problem	Establish what the sleeplessness consists of, and who is troubled by it, before any prescription
She has had a depressive illness before	Here the threshold genuinely moves, because a previous episode makes recurrence under this load likely	Assess for recurrence on its own terms; treatment of a depressive episode is set out in the Mood disorders: pharmacotherapy notes

Two further findings should move a clinician however recent the death: alcohol or sedatives recruited to get through the evenings, easy to normalise early and hard to stop later, and a settled conviction of worthlessness that is about the person rather than the loss. Neither arrives as a referral sentence, which is why neither is in the table. Both have to be asked for.

31.7 End-of-life psychiatric care as a way of working

A psychiatrist attached to a palliative service works differently from one holding an outpatient clinic, and the difference is examinable. Referrals arrive as behaviour or as communication rather than as diagnoses. Reviews are short, frequent and at the bedside with relatives present, because a patient who cannot sustain one long interview can sustain several brief ones. The drug chart is read for what is sedating the patient as much as for what is treating them. And the goal shifts from clearing a symptom to making the time tolerable, which changes what counts as a good outcome.

- What the patient has been told, by whom and when, or the next clinician repeats the disclosure or contradicts it.
- Whom the patient identified as the relative who speaks for the family, and what was agreed with that person.

- What remains unattended that the patient still has the capacity and the time to attend to.
- Who is likely to need finding afterwards, and who has agreed to look for them.

GOOD TO REMEMBER

The most useful question in an end-of-life interview is not about mood. It is a version of: is there anything you still want to say to somebody, or anything you still want arranged. A very ill patient can answer it, it takes under a minute, and it turns an abstract worry about unfinished business into a list somebody can act on this week. Whether it can be answered at all also tells you how much the patient has been allowed to know.

Grief needs accompaniment far more often than it needs treatment, and the decision to move from one to the other turns on function, safety and a qualitative change rather than on how intense the sorrow looks to whoever made the referral.

32 · Demoralization and desire for hastened death

Why the marks are here. A patient with advanced disease says, quietly and without drama, that there is no point going on and that they would rather it ended. Nothing in that sentence tells you which of several quite different clinical situations you are in, and the examiner is testing whether you can hold them apart, whether you know that one of them has a name and a literature of its own, and whether you know what the law in this country permits the treating team to do once the sentence has been said. This topic pairs demoralization and desire for hastened death because the proposal that named the first identifies the second as where it predictably leads, and because a candidate who can only reach for depression will medicate a problem that is not primarily a disorder of mood and will still not have answered the patient.

Two boundaries are worth fixing first. The recognition and treatment of depressive and anxiety disorders in a patient with advanced disease, and of delirium in that setting, belong to the companion topic of this chapter on depression, anxiety and delirium in cancer and palliative care; anticipatory grief and bereavement belong to the companion topic on grief, bereavement and end-of-life psychiatric care. The assessment and management of the suicidal patient in general psychiatric practice is taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. That subject is adjacent to this one and is not the same as it, and the difference is examined more often than the resemblance.

2001	2005	9 March 2018
YEAR THE DEMORALIZATION SYNDROME WAS FIRST PUT FORWARD AS A PALLIATIVE-CARE DIAGNOSIS	YEAR THE WRIT PETITION THAT SETTLED THE INDIAN END-OF-LIFE POSITION WAS FILED IN THE SUPREME COURT OF INDIA	DATE OF THE CONSTITUTION BENCH JUDGMENT DECIDING THAT PETITION

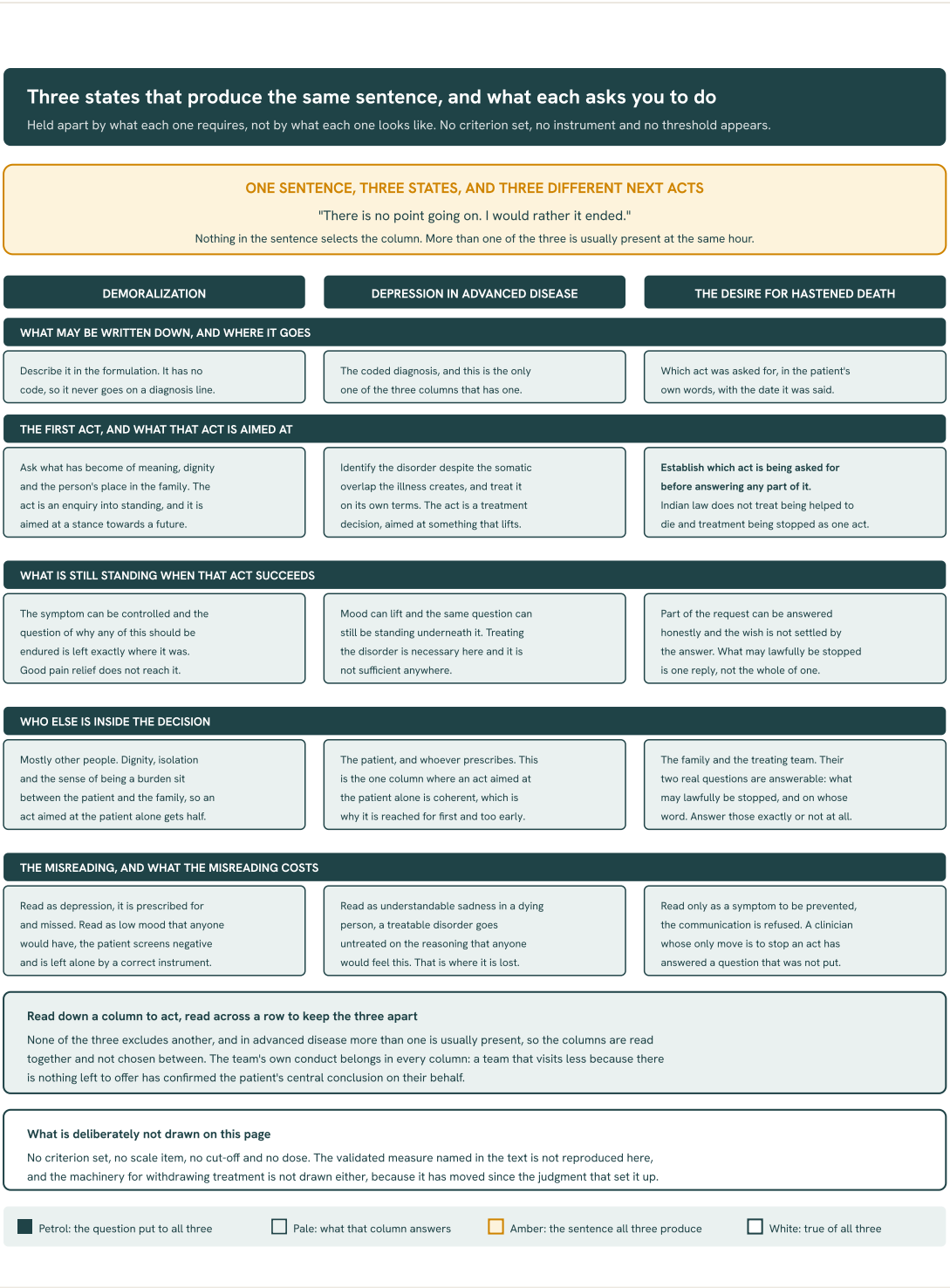


Fig 29.12. Demoralization, depression in advanced disease and the desire for hastened death set in three columns and separated by act rather than by feature, giving for each what may be written down and where it goes, what the first act is and what it is aimed at, what is still standing once that act has succeeded, who besides the patient is inside the decision, and what the characteristic misreading costs, with the single sentence all three can produce placed above them and the criteria, instruments and thresholds that belong to other chapters named as absent.

32.1 Demoralization as a named construct, not as an ordinary word

Demoralization is ordinary English, and clinical writing uses it loosely to mean discouraged, flattened, worn down. That is why the technical sense has to be introduced deliberately: a term with a colloquial meaning is read colloquially unless the reader is stopped.

One older technical use is worth knowing, and it comes from a different literature. In the account of what the psychotherapies share, **remoralization** is named as the antidote to demoralization,

the patient's restored expectancy and hope being one of the common factors that operates whatever the modality. That is a claim about every consulting room, and it is taught in the Psychotherapies, clinical assessment, MSE and nosology notes. What is added here is narrower, and belongs at the bedside of a person whose illness will not be cured.

The palliative-care proposal came from Kissane, Clarke and Street, working from a centre for palliative care in Australia, and was published in the Journal of Palliative Care. It put forward demoralization syndrome as a diagnostic category for palliative care, resting on **three** core features:

- **Hopelessness.** Not sadness about the illness, but the absence of any expectation that anything ahead can be different or better.
- **Loss of meaning.** The collapse of the answer to why this is being endured, which is a question a person under active treatment can usually answer and a person no longer under it often cannot.
- **Existential distress.** Suffering that is about the person's situation and standing in the world rather than about a symptom, and which therefore does not move when the symptom is controlled.

Read together, the three describe not a mood state but a stance towards a future, and it is that stance rather than any particular affect which the proposal argues can be separated from a depressive disorder and recognised in a palliative-care setting. The proposal went further and claimed the syndrome had satisfactory face, descriptive, predictive, construct and divergent validity, which is the argument for treating it as a diagnostic category rather than a good description. Whether that argument was accepted is dealt with below.

RULE **Hopelessness in advanced physical illness is a clinical target in its own right, not merely a severity marker of depression.** Read only as an item within a depression scale, the sole decision it can drive is whether to treat depression harder. Read as the core of a separate construct, it opens questions about meaning, dignity and the patient's position in the family, which are the questions the patient is already asking themselves.

32.2 What the construct is associated with, and the mechanism that carries it forward

The original proposal names the company demoralization keeps, and the list is worth learning in clusters rather than as a flat run of risk factors, because grouped this way it stops being a checklist and starts describing how the state is produced.

- **The illness and the body.** Chronic medical illness, disability and bodily disfigurement. What these share is permanence: each is a loss that will not be given back, and each is visible to the patient every day without any clinical event to prompt it.
- **Standing in the world.** Fear of loss of dignity and social isolation. Both are about how the person is seen and by whom, and both worsen precisely as the illness advances and the circle of people who visit contracts.

- **Position in the family.** Greater dependency on others and **the perception of being a burden**, which the proposal ties to a subjective sense of incompetence rather than to the objective level of care being provided.

That last qualification is the one candidates drop and the clinically decisive one. Burdensomeness here is a perception, not a measurement. It does not track the hours a family actually spends, and it can be most severe in a household that is coping well and complaining least. A clinician who reasons from the visible care burden to the patient's distress gets exactly those patients wrong, because a family that manages without visible strain is the family in which a patient concludes the strain is being hidden.

The mechanism the proposal offers is the hinge of this topic. Because of the sense of impotence or helplessness, those with the syndrome predictably progress to a desire to die or to suicide. That is framed not as a comorbidity but as the endpoint of a state whose defining property is that the person can no longer see themselves acting effectively on anything. The wish to die is therefore the far end of a process that began with meaning, not an independent symptom that happens to have arrived.

32.3 Demoralization and depression, and the limits of what can be claimed

The differentiability of the two is the examinable claim, and it should be stated at the strength its source states it. The proposal holds that demoralization syndrome can be differentiated from depression and is recognisable in palliative-care settings. It does not hold that they are mutually exclusive, and nothing here permits saying that a demoralized patient is therefore not depressed. Both can be present, and in advanced disease both often are.

What is useful in an answer is why the separation was proposed at all. Depression in advanced disease is difficult to identify because its somatic criteria are confounded by the illness itself, a problem the companion topic on depression, anxiety and delirium in cancer and palliative care takes up. Demoralization does not solve it, but it names a group for whom counting somatic symptoms is beside the point: the trouble is not that they cannot enjoy things, it is that they cannot see why anything should be endured. A service screening only for depressive disorder registers them as negative, correctly by its own instrument.

How often the two dissociate is not something this account will put a number on. The proportion of patients with advanced disease who are seriously demoralized without being clinically depressed, and the correlates that predict which patients those are, have a research literature behind them, but no comparable standard is available to quote, and none is invented here. Carry the dissociation as a qualitative possibility with clinical consequences, which is what the construct's own proposal supports, and do not attach a figure to it in a viva.

TRAP **Writing demoralization syndrome on the diagnosis line as though it were a classified disorder.** It was proposed, and it has not been adopted: neither the current revision of the American classification nor the eleventh revision of the international classification carries it. Candidates err because the construct is taught in criteria-like language and because its own validity claim reads like an argument already won. Describe the state in the formulation, use the accepted category for whatever disorder the patient also meets, and say in a viva that this is a proposed construct and not a coded diagnosis. That is not a hedge; it is the accurate answer.

32.4 The desire for hastened death as a presentation

The wish to die in a person whose death is already expected is a different clinical object from suicidal ideation in general psychiatric practice, where the wish is understood as a symptom of a treatable disorder in someone who would otherwise be expected to live. Here the person is dying anyway, the request is often about manner and timing rather than the fact, and the reasons given are more often about meaning, dignity and dependency than about mood. None of that removes the psychiatric task; it changes what the task is, because a clinician whose only move is to prevent an act has misread a communication.

What the same sentence can carry. At least three different things arrive in the same words. There is the wish to be dead, which is a state and not a plan. There is a request for assistance in dying, which asks another person to act. And there is a request that treatment be stopped, which asks another person to desist. These are not gradations of one thing: Indian law, set out below, treats the second and the third as different acts, so confusing them is a legal error and not only a clinical one. The enquiry that separates them, meaning the wording, the order of the questions and what follows from each answer, is not settled by any source quoted here and is not invented here. Published instruments and interview approaches exist for this purpose and a candidate should read one; a plausible protocol manufactured from memory would be a procedure nothing supports.

The same restraint applies to what such a request means in this country, and here the gap is larger. No Indian study of the desire for hastened death in advanced illness is available to quote here, and none is invented. That absence matters, because the meaning of the request is not constant across jurisdictions. Where assisted dying is lawfully available it can be a step in a defined process. Where it is not, the same words cannot be a procedural request at all and are doing something else: expressing suffering, testing whether the clinician will stay in the room, or asking that a burden be lifted from a family. Importing a Western prevalence figure, or a response framework built around a legal option that does not exist here, describes a practice that is not Indian practice.

32.5 Measurement, and what a scale can and cannot settle

A validated measure of the construct exists. The **Demoralization Scale**, developed by the same originating group, is the instrument to name if asked how demoralization is assessed formally. Name is all that is offered here: its item count, its subscale structure, its response format, its cut-offs and its later revision are not reproduced, because no comparable standard is available to

quote, and none is invented here. A candidate who quotes a threshold for this scale is quoting something unverified, and a threshold is exactly the kind of specific an examiner follows up.

What matters is what a scale of this kind is for. Demoralization was proposed because a group of patients in palliative care were being missed by the instruments already in use, so a measure of it earns its place by identifying that group rather than by grading severity within it. Two consequences follow without any numbers. A positive screen is not a diagnosis and does not by itself justify a prescription, since the construct is not a coded disorder. And a negative screen in a patient who has said they want to die settles nothing, because the request has already given you information no instrument can subtract.

32.6 What the request runs into: the Indian legal position

Every clinical response to a wish for hastened death here is bounded by one Constitution Bench judgment of the Supreme Court of India, Common Cause (A Registered Society) v. Union of India. The ethical vocabulary this area is usually taught in, meaning autonomy, double effect and the distinction between withholding treatment and actively killing, is treated with the ethics material and is not repeated here. What is set out here is the legal position itself, which is what a clinical question about a request to die turns on.

Three propositions from it are the ones to hold, and the accompanying table sets out how the Court itself characterises each of the acts they concern. The first is about **active euthanasia**, which the Court records is to be treated as legally impermissible, at least for the time being, there being no statutory law permitting it. That qualification belongs to the Court's own sentence and should be reproduced with it, because dropping it converts a dated position into a timeless one.

The second is the line between that act and **passive euthanasia**, which the judgment treats as an inherent difference rather than a matter of degree, and what follows once the second applies: when passive euthanasia becomes applicable as a situational palliative measure, the best interest of the patient overrides the State interest. That is the sentence to have ready when a viva turns to whether a ventilator may lawfully be withdrawn.

The third concerns the **advance medical directive**, for which the Court laid down a procedure in exercise of its power under **Article 142**. The consequence is the examinable point, and candidates routinely get it backwards: the Indian advance directive at the end of life rests on judicial direction and not on legislation, and the Court expressly provided that its directions remain in force only until Parliament legislates in the field.

WHAT IS BEING ASKED FOR	HOW THE COURT CHARACTERISES THE ACT	WHAT THIS ACCOUNT DOES NOT STATE
A positive act to end life	A positive affirmative act, an overt act done to end the patient's life	Whether Parliament has since legislated on the subject
That life-prolonging treatment be stopped or not started	Withdrawal of life support measures, or withholding of medical treatment meant for artificially prolonging life	The steps, authorisations and safeguards through which it is given effect
That the patient's own prior refusal be honoured	An advance medical directive, for which the Court records there was no legal framework in the country	The current form of the execution procedure and its safeguards

The last column is not decoration. The procedural machinery that judgment set up, meaning the steps by which a decision to withdraw treatment is authorised and recorded, has been revisited since, and this account does not specify it. Modal verbs are where that error does its damage: saying that a treating team shall approach a particular authority asserts a current obligation, and that is exactly what a revision changes. Know the three propositions above, know that the procedure has moved, and check the operative steps against the Court's own current text before advising a team.

One further separation must be made explicitly, because the two instruments share a name. The advance medical directive discussed here concerns life-sustaining treatment at the end of life and arises from this judgment. The advance directive under India's mental healthcare legislation is a different instrument for a different purpose, concerning a person's preferences about mental healthcare, and it is taught with that legislation. Conflating them is a serious error and an easy one to make under pressure, because both are called advance directives and both concern a decision taken ahead of incapacity.

IN INDIA

Because the Court has placed an act done to end a patient's life outside what is legally permissible, a request for one cannot be a procedural request, and the clinician is not being asked to start a process. That changes what the response is for, but not what the psychiatrist must state accurately when a family or a treating team asks, and their two real questions are answerable from the judgment: what may lawfully be stopped, and on whose word. Indian evidence on how often such requests are made and with what course is not something this account can supply, so an answer opening with an Indian prevalence figure has invented one.

32.7 What is actually done, and what the direction of travel is

The construct arrived with a treatment approach attached, and the honest statement is short: the original proposal states that an approach is described, the approach itself is not established by anything quoted in this account, and nothing is invented in its place. What can be reasoned safely is the direction, and it is named in the older literature this topic opened with. If demoralization is the state, remoralization is the movement out of it, and what does the work there is restored

expectancy and hope, a factor operating across every psychotherapy rather than belonging to one. That is not a technique. It is a specification of what any technique used here has to achieve.

Three consequences follow that a candidate can defend without a protocol. Treating a comorbid depressive disorder is necessary and not sufficient: it is indicated where the disorder is present, with the drug detail belonging to the Mood disorders: pharmacotherapy notes and its use in advanced disease to the companion topic of this chapter, but a good response in mood can leave the same unanswered question about why anything should be endured. Next, the associations here are mostly interpersonal rather than symptomatic, so an intervention aimed at the patient alone addresses the smaller half: dignity, isolation and burdensomeness sit between the patient and other people. Last, the team's own behaviour is part of the clinical field, and a team that stops visiting because there is nothing more to offer has confirmed the patient's central conclusion for them.

GOOD TO REMEMBER

Before the conversation about a wish to die goes further, be clear which act is actually in question, because Indian law does not treat them as one. A request that treatment which is only prolonging dying be withdrawn falls within a category the Supreme Court has recognised and given effect to; a request that someone act to end life does not. That is not legalism at the bedside. It is what allows a clinician to answer part of the request honestly instead of deflecting all of it.

Demoralization is hopelessness and loss of meaning in a patient who may not be depressed, its predicted endpoint is a wish to die, and in India that wish arrives in a system where a positive act to end life is impermissible while withdrawal of treatment that only prolongs dying is not.

Both halves of this topic guard against the same failure, a purely symptom-based reading. A patient is counted as not depressed and is left alone; a request to die is counted as a symptom and is only prevented. Both readings are defensible from a list of criteria and both leave the patient where they were.

The OSCE and practical exam bridge

33 · Structure of OSCE stations in psychiatry (history, MSE, management)

Why the marks sit here. Every other part of a clinical examination lets you choose your own words and your own order. An observed station does not. It hands you a written instruction, a fixed span of time and a person to work with, and scores what you are seen to do with them. That design reached Indian postgraduate psychiatry from the regulator, not from departmental custom: the national Post-Graduate Medical Education Regulations, 2023, made by the National Medical Commission's Post Graduate Medical Education Board, name the **objective structured clinical examination** inside the criterion by which the practical is passed, beside the clinical

examination and the viva voce. A component named in a pass criterion is not a teaching exercise, whatever your department has been calling it.

What follows is the structure of OSCE stations in psychiatry (history, MSE, management): what a station is built from, what each of those three task families asks you to produce, how a watched performance is scored, and where the format sits in the instruments that govern an Indian postgraduate examination. It also sets out the parts of that picture no retrievable document fixes. The topic has a firm centre and an unsettled edge, and knowing which is which beats a confident schedule that belongs to another university.

50% AGGREGATE REQUIRED ACROSS ALL FOUR THEORY PAPERS BY THE NATIONAL POST-GRADUATE MEDICAL EDUCATION REGULATIONS, 2023	**50%** REQUIRED IN THE PRACTICAL, WHICH THOSE SAME REGULATIONS DEFINE AS CLINICAL PLUS OBJECTIVE STRUCTURED CLINICAL EXAMINATION PLUS VIVA VOCE	**Nil** GRACE MARKS PERMITTED IN A POSTGRADUATE EXAMINATION, IN THEORY OR IN PRACTICAL	**Not fixed** STATIONS, MINUTES OR MARKS FOR AN OBJECTIVE STRUCTURED COMPONENT, BY ANY INSTRUMENT QUOTED ON THIS PAGE

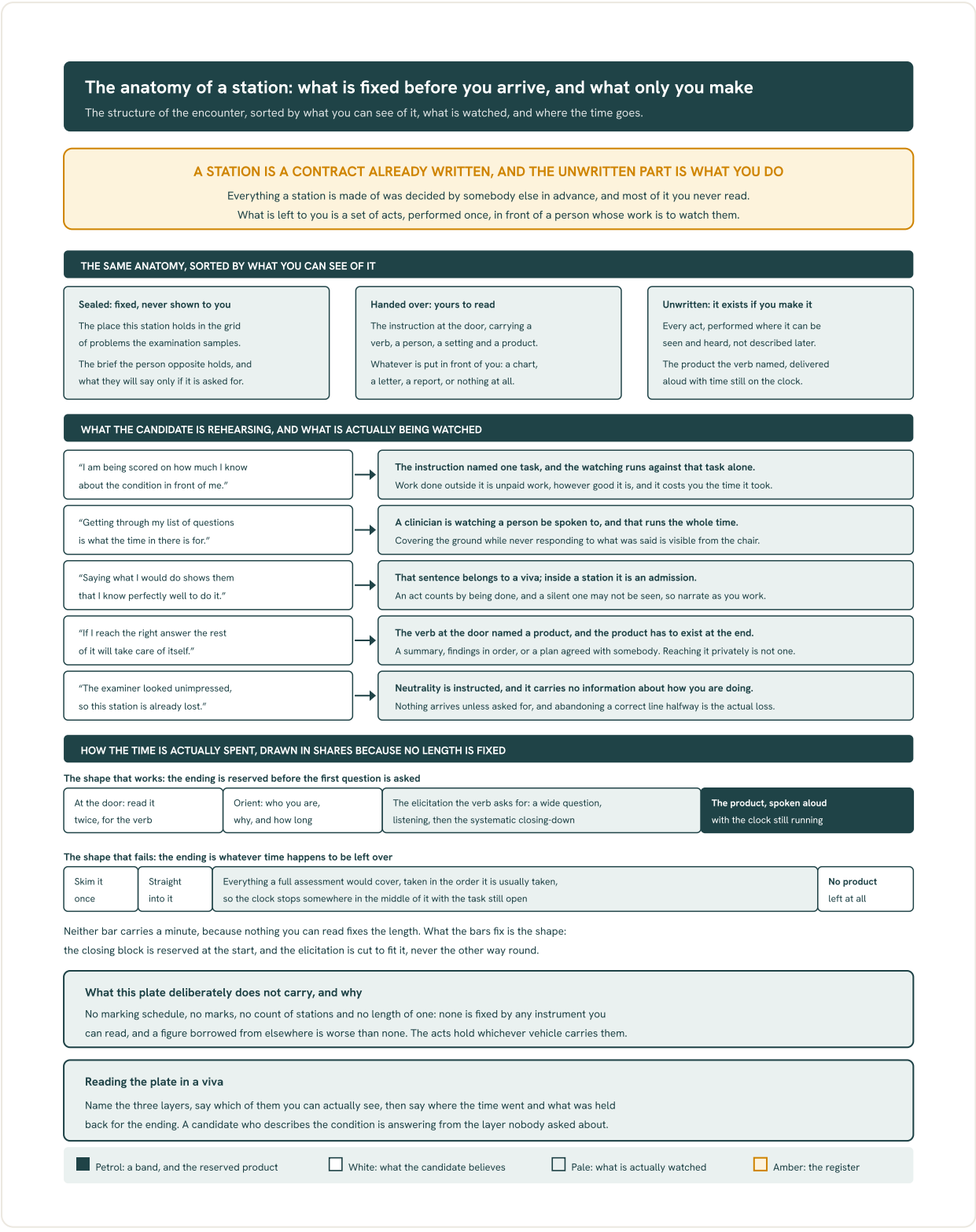


Fig 29.13. The station drawn as a structure rather than as a list of its parts, with the same anatomy sorted into what is sealed from the candidate, what is handed over at the door and what exists only if the candidate performs it, five ordinary beliefs about what is being scored set against what a watching clinician is in fact following, and the time drawn twice in shares rather than in minutes, once with the closing product reserved from the start and once with it crushed out by an elicitation that was never cut to fit.

33.1 What an objective structured station is, and the problem it was built to solve

Standardise the task, and the differences you measure become differences between candidates. In a conventional clinical examination the patient, the pathology, the examiner and the questions all vary, so two candidates given the same mark have not necessarily been asked the

same thing. A station removes those variables one at a time: every candidate meets the same written instruction, the same task, the same time and the same marking schedule, and where a real patient cannot be standardised the station substitutes a briefed person who can be.

The second gain is breadth. Clinical competence is not a single trait that transfers cleanly from one problem to another, and a candidate strong on a psychotic presentation may be weak on an alcohol history. This is **case specificity**, and it is the argument for sampling many short tasks rather than examining one case deeply: a circuit trades depth for coverage, deliberately.

So is the cost, which is why the format sits beside the traditional clinical rather than replacing it. A short task cannot test a whole clinical argument: the summary that stands alone, the differential defended against its alternatives, the formulation that earns the plan. Those need a long case, and that presentation is taken up in the section of these notes on long and short case presentation.

33.2 The anatomy of a single station

Six things exist before you arrive, and five of them are written down. Knowing them tells you where the marks are, because each is something somebody had to decide in advance:

- the place it occupies in the **blueprint**, the grid of problems and skills the examination has undertaken to sample, which is why stations feel unrelated to one another;
- the **candidate instruction** posted at the door: the task, the person, the setting, and what must exist by the time you leave;
- the brief carried by the patient or the **simulated patient**: an opening statement, information released only when asked for, cues shown rather than volunteered;
- the setting and any material handed to you, which may be a chart, a prescription, a report or nothing;
- the marking schedule the examiner holds, itemised against the task rather than against the diagnosis;
- the standard that schedule is read against, a decision of the examining board and not of the examiner in the chair.

Two consequences follow. Because the patient's information is released on request, silence is yours to fill: the person opposite is not withholding, they are waiting to be asked. And because the schedule is written against the task, material that is clinically excellent but outside it earns nothing. A station is a contract, and the instruction at the door is its text.

MNEMONIC

Instruction, Introduction, Information, Interpretation, Invitation

The five acts of any station, in order. **Instruction**: read it twice at the door, naming the verb, the person and the product. **Introduction**: name, role, purpose, consent, time. **Information**: the elicitation the verb asks for, and nothing outside it. **Interpretation**: say aloud what you found and what you make of it. **Invitation**: hand back to the patient with a question and to the examiner with a finished product. A station that fails has usually skipped the first or the fourth.

33.3 The task verb, and why the whole station turns on it

Read the instruction for its task verb before its clinical content. The verb names the product that must exist when time runs out, and the station is scored against that product. "Take a focused history of" asks for a defined territory covered and a closing summary. "Elicit and describe" asks for a technique performed in front of somebody and findings reported in the language of the phenomenon. "Explain" and "discuss with" ask for something delivered to a person who must understand it, which means checking that they did. "Assess" asks for a judgement, stated, not for the material from which one could be made.

Candidates lose stations by substituting an adjacent verb they have practised more. Asked to explain a plan, they take a history first, because history-taking is what they are fluent in. Asked to assess, they gather and never conclude. Asked for a focused history, they run the full ward assessment and reach the end of the time somewhere in the personal history. The correction is mechanical: after reading the instruction, say the product to yourself in one sentence, and let that sentence dictate your first question.

33.4 The history station: a focused history is not a shortened long case

A focused history is defined by what it deliberately leaves out. The long-case history is comprehensive because there is time to be, and because the argument you build later needs all of it. A history station names a territory and expects it covered to the depth a decision would require, with everything outside it acknowledged rather than explored. Where the instruction says a focused history of a first-episode psychosis, the marks are in onset and course, the phenomena, substance use, organic screening, risk and the effect on function and family, not in a developmental history that leaves no time for any of them.

Open by orienting the patient: who you are, why you are speaking to them, and how long you have. This is a scored act, not politeness, and it buys you the right to interrupt later. Then work from open to closed: a question wide enough to let the person say what is actually wrong, a period of listening without steering, then the systematic closing-down that covers the territory. Signpost the change of gear, and it reads as method rather than impatience.

Two elements are forgotten under time pressure and are almost always on the schedule. Risk is one: ask it, in plain words, wherever the presentation admits it, rather than saving it for a station labelled as a risk station. Corroboration is the other: an informant is rarely available inside a

station, so say whom you would seek, what you would ask and why it would change your view. Naming the collateral you cannot obtain scores; assuming it does not.

33.5 The mental state station: examining rather than interviewing

In this station the examination has to be made visible. The mental state examination as a construct, its domains and the vocabulary of its findings, is taught in the Psychotherapies, clinical assessment, MSE and nosology notes and is not repeated here. What changes when it becomes a station is that the examiner must be able to see you doing it. On the ward much of the mental state is gathered passively while you talk about something else; under observation, passive gathering is indistinguishable from not having gathered.

So the work becomes explicit. Separate what you observed from what you elicited, and say which is which. Where you find a phenomenon, probe it far enough to establish its form rather than its content alone, then stop: the schedule credits the probe, not the tour. Ask the discriminating questions: whether the voice was heard through the ears or inside the head, whether the belief is held against evidence the patient accepts as evidence. Then report in a fixed order, so nothing is lost to improvisation.

Two boundaries. A mental state station often reaches cognition, and the conduct of a named scale or bedside cognitive test under observation is set out in the section of these notes on demonstrating clinical scales and bedside tests. And the examiner is watching for damage as well as coverage: a probe pressed too hard on a frightened patient scores on the schedule and sinks the overall judgement, and both marks come from the same station.

33.6 The management station: a plan spoken to a person

Management is examined as an act of communication, not as a list. This station puts you with a patient, a relative or a colleague and asks you to explain what you propose and reach agreement about it, and the same plan delivered to those three is three different performances. The clinical content is the easy half. What is scored is whether the plan arrived in a form the person could act on: in sequence, the immediate step first, what happens where and who does it, the risks that matter to this person rather than a recitation of all of them, and an explicit invitation to disagree.

Structure it so nothing essential is crowded out. Safety and the immediate decision first, because if time runs out that is the part that must already have been said. Then the setting of care and why. Then the plan proper, biological, psychological and social, each in a sentence. Then follow-up: who reviews, when, and what brings the person back sooner. Then ask them to tell you what they have understood, the most reliably credited act in the station and the one most often skipped.

Two neighbouring station types are not developed here. Where delivering serious news or conducting a risk assessment is the whole purpose, those conversations are set out in the section of these notes on communication, breaking bad news and risk-assessment stations; where the task is to interpret something handed across the table, in the section on interpreting investigations and instruments.

STATION FAMILY	WHAT THE INSTRUCTION ASKS FOR	WHAT IS ACTUALLY SCORED	THE PRODUCT DUE BEFORE TIME ENDS
History	A defined territory covered to the depth a decision needs, with risk and missing collateral named	Question craft: open before closed, signposting, the discriminating question at the right moment	**A spoken summary, and what you would seek next**
Mental state	An examination performed and reported, observation separated from elicitation	Whether it was visibly done, whether phenomena were probed to their form, and the manner of the probing	**Findings in a fixed order, with domains not examined named as such**
Management	A plan explained to a named person and agreed with them	Sequence, specificity to this person, the invitation to disagree, the check of understanding	**An agreed immediate step, a follow-up, and a trigger for earlier review**

33.7 How a watched performance is scored

Two instruments, one performance. Observed clinical assessment is conventionally marked in two layers at once. The first is itemised: a schedule of acts specific to the task, ticked as they occur, which makes the format reproducible between examiners. The second is a **global rating**, one overall judgement made by a clinician asking whether they would be content to have this seen by a colleague at this stage of training. Neither alone is sufficient: an itemised schedule alone rewards a candidate who never notices the person answering, and an overall impression alone reintroduces the variability the format was built to remove.

Three consequences follow. An act you did not perform is not credited because you said you would have performed it, so do the thing rather than describe it. An act performed silently may not be credited either, so narrate the examination as you conduct it. And the examiner is usually instructed not to help: silence is not disapproval, and information will not arrive unless it is asked for. Candidates read that neutrality as failure and abandon a correct line halfway through.

The limit of all this should be explicit. No Indian regulatory instrument retrievable for this chapter prescribes a marking schedule, a rubric or a standard-setting method for a psychiatry station. What is written above is the general logic of observed assessment, not your board's published rubric, because no comparable standard is available to quote, and none is invented here.

RULE **A station scores the act, not the knowledge behind it.** This is the difference between a station and a viva, and where prepared candidates lose marks they had the knowledge to earn. In a viva, saying what you would do is the performance. In a station, it is an admission that you did not do it. Convert preparation into sentences you would say to a patient and acts you would perform, and rehearse it in that form.

PITFALL

Performing to the schedule and losing the person. A candidate who has memorised a list of questions gets through it, ticks a satisfying number of items and is still marked down, because the overall judgement is made by a clinician who has just watched a distressed person be processed. The tell is a station run without a pause and without any response to what the patient said. Cover the schedule by knowing the territory, not by reciting a sequence.

33.8 Where the station sits in the Indian postgraduate practical

Three instruments govern this, a fourth is only a contrast case, and they span a generation. The oldest is the MD Psychiatry ordinance of a Karnataka state health-sciences university, dated 2000. It makes no provision at all for an objective structured clinical examination, its clinical examination being entirely long cases and short cases. That is a finding about the document, not about your examination, and it is superseded on this point.

The national regulations of 2023 changed the position by naming the objective structured clinical examination inside the practical pass criterion, alongside the clinical and the viva voce. That placement is load-bearing: a component named in the sentence deciding whether the practical is passed is part of the practical. Then the state health-sciences university acted. By a notification dated 16 December 2024, made under section 35(1) of its governing Act of 1994 as amended in 2013 after a special meeting of its Syndicate on 22 November 2024, it decided to apply the 2023 regulations to the 2021-22 academic batch and to the upcoming broad-specialty postgraduate examinations, subject to relaxations on attendance, publications, the district residency programme and the courses in research methodology, ethics and cardiac life support. What carries new regulations onto candidates admitted before they were made is recorded in the same notification: the university states that it received a clarification from the National Medical Commission dated 28 November 2024, that the 2023 regulations apply to all students appearing in the forthcoming postgraduate examination. That is the university's account of the letter, not the letter itself.

The operative clause on the station is narrower than candidates assume. The notification provides that an objective structured clinical examination or a short case shall be included from the ensuing postgraduate examinations. The obligation is mandatory and the vehicle disjunctive: one or the other shall be included, and nothing establishes that you will face a circuit rather than a short case. The same notification puts valuation of theory scripts and computation of results under the 2023 regulations, and a 2025 judgment of that state's High Court records that evaluation of marks is governed by the notification of 16 December 2024, confirming it is in force and not a proposal.

INSTRUMENT	DATE	WHAT IT SETTLES ABOUT THE STATION	WHAT IT LEAVES OPEN
MD Psychiatry ordinance of a Karnataka state health-sciences university	2000	Nothing: no objective structured component, and a clinical examination of long cases and short cases only	**Superseded on this point, and never a source for a station's format**
MD Psychiatry ordinance of a private university in Karnataka	edition year 2019-20	That one institution listed it among training activities, a weekly interviewing-skills programme with no mark line	**Everything about examination use: a contrast case, not evidence of anybody else's practice**
National Post-Graduate Medical Education Regulations	2023	That it is named inside the practical pass criterion, beside the clinical examination and the viva voce	**Station number, length, marks and marking schedule**
Notification of the state health-sciences university applying the 2023 regulations	16 December 2024	That an objective structured clinical examination or a short case shall be included from the ensuing examinations, so such a component is now mandatory	**Which vehicle, and the weight of either: the division of practical marks is referred to a board of studies**

IN INDIA

Because the clause is disjunctive and the marks division referred onward, the answer for your own examination sits in a departmental decision rather than in any document you can read. Put three questions to your department and the examination section, in writing, early enough that the answers can still change your plan: whether a station component will be conducted at all or the requirement discharged by a short case; if stations, how many and how long; and how those marks sit inside the practical total. Expect the answer late or informally, and prepare for the heavier possibility meanwhile.

TRAP **Reading the acronym instead of the instrument.** The same four words denote two different things in two Indian documents: a component named inside the national practical pass criterion of 2023, and a weekly interviewing-skills training programme with no mark line at all in a private university's ordinance of 2019-20. Candidates take their seniors' usage for the regulation's, hear that the station in their department is a teaching session, and conclude nothing is at stake. What decides it is the instrument governing your own examination, read in its own words.

33.9 The arithmetic that decides the result, and where a station's marks land

Three conditions, all of them conjunctive. Under the 2023 national regulations, passing the examination as a whole requires a minimum of **40 per cent** in each theory paper, then the aggregate across all four papers set out in the strip above, and then the separate line in the

practical. Failing any one fails the examination: a strong practical does not repair a paper below the per-paper floor. That floor is the new element. Under the superseded ordinance of 2000 the rule was not less than half the marks in each of two heads of passing, theory, and practical including clinical and viva voce, with no per-paper requirement, so a weak paper could be carried by strong ones. It cannot now.

Where a station's marks land follows from that criterion's wording. Because the practical is expressly composed of the clinical examination, the objective structured clinical examination and the viva voce, marks won or lost in a station sit inside the same practical line as your long case. There is no separate station threshold and no separate station failure, which is also why the station cannot rationally be written off.

Two further provisions decide results. No grace mark is permitted in a postgraduate examination, in theory or in practical, so a shortfall is a shortfall. And scripts are handled under the national machinery the notification adopted: every theory script receives two valuations, a third follows where the two differ by **15 per cent** or more of that paper's total marks, the best two are then averaged, and there is no revaluation once results are declared.

The board is fixed by the same regulations: at least **four** examiners for a postgraduate examination, of whom at least two shall be external, and at least one of those external examiners shall be from a different university outside the state. At least half the people marking you have never taught you and will read an unexplained local abbreviation as an error rather than a convention.

One point of revision strategy belongs with that floor. The older ordinance placed consultation-liaison psychiatry, geriatric psychiatry and psycho-oncology in the second theory paper and cultural psychiatry in the third, adding that its distribution of topics against papers is suggestive only. Its fourth paper is displaced: under the current instruments the fourth carries recent advances and the first basic medical science. With a floor in every paper, recent advances cannot be written off against strength elsewhere.

GOOD TO REMEMBER

Convert revision into rehearsal by building your own stations. Write a one-sentence instruction on a card carrying the verb, the person and the time. Give it to a colleague, let them hold the clock and play the patient from a brief you did not write, and require yourself to deliver the product aloud before time ends: the summary, the reported findings, or the agreed plan. Then swap, and mark each other against what the instruction asked for rather than what you would have liked to say. This does more for a practical than the same hours spent reading: the failures that cost marks here are failures of shape, and shape only changes under a clock.

33.10 What is not settled, and how to prepare when the format is not fixed

Name the unknowns rather than guessing them. Four things about an Indian postgraduate psychiatry station are not established by any instrument quoted here, and a confident figure for any of them is somebody's local arrangement until you have seen the document it comes from:

- how many stations a circuit contains, if a circuit is used at all;
- how long a single station runs;
- what a station is worth, as marks or as a share of the practical, the division of practical marks being referred to a board of studies;
- whether the requirement will be discharged by stations or by a short case, the instrument being disjunctive on its face.

That is unsatisfying, and better than the alternative. Numbers circulate for all four, usually borrowed from another state or from an undergraduate examination, and a schedule built on a borrowed pattern is worse than one built on none. What is settled is enough to work from: such a component is now mandatory, its marks sit inside the practical line, and the acts it scores are the same whichever vehicle carries them.

That last point is the resolution. A short case and a station both put you in front of a person with a narrow brief and an examiner watching, and both score the performance rather than the account of it. So prepare the behaviour, not the format: read instructions for their verb, introduce yourself and take consent, ask before assuming, narrate the examination as you do it, reach a stated conclusion before time ends, and check that you were understood.

> A station scores what you are seen to do, inside one practical pass line that also holds your long case and your viva; the component is mandatory for the ensuing examinations while its vehicle, count, length and marks are fixed by nothing you can read, so rehearse the acts under a clock and ask your department which vehicle it will use.

34 · Long case and short case presentation format

Why the marks sit here. The clinical examination is the one part of a postgraduate examination that cannot be got up in the week before it, and the part that decides whether a candidate is judged fit to work unsupervised. Its purpose is stated in the regulations, not left to custom: the clinical examination in a clinical-science subject is conducted to test the candidate's knowledge and competence for undertaking independent work as a specialist and teacher. That aim tells you what is being listened for: not whether you can take a history, which is assumed by this stage of training, but whether the account you give of the patient afterwards could be handed to a ward and safely acted upon.

Two formats carry that assessment. The **long case** gives you one patient and expects a whole clinical argument, from the history to a plan in sequence. The **short case** gives you a narrow task and expects competence rather than narrative: elicit this, demonstrate that, interpret what you find, answer for it. The examiner's attention moves accordingly, from your reasoning in the first to your hands and your questions in the second. What follows is the long case and short case presentation format itself, from the shape of the time with the patient to the last answer you give.

1 + 2	2 + 2	300	100
LONG CASE PLUS SHORT CASES REQUIRED OF A CLINICAL-SCIENCE SUBJECT BY THE NATIONAL POST-GRADUATE MEDICAL EDUCATION REGULATIONS, 2023	LONG CASES PLUS SHORT CASES SET BY THE MD PSYCHIATRY ORDINANCE OF A KARNATAKA STATE HEALTH-SCIENCES UNIVERSITY DATED 2000, A MARK SPLIT SINCE SUPERSEDED	MARKS FOR THE PRACTICAL EXAMINATION, THESIS INCLUDED, UNDER A KARNATAKA STATE HEALTH-SCIENCES UNIVERSITY NOTIFICATION OF 16 DECEMBER 2024	MARKS FOR THE VIVA VOCE UNDER THAT SAME KARNATAKA NOTIFICATION OF 16 DECEMBER 2024

34.1 What the two formats are for, and why no single allocation is universal

The format is national; the arithmetic is local. The national regulations governing postgraduate medical education, made in 2023 by the National Medical Commission's Post Graduate Medical Education Board, state that candidates in the clinical sciences shall be examined for **one long case and two short cases**. A university ordinance can set out something heavier. One Karnataka state health-sciences university's MD Psychiatry ordinance, dated 2000, sets a second long case in neurology worth the same as the psychiatry one, with two psychiatry short cases at 25 marks each; those four cases account for the whole of that ordinance's clinical examination, which it sets at 200 marks. That split has since been overtaken at its own university: a notification of 16 December 2024 sets the practical examination at 300 marks including 20 for the thesis and the viva voce at 100, and expressly leaves the division of marks inside the practical to be settled in consultation with its board of studies. The totals are fixed and the per-case figures are not, so no long-case or short-case mark value can honestly be quoted for it now, and none from an older document may be carried across to fill the space.

The relation between the national regulation and the older ordinance is not something either text settles. The national provision is cast in the mandatory form and the older ordinance sets more cases than it specifies; whether that extra long case is a permitted enhancement of a national minimum or a divergence from a national specification is not resolved by the words of either instrument, and it is not resolved here. Prepare for the heavier pattern, because a candidate ready for two long cases is ready for one and the reverse is not true.

DOCUMENT AND DATE	LONG CASES	SHORT CASES	MARKS AND BOARD AS THAT DOCUMENT STATES THEM
The national Post-Graduate Medical Education Regulations, 2023 (India)	One	Two	**The provision that sets the case count carries no mark allocation and no board composition; both are governed by separate provisions of the same regulations**
MD Psychiatry ordinance of a Karnataka state health-sciences university, dated 2000	Two: one psychiatry at 75 marks, one neurology at 75 marks	Two, both psychiatry, 25 marks each	**Clinical examination 200 marks; a board of four members, of whom one should be a neurologist or clinical psychologist**
Notification of the same Karnataka state health-sciences university, 16 December 2024	Not stated	Not stated	**Practical 300 marks including 20 for the thesis, viva voce 100; the division of marks inside the practical is referred to consultation with the board of studies, so no per-case figure is published**

RULE **The clinical examination tests whether you can be left alone with the patient.** Both the national regulations and the university ordinance state the aim in the same terms, competence for independent work as a specialist and teacher, and every marking decision descends from it. A presentation that proves you gathered information but never commits to what happens next has answered a question nobody asked. Commit, then defend the commitment.

34.2 Read the document that governs your own examination

The act that comes before any revision. The single most useful hour of preparation is spent not on a textbook but on the **ordinance** under which your university examines, together with any later notification amending it, because between them they tell you what you are walking into, and because departmental custom drifts from both in either direction. Obtain what your university publishes for your degree and your subject, and read the examination provisions in full rather than the summary a senior has drawn from them. Extract, in writing:

- how many long cases there are, and whether one of them is a neurology case rather than a psychiatry case;
- the marks on each long case and each short case, if the governing document states them at all rather than fixing only the totals and leaving the split to be settled later;
- how many short cases there are, and whether they are drawn from psychiatry alone;

- whether any objective structured component is marked as part of the practical, which is set out in the section of these notes on the structure of objective structured stations in psychiatry;
- the composition of the examiner board, including whether a non-psychiatrist sits on it;
- how your marks are grouped when the result is decided, which is a separate provision and is treated in that same section rather than assumed here.

Do this early enough that it can still change your plan.

IN INDIA

Ordinances are published unevenly. A university may host a scanned regulation many years old, amended since by notifications and circulars that are not printed alongside it, while the department examines to a pattern that has moved on again. Two consequences follow. The published instruments, ordinance and amendment together, are what an appeal, a grievance or a query to the examination section has to rest on, so read them even where you expect them to be stale. And ask the department directly, in writing if you can, whether the pattern in force differs from what is published, well before the final months.

34.3 The time with the patient, and what must be finished before it ends

The long case is decided before you open your mouth. How long you are given with the patient is set locally, and no comparable standard is available to quote, and none is invented here. What is general is how the time should be shaped. Consent and a workable rapport come first, because a patient already examined by several candidates will give a thin history to the next one unless that candidate troubles to be human about it. Then the history, taken in the order you always take it, because a familiar order is what protects you from omission under pressure. Then the examination, mental state and physical, actually performed. Then, and this is the part candidates sacrifice first, a period in which nothing new is collected and the case is turned into an argument.

That last period is not optional. It is where you write the summary you will speak, decide the diagnosis you will lead with, name the alternatives you will dismiss and the grounds for dismissing them, and rehearse your opening until it is fluent. A candidate who spends the whole allotted time collecting arrives with a full notebook and no position, and then reads it out. The corroborative history is part of this work rather than an appendix to it: seek the informant, record who they are, how long they have known the patient and how much they witnessed themselves, because **informant reliability** is a judgement the examiner expects you to have made and stated, not a box filled.

GOOD TO REMEMBER

Do the general physical and neurological examination on the long-case patient, every time, even when the case is plainly psychiatric and the time is short. It is the element most often skipped and, precisely because it is skipped, among the most reliably asked about. An examiner who finds you have not looked at the fundus, the gait, the pulse or the thyroid has been handed a way to test whether the rest of your account was gathered or assumed.

34.4 The presentation: a summary that stands on its own

The examiner should know the case by the end of your third sentence. The presentation opens with a **summary statement**, and its test is severe: if the examiner stopped you there and heard nothing else, they should be able to say what kind of illness this is, roughly how long it has run and what shape it has taken. That means the opening carries the patient's identifying particulars and social position, who gave the history and how reliable it is, the duration and the course, and the dominant syndrome named in phenomenological rather than diagnostic language. It does not carry the diagnosis yet, and it does not carry chronology for its own sake.

Two habits of speech matter as much as the content. Expand every abbreviation aloud; shorthand that saves time on a case sheet reads as imprecision when spoken, and some of it is genuinely ambiguous across specialties. And report phenomenology in the patient's own words before translating it into a technical term, so the examiner can hear the raw material and check your translation. A candidate who says the patient described a voice speaking about him in the third person, and then names the phenomenon, has shown two things. A candidate who names the phenomenon alone has shown one, and has invited the examiner to ask what the patient actually said.

MNEMONIC

Whose, What, Why, What next

The four questions a long-case presentation has to answer, in order. **Whose** problem this is: the patient, their circumstances, the informant and the reliability of the account. **What** is wrong: the phenomenology, then the diagnosis argued against its alternatives. **Why** it has happened to this person now: the formulation. **What next**: investigations and a plan in sequence, with a prognosis you can justify. A presentation that stalls does so almost always because it never left the first question.

34.5 Marshalling the evidence, including what you did not find

Group your findings by the argument they serve, not by the order you collected them. After the summary, the body of the presentation is evidence, and evidence persuades in proportion to its arrangement. Take the positives supporting your leading diagnosis together, then the features that would ordinarily point elsewhere and what you make of them, then the course and the treatment history with an explicit statement of whether previous treatment was adequate in dose and duration and whether it was actually taken. Chronology belongs inside each of these, not across the whole.

The element that separates a competent presentation from a strong one is the **pertinent negatives**: the findings you specifically sought and did not obtain. Stating them is how the examiner learns that your differential existed before your conclusion did. A candidate who says there was no head injury, no seizure, no sustained elevation of mood and no substance use in the relevant period has closed doors deliberately. A candidate who omits them leaves the examiner unable to tell whether those doors were closed or never opened, and the examiner will find out by asking. Risk belongs here too, stated rather than waited for; the assessment of suicidal risk itself

is developed in the Somatic-symptom, sexual, impulse-control disorders and suicide notes, but the fact that you have made one, and what you concluded, is yours to say before anybody asks.

> **PITFALL**
>
> Never state a finding you did not elicit. Under pressure, and especially when an examiner asks about something the presentation omitted, there is a strong pull towards supplying the answer the case seems to require. The correct answer is that you did not ask, or did not examine for it, and, if you can, what you would ask now and why. An examiner who catches one invented detail has a reason to distrust the entire account, including the parts that were true and carefully obtained. The cost of the honest answer is one mark; the cost of the invented one is the case.

34.6 From diagnosis to formulation, which is what the second half of the questioning is about

A diagnosis is a claim, and a claim invites the question "what else?" State the diagnosis you have reached, with the classificatory system you are using, and then do the work that earns it: name the serious alternatives and give the grounds on which each is set aside. Alternatives are set aside on evidence, not on adverbs, and the evidence is what you have just presented. Where you genuinely cannot decide, say so, say what would decide it, and say what you would do in the meantime. That answer is more mature than a false confidence and is usually marked as such.

Then move to the **formulation**, which asks a different question: not what this illness is but why this person has it now, and why it is taking this shape and this course. Predisposing, precipitating, perpetuating and protective factors are the frame, and the substance is reasoning that ties them to the person in front of you, not a list applied generically. The construct itself, and how a formulation is built and written, is taught in the Psychotherapies, clinical assessment, MSE and nosology notes; what belongs here is the discipline of presenting one. Keep it short and specific to this patient, and make sure it does work: a formulation that explains nothing about the plan you are about to propose has not been used. Then give the plan in sequence, with the investigations you would send and, more searchingly, the ones you would not and why. Deciding not to investigate is a clinical decision and is examined as one.

34.7 The neurology long case, and the commonest error of preparation

Where a second long case is neurological, half the long-case marks are not psychiatric. In the Karnataka ordinance of 2000 the neurology long case carried **75** marks, exactly what the psychiatry long case carried, and that equality is the part worth holding on to even where the current figures are unpublished. A revision plan built entirely from psychiatry is therefore not cautious; it has conceded a substantial block of marks before the examination begins. This is the commonest strategic error on this format, and it is invisible to the candidate making it, because psychiatry revision feels like the responsible use of the time.

A neurological long case asks for a different sequence, and the difference is worth rehearsing rather than reading about. The history is taken to localise before it is taken to diagnose. The examination is then not merely performed but demonstrated, in a sequence the examiner can follow, with signs elicited cleanly and described in the language of the system involved. The presentation ends with an anatomical statement and then a pathological differential, in that

order: where the lesion is before what caused it. The neurological syndromes themselves, and the examination that discloses them, are taught in the Neurology foundations for psychiatrists notes and the Stroke, TBI, delirium and focal brain syndromes notes, with the seizure disorders in the Epilepsy and psychiatry notes and the cognitive syndromes in the Dementias and neurocognitive disorders notes. What is owed here is the instruction to prepare for the case as a case: on real patients, out loud, in the order you will use in the hall.

34.8 The short case: competence under a narrower brief

A short case is a task, not a story. The two instruments that state a case count agree on the number of short cases: two in the national regulations and two in the older Karnataka ordinance. What changes is not the standard of clinical work but its scope. You are given a defined brief, usually to elicit and then to show: a mental state examination of one domain, a cognitive assessment, a set of neurological signs, an interview segment with a stated purpose. The examiner is often present while you work, and that is the point: in the long case your technique is inferred from your account, in a short case it is watched.

So **demonstration** becomes the marked activity. Say what you are about to do and why, do it in a sequence, describe what you find as you find it, and offer an interpretation that is proportionate to the amount you were able to examine. Do not deliver a full formulation for a short case, and do not open with a summary designed for a long one; both read as a candidate with one script and no judgement. Where the brief involves eliciting motor or catatonic phenomena, the phenomena themselves are taught in the Other psychotic disorders, delusional syndromes and catatonia notes, and the bedside conduct of scales and structured tests is set out in the section of these notes on demonstrating clinical scales and bedside tests. What is examined here is whether you can do a small thing correctly while observed, and stop when it is done.

AXIS	THE LONG CASE	THE SHORT CASE
What you are given	One patient and an open brief: assess and present	**A narrow, stated task on a patient or an interview segment**
What you do with the patient	Full history, informant account, mental state and physical examination, then time to build the argument	**The specified elicitation or examination, performed while it is watched**
What you present	Summary, evidence with negatives, argued diagnosis, formulation, plan in sequence, prognosis	**Findings as they were obtained, then an interpretation proportionate to the brief**
What is actually marked	Clinical reasoning: whether the plan could be acted on unsupervised	**Technique and economy: whether the procedure was done correctly and cleanly**
What ends it	The examiner's questions, which begin where your argument stopped	**The completion of the task, after which a candidate should stop talking**

34.9 The board across the table, and what a mixed board changes

Not everyone examining you is a psychiatrist. Under the Karnataka ordinance of 2000, the **board of examiners** for the clinical examination consists of **four** members, one of whom should be a neurologist or a clinical psychologist. Note the ordinance's own verb: the requirement is expressed as what should be the case rather than as an absolute, so the board you actually meet may be composed either way, and preparing on the assumption of a mixed board costs nothing.

The consequence is practical. If a neurologist sits on the board, your neurological examination is watched by somebody who performs it daily and will notice a manoeuvre done for form rather than for information. If a clinical psychologist sits on it, expect more exacting questioning around assessment instruments, including what a test measures and what its result does not license you to conclude; that material is developed in the Psychotherapies, clinical assessment, MSE and nosology notes. Either way, pitch the presentation to a competent colleague from outside your own subspecialty interest, another reason to expand abbreviations and give phenomenology before jargon.

34.10 Where the marks are actually lost

The failures on this format are few and repetitive. Each is avoidable by a decision rather than by more knowledge:

- the summary never arrives, because the candidate began at the beginning of the history and is still there when the examiner intervenes;
- the negatives are missing, so the differential appears to have been constructed after the conclusion;
- the diagnosis is asserted, not argued, and the alternatives are named without grounds for dismissing them;
- the physical and neurological examination was not done, and the candidate is asked about it;
- the plan is a list of everything rather than a sequence, with no statement of what comes first and what would change it;
- risk is not mentioned until the examiner raises it.

Only one of these is a knowledge failure. The rest are failures of shape, and shape is trainable: present real cases aloud, to a colleague who will interrupt, against a clock, until the summary and the argued diagnosis arrive early enough to be heard.

TRAP **Presenting the case sheet instead of the case.** The commonest failure is to narrate the written record in the order it was written, treating completeness as the virtue being marked. It is not: the case sheet is the raw material and the presentation is the argument built from it. The candidate who reads the record runs out of time in the personal history, delivers the diagnosis and plan as bare assertions, and is then examined on precisely the reasoning that was crowded out. Write the record in full, and then present something else.

34.11 Currency, disagreement, and the part of this that does not vary

The honest position on the documents. The instruments discussed here do not sit comfortably together, and a reader is better served by seeing that than by a tidy synthesis. The Karnataka ordinance is dated 2000 and applies from that academic year, and both of its arithmetics have since moved. Its written papers were four of three hours each, carrying two long essay questions at 20 marks and six short essay questions at 10, and that pattern is not what the same university now sets: under the notification of 16 December 2024 each of the four theory papers is set at **ten questions of ten marks**. Revising to the older pattern would be revising to the wrong shape. The national regulations of 2023 supply the frame the newer notification works inside: the theory examination may be of descriptive or multiple-choice type of equal duration, the descriptive form runs to four papers, and the first and the fourth are on basic medical sciences and recent advances respectively. The newer notification does not give a paper's duration and does not say what the middle two papers contain, and neither is supplied here. What the older ordinance remains good for is shape rather than schedule: it is evidence that allocations differ between universities, not a table to memorise for your own examination.

What does not vary is what this page is for. Whether you face one long case or two, whether one of them is neurological, whatever the short cases turn out to be worth, the presentation that earns the marks has the same architecture: a summary that stands alone, evidence arranged as an argument with its negatives stated, a diagnosis defended against named alternatives, a formulation that does work, a plan in sequence, and a candidate who says what they did not find. The arithmetic, where a document publishes it, tells you how to divide your preparation. It does not change how you present a patient.

> Read the ordinance and any later notification that governs your own examination before you plan a single revision session, and prepare for the heavier of the patterns you find: how many long cases there are, whether one of them is neurological, who sits on the board, and whether the marks on each case are stated at all rather than left to be settled later.

35 · Demonstration of clinical scales and bedside tests

Why the doing is its own competence. A candidate can describe an instrument accurately, say what it was built for, and still be unable to run it on a real patient while somebody watches. Knowing an instrument and conducting one are different competencies, and only the second shows at a bedside. In the demonstration of clinical scales and bedside tests, what is on display is not the instrument's content, which could have been read the night before, but a procedure: whether you obtained permission, whether you set the conditions the instrument assumes, whether you delivered its instruction unaltered, whether the patient was left with their dignity intact, and whether you could then say out loud what you had and had not established.

Set the boundaries first. The instruments themselves, the bedside cognitive screens among them, together with the rating scales and the detailed neuropsychological batteries, are taught in the Psychotherapies, clinical assessment, MSE and nosology notes and in the Dementias and

neurocognitive disorders notes. No item, scoring rule or cut-off is reproduced here, and none is needed for the skill this section teaches. The second boundary is a silence, and it is stated at the front rather than buried: how a demonstration of this kind is called for, whether it is marked as a thing of its own, in what time, and against what weighting cannot be stated, because no comparable standard is available to quote, and none is invented here. A reader not told that will assume a marking scheme exists which they were simply never shown, and will prepare for the tariff instead of the act.

35.1 What you can be handed, and why it matters which

The instruction can arrive in more than one form, and they are not the same task. A **rating scale** is a published instrument with fixed items, a fixed order and a scoring convention, so its demonstration is mostly a question of fidelity: you are showing that you can run somebody else's procedure without deforming it. A **bedside test** is a manoeuvre drawn from the clinical examination, elicited and described rather than scored, so its demonstration is one of technique and accurate description: the burden shifts from following a script to eliciting a sign cleanly and reporting exactly what you saw.

A third instruction is thinner and carries more risk: assess this patient's cognition, or show how you would quantify this patient's depression, with no instrument named. Here the choice of instrument is itself part of what you are demonstrating, and it has to be defended in one sentence before you begin: what the question is, what the patient can physically and linguistically do, and how much the task will take out of someone who is unwell. Choosing an instrument the patient cannot complete, and discovering it mid-administration, is an avoidable failure that begins before the first item.

35.2 The conditions the instrument assumes, and whose job they are

Every instrument silently assumes conditions, and the person administering it owns all of them. A patient who cannot hear the instruction has not failed the item; the administration has. The **conditions of administration** are therefore fixed first, visibly, and named aloud so that anyone watching knows they were fixed rather than assumed:

- Spectacles and hearing aids in place and working, and if they are not available, that fact stated before the task rather than after the result.
- Adequate light on the page and on your face, and a position where the patient can see your mouth while you speak.
- A firm writing surface and a working pen for any task requiring drawing or writing, arranged before the instruction is given, not searched for mid task.
- The language of administration settled, and a decision made about whether you or somebody else will speak it.
- A patient who is awake, not in pain and not mid-procedure, with a clear agreement that the task stops if that changes.

The last is regularly skipped because it feels like a courtesy rather than a technical prerequisite. It is technical: a drowsy or distressed patient generates a result that describes the drowsiness, and reporting it as the patient's performance is a substantive error, not a soft one.

35.3 The words before the first item

The opening should be short, said once, and delivered as though the patient rather than the observer were the only person in the room. It has to do a few things at once: identify you, describe what is about to happen, warn that some tasks will feel easy and others harder, remove the sense that a wrong answer has consequences, and make explicit that the patient may stop. Then stop talking and wait for an answer, because permission that is not actually given is not permission, and a task begun while the explanation is still running was agreed to by a patient who did not yet know what they were agreeing to.

Keep this at the level of ordinary clinical courtesy. The separate legal question of the patient who cannot give a valid consent to being assessed at all is a different subject, treated on its own elsewhere in these notes. What matters here is that permission was sought, that it was audible, and that it was obtained before anything was administered.

35.4 Fidelity: the instruction as written

The core of the whole act is delivery of the instrument's own wording, at its own pace, as often as it permits and no more. **Verbatim instruction** feels stilted to a clinician who has spent years learning to speak in a patient's idiom, and the temptation to improve on it is strong. Resist it. The improved instruction is a different instruction.

RULE **An instrument administered differently is not that instrument.** Every deviation, however kindly meant, moves the result off the standard procedure the published version rests on, so the result you obtain belongs to your improvised version rather than to the instrument you are about to name in your report. This is a clinical matter and not a formality: a generous administration produces a reassuring result on a patient who is not reassured, and the next clinician to read the record has no way of knowing that it happened.

The mirror of fidelity is tolerance of failure. **Coaching** is the reflex to rescue a patient who is struggling, with a hint, a gesture, a slower repetition, an encouraging partial answer, or a generous reading of a near miss. It comes from decency and it destroys the observation. An item the patient cannot do is left undone and recorded as undone, and the discomfort of watching that happen is part of the skill. If the patient becomes distressed, the correct act is to stop the task, not to soften it: a stopped task with a stated reason is interpretable, whereas a completed task that was quietly assisted is not.

35.5 The patient and the observer in one room

A demonstration asks you to be intelligible to somebody standing behind you while remaining engaged with the person in front of you, and the tension is usually resolved badly in one direction or the other. Turning towards the observer converts the patient into an exhibit, and the discourtesy is visible. Turning away entirely leaves nobody able to tell whether the instruction was given correctly at all, which is the part an observer cannot reconstruct afterwards.

The workable answer is positional and vocal rather than verbal. Sit where your voice carries past you, keep your eyes and your body oriented to the patient, deliver instructions at a volume that carries behind you, and do all commentary about the patient after the task and away from the bed. Nothing about a finding is discussed over the patient's head. If something must be said mid-task, it is said to the patient.

GOOD TO REMEMBER

One line in the record does most of this work, and it is written at the time or not at all: which instrument and which version was used, the language it was administered in and by whom, the sensory aids that were in place, and any item not attempted with the reason it was not. A result recorded without them cannot honestly be compared with the same patient's result on another day, and a comparison you cannot trust is worse than no baseline.

35.6 The act, step by step, and what deforms each step

The table sets the sequence against its characteristic failure. The right-hand column is the operative one: each entry is a deviation that looks small at the bedside and changes what the result can be used for.

STEP	WHAT HAS TO BE VISIBLE IN THE DOING	THE ALTERATION THAT MAKES IT A DIFFERENT TEST
Permission and framing	The patient hears who you are and what the task is, and agrees, before anything is administered	Starting the first item while still explaining, so the permission covers a task the patient had not yet heard
Conditions	Aids, light, seating, writing surface and language settled and stated aloud	Running the task through an uncorrected sensory deficit and reporting the output as the patient's performance
Instruction	The instrument's own wording, at its own pace, repeated only as it permits	Paraphrasing, simplifying, repeating a single-presentation item, or translating on the spot without saying so
Response handling	What the patient did, recorded as they did it, including refusals and near misses	Rescuing a failing item with a hint, a gesture or an encouraging repetition
Failure	An item the patient cannot do left failed and noted as failed	Reading it generously because the patient is old, tired or unwell
Closure	The patient brought out of the task, thanked, and told what happens next	Turning away to report while the patient is still sitting in the middle of it
Report	Conditions, procedure, observation and limits, in that order	Opening with a total, or with a diagnosis

35.7 Stopping the task, and what the report contains

Closure is the step most often lost, because by the end of the task the candidate's attention has already moved to the report. The patient has just been asked to do things they may have done badly, in front of strangers, and leaving them there is unkind and conspicuous. Close the task explicitly, thank them, answer the question they usually ask about how they did in terms of what happens next rather than the result, and only then turn to reporting.

Conditions	Procedure	Observation	Limits
THE STATE OF THE PATIENT AND THE ROOM WHILE THE TASK WAS RUN	WHICH INSTRUMENT, IN WHICH LANGUAGE, ADMINISTERED BY WHOM	WHAT THE PATIENT ACTUALLY DID, IN THE ORDER THEY DID IT	WHAT THIS OBSERVATION CANNOT SETTLE BY ITSELF

Conditions first tell the listener how much weight the rest of the report can carry. Procedure next fixes what was actually administered. Observation is then description rather than verdict: which domains the patient managed, where the difficulty sat, and what it looked like. The limits are stated by you rather than extracted from you, and they matter, because a screening observation obtained once, at the bedside, in a patient who is acutely unwell settles very little on its own.

TRAP **Reporting a total instead of a performance.** Candidates do it because a number sounds like an answer and appears to close the task cleanly. It does neither. A single total conceals which domain the patient actually struggled in, which is the part that changes what happens next, and it puts the weight of the answer on interpreting the figure, which is a separate skill treated on its own elsewhere in these notes. Describe what the patient did, name where the difficulty sat, say what you would do next, and say what you would want before committing to any reading of the result.

35.8 When the demonstration cannot be completed as designed

The situation to expect, rather than the clean one. Real patients refuse, tire, become distressed, cannot see the page, cannot hold the pen, do not share your language, or have an attendant who answers on their behalf. **Incomplete administration** is not a failed demonstration; it is a demonstration of something harder, which is judgement under a constraint you did not choose. What converts it into a failure is concealment: an abandoned task described as though it had been completed, or a partial result presented without the conditions that made it partial. Say what you did, say where you stopped, say why, and say what you would do instead.

IN INDIA

An instrument published in English, a patient whose first language is not English, and a relative who answers on the patient's behalf are the ordinary conditions of a bedside demonstration in an Indian general hospital, and each is handled by an act rather than an apology. If a validated version in the patient's language exists and is available, use it and say which one. If it does not, say aloud that you are translating, name who is translating, and treat the output as an observation obtained under translation rather than as the instrument's own result. Where a family attendant is present, ask them courteously and audibly not to supply answers during the task, and record that you asked: an attendant's prompting is the ordinary way a bedside cognitive task quietly becomes a family interview. Schooling and literacy are recorded alongside the sensory aids as conditions of the observation. How far they move a given instrument's result is that instrument's own literature and belongs to the Psychotherapies, clinical assessment, MSE and nosology notes.

MNEMONIC

Ask, Adjust, Administer, Acknowledge, Account

The spine of the act, in the order it happens. **Ask**: name yourself, name the task, obtain permission, and wait for it. **Adjust**: aids, light, seating, surface and language settled aloud before the first item. **Administer**: the instrument's own wording, at its own pace, with failure left standing. **Acknowledge**: close the task with the patient before you turn away from them. **Account**: conditions, procedure, observation and limits, in that order, with the limits volunteered rather than extracted.

In a demonstration the product is the procedure, not the patient's score: the conditions you fixed, the instruction you gave unaltered, the performance you recorded as it happened, and the limit you placed on it yourself.

36 · Communication, breaking bad news and risk-assessment stations

Why the marks sit here. Most of a postgraduate examination asks for an account of something. Communication, breaking bad news and risk-assessment stations ask instead for the thing itself, performed once, in front of somebody whose task is to watch how it is done rather than to hear what is known about it. That difference is the whole of the assessment, and it is why these stations separate candidates whose written papers look alike. A candidate can define collusion, name a disclosure protocol and list the correlates of suicidal intent, and still be unable to sit down with a frightened man and tell him what the biopsy showed. The examination exists in part to find that out.



Fig 29.14 The SPIKES protocol structures breaking bad news through setting up the conversation, assessing perception, obtaining an invitation, sharing knowledge, responding to emotions and agreeing a strategy and summary.

There is a second reason the marks are here, and it is a claim the profession makes about itself rather than an examiner's convention. The Indian Psychiatric Society's clinical practice guidelines on breaking bad news, published in 2023, record that many physicians consider psychiatrists best suited to breaking bad news, being better at handling emotions and more effective in communication skills, and that this role becomes much more important in a consultation-liaison set-up. Read the first of those exactly as written: it is a view attributed to colleagues, not a finding about outcomes, and the guideline reports it as such. It is nonetheless why a surgical unit telephones on a Friday afternoon about a family that will not let its patient be told.

6	4	2023	13.6%
STEPS IN THE SPIKES PROTOCOL FOR BREAKING BAD NEWS	OBJECTIVES THAT SAME PROTOCOL SETS FOR THE CONVERSATION AS A WHOLE	YEAR OF THE INDIAN NATIONAL PROFESSIONAL-BODY CLINICAL PRACTICE GUIDELINE ON BREAKING BAD NEWS	OF ONE IRANIAN MEDICAL-SCIENCES UNIVERSITY'S FACULTY AND RESIDENTS FOUND TRAINED IN DELIVERING BAD NEWS; NOT AN INDIAN FIGURE

36.1 What is actually being examined, and the yardstick it is examined against

The station marks a transaction, not a recitation. What the tasks grouped as communication, breaking bad news and risk-assessment stations have in common is that an examiner is watching an exchange rather than hearing a report about one. What can be seen from outside that conversation is a short list of things: whether the patient was allowed to say what he already believed before he was told anything; whether the information was released at a rate the person in front of you could absorb; whether an emotion, when it arrived, was answered rather than talked over; and whether the two of you finished with something agreed that was not agreed at the start. Everything else is commentary. The candidate who has prepared the content of the news and not the shape of the conversation will deliver an accurate, complete and useless five minutes.

There is a published yardstick for this and it is worth holding, because it converts a vague instruction to communicate well into **four** checkable objectives: gathering information from the patient, transmitting the medical information, providing support to the patient, and eliciting the patient's **collaboration** in developing a strategy or treatment for the future. Notice that only one of the four is about telling. The first is listening, the third is emotional work, and the fourth is a joint plan. A candidate who treats the task as pure transmission has satisfied a quarter of its declared purpose and will be marked accordingly, whatever the accuracy of what was said.

36.2 Why this task falls to the psychiatrist, and why it falls hardest on the ward

The referral usually arrives after the news has already gone wrong. Two things follow from the Indian guideline's positioning of this skill. The first is that the psychiatrist is being asked to do a job other specialties own clinically: the oncologist knows the staging, the nephrologist knows what dialysis will mean, and neither is asking you to take over the disclosure so much as to make it survivable. The second is that the setting where this matters most is named, and it is the **consultation-liaison** set-up, where you are a guest on somebody else's ward with no independent authority over the patient's treatment and a very short relationship to work from. How a consultation service is configured, and what a liaison model changes about that authority, is developed in the section of these notes on the principles and models of consultation-liaison psychiatry.

That guest status is the practical difficulty, and it should shape the answer you give an examiner. You rarely control who has already spoken to the family, or what they were told. So the first act of a real consultation is almost never the disclosure. It is finding out what has already been said, by whom, to whom and in what language, because a second version of the truth delivered by a new face is not a clarification to a frightened family: it is evidence that somebody is lying. Ask the

referring team what words they used, and the patient what he has been told; the gap between those two answers is frequently the referral's actual problem.

36.3 The two ways of getting it wrong, and why the decision is not binary

Both silence and bluntness are failures, and the guideline names them symmetrically. This is the ethical spine of the topic and it is where most candidates go wrong, because they arrive holding one side of it. Withholding a diagnosis or a prognosis from the patient on the presumption that he will not be able to handle it may not always be justified in terms of the patient's autonomy and the **right to know**. Hold that modal exactly as the guideline sets it: not that withholding is never justified, but that it may not always be, which leaves the clinical judgement open rather than closing it by rule. Against that stands the opposite failure, which is **insensible disclosure**: pouring out bad news with disregard for its emotional consequences, which may harm the patient's mental health and the therapeutic relationship between patient and doctor.

Set side by side, the two propositions do something useful to the examination answer. They dispose of the question the candidate is silently asking, which is whether to tell or not to tell, and replace it with a better one: how much, to whom, at what pace, and with what support in place afterwards. The candidate who announces that the patient has an absolute right to know and proceeds to exercise it has taken half the frame. So has the candidate who defers entirely to the family. The examinable position holds both halves and then reasons about this patient, and it is available to you as a stated position of the national guideline rather than as your own opinion.

RULE **Disclosure is a process with a rate, not a decision with two options.** The clinical question is never simply whether the patient is told. It is what he already suspects, how much he is asking for today, what will be said next, and who will be with him when it lands. Framing the task as a binary is what produces both classic failures: the conspiracy of silence on one side and the corridor announcement on the other. A protocol is useful precisely because it converts a yes-or-no decision into a sequence that can be paced, paused and resumed.

36.4 The protocol, and an honest word about where this version of it comes from

Name it, then be able to do it. The protocol every examiner expects you to name is **SPIKES**, and its **six** steps are setting; perception of the condition or its seriousness; the **invitation** from the patient to give information; knowledge, meaning the giving of medical facts; exploring emotions and sympathising; and strategy and summary. The Indian guideline of 2023 describes it as the oldest and most commonly used protocol worldwide, which is the sentence to have ready if asked why this one rather than another.

One caveat belongs on the page rather than in a footnote, because a candidate who attributes a protocol wrongly in a viva has made an avoidable error. The wording of the steps given here follows a teaching adaptation issued by a Canadian university's continuing professional development office, which states in its own opening line that it is an adaptation. That document credits the original description to Baile and colleagues in 2000 and a further account to

Buckman. Saying that aloud if pressed on the source is a better answer than a confident misattribution.

MNEMONIC

SPIKES

The six steps in order. **S**etting: the room, the seat, the interruptions. **P**erception: what the patient already believes about the condition or its seriousness. **I**nvitation: the patient's own invitation to you to give the information. **K**nowledge: the medical facts themselves. **E**: explore emotions and sympathise. **S**trategy and summary: what happens next, said plainly, and a summary of what has been agreed. The order carries the teaching. Two of the first three are the patient talking, and the news does not arrive until the fourth.

36.5 The act, step by step

Each step has a condition that must be true before you may move on. The table sets out what the protocol requires and where each step is lost under examination conditions. The detail given for setting, for knowledge and for the exploration of emotion is the protocol's own; the conduct advice attached to the remaining steps is general clinical teaching and is offered as such. Setting is the step candidates believe they can skip because the room is already arranged for them. It cannot be skipped, because sitting down, silencing the interruption and asking whether the patient wants somebody present are visible acts, and the examiner is watching for them.

STEP	WHAT THE STEP REQUIRES	WHERE IT IS LOST
Setting	Arrange privacy, involve significant others, sit down, make a connection and establish rapport, and manage time constraints and interruptions	**Standing, or talking across a trolley. A candidate who stays on his feet has told the patient this will be brief before saying anything**
Perception	Establish what the patient understands of the condition or its seriousness	**Asked as a formality and then ignored. The answer should change what is said next, including whether a warning is needed at all**
Invitation	Obtain the patient's invitation to give the information	**Skipped, or made rhetorical, leaving no room for the patient to decline or to ask for less today**
Knowledge	Use language the patient understands, taking account of educational level, socio-cultural background and current emotional state; give information in small chunks; check whether the patient understood; respond to reactions as they occur; give any positive aspects first	**Delivered whole, in one breath, in the register of a case presentation. Checking understanding is the most commonly omitted act in the protocol**
Emotions	Identify the emotion the patient shows, identify its cause, allow time for it to be expressed, then respond in a way that shows you have connected the two	**Answered with reassurance or with more information. Both end the emotion rather than acknowledge it**
Strategy and summary	Agree a strategy and summarise	**Lost to the clock, because the earlier steps ran long. The patient then leaves with the news and without a plan, which is the worst possible use of the time**

Two habits make the difference on the day. Stop after each small quantity of information, because the first sentence of bad news suspends comprehension and much of what follows it is lost. And when the patient becomes tearful, the station is being marked: name what you see, connect it to its cause, and wait.

36.6 What the protocol has been criticised for, and the modifications that answer it

Know one criticism and two modifications, and the viva answer is finished. The Indian guideline records that clinicians have modified the protocol by adding steps they judged essential. In 2005 a version was published in which a preparation step was prefixed, covering the review of all information about the patient that needs to be communicated and rehearsing it if necessary. A later modification inserts the **warning shot** as a step of its own and replaces the knowledge step with a composite that juggles providing information, clarifying, and dealing with emotions.

The criticism the guideline records is that the protocol has no step on patient questions and clarifications. Be careful with the referent when you repeat it. That sentence follows immediately on the description of the version with the preparation step, so whether the criticism is aimed at the original protocol or at that modification is not settled by the text, and a candidate who asserts one reading confidently has read more into the source than it contains. The safe formulation is that the criticism attaches to this family of protocols, and that the later modification is the answer to it.

VERSION	WHAT IT ADDS	WHAT THE INDIAN GUIDELINE RECORDS
The original six-step protocol	Setting, perception, invitation, knowledge, emotions, strategy and summary	**The oldest and most commonly used worldwide**
The version published in 2005	A preparation step at the front: review everything that must be communicated, and rehearse it if necessary	**Presented as a modification clinicians made by adding a step they felt was essential**
The later modification	A warning-shot step, and an information, clarification and emotions composite in place of a plain knowledge step	**Described as a recent modification; it is the version that meets the recorded criticism about questions and clarifications**

36.7 The Indian consulting room: who is told, and who asks that the patient not be

The protocol assumes a dyad and you will usually be handed a family. In much of Indian practice the relatives receive the information first, often in the corridor, and arrive at your door having already decided what the patient will and will not be told. The request that follows is **collusion**: do not use the word for the diagnosis, tell him it is an infection, he will lose hope. This is not obstruction and it is rarely selfish. It is a protective act inside a model of illness in which the family, and not the individual, is the unit that copes, and it should be met as one.

What works is neither compliance nor confrontation. Ask the relatives what they fear will happen if the patient is told, because the answer is usually a specific and addressable dread rather than a general principle. Ask what the patient has already asked them, which frequently reveals that he knows. Offer to find out what he wants to know rather than to tell him everything, which is the invitation step doing exactly the work it was designed for, and is also the offer families most often accept. The same negotiation runs when the illness is a progressive neurocognitive one and the patient's own comprehension is in question; those syndromes are taught in the Dementias and neurocognitive disorders notes, and capacity at the bedside in the section of these notes on it in the general hospital.

IN INDIA

Do not present the family's request as an ethical error to be corrected. The national guideline's own frame gives you a better position: withholding on a presumption about what the patient can handle may not always be justified against autonomy and the right to know, and disclosure that ignores emotional consequences may damage both the patient and the therapeutic relationship. Both halves sit in the same document, so a candidate can hold the family's protective intent and the patient's entitlement in one answer without appearing to import a foreign standard. The workable route is the patient's own invitation: establish what he wants to know, tell him that much, and tell the family exactly what you did and why.

36.8 The risk-assessment station: an interview that has to arrive somewhere

A risk station examines an act of enquiry, not a list of correlates. This is the station where the mismatch between what candidates revise and what is marked is widest. The epidemiology of suicidal behaviour, the risk and protective factors and the instruments used to structure their assessment are clinical content taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes, and reciting them is not what a **risk-assessment station** is for. What is examined is whether you can ask a person directly about self-harm and death without flinching, follow what he says rather than your schedule, tolerate the answer, and then convert the conversation into a stated level of concern and a plan somebody else could act on.

Three features of the interview are visible from outside it, and all three are marked:

- whether the question was asked plainly and early enough to matter, in words the patient would use rather than in euphemism, because an oblique question invites an oblique answer and the candidate then reports an absence that was never really tested;
- whether the enquiry moved from thought to intent to plan to preparation and access to means, following the patient's disclosures rather than a checklist, and whether protective considerations were sought with the same seriousness as the risk ones;
- whether it ended anywhere at all, because a risk interview that stops at information has not finished.

That last feature is the one candidates lose. Say what you conclude, say what you will do about it now, say what would change it, and say who else needs to know before the shift ends.

TRAP **Performing the label instead of the task.** The commonest failure in both stations is the same, and it is visible from the first sentence: the candidate narrates the protocol at the examiner instead of using it on the patient. Announcing that one would establish the setting, ascertain the perception and then obtain an invitation, while the simulated patient sits unaddressed, scores nothing; nor does reciting risk factors in the examiner's direction while the person who might die that night is asked no direct question. Name the framework once if asked to, then turn your chair towards the patient and do it.

36.9 What must be in the note before you leave the ward

An unwritten risk assessment is an unmade one. On a consultation-liaison service the record is the only part of your work that persists, because the team that acts on it was not in the room. The

entry after a disclosure should state:

- who was present, and who did the speaking;
- the words actually used for the diagnosis and the prognosis, rather than a paraphrase of them;
- what the patient said he had understood;
- what he asked, and what he chose not to be told;
- what was agreed about who would be told what next, which is the line that prevents a second version of the truth reaching the family.

The entry after a risk interview needs a different spine: what was asked, what was said in reply, the level of concern reached and the reasoning that produced it, the actions taken now, and the specific changes that should trigger a fresh assessment. A note recording only that the patient denied suicidal ideation has documented an answer without documenting the question, and it protects neither the patient nor the clinician. It is also how the examiner's follow-up is answered before it is asked, because the viva after a risk station is usually a request for the plan you would write.

GOOD TO REMEMBER

Before you leave the bedside, close three loops out loud: tell the patient what happens next and when somebody will return; tell the referring team, in person where you can, what you said and which words you used, so the next clinician does not contradict you; and write the entry immediately rather than at the end of the round, while the patient's own phrasing is still available to you. The patient's words are evidence and your paraphrase of them is not.

36.10 Who teaches this, and a figure that belongs to somebody else

The guideline gives psychiatry a teaching duty, not only a clinical one. Alongside the clinical role, the Indian guideline states that psychiatrists should play a leading role in teaching communication skills and skills in breaking bad news to their fellow colleagues in other disciplines. That is a useful sentence in a viva on service development, and an unusually concrete duty for a guideline to assign: it makes the department, and not only the individual consultant, answerable for how bad news is delivered across the hospital. A candidate asked how they would improve disclosure practice in their institution has a national document to cite rather than a personal preference to defend.

Behind that duty sits an evidence problem worth understanding rather than repeating. Training in this skill is not assumed to be universal, and the guideline illustrates the point with a study of how few clinicians had been trained. The illustration comes from a population that is not ours, and it is routinely transposed.

PITFALL

The figure of **13.6 per cent** trained in delivering bad news belongs to faculty and residents at a medical-sciences university in Iran, and to nobody else. It sits close to Indian material in the same discussion, which is exactly the arrangement in which a population quietly changes on its way into an answer script. Quote it with its population attached or do not quote it at all. To assert that Indian clinicians are undertrained in this skill is a separate claim requiring Indian evidence, and no Indian figure for it is asserted anywhere on this page.

36.11 The limits of what can be said about the station itself

The honest position on the format. Everything above concerns the act. How an objective structured communication or risk-assessment station is built for an Indian postgraduate examination is a different question and should be treated separately: no comparable standard is available to quote, and none is invented here. Nothing available sets out how such a station is constructed, how long it runs or how its marks are distributed, and a candidate who rehearsed to an invented schedule would be preparing for an examination that does not exist. What is known about how objective structured stations are organised in general is set out in the section of these notes on the structure of objective structured stations in psychiatry, and the conduct of instruments at the bedside in the section on demonstrating clinical scales and bedside tests. Read your own university's ordinance for whether a structured component is examined at all, and ask the department whether the pattern in force differs from the printed document.

What does not vary is the material this page is for. Whichever format your examination uses, the same conversation is being assessed: a patient asked what he already believes before he is told anything, information released at a rate a frightened person can take, an emotion answered when it arrives, a plan made jointly rather than announced, and a record that lets the next clinician continue the same account rather than begin a new one. Practise it on real patients, with a colleague watching, and be corrected out loud. There is no other route to competence in an act, and the interview technique underpinning it is developed in the Psychotherapies, clinical assessment, MSE and nosology notes.

Ask what the patient already believes and how much he wants to be told before you tell him anything, and check what he has understood and state what happens next before you leave: the first two steps and the last two steps of the protocol are where the marks and the clinical outcome both sit, and the news itself is the easy part in the middle.

37 · Interpretation of investigations and instruments in vivas

Why the marks are here. Somewhere in almost every oral examination a piece of paper is turned around and pushed across the table: a report, a chart, a film, a printout or a completed rating form. What is tested is not whether you have memorised a reference range. It is whether you can take an object you did not order, from a patient you may not know, and convert it out loud into a clinical decision, in order, without overreaching and without going silent. The interpretation of

investigations and instruments in the viva is written into the regulations governing the examination rather than left to departmental habit.

Two boundaries first. What an abnormality signifies, what an imaging sequence demonstrates, what an electroencephalogram or a cerebrospinal fluid profile can establish, and how a rating instrument is scored and where its cut-offs fall are taught in the Neurology foundations for psychiatrists notes, in the Dementias and neurocognitive disorders notes and in the Psychotherapies, clinical assessment, MSE and nosology notes. No finding, constant or cut-off is reproduced here. The second boundary is a silence, better stated at the front than discovered late: how many such questions are put, how long you are given for one, and what share of the oral's marks they carry cannot be stated, because no comparable standard is available to quote, and none is invented here.

37.1 What the oral examination is directed at

The national regulations governing postgraduate medical education, made in 2023 by the National Medical Commission's Post Graduate Medical Education Board and applying across India, provide that the oral examination shall be thorough and shall aim at assessing the candidate's knowledge and competence about the subject, about **investigative procedures**, about therapeutic technique, and about other aspects of the specialty. That list settles an argument candidates have with themselves every year: investigations are not an intrusion of general medicine into a psychiatry viva, and the regulation places them alongside the subject itself.

A university ordinance can add how the questioning is conducted. The MD Psychiatry ordinance of a Karnataka state health-sciences university dated 2000 provides that all the examiners **will conduct the viva conjointly**, assessing comprehension, analytical approach, expression and **interpretation of data** across all components of the course contents. Interpretation of data is named there as an assessed quality rather than as a topic, so it is watched throughout and not only when a film appears; and because the questioning is conjoint, your answer must be intelligible to the whole board at once, not only to the examiner who asked.

37.2 What can be put in front of you, and why it is not folklore

That ordinance is unusually explicit about the material. It provides that candidates may also be given case reports, charts, gross specimens, histopathology slides, radiographs, ultrasound and computed tomography images for interpretation, and that **questions on the use of instruments** will be asked. Notice the two modal verbs. The interpretation material is what a candidate may be given. The instrument question is what will be asked.

The clause is not one department's tradition. It appears word for word in that ordinance of 2000 and again in the MD Psychiatry ordinance of a private university in the same state, edition year 2019-20, which marks it as inherited regulation text carried across institutions rather than a local quirk you might be spared. The material listed is therefore generic to the clinical sciences rather than tailored to psychiatry, and the candidate who protests inwardly that a slide has nothing to

do with the specialty has missed that the ward asks the psychiatrist every week to exclude a medical cause before attributing a presentation.

RULE **Describe before you interpret, and interpret before you commit.** Every recoverable answer here has that shape; every unrecoverable one skipped a stage. A description can be corrected by the examiner and the answer continues; a diagnosis offered first has nothing standing under it, so when it is wrong there is nowhere to retreat and what follows is about your error rather than the patient. The order also makes an answer auditable to a board listening conjointly.

37.3 The order of interpretation

A fixed order is faster, not slower, because it removes the decision about what to say next. The order set out below is a working discipline rather than a published convention, and it changes little with the object in front of you. One step deserves emphasis in advance because it is the one most often skipped: say whether the object is technically adequate for the question being asked of it. **Technical adequacy** decides how much weight everything said after it can carry.

STEP	WHAT THE BOARD IS LISTENING FOR	THE ANSWER THAT LOSES THE MARK
Name the object	What it is, whose it is, when it was obtained, in what context	**Reading findings aloud before establishing what is being read**
Adequacy	Whether it can answer the question asked of it at all	**Treating an inadequate study as though it were a normal one**
What is present	Description in the order the object dictates, not the order your eye jumps	**Naming the one striking abnormality and then stopping**
What is absent	The negatives the clinical question required you to look for	**Silence, which a board cannot distinguish from never having looked**
Synthesis	One sentence tying the findings to the question actually asked	**Findings with no answer, or an answer with no findings under it**
Limits and next step	What this object cannot settle, and what you would obtain next	**Closing on a conclusion the object cannot carry**

MNEMONIC

What it is, whether it reads, what is there, what is not, so what, what next

The six steps in the order they are spoken. The last two are dropped first under pressure and are the two that separate a description from an interpretation: **so what** forces the commitment, **what next** shows you know where your evidence stops.

37.4 The trap answers

The failures worth rehearsing are not failures of knowledge. They are things a well-prepared candidate says because the room is tense and a decisive-sounding answer feels safer than a careful one.

- **Accepting the premise.** An examiner who says "this patient's scan is abnormal, what is your diagnosis" has embedded a claim in the question. If you cannot see the abnormality, say what you can see and ask to be shown what is meant. Agreeing first and searching afterwards leaves you defending a finding you never identified.
- **The unpointable finding.** Never name an abnormality you could not put a finger on if the object were handed back. The follow-up is always to show it, and from there the exchange is about your credibility.
- **Supplying a number you do not hold.** A range guessed to fill a pause is the one error that survives the examination and reaches a patient. Say you would check it against the reporting laboratory's own range, which is also the correct clinical answer.
- **Reading a normal result as an exclusion.** A normal test narrows a probability; it does not delete a diagnosis. State what remains possible and what would move you.
- **Reading an instrument's total without its conditions.** A score obtained through an uncorrected sensory deficit, in a language the patient uses poorly, or with a relative supplying answers, describes the conditions rather than the patient. Ask how it was administered first.

TRAP **Leading with the diagnosis.** The commonest single error at this table, and made for an understandable reason: a named condition sounds like mastery and appears to close the question cleanly. It does the opposite. It hides the reasoning that is the only thing being marked, it invites the follow-up you are least ready for, and it leaves nowhere to fall back to when the object turns out to be something else.

37.5 Questions on the use of instruments

The instrument question is a different task and is prepared differently. It does not ask what a device measures in the abstract; it asks whether you have handled one. Which instruments a psychiatry board selects is not specified by any of the documents that create the requirement, so no list is offered here and none is guessed. What is stable is the shape of a good answer, in four moves:

- Identify the object plainly, and say so if you are unsure rather than producing a confident wrong name.
- State what it is for, in terms of the clinical decision it supports rather than its mechanism.
- Describe how it is used and what has to be true before it is used, including the check that gets skipped on a busy ward.
- Say honestly what your own experience of it is: used independently, used under supervision, or seen used. An overstatement here is tested by the next question.

GOOD TO REMEMBER

Build this answer during residency, not during revision. For every investigation you order and every instrument you handle, keep one line: why you used it in that patient, what came back, and what you did differently because of it. A candidate with that habit answers from clinical memory rather than from a list.

37.6 The dissertation viva: the one investigation that is yours

The result you cannot be handed cold. One set of findings you will certainly be asked to interpret aloud, and you generated it. The national regulations of 2023 provide that **five per cent** of the practical marks will be for the dissertation, that an external examiner from outside the state will evaluate the dissertation thesis and take the viva on it, and that marks will be given on the quality of the dissertation and on performance in the viva voce. Both halves are marked, so a sound thesis does not carry a poor defence of it.

20	Outside the state	Before it begins	100
MARKS THE THESIS SHALL BE EVALUATED FOR DURING THE PRACTICAL, UNDER A KARNATAKA STATE HEALTH-SCIENCES UNIVERSITY NOTIFICATION OF 16 DECEMBER 2024	WHERE THE EXAMINER WHO EVALUATES THE DISSERTATION AND TAKES THE VIVA ON IT COMES FROM, UNDER THE NATIONAL REGULATIONS OF 2023	WHEN A COPY OF THE THESIS SHALL REACH THE HEAD OF DEPARTMENT, RELATIVE TO THE START OF THE PRACTICAL EXAMINATION	MARKS THE VIVA VOCE IS FIXED AT BY THAT SAME 2024 NOTIFICATION, WHICH REFERS ITS INTERNAL DIVISION TO A BOARD OF STUDIES

That Karnataka state health-sciences university, by a notification of 16 December 2024 issued under section 35(1) of its 1994 Act as amended in 2013, restates that share as an absolute figure: the thesis shall be evaluated for 20 marks during the practical examinations, the student shall submit a copy to the head of department before the practical examination begins, and those marks form part of the clinical or practical examination marks. Two consequences: the submission is a deadline a candidate can miss by assuming the department will collect the copy, and a weak defence costs you in the same pot as a weak long case.

An honest word on that document. Its wording as reproduced here comes from a copy of the scanned notification rather than the university's own published file, so its authority is corroborated rather than primary: a judgment of the High Court of Karnataka dated 12 March 2025, neutral citation 2025:KHC:10432, records that evaluation of marks is governed by the notification of that date. Plan around the figures; obtain your department's copy before relying on the exact words.

Prepare the defence as an interpretation task, because that is what it is. You will be asked why this design, why this instrument and not the alternative, what the sample will and will not support, and what you would do differently. An examiner from another state shares none of your department's assumptions and no local shorthand.

37.7 Which document governs you, and what has already changed

The scope clause above is the fullest published statement of what the viva contains, and it sits in an ordinance dated 2000. Whether every part of it still governs an examination sat now is not established, and you are better served by that sentence than by a confident assurance. Some of it has certainly moved. Under the older ordinance the viva proper carried **eighty of the viva's hundred marks**; the notification of 16 December 2024 fixes the viva voce at 100 marks and refers the internal division of those marks to a board of studies, so the older split is superseded. That notification does not address the scope of the viva, so the clause listing interpretation material and instrument questions is not expressly displaced.

One further variation is named only so that it is not carried across. The MD Psychiatry ordinance of a private university in Karnataka, edition year 2019-20, splits a 100-mark viva into 80 for the viva proper and 20 for a pedagogy exercise, in which a topic is given to each candidate at the beginning of the clinical examination and presented for **eight to ten minutes**. That **pedagogy exercise** is that institution's own scheme in its own document and is not established for any other examination. Read the ordinance and any later notification your own university publishes for your degree, as the section of these notes on long and short case presentation sets out, and ask which is in force.

IN INDIA

The object pushed across the table in an Indian examination hall is usually one another unit ordered for another purpose. The report may be a line written on the film jacket rather than a formal one; the earlier study that would make the current one interpretable may never have been done, or may be travelling in a folder the family carries between hospitals. None of that is an excuse and all of it is examinable. Say what you have, say what is missing, and name what you would want beside it: the previous film for comparison, the earlier value, the reporting laboratory's own range, or an account of how the instrument was administered.

The board is not asking you to name the abnormality. It is asking you to show that a result changes what you would do next, and to say out loud where your evidence stops.

Cross-cutting synthesis

38 · Cross-cutting synthesis

Four questions, one page. These notes have taught what a consultation is and whose need it answers, what changes when the patient is old, what changes when the account of the cause was settled by the family before anyone sent for you, and how all of it is asked for across a table by examiners. That looks like four subjects. It is four questions put to a single encounter, and they converge on one object: a page written into somebody else's file and acted on tomorrow by somebody who was not in the room. That page is the **consult note**. Anything you elicited that does not reach it has not, for the purposes of the patient's care, happened.

Putting it this way is practical rather than tidy. An unfamiliar referral becomes navigable once you know the pathway it sits inside and the points at which each question has to be asked, because those points are fixed and there are few of them. Asked at the right point, each costs a few minutes. Asked late, each costs a second visit, or a plan agreed in the room and abandoned outside it, or a record that cannot show you did what you actually did.

Not the patient WHOSE FELT NEED PUT A PSYCHIATRIST AT THIS PARTICULAR BEDSIDE	**Against baseline** THE COMPARISON EVERY LATE-LIFE JUDGEMENT IN THE NOTE IS MADE AGAINST	**Already explained** WHAT THE FAMILY HAS USUALLY SETTLED ON BEFORE THE REFERRAL IS WRITTEN	**Somebody else acts** WHY THE NOTE IS AN INSTRUCTION TO ANOTHER TEAM AND NOT A RECORD OF YOUR THINKING

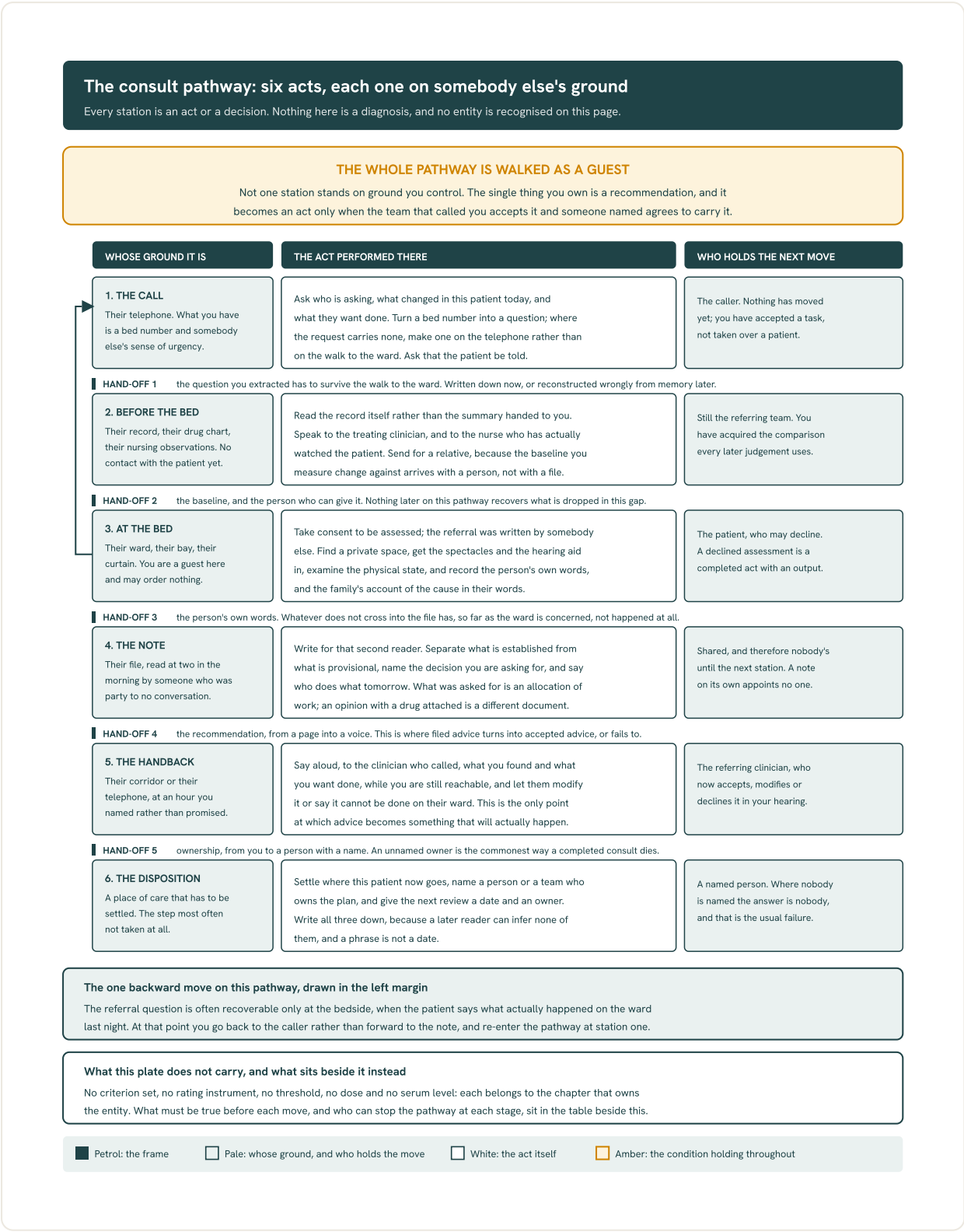


Fig 29.15. The consultation drawn as a pathway of six acts rather than as a set of entities, each station stated as something done or something decided, with the ground the act is performed on named on the left and the person who holds the next move named on the right, the five hand-offs between stations marked as the points at which information is lost, the standing condition that the whole route is walked as a guest set at the head, and the single backward move, from the bedside back to the caller, drawn in the left margin.

38.1 One artefact, and the two people who will read it

A consultation produces two outputs and they are not interchangeable. One is a conversation with the clinician who asked for you, the only point at which the team can say that what you want

is not possible on their ward, and the commonest difference between advice taken and advice filed. The other is the written record, the only output that persists after you leave the building.

The note has two readers who need different things from it. The first is the consultant who called, who wants to know whether what worried them is what you found. The second is the one nobody writes for: the **second reader**, a duty doctor at two in the morning who has never met this patient, was party to no conversation, and has your page and the drug chart. Write for the second reader and the first is served anyway. Write for the first and the note becomes a reply to a colleague, full of things that were obvious in the corridor and opaque by nightfall. That is why a good consult note names the decision it is asking for rather than gesturing at one, and separates what is established from what is provisional, since the person reading it at night cannot ask you which is which.

RULE **Everything this material teaches has to survive into a document another team will act on without you in the room.** That one constraint generates most of what looks like separate advice. Consent is established rather than assumed because a reader must be able to see the patient agreed to be seen. An informant is summoned before the visit because a judgement about change is worthless without the baseline it was measured from. The family's account of the cause is recorded in their words because the reader needs to know what will be accepted. And the decision, its owner and the next review date are written down because none of the three is inferable. An assessment that stays in your head is, to the ward, indistinguishable from no assessment.

38.2 The pathway, and the hand-offs inside it

The consult is a short sequence of acts with a hand-off between each pair, and a hand-off is where information is lost. The accompanying figure sets out the same sequence. Read the table as conditions rather than as a checklist: each row states what has to be true before you are entitled to move on, and who is placed to stop the pathway there.

STAGE	WHAT MUST BE TRUE BEFORE YOU MOVE ON	WHO CAN STOP IT HERE, AND WHAT STOPPING LOOKS LIKE
The call	You know who is asking, what has changed in this patient today, and what they want from you; and the patient has been told a psychiatrist is coming	The person who called, by leaving a bed number and nothing else. The repair is a question put back down the telephone, not a walk to the ward
Before the bed	The record has been read rather than the summary handed to you, the treating clinician has been spoken to, nursing observation is known, and word has gone to a relative to attend	You, by arriving with only the referral slip. Nothing later in the pathway recovers what this stage would have given you
At the bed	Consent taken, a private space found, hearing and language made adequate, the person's own words recorded, and the physical state examined before anything is scored	The patient, who may decline. A declined assessment is a completed act with an output, not a failure to be argued around
The note	Written into the team's own record, in implementable language, naming what is established, what is provisional, and the decision being asked for	You, by writing a diagnosis and a drug. That is an opinion; what was asked for was an allocation of work
The handback	The clinician who called has been told in words what you found and what you want done, and has had the chance to say it cannot be done here	The clock. The repair is to name the hour you will call rather than to promise that you will
The disposition	A named person owns the plan, the place of care is settled, and the next review has a date and an owner	Nobody stops this one. It is simply the step most often not taken at all

Two features of that sequence matter apart from its content. The pathway is a sequence of acts while the note is an artefact with its own spine, and the two are not the same list. And the pathway is less linear than a checklist implies: the **referral question** is often recoverable only at the bedside, when the patient says what actually happened on the ward last night, at which point you go back to the caller rather than forward to the note.

38.3 Where the other three questions enter, and what it costs to ask them late

Age, the explanatory account and decisional capacity are taught as separate subjects, which conceals what makes them manageable at a bedside: each enters this same pathway at a definite point, cheap there and expensive afterwards. The cost of lateness is not embarrassment but a specific, predictable clinical loss, and naming that loss turns three large topics into three questions you remember to ask.

THE QUESTION	WHERE IT ENTERS THE PATHWAY	WHAT IT COSTS WHEN IT ENTERS LATE
What was this person like before, and who can tell me	Before the bed, because the informant has to be summoned in advance and is rarely still there afterwards	Every cognitive and behavioural finding becomes uninterpretable. A second visit is then needed to obtain what one telephone call would have obtained
Whose account of the cause is already in the room	At the call and again at the bedside, since it governs what will be accepted; by the time the note is written the negotiation is over	A plan agreed in front of you and abandoned in the corridor. The abandonment is then misread as denial or as poor insight
Can this person make the decision actually in front of them, now	The moment a decision exists, which is usually before the referral was written	An assessment done only after a refusal reads as retaliation, and the record can no longer show capacity was presumed before it was questioned

The third row carries a trap worth spelling out. Capacity is decision-specific and time-specific, so a note recording that a patient lacks capacity, without saying which decision and on what date, has recorded nothing usable and may do harm when read months later as a settled characteristic of the person. The statutory test, the presumption it starts from and the duty to give information in a usable form are set out in the part of these notes dealing with refusal of treatment in the general hospital. What belongs here is where in the pathway the question arises, and that is earlier than most candidates place it.

38.4 What being old does to the note

Age does not add a paragraph. This is the most useful single point on the life-stage axis, and it is why appending an elderly-patient line to an otherwise unchanged note is not an answer. Age changes what the existing lines mean, and changes them in ways a reader has to be able to see.

- The history line acquires a source. Much of it comes from an informant by necessity, so the note says who gave it and how well placed they were to know: a daughter visiting monthly and a spouse in the same room are not equivalent witnesses.
- The examination line acquires preconditions. A cognitive item put to a patient who cannot hear the instruction measures hearing. Record that the spectacles and the hearing aid were in place, because a reader is otherwise entitled to disbelieve the score.
- The drug line becomes part of the physical examination rather than an administrative detail, and stopping a drug becomes a decision to be written down and justified in the same way as starting one.
- The diagnostic line becomes explicitly comparative, made against this person's own **baseline** rather than against a population, since the range of normal function in later life is wide enough that a population comparison decides nothing.
- The plan line is constrained by who will deliver it. A regimen assuming a supervising relative, a working refrigerator or a return visit next week is a proposal about a household, and the note

should say which household it assumes.

One further change is easy to miss. In an older medically ill patient much of what you write is a request for observation rather than a treatment: what the ward should watch for, when to call you back, and what would change the formulation. That is often the correct output of a single visit, and it reads as indecision only if you fail to say what the observation is for.

38.5 What a different account of the cause does to the note

By the time most of these patients meet a psychiatrist, somebody has decided what is wrong and why, something has been tried on the strength of that decision, and a view has been taken about how much the patient should be told. That is the **account already in the room**, and eliciting it is assessment rather than courtesy, because it predicts what treatment will be accepted, what the family will do next if your plan disappoints them, and what has already been spent in money, time and hope.

Getting it into the note has two halves. Record it in the patient's and the family's own words, attributed to whoever holds it, and place it beside your formulation rather than inside it. A belief held by the patient's community, expressed as that community expresses it and offered as an explanation rather than defended against evidence, is not by itself a finding of disorder; a note folding it into the phenomenology has told every later reader that it was one. The boundary between a sanctioned practice and a disorder is drawn by the ordinary questions: what changed in this person, when, whether the community itself regards the state as expected, and whether function has been lost. Drawn in those terms, the record survives being read both by someone who shares the belief and by someone who does not.

The second half is that the account must then do work. A history eliciting a prior healing episode and a family theory of causation, which then produces exactly the note that would have been written without them, has collected information and wasted it. If the family holds the cause to lie outside the body, the note should say what has been agreed about continuing what they are doing alongside treatment, because that agreement is the adherence plan and there is rarely another.

IN INDIA

The Indian pathway loads its front end. The referral commonly carries no question, so the question has to be created rather than answered. The relative is present, frequently decides, and is often told the diagnosis before the patient, so the consult happens in front of an interested third party whose agreement to the plan is in practice necessary. A patient may have spent weeks in a religious or traditional healing setting before meeting any clinician, which is a fact about the route to care and a question worth asking, never in itself a finding about pathology. Where the patient is an older person and the concern is neglect at home, the statutory route runs to a maintenance tribunal rather than to a protection service, which changes what can be promised in the room. And a consult service that looks quiet is reporting on referral behaviour, not on how much psychiatric illness the hospital holds.

38.6 Consent, capacity and the record that shows its own working

Two consent questions run through the pathway and are constantly conflated. The first is consent to be assessed, which belongs at the start and is not supplied by the referral, since the referral was not written by the person being seen. The second is capacity for a particular treatment decision, which arises only when a decision exists. A patient may agree to talk to you and still refuse the operation; a patient may refuse to talk to you at all, which ends the assessment without settling anything about capacity.

On both, the record has to show its working. What a later reader needs is not your conclusion but the route to it: that the person was told what was proposed in a form and at a time they could use, what decision was put to them, what they said in their own words, and what you concluded about that decision on that date. A refusal considered on its merits looks entirely different in a file from a refusal overridden, and the difference is visible only if the working is written down.

38.7 The handback and the disposition

The last two stages carry a disproportionate share of both the clinical value and the marks, and are the two most often left out. The **handback** is a spoken account to the clinician who called, and its purpose is not to repeat the note but to let them accept the recommendation, modify it, or say it is impossible on their ward. It is the only moment at which advice can be negotiated into something that will actually happen, and advice that cannot happen is worth nothing however correct it is.

The **disposition** answers where this patient now goes and who is responsible. It settles the place of care, the named owner of the plan and the **review interval**, and settling the owner explicitly prevents two opposite failures: a patient followed by nobody because each side assumed the other, and a team that stops referring because referral has begun to feel like losing patients.

> **GOOD TO REMEMBER**
>
> Before leaving the ward, make sure four sentences exist somewhere in the file, because each is the sentence whose absence causes a predictable failure. Who asked, and what for. What is established and what remains provisional. Who owns the next decision, named as a person or a team rather than as a specialty. And when this patient will be seen again, with a date rather than a phrase. If you write nothing else, write the last two: they convert an opinion into a plan somebody can be held to.

MNEMONIC

Called, changed, caused, capable, carried, called back

The spine of the note itself, as distinct from the sequence of acts that produced it. **Called**: who asked, and what they actually wanted, which is rarely what the request said. **Changed**: what is different in this person compared with their own previous state, when it changed, and who says so. **Caused**: where the psychiatric picture stands in relation to the medical illness and its treatment, which is the question that required a psychiatrist to attend at all. **Capable**: whether the person can make the decision in front of them now, and whether they were told what they needed in a form they could use. **Carried**: who does what tomorrow, named. **Called back**: when the patient is seen again, and by whom.

38.8 The same pathway as an examined performance

The examined version compresses this pathway without altering it, and knowing that is worth more than rehearsed phrasing. A short clinical station, a long case discussion and a viva question all ask you to walk the same route aloud, under observation, with the time cut down. The compression falls on the assessment, not on the beginning or the end, which is exactly where candidates cut.

- Say who asked and what for, before you say what you found. An answer opening with a diagnosis has skipped the part that establishes you understood the setting.
- Say what you would have established before going to the bedside, even when the patient was handed to you directly. Naming preparation you were not given time for is not an excuse; it shows you know the act has a shape.
- Separate the established from the provisional aloud, and say what would settle the difference. Follow-up questions land on certainty far more often than on admitted ignorance.
- Finish at a destination: the place of care, the person who owns the decision, and when the patient is seen again, in that order, then stop rather than trailing into further differentials.

The same structure answers the essay forms these subjects arrive in. Asked to write about psychiatric work in a particular ward or with a particular group of patients, an answer organised as pathway, entry points and note is complete and is visibly about practice. An answer organised as a list of the conditions found in that setting answers a different question, and usually one another part of the syllabus owns.

TRAP **Collecting the extra information and then writing the note you would have written anyway.** This is the characteristic failure of an answer that has learned the vocabulary of these subjects without the logic. The candidate asks about the shrine visit and records it under a cultural heading, then gives a formulation and a plan untouched by it. The candidate notes that the patient is old and prescribes at the adult dose. The candidate raises capacity and then proceeds exactly as if it had never been raised. Every item was elicited and nothing changed, so the extra questions worked as decoration. The test is direct: point to the line of your plan that is different because you asked. If no line is different, you did not ask the question, you performed it.

The pathway is call, preparation, bedside, note, handback and disposition; the note says who asked, what changed, what it stands in relation to, whether the person can decide, who acts tomorrow and when you see them again; and age, another account of the cause, or a decision on the table changes what those lines say rather than adding new ones.

Apply, consolidate and close the paper

39 · Applying the chapter

Four vignettes, and in every one of them the wrong answer arrives first. None of what follows tests whether you can name a condition. Each **worked case** is built so that a correct, well-organised and entirely defensible answer about a disorder is available within seconds, and so that this answer earns almost nothing. Work the case by itself first, aloud, in the sequence set out below; read the commentary only afterwards, against what you actually said.

No two of the four share a **pull**. On a general ward the pull is towards a psychiatric label. With an older patient it is towards adding something to a list nobody has read. With a family who have already settled the cause it is towards correcting them. Under observation it is towards reciting the entity, because reciting is what fluency feels like from the inside. Recognising the pull is worth more than learning the four answers: a pull recurs across cases you have never seen, and an answer does not.

Reach for the label	Add a drug	Correct the family	Recite the entity
THE PULL IN THE FIRST CASE, ON A SURGICAL WARD LATE AT NIGHT	THE PULL IN THE SECOND, WITH AN OLDER PATIENT AND A LONG LIST	THE PULL IN THE THIRD, WHERE THE CAUSE WAS SETTLED BEFORE YOU ARRIVED	THE PULL IN THE FOURTH, WHERE THE SAME MATERIAL IS PERFORMED AND SCORED

39.1 How to work a case, and what is actually being practised

What is practised here is the reassembly of an act from a situation, under the condition every referral in this chapter arrives in: most of what you need has not been given to you.

- Read only the case and stop. Read the commentary first and the exercise becomes recognition, which feels identical to knowledge and transfers nothing to a bedside.
- Say aloud, in order: who asked and what act they wanted; what you would establish before walking to the patient, and from whom; what you would do there; what you would write, and in whose record; and where this person is by morning, with a named owner.
- Name what you were not given, and who holds it. That is the part candidates leave out and the part that is marked.
- Commit. One explanation you would act on, one you are setting aside, and the ground for setting it aside. A descending list of possibilities is not a commitment and cannot be tested.
- Only then read the commentary.

RULE **A case here is a bedside with information missing, not a puzzle with an answer hidden.** What you are given is what a referral gives you: a bed number, one word, somebody else's diagnosis, a family's account. What is absent is what a clinician goes and obtains, and in all four cases below the decisive fact is one nobody has yet written down. So the first productive move is never to work out what the stem is pointing at. It is to say what you would obtain, from whom, and before which step. Answer only from the sentences supplied and you have agreed to be a reader of referrals rather than a clinician, leaving the marks exactly where they sit, which is in the questions.

39.2 A surgical ward telephones late at night

The case. A surgical ward telephones about a woman of seventy-eight, four nights after an operation on her hip. The slip carries a bed number and the word confused. The duty registrar asks whether you can start something to settle her, because she has pulled out her cannula and the night staff cannot manage her. Her son, outside, tells you she has been depressed for years and that this is her depression returning, and asks you not to say anything to her about her mind. Nothing else is offered.

Working it. Two things reached you before the patient did, and both are wrong to accept. The first is a request for an act rather than an opinion, and granting it means prescribing for the ward's difficulty. The second is a diagnosis from a relative who knows her past well and witnessed nothing of last night. A long history of depression makes her more vulnerable to almost everything; it does not explain a change over four nights.

What is missing is a **baseline** and a time. Before you leave for the ward: what she was like a fortnight ago, from whoever saw her then; when the change began, and what stands beside it on the chart, which may be the operation, the anaesthetic, a drug added since, a fever, poor urine output, or nothing yet identified; what the night staff saw, and at what hour; and what she has already been given for it. All of that is obtainable before you enter the bay and none of it afterwards, once the son has gone home and the shift has handed over.

At the bedside the order matters more than the content. Spectacles and hearing aid go on first, because an assessment conducted without them measures her hearing. Her own words are recorded before being translated into anything. Her physical state is examined. Only then is anything scored, and what a screening instrument is for on a ward is dealt with where these notes take up the consult on delirium in the medically ill.

The answer is delirium, and the discipline is that nothing in the account requires a psychiatric diagnosis. The condition itself is taught in the Stroke, TBI, delirium and focal brain syndromes notes; what belongs here is the decision that follows. She is not moved, because the cause is being sought where she already is and a transfer costs her the staff and the routine she has some chance of recognising. What you write names acts and owners: who searches for the cause, who reviews the chart, what the ward watches for overnight, and when you are to be called again. The son's request not to tell her is a second question with an owner elsewhere in these notes, and the error is to settle it by default, which is what saying nothing does.

39.3 An older man, pain in several places, and a cloth bag of tablets

The case. A man of seventy-one is referred from a cardiology clinic with a note saying his investigations are normal and he continues to complain. For most of a year he has had chest tightness, poor appetite, weight his family describe as a great deal lost, and he has stopped walking to the temple he went to every morning. He brings a cloth bag holding more strips of tablets than he can name; two prove to be the same drug under different trade names. His daughter says he has also become forgetful. He does not say he is unhappy: asked why he has come, he says his chest is not right and the doctors have found nothing.

Working it. The pull is to write an antidepressant. It is decisive, it answers the referral, and reading a bag of tablets feels like inaction beside it. Follow it and a drug joins a list that may be producing the picture, after which nothing can be attributed to anything.

The **drug list** is a history and not an administrative annex. Taken as one it yields what was started, when, by whom and for what; whether each item is still swallowed as opposed to still prescribed; what has been stopped and on whose decision; and what was added most recently before the change his family describe. The cumulative anticholinergic and sedative load of a list assembled by several prescribers over years is a recognised cause of exactly this presentation, dulled cognition and low mood together, and the agents, the burden and the arithmetic of a starting dose in later life belong to the part of these notes on prescribing in the elderly.

The presentation is the second half of the problem. He arrived complaining of his chest and his weight, which his physical illness and his tablets can equally produce, so the ordinary somatic signals are unavailable as evidence and recognition must be done another way. How that is done is taught where these notes deal with late-onset depression; the choice between agents is in the Mood disorders: pharmacotherapy notes. His daughter's word forgetful is not settled by administering a cognitive test to a man in this state, and the assessment it belongs inside is taken up where these notes deal with the comprehensive assessment of an older patient.

The act that separates a good answer here is small. Something comes off the list, or you write down why nothing does and what would change that. Then you tell the referring clinic what you altered and why, because they prescribe on it and a change they do not know about is reversed at the next visit. The review is set with the bag in the room.

39.4 A family who already know the cause

The case. A young man of twenty-four is brought by his father and his uncle. For close to a year he has spoken less, stopped work, stopped washing unless told, and spends the day on the roof of the house. The family have twice taken him to a healer some distance away and have spent a great deal doing so. They say without hesitation that someone has done this to him, that the healer confirmed it, and that he was a little better for a few weeks after the second visit. His father does not want tablets that will make his son a patient for life. The young man says almost nothing; asked what he thinks is wrong, he says his father knows.

Working it. The pull is to correct them, and it is strong because the explanation is not true and because correcting error feels like the job. Follow it and you spend your entire credit in the first

two minutes on an argument you cannot win, in front of the two people who decide whether your plan is carried out.

What is in front of you is the account already settled at home, and eliciting it is assessment. It predicts what will be accepted, what they will do if your plan disappoints, and what has already been spent, which measures their commitment to it. The questions are ordinary, and are asked in a tone that assumes the family were doing their best, because they were. Who first noticed, and what did they notice. When you went, what were you told the cause was, and what were you asked to do. Did anything change afterwards, and for how long. What do you think will happen if it stops. And then the one that does most of the work: what would you want him to be able to do again.

That question moves the encounter off the disagreement about cause and onto an agreement about function, where the family and the clinician usually want the same things. The **negotiation** that follows is not a request that they abandon their account. It is a proposal that what you offer runs alongside what they are already doing, and said in those terms it is the adherence plan; there is rarely another. Something can be conceded honestly too: his few better weeks are a real observation, worth exploring rather than dismissing, since whatever produced them may be usable.

Two further acts are owed. He has not been asked, and at some point he is seen alone, which is the only way his own view of the cause becomes recordable. And whether this is illness at all is settled by neither explanation: work and self-care have gone over close to a year, and that loss of function stands whatever anybody believes about its origin. Their words go into the record attributed to them, beside your formulation rather than inside it, so a later reader can tell which is which. The cultural framework and the formulation outline are taught in the Psychotherapies, clinical assessment, MSE and nosology notes, and the classic culturally shaped presentations where these notes take them up; what is owed here is the negotiation.

TRAP **Deciding who is in the room by reflex.** Candidates hold one of two reflexes firmly, and both are wrong. The first clears the relatives out at the start, in the name of confidentiality, and loses the only person who can say what the patient was like a month ago, whose agreement the plan needs, and who will fetch and give the tablets. The second never separates them, and then cannot ask about neglect at home, cannot hear the patient's own account of the cause, and produces a history in which the patient does not speak. Both are visible above, in a son who speaks for his mother before you reach the ward and a young man who defers to his father. The examinable act is not a preference between reflexes but a statement, made before the interview starts, of who you will see together, what you will ask each of them alone, and why.

IN INDIA

Three features of the room change how these cases are worked rather than merely colouring them. Somebody who knows the patient well is almost always in the corridor, so an answer resting on an informant who could not be reached will not be believed here; send for them before you go to the bed. The person paying is frequently not the patient and much of it is paid at the counter, so what a plan costs each month is a clinical variable and belongs inside the plan: a regimen nobody can sustain is stopped without anyone telling you. And the interview is usually in one language while the record is written in another, so the original phrase is kept beside the translation, because the phrase is what the family will repeat to the next clinician and a translated summary quietly loses the thing you were listening for.

39.5 The first case again, this time performed and scored

Nothing is removed by an examination; the middle is shortened. Take the woman of seventy-eight again, now in a practical examination. There is no chart, no nursing record, no son and no telephone. You have the patient, examiners and a clock, and one of them says: this lady had an operation last week and the ward says she is confused, take a history and tell us what you think. The material is identical and the act is different, because it is now an act of speech performed in front of people deciding something about you while you do it.

The **compression** falls on the assessment, not on the two ends. Candidates cut the opposite way, abbreviating the beginning, which establishes that they understood the setting, and abandoning the end, where the marks for the plan sit, in order to protect a middle the examiners can watch for themselves. So open on the referral: whose ward this is, who sent for you, what they wanted done. Then say what you would have established beforehand and from whom, and say plainly that you were not given it, which is a statement about the shape of the act and not an excuse. Then the assessment, briskly. Then the disposition and the review, in words, before you stop.

What the marking consists of is worth making explicit. Candidates imagine a running total of facts; it is a small number of decisions taken at identifiable moments, most of them before you have said anything at all about a diagnosis.

THE MOMENT	WHAT EARNS	WHAT LOSES
Your first sentence	The referral before anything else: whose ward this is, and what act was asked for	Opening with a diagnosis, which answers a question nobody asked
Before you touch the patient	What you would have obtained beforehand, from whom, and that it was unavailable here	Apologising for the gap, or filling it with a detail you did not elicit
The examination	Spectacles and hearing aid on, aloud and with the reason given, before anything is administered	Administering an item to a patient who has not heard the instruction, then reporting the result
The commitment	One explanation named, one serious alternative rejected, and the reason for rejecting it	A ranked list of possibilities, which gives the examiners nothing to test
The plan	Who does what, where she is by morning, and when she is seen again	A drug with no owner, no place of care and no review
The last thing you say	Stopping at a destination	Trailing into further differentials after the answer was complete

Two consequences follow, both counter-intuitive enough to rehearse. A wrong commitment defended on stated grounds is recoverable, because the questioning can go to the grounds and you can move; an absent one is not, because there is nothing there to examine. And the beginning repays rehearsal more than the middle, since several of those decisions are taken in the opening sentence and in the preparation you name, and both can be prepared word for word without sounding rehearsed.

39.6 What the four share, and how to make more of them

Set side by side, the four are one case. In each of them somebody else's account arrived before the patient did, the decisive information was held by a person nobody had asked, and a fluent answer was available that belonged to another part of these notes. Only the fluent answer and its cost differ.

THE CASE	THE PULL, AND WHY IT IS STRONG	WHAT FOLLOWING IT COSTS THE PATIENT
The confused surgical patient	A label, handed over by the ward and confirmed by a relative; it settles the night, and sedation is the act requested	Nobody hunts the cause while the picture is being suppressed
The somatic complaint in later life	Prescribing. Writing something is an act, where auditing a bag of strips looks like inertia	Attribution becomes impossible: no one afterwards can say which agent does what
The family with an explanation	Correction. The account is untrue, and putting error right feels like the clinician's proper work	They withdraw rather than argue, and treatment lapses where you cannot observe it
The same material under observation	Recitation. It is the prepared, fluent and entirely correct answer to a different question	The answer expires before any disposition, and the questioning goes straight to what was skipped

Four cases are not enough practice, and the supply is sitting in your own week. Building them is quick, and the building is itself useful, because writing a case forces you to notice what a referral actually contained.

- Take referrals your unit genuinely received, strip out every identifying particular, and write each as four sentences ending at the word the referrer used. Answer them cold a week later, once you have forgotten what happened next.
- Write the pull in beside each one before you write the answer. A case with no plausible wrong answer is not a case; it is something you already know, arranged as a question.
- Work them with a colleague playing the referrer, who may answer only what you actually ask. Most of what these cases teach is which questions you fail to ask, and that is invisible when you work alone.

MNEMONIC

Read the slip, read the sheet, read the story, read the room

Four things exist before you say a word, and in each case above the decisive fact was in one of them. **The slip**: who asked, in whose ward, and what act they want rather than what opinion. **The sheet**: the drug chart and the observation record, which between them hold when this began and what has already been given. **The story**: the account of the cause settled at home, in the words of whoever holds it. **The room**: who is present, who decides, who pays and, in the examination, who is scoring. Not one of the four is obtained by asking the patient a better question at the bedside.

GOOD TO REMEMBER

Keep a list of your own pulls rather than of your own wrong answers. After a case you get wrong, write down the move that produced it and not the answer you missed: reached for the label, did not send for the informant, added a drug instead of reading the list, corrected the family, stopped at the diagnosis. Within a few weeks the list stops growing, because there are only a handful of them and they are yours. A wrong answer teaches you one case; a named pull changes what you do at the next bedside, including the ones nobody has written a case about.

Work a case forward from what is missing: the referral and the act it asks for, the fact you would go and obtain and the person holding it, the explanation you are acting on and the one you have rejected with your reason, and who does the next thing by morning; then name the pull rather than the answer.

40 · Consolidation

A closing list earns its time only if it forces production rather than recognition. Everything below is an **ask-and-hold** pair: on the left the question in the form an examiner puts it, on the right what you must produce before you look at anything. Cover the right column, answer aloud, then read across. Recognition feels identical to knowledge from the inside and is worth little across a table from two external examiners, which is why this consolidation, the last in Paper III, is set in two columns.

The right column asks almost nothing about what a condition is, because the marks here sit in **the encounter** rather than in **the entity**: who asked, on whose ward, what changed because the patient is old, whose account of the cause was already in the room, and how the performance is scored. It closes on a register of addresses, because a reader who comes here for an entity and is not told where it is taught has been failed twice.

Ask, then hold	The encounter	Named in full	Never backwards
THE TWO COLUMNS EACH PROMPT IS BUILT FROM	WHAT AN ANSWER HERE IS MADE OF, NOT THE ENTITY	HOW THE REGISTER PRINTS EACH ONWARD DESTINATION	THE DIRECTION A POINTER MAY NOT SEND A READER

40.1 How to run the list

Work the three groups in order, because sequence is most of what is marked: the right acts in the wrong order satisfy nobody. Name who performs each act, since almost every failure here is an act nobody owned rather than one nobody knew, and keep talking until you have said where the patient goes and when they are seen again.

Mark two failures apart. A prompt you could not answer is ordinary, fixed by rereading that section. A prompt you answered by describing a condition is worse: it is the error this material exists to correct, and it feels like competence as you produce it.

RULE **Answer at the address the question was asked from.** Every heading here has two possible answers and only one earns anything. The first describes the condition: features, subtypes, how it differs from its mimics. The second describes what was done: who called and what they wanted, what was established first, in whose records it was written, who held the decision, and where the patient went. These notes own the second and name the address of the first; give the first and you have written a correct paragraph belonging elsewhere.

40.2 Ask and hold: the general hospital

These eleven share one structure: the psychiatrist is a guest, the notes belong to somebody else, and the request came from a treating team, not the patient.

THE ASK	WHAT YOU MUST BE ABLE TO PRODUCE
Principles and models of consultation-liaison psychiatry.	The referral as a procedure: what the caller must convey, what you establish on the call including whether the patient consented, the **preparatory phase**, the note's headings, and why writing in the file is not by itself sufficient feedback.
A medical ward calls overnight about a confused patient.	That confusion with behavioural abnormality is the commonest reason an Indian liaison service is called, the discrimination made first, and that the patient stays on the medical ward under psychiatric observation.
Psychiatric aspects of medical and surgical illness.	The signature read both ways: the psychiatric presentation a medical illness produces, and the occult medical cause behind a psychiatric one, organised by system and by drug.
Psychological reactions to physical illness and chronic disease.	That a reaction is universal and does not always reach morbid level, that separating reaction from disorder is the liaison task, and adherence as the stake.
Somatic symptom disorders in a consultation-liaison setting.	How such a patient reaches psychiatry, through a physician out of investigations, and the address of the nosology.
A physically ill patient refuses treatment.	That the national mental health legislation of 2017 presumes capacity at section 4, the ability test applied to this decision now, that section 4(2) is unsatisfied until information is given in a form the person can take in, that an unwise decision is not incapacity, and that the Act expressly reaches a general hospital.
Psychiatric work in transplant, dialysis and intensive care.	What a pre-transplant psychosocial evaluation is for, why uraemic symptoms mimic and mask depression on dialysis, and the syndrome after critical illness.
Psychiatric aspects of HIV and chronic infection.	Consent for testing as a statutory question, disclosure, adherence, stigma, and how the clinic relationship is built rather than improvised.

THE ASK	WHAT YOU MUST BE ABLE TO PRODUCE
Psychiatric aspects of cardiac, skin and kidney disease.	The bidirectional relationship in each, the burden the specialty clinic carries, the drug-safety signals constraining prescribing, and which head terms are attested.
Epilepsy and neurological disorders as they arrive on a consult.	The frame only: why they generate referrals, what is asked, and the address.
The ward believes the patient is fabricating.	What the liaison psychiatrist does and, more importantly, does not write down; and how such a referral often follows the team's frustration, itself part of the assessment.

40.3 Ask and hold: the older patient

These ten share a different structure. The condition is taught elsewhere; what is asked is what age does to the assessment, the prescription and the safeguarding question.

THE ASK	WHAT YOU MUST BE ABLE TO PRODUCE
Psychiatric assessment of an elderly patient.	That the skeleton does not change with age and the weight given to comorbid physical illness does, the added domains of sensory deprivation, frailty and elder abuse, the last needing active suspicion, and what normal ageing does and does not take away.
Dementia in the elderly.	Its place in the geriatric frame, and the address where it is taught.
Late-onset depression.	The presentation that misleads, the somatic and cognitive mask, the vascular contribution, and that current Indian guidance holds age to influence which antidepressant is chosen.
Late-onset psychosis and paraphrenia.	The exclusions run first with the drug classes named, when neuroimaging is indicated, and what changes in management because the patient is old.
Delirium in an older person.	Ageing as the predisposition: frailty, sensory impairment, polypharmacy, delirium superimposed on dementia, and that the hearing aid and the spectacles go on before any cognitive item is administered.
Principles of psychopharmacology in the elderly.	The pharmacokinetic and pharmacodynamic changes, the starting dose as a fraction of the adult dose with the agent named, anticholinergic burden as a crucial cause of delirium, falls, and deprescribing.
Elder abuse and neglect.	Recognition against a definition including acts of omission, a history taken with the patient interviewed separately and given time and reassurance, the screening instrument, and the legal position below.

THE ASK	WHAT YOU MUST BE ABLE TO PRODUCE
Sleep disturbance in the elderly.	What changes in timing and architecture, then the finding that reframes the heading: in older adults in excellent health insomnia prevalence resembles that in younger people, so the complaint is comorbid and a hypnotic the wrong reflex.
Comprehensive geriatric assessment.	That it is an interdisciplinary, multidimensional process for frail or vulnerable older people and not a questionnaire, its product of a problem list, goal-driven interventions and one coordinated plan, its domains with cognition one item inside the mental-health domain, and how falls risk is stratified.
Pseudodementia versus dementia.	The distinction, why it matters at the bedside, and the address of the table.

40.4 Ask and hold: the explanatory model, dying, and the examined performance

The last group holds the two hardest kinds of question. One asks you to work with an account of causation that is not biomedical and that the family has accepted; the other asks you to perform, observed, in a fixed time. Hold the scheme you perform inside: the national regulations make passing conditional on three things, not less than **40 per cent** in each theory paper, not less than **50 per cent** in aggregate across the four theory papers, and not less than 50 per cent in the practical examination, so a strong practical rescues nothing.

THE ASK	WHAT YOU MUST BE ABLE TO PRODUCE
Concepts of culture and illness.	The current umbrella term, the parts it holds, the address of the definitions, and the move to the clinic.
The classic culturally shaped presentations.	Not the roster. How the patient arrives, what has been tried and who advised it, what the family believes the cause to be, what else may sit behind it, and how the explanation is negotiated.
Cultural formulation and its interview.	Name both, say where in an assessment they belong, give the address, print no counts.
Migration, ethnicity and mental health.	Who moves and why, with India's official migration rate and its split by sex and reason, the four acculturation strategies and the two questions generating them, and that current Indian guidelines carry nothing on migration or acculturation.
Idioms of distress and explanatory models.	Name both constructs, say what each does to a history, give the address.

THE ASK	WHAT YOU MUST BE ABLE TO PRODUCE
Religion, spirituality and faith healing.	What happens at a healing site and in what conditions; the one measured Indian study with its design and its authors' bar on generalising; that the government primary health centre stood in the same village and had almost never been consulted; and the boundary between sanctioned practice and disorder, drawn without turning practice into a symptom list.
Psychological reaction to a cancer diagnosis.	The trajectory of the reaction, adjustment disorder as the largest single group in Indian inpatient series, and **collusion** as graded rather than binary, with the sequence for working through it and both sides of the bind.
Depression, anxiety and delirium in advanced disease.	How each is recognised when the somatic criteria are confounded, that pharmacotherapy remains indicated alongside medical comorbidity although response tends to be poorer, and how running treatment constrains the choice.
Grief, bereavement and end-of-life care.	Normal grief and when to intervene; that the standard frameworks were built for a dyad while in Indian practice the patient is almost always accompanied; and that business left unattended before a death obstructs grief after.
Demoralization and desire for hastened death.	The core features and why the construct is separable from depression; and the legal boundary, that the 2018 Constitution Bench treats active euthanasia as impermissible for the time being, absent any statute permitting it, against the passive form, withdrawal or withholding of measures sustaining life artificially.
Structure of an objective structured clinical examination station.	That it is named inside the national practical pass criterion beside the clinical and the viva voce, that the state health-sciences university has notified it shall be included from the ensuing examinations, the examiner board, that no grace mark is permitted, and that a station's weight is unsettled.
Long case and short case format.	That the national provision is one long case and two short cases, a theory examination of four papers, each of ten questions carrying ten marks, and a 300-mark practical including 20 for the thesis, with a 100-mark viva voce.
Demonstrate a scale or a bedside test.	Administration as an observed performance, not a recitation: what is said to the patient before it starts, how timing is managed, what is reported aloud, and how a refused performance is handled without abandoning it.

THE ASK	WHAT YOU MUST BE ABLE TO PRODUCE
Break bad news to this relative.	The six-step protocol with each letter unpacked, its later modifications and the criticism against them, and the ethical frame both ways: withholding on the presumption the patient cannot cope may not be justified against autonomy, and insensible disclosure may harm the patient and the relationship.
Interpret this investigation or instrument.	What the oral examination is directed at, that case reports, charts, specimens, slides and imaging are expressly examinable and questions on instruments will be asked, and the order a result is read in.

40.5 The rules that survive an unfamiliar question

Six rules run underneath every prompt above. They are worth holding because they generate an answer to a question you did not prepare for, which is the kind that decides a viva.

- **Name whose ground you stand on.** In the general hospital the records, the ward and the discharge decision belong to another team, and consent to be seen, a private space and who is spoken to afterwards all follow from that.
- **Exclude before you attribute, and harder at seventy-eight.** The commonest referral is behavioural and the first move separates a neurocognitive from a primary psychiatric explanation; reduced physiological reserve is why the same change means more in an older patient.
- **A figure belongs to a document and a population.** Quote the issuing body and the population it was measured in, or quote the reasoning and say plainly that you assert no figure. A prevalence and a referral rate differ even in the same unit, and a statistic from one country is not evidence about another.
- **Ask whose explanation is already in the room.** By the time most of these patients reach you a cause has been settled on, a treatment tried, and somebody has decided how much they are told. Eliciting that is assessment, not courtesy: it decides what will be accepted.
- **The statutory answer is usually narrower than the clinical one, so state both.** The clearest instance is elder abuse: the 2007 Indian statute on maintenance and welfare of parents and senior citizens carries no elder-abuse-specific mandatory reporting duty, and what it provides is different in kind, since the Maintenance Tribunal may take cognizance on its own motion, a power and not a duty. The obligation to act is professional: a national society guideline places elder abuse under forensic issues and directs that where assessment suggests safety may be compromised, a report to the police must be made.
- **Finish where the patient goes next.** Every answer ends with a destination, a named owner of the decision and a review interval. An answer ending at the diagnosis stops where this material begins.

MNEMONIC

Before the bed, at the bed, after the bed

The consult has three beats, and marks are lost almost entirely in the first and the third. **Before the bed**: the call is clarified, consent and willingness checked, the chart read, the referring consultant asked what they actually want, word sent for a family member. **At the bed**: introduction and consent, a private space, a history keyed to onset, fluctuation and treatment events, physical examination, then the mental state examination. **After the bed**: the consultee is spoken to directly, the note written to its headings, patient and family told the plan, the review interval set. Most answers start at the second beat and stop there.

GOOD TO REMEMBER

Two habits change what you do on the next working morning rather than what you can recite. Write the consult twice: the guideline requires **dual documentation**, in the primary team's records so the plan can be acted on and in your own so the case is retrievable when the patient returns. And set the interval before leaving the ward: where the consult starts drug treatment, review falls **within a week**, with outpatient follow-up after discharge treated as obligatory.

40.6 The cross-reference register

This material is deliberately incomplete and the register below is the other half of that decision. Every destination is printed in full so the route survives on a printed page with nothing else to hand. Read it one way only: it says where an entity is taught and is never the route back to anything owned here, since the consult, the organ cross-links, the disease-specific settings and the psycho-oncological material are owed by these notes rather than borrowed.

WHAT YOU WENT LOOKING FOR	WHERE IT IS TAUGHT
Delirium as an entity: definition, subtypes, screening, causes, management	the Stroke, TBI, delirium and focal brain syndromes notes
The dementias, and the cognitive screening instruments	the Dementias and neurocognitive disorders notes
The late-life psychosis construct with its history, and catatonia	the Other psychotic disorders, delusional syndromes and catatonia notes
Antidepressant classes, selection and switching behind a late-life prescription	the Mood disorders: pharmacotherapy notes
The anxiety and trauma-related entities, and the grief-related diagnosis	the Anxiety, OCD and trauma-related disorders notes
The sleep-wake disorders as entities, including what an older complaint proves to be	the Eating and sleep-wake disorders notes
The somatic-symptom and factitious nosology, the culturally shaped semen-loss presentation, self-harm and suicide, and the psychosomatic concept with its service-model table	the Somatic-symptom, sexual, impulse-control disorders and suicide notes

WHAT YOU WENT LOOKING FOR	WHERE IT IS TAUGHT
The cultural framework and its terminology, the formulation outline and its interview, idioms of distress, explanatory models, the mental state examination	the Psychotherapies, clinical assessment, MSE and nosology notes
Epilepsy and its psychiatric syndromes, including treatment-related ones	the Epilepsy and psychiatry notes
The neurological examination, and the investigations a viva hands you	the Neurology foundations for psychiatrists notes
The neuropsychiatry of chronic infection and systemic medical disease	the Neuropsychiatry of systemic and neurological disease notes

PITFALL

The worst thing a **register** can do is send a reader in a circle. A pointer returning somebody to the page which sent them has failed them twice: once for not teaching the thing, once for the search it cost. Building your own revision map, test every arrow by asking what the destination actually teaches rather than what its title suggests. The same holds in a viva: saying a topic belongs to another specialty is legitimate only if you can say what that specialty would do with it.

IN INDIA

Many of these prompts have an Indian answer that differs from the standard one, and saying so plainly earns more than reproducing a specification the setting cannot meet. Referral rates are low while measured morbidity in the same units is high, so a quiet consult service is evidence about referral behaviour and not about need. The composite liaison clinic the sources call preferred is qualified in the same breath by a dearth of specialists, so that it may not be possible across the country. The family is routinely the decision-maker and is often told first. The statute for an abused older person routes to a tribunal rather than a protection service. And a patient may have spent weeks in a religious healing setting before meeting any clinician, which is a fact about the pathway to care and a question to ask, never a finding about belief.

TRAP **Producing a fluent paragraph that belongs to another chapter.** Asked about delirium on a surgical ward, candidates describe delirium. Asked about depression in the elderly, they list depressive criteria. Asked about a culturally shaped presentation, they recite a roster. Each is accurate, well organised and worth very little, because the entity is taught elsewhere and the examiner knows where. The test is simple: if your answer would be equally true had the patient never been referred, never been old and never held an explanation of their own, you answered the wrong question.

Answer the encounter and name the address of the entity: who called and what they wanted, what was established before anything was done, what age or the explanatory model changed, in whose records it was written, who owns the decision now, and where the patient goes next.

41 · Drawing the ten chapters together

Paper III is closed properly only when you can say what it trained you to do. Read as a list of headings, this one looks like a miscellany: children and their development, running across the chapters at the front of the paper; mental health legislation and forensic psychiatry; forensic ethics and consent; a physical treatment and its neurostimulation relatives; the perinatal period and the psychiatric emergency; and then the consult, the older patient, culture and the examined performance. Not one of those entries is a diagnosis. No two of them share an organ, an age or a class of drug. That is worth noticing before any revision plan is made, because a candidate who revises this paper the way the disorder papers are revised will write accurate answers that score badly.

What the entries share is a predicament. In every one of them the psychiatrist has to act while somebody else holds part of the decision: a parent, a statute, a magistrate, a treating team, a family, a tribunal, an anaesthetist, a second person whose interests are engaged, or an examiner with a clock. The diagnosis is seldom the difficult part and is almost never the whole answer. The difficult part is the authority the act rests on, the consent it needs, the baseline it will be judged against, the record it leaves and the person who has to do something next. What follows sets out that shared structure, and then says where these subjects actually sit in the scheme of examination, which is not where the paper's name would lead you to expect.

Four papers	Ten by ten	Suggestive only	Superseded
THE SHAPE OF THE DESCRIPTIVE THEORY EXAMINATION UNDER THE 2023 NATIONAL REGULATIONS	QUESTIONS IN EACH PAPER, AND THE MARKS EACH QUESTION CARRIES, AS NOW NOTIFIED	WHAT THE OLD ORDINANCE CALLED ITS OWN ALLOCATION OF SUBJECTS TO PAPERS	THE STANDING OF THAT ORDINANCE FOR THE EXAMINATION NOW BEING SAT

41.1 What this paper actually trains

The other papers ask what a thing is. They reward a candidate who can define a syndrome, trace a mechanism, name a class of drug and defend a choice between two of them. This paper asks something else and rewards something else: **the defensible act**, meaning an action a psychiatrist takes that can be justified afterwards to a person who was not in the room. Who that person is varies. It may be a court, a hospital committee, an aggrieved relative, a regulator, or simply the consultant who inherits the case next week. The examiner is standing in for all of them, which is why the questions are phrased as situations rather than as topics.

An act is defensible when these can be stated without hesitation: on whose **authority** it was done, what the person or their proxy was told and agreed to, what the finding was measured against, and where the whole of it is written down. Those are not ethics-lecture abstractions. They are the substance of almost every question this paper sets, and they explain how the same clinical facts earn very different marks. Two candidates may agree entirely about the diagnosis and the drug, and only one of them will say who was entitled to make the decision and what would have followed had the family refused.

This also explains why the paper is harder to revise than it looks. A disorder can be learned once and recalled whole. An act has to be reassembled from the situation in front of you, because the constraint keeps moving: the same clinical picture in a child, in a courtroom, before a physical treatment, late in pregnancy, on somebody else's ward and in old age generates a different correct answer each time, while the underlying illness may be identical. The paper is a training set for that reassembly, and its chapters are the settings in which it is practised.

RULE **Name the authority before you name the treatment.** In every band of this paper the first marks are for establishing who is entitled to decide and on what basis, and the treatment is the second half of the answer rather than the first. A management plan offered without its authority is an opinion; the same plan with the authority named is a clinical decision, and only the second can be defended by anyone who has to stand behind it later. Candidates who open with the drug, the modality or the ward round are answering the question the disorder papers ask.

41.2 The bands, and the constraint each one works under

Grouping the paper by constraint rather than by subject is what makes it revisable in the time available. The child and developmental chapters work under a **developmental baseline**, which is the standard by which a behaviour is called abnormal at all. The legal and ethical chapters work under an instrument and a procedure. The treatment chapter works under a set of safeguards that exist precisely because the treatment is given to people who may not be in a position to ask for it. The perinatal and emergency chapter works under a clock and under a second person whose interests are engaged. The closing chapter works under somebody else's ward, another stage of life, an explanation of the illness that reached the patient before you did, and an observer with a marking sheet.

THE BAND	THE CONSTRAINT THAT IS NOT THE DIAGNOSIS	WHAT AN ANSWER IN THIS BAND MUST NAME
Child and developmental psychiatry, across the chapters that open the paper	What is expected of a person at this stage of development, and the fact that the patient did not bring themselves	The norm the behaviour is judged against, who gave the account and what their stake in it is, and the adult whose agreement makes any of it lawful
Mental health legislation and forensic psychiatry	An instrument: what it permits, in which jurisdiction, in whose hands, and with which verb	The instrument, the provision and the jurisdiction, using the source's own permissive or obligatory wording, stated before the clinical opinion rather than after it
Forensic ethics, consent and legal procedure	A procedure with its own rules of admissibility, and a relationship that may not be therapeutic at all	Whose agent you are in this encounter, what was disclosed and to whom, the limits of the opinion, and what you decline to say
ECT and neurostimulation	Safeguards around a physical treatment, and an authorisation that may not come from the patient	The indication, who authorised it and under what provision, the checks before it is given and the monitoring it obliges afterwards
Perinatal and emergency psychiatry	A clock, and a second person whose interests are engaged by the same decision	Who is at risk and over what interval, what must be settled now, what may safely be deferred, and how the two interests were weighed
The consult, the older patient, culture, and the examined performance	Another team's ward, another stage of life, an account of the cause already accepted at home, and an observer scoring the performance	Who asked and what they wanted, what age or the patient's own account changed, in whose record it is written, and where the person goes next

Read the right-hand column as an answer plan rather than as a summary. Each entry is a sentence that has to appear somewhere in what you write, and its absence is what an examiner notices first, because it is the part a textbook paragraph never contains. Its presence is also what lets you say something serviceable about a scenario you have never met, which is what a viva mostly consists of.

41.3 The questions that generate an answer anywhere in this paper

Underneath the bands the same interrogation runs, and learning it as a sequence is worth more than any single fact in the paper, because it survives an unfamiliar scenario and produces a structured answer within seconds of the question ending. Work it in order. The order is itself examinable, since several of the classic failures in this paper are the right acts performed in the wrong sequence.

- **Who permits this?** Some acts need only a professional judgement. Others need a guardian, a statutory provision, a board, a tribunal or a court, and a few need more than one of those at

once. Name the source of permission before describing what you would do, and if the permission is contested, say who resolves the contest.

- **Who consents, and to what exactly?** Consent is specific to a decision, a moment and a piece of information, not a signature filed in a chart. Say what was disclosed, in what form, who received it, whether the person could use it, and what happens to the plan if the answer is no. A plan with no described refusal branch has not been thought through.
- **What is usual here?** Nothing in this paper is abnormal in the abstract. It is abnormal against a developmental stage, a physiological state, a cultural account of causation, or the reserve an older body has left. State the comparator, because a finding without one is an impression.
- **What is written, and in whose record?** In almost every setting this paper covers, the notes belong to somebody else or will be read by somebody adversarial. Say what goes in the file, what goes in your own record, and what deliberately does not go in either.
- **Who acts next, and when is the person seen again?** Finish at the **disposition**. An answer that ends at the formulation has stopped one step before the part that is actually being marked, and in practice it is the step whose absence causes harm.

41.4 Where these subjects sit in the scheme of examination

The name of a paper is not a syllabus, and treating it as one is a revision error with a measurable cost. Under a Karnataka state health-sciences university's postgraduate ordinance of 2000, consultation-liaison psychiatry, geriatric psychiatry and psycho-oncology were placed in the second paper, and cultural psychiatry alone was placed in the third; that same ordinance then closed its own allocation by calling it **suggestive only**. Take both halves of that seriously. Most of what this closing chapter teaches sat, on that document's own reckoning, under a different paper from the one it is now revised for, and the allocation was disclaimed by its own author even while it was in force.

The position has since moved, and moved in the direction that matters for planning. That ordinance is superseded for the postgraduate broad-specialty examinations now being sat, and its placing of neurology and general medicine in the fourth paper is displaced: both the national regulations of 2023 and the state university's later notification put basic medical sciences in the first paper and recent advances in the fourth. What neither instrument does is assign any subject at all to the second or the third paper. On the documents in force, the contents of those two papers are unassigned, which is a different and more useful statement than saying the old allocation still holds.

Two practical consequences follow, and they point the same way. First, revise these subjects by name rather than by paper number: a question on the consult, on the older patient or on psycho-oncology may reach you under either of the middle papers, and being surprised by its location wastes minutes you do not have. Second, do not attempt to predict which paper a subject will appear in, because no instrument currently in force supports such a prediction; no comparable standard is available to quote, and none is invented here. The safe planning assumption is the one

the old ordinance itself invited: the boundary between the middle papers is soft, and preparation should be indifferent to it.

IN INDIA

Two instruments matter here, and they operate at different levels, which is worth knowing because candidates are usually told about only the local one. The National Medical Commission's postgraduate regulations of 2023 set the architecture: a descriptive theory examination of **four** papers, with the first on basic medical sciences and the fourth on recent advances, and with a multiple-choice format of equal duration expressly permitted as an alternative. The state health-sciences university then applies that national instrument locally: by a notification of 16 December 2024 its special Syndicate decided to apply the 2023 regulations to the upcoming broad-specialty postgraduate examinations, with stated relaxations. The reasoning that carries them onto candidates admitted long before they were made is recorded in the same notification: the university acted on a clarification from the Commission that the 2023 regulations apply to all students appearing in the forthcoming examination, irrespective of the year of admission. A candidate who prepared against the scheme a senior sat under is therefore preparing against a document that no longer governs.

41.5 What the shape of the answer now asks of your revision

The **answer unit** has changed, and revision strategy should follow it rather than tradition. The state university's notification provides for **ten questions in each paper, each carrying ten marks**. Every answer therefore has the same weight as every other, and there is no single large essay to bank a prepared performance on. The arithmetic of that is unforgiving in a way candidates underestimate: a topic you cannot begin is not a weak paragraph inside a long answer, it is an entire question surrendered, and there are not many questions in a paper to absorb such a loss.

Two further features of the current scheme bear directly on how this paper in particular is prepared. **Recent advances** now belong to the fourth paper, so the reflex of decorating every answer with the newest trial is misdirected effort here; what earns marks in this paper is the act, its authority and its record, which are stable and can be prepared once. And each paper carries its own minimum in addition to the aggregate across the papers, so a paper cannot be written off against strength elsewhere. A miscellany that a candidate quietly deprioritises because it holds no favourite disorder is precisely the paper that can fail an otherwise strong performance.

How long a paper runs is not stated by the instrument that fixes this ten-question structure, nor is the number of questions in it declared to be of one kind rather than of mixed length; no comparable standard is available to quote, and none is invented here. Plan on the safe reading instead: equal marks per question means equal minutes per question, and a candidate who spends the time of several answers on one has broken the only budget the paper actually enforces.

GOOD TO REMEMBER

Write for a second reader you will never meet. Under the valuation machinery the state university has adopted, every theory script is valued more than once, a third valuation is triggered where the first two differ by **15 per cent** or more of the paper's total marks with the best two then averaged, and there is **no revaluation** once results are declared. Two things follow on the day. Make the structure of each answer visible without reading the prose, through headings, a named instrument, a labelled plan and a stated disposition, because that is what survives two independent readers. And accept that the script is the whole of your case: there is no later stage at which you get to explain what you meant.

41.6 How this paper is lost, and what closes it

Failures here have a family resemblance. Almost none of them are failures of knowledge. A candidate loses this paper by producing a correct account of a condition when the question asked what should be done about a person; by giving a management plan with no named source of permission; by describing an assessment with no comparator, so that a finding floats free of the stage of life or the account of causation it should have been judged against; and by stopping at the formulation, leaving the examiner without a disposition, an owner or a review interval. Each of those answers reads fluently while it is being written, which is exactly why they persist.

There is one further failure, and it is the one this closing section exists to prevent: preparing for an examination that has been replaced. Schemes change quietly, the seniors who describe them are describing the one they sat, and nothing in the day-to-day of residency announces the difference. Check the instrument, not the folklore, and check it for the year you are sitting.

TRAP **Carrying a superseded scheme into a current examination.** The pattern candidates rehearse is often the one their seniors sat: under the state university's ordinance of 2000 each theory paper carried two long essay questions of twenty marks and six short essay questions of ten marks, and recent advances could be asked in any or all of the papers. Both features have gone. Practising a long-essay technique for a paper built of equal short answers wastes the scarcest resource in the hall, which is time, and reserving a recent-advances flourish for a paper that no longer wants one wastes preparation. The general form of the trap matters more than this instance: a rule about an examination is only as current as the document you read it in, and a document that has been superseded remains a perfectly accurate description of something that no longer happens.

What closes the paper is not a summary of it. It is a habit of mind that the chapters have been building one setting at a time: when a situation is put to you, resist the pull towards the diagnosis, and answer instead with the act and its warrant. That habit is portable. It works in a paediatric ward, in a magistrate's remand order, in a consent conversation before a physical treatment, in an obstetric emergency in the small hours, on a surgical ward that has called you about a confused patient, and in front of examiners who did not train you. It is also, not coincidentally, what makes a psychiatrist safe to leave alone with a difficult decision, which is what the whole examination is trying to establish.

This paper is not a set of disorders: for every situation say on whose authority you act, who consented and to what, what you judged the finding against, in whose record it is written and who does the next thing and when; and revise its subjects by name rather than by paper number, because no instrument in force assigns a subject to the middle papers at all.

Previously asked

Unlike every earlier chapter of this series, this table is not representative. Sixteen of the rows below are catalogued past questions, each carrying the year the index records against it, taken from the question index this build holds under `intel/`. The equivalent page in the Perinatal and emergency psychiatry notes had to open by declaring that no indexed bank existed for that chapter; that was true of its topics and is not true of these. **One caveat governs the whole table and is not buried:** these are another state health-sciences university's questions, catalogued from that university's own index. This series is built for the examination you sit, and no claim is made that any of these appeared on one of its papers. They are evidence of what Indian examiners ask about this material, which is a weaker and more honest claim than an attribution to your own paper would be.

The frequency is the finding. Culture-bound syndromes is the highest-yield subject in this chapter by a wide margin: four distinct question forms, seven total appearances, and three of those appearances as long answers. That measurement, which no ownership census could see, is why the culture-bound syndromes section was raised from LENS to MAJOR after the depth scheme was otherwise settled. HIV follows with two appearances of a single question form, and grief with four spread across three. Everything else in the table has appeared once.

Almost every question here is a mixed question and only one half belongs to this chapter. The naming half is taught elsewhere in the series and is expected rather than supplied: the DSM-5 cultural-concepts framework, the eight classic syndromes as definitions and the Cultural Formulation Interview by the Psychotherapies, clinical assessment, MSE and nosology notes; dhat itself by the Somatic-symptom, sexual, impulse-control disorders and suicide notes; delirium in full by the Stroke, TBI, delirium and focal brain syndromes notes; HIV-associated neurocognitive disorder and the antiretroviral interactions by the Neuropsychiatry of systemic and neurological disease notes; and prolonged grief disorder as a diagnosis by the Anxiety, OCD and trauma-related disorders notes. **Bring those.** What this chapter supplies is the other half: who asked, in whose ward, what changes at seventy-eight, what the family believes, and what the clinician actually does.

QUESTION, VERBATIM FROM THE INDEX	FORM	ASKED	OWNED HERE BY
Discuss culture bound syndromes	Long answer	2011 MD, 2015 MD, 2017 MD	Culture-bound syndromes (dhat, koro, amok, latah and others)
Discuss neuropsychiatric aspect of HIV/AIDS	Long answer	2012 MD, 2017 MD	Psychiatric aspects of HIV and chronic infection
Enumerate culture bound syndromes. Describe Dhat syndrome in detail	Short note	2013 MD, 2018 MD	Culture-bound syndromes (dhat, koro, amok, latah and others)
Grief / complicated Grief	Short note	2021 MD, 2011 MD	Grief, bereavement and end-of-life psychiatric care
Discuss the differential diagnosis of delirium	Long answer	2012 MD	Delirium in the medically ill (CL perspective)
Psychiatric conditions encountered in general hospital settings - discuss in detail commonly occurring conditions	Long answer	2017 MD	Psychiatric aspects of medical and surgical illness
Consultation Liaison Psychiatry	Short note	2016 MD	Principles and models of consultation-liaison psychiatry
Role of Psychiatrist in patients having Psychosomatic Medicine	Short note	2020 MD	Psychological reactions to physical illness and chronic disease
ICU Delirium	Short note	2018 MD	Transplant, dialysis and ICU psychiatry
Psychiatric evaluation of donors in organ transplant	Short note	2021 MD	Transplant, dialysis and ICU psychiatry
Psychological aspects of aging	Short note	2012 DPM	Normal ageing and psychiatric assessment of the elderly
Abuse of elders	Short note	2011 MD	Elder abuse and neglect
Culture bound syndromes	Short note	2017 MD	Culture-bound syndromes (dhat, koro, amok, latah and others)

QUESTION, VERBATIM FROM THE INDEX	FORM	ASKED	OWNED HERE BY
Dhat syndrome	Short note	2015 MD	Culture-bound syndromes (dhat, koro, amok, latah and others)
Grief	Short note	2021 MD	Grief, bereavement and end-of-life psychiatric care
Complicated grief	Short note	2020 MD	Grief, bereavement and end-of-life psychiatric care

Sixteen catalogued questions, mapped by hand to the section that owns each in this chapter. The years are as the index records them; the mapping is this build's judgement and is stated as such.

A declared gap, in place of three figures that would otherwise have sat on this page. The number of questions the index holds, the span of years it covers, and the mark value it records against each question are all absent here, and deliberately so. Nothing in this chapter's claim ledger stands behind any of the three: their only authority would be this build's own reading of a file it happens to hold, which is not a source you can check. The mark values are the omission that matters, because they belong to another institution's scheme and not to the one that governs the paper this series is built for, whose notification sets four theory papers of ten questions each, every question carrying ten marks. The Form column carries what the omitted figure distinguished, and carries it honestly: this build renders the index's higher allocation as Long answer and its lower one as Short note, so the distinction between a question that wants an essay and one that wants a note survives without a digit from someone else's scheme being printed as though it were yours.

What has never been asked as a theory question, and why that is expected. A search this build ran across the whole of that index, for *OSCE*, *OSPE*, *objective structured*, *long case* and *short case*, returns **zero**. The five sections that close this chapter, from the structure of objective structured clinical examination stations through to the interpretation of investigations and instruments in vivas, are the practical examination itself, so their absence from a theory index is the correct result rather than a gap: they are examined in the practical and the viva voce, which the governing notification fixes at 300 marks and 100 marks while expressly leaving the division inside the practical to be settled elsewhere, and where a candidate cannot be carried by theory.

The quick review

One table, read down the left column and cover the right. Every line is taught in full somewhere above and nothing here is new: each is that topic's single must-hold line, so a line you cannot recover is a section to reread rather than a fact to learn here. Five things are load-bearing across the chapter. Every row answers who asked, in whose ward, what changed because the patient is seventy-eight, whose account of the cause reached the room first, and how the whole of it is produced aloud under observation; none of them answers what a

disorder is, so a row that says almost nothing about a condition you already know has been written on the assumption that you know it. The psychiatrist is a guest everywhere in the first half: the bed, the record and the discharge belong to another team, so consent to be seen is established rather than inherited and the referral question is extracted rather than received. Age changes what the existing lines of a note mean rather than adding a line to it. An account of the cause that reached the family before you did is assessment and not courtesy, because it predicts what will be accepted. And an answer here finishes at a destination: a place of care, a named owner and a review interval, in that order. The figures printed below are the ones this chapter itself owns, referral rates, intervals, thresholds, statutory sections and denominators, each carried back from the section that grounded it; every treatment dose and every figure belonging to an entity rather than to an act stays in the chapter that owns it, and those chapters are named here in words. Where the chapter declared that something could not be sourced, this page says so rather than smoothing it, because a revision table read at speed is exactly where an ungrounded number acquires a confidence nobody earned.

ASK	HOLD
THE CONSULT AS AN ACT, AND WHAT ARRIVES ON THE WARD	
WHOSE NEED THE CONSULT ANSWERS	Not the patient's. The need to appoint a psychiatrist is felt by the primary treating team, and everything procedural follows from that: consent to be seen is established rather than inferred from a referral the patient did not write, the referral question is extracted rather than read off the request, and the output is a recommendation inside somebody else's treatment, written for a physician to implement rather than for a psychiatrist to admire. A consult conducted as though the patient had walked into a clinic is procedurally wrong even where the diagnosis is right. The patient may also decline, since the right to refuse psychiatric assessment is to be respected if possible, and a refusal recorded and fed back has obstructed nothing.
THE REFERRAL RATE, AND THE GAP IT CONCEALS	There is no single Indian referral rate, and quoting one is an error of construct rather than of arithmetic: 0.01 to 3.6 per cent from the inpatient setting, 1.42 to 5.4 per cent from the emergency setting and 0.06 to 7.17 per cent from the outpatient setting, three denominators asking three different questions. The morbidity figures behave the same way, about 30 per cent in medically ill inpatients against 48 to 87 per cent in single-specialty liaison populations. What settles the argument is a pair measured in one unit: delirium in 68.5 per cent of one Indian intensive care unit against a referral rate of 1.71 per cent from the same unit. A quiet service is reporting on referral behaviour, not on how much illness the hospital holds.

ASK	HOLD
WHAT HAS TO HAPPEN BEFORE YOU WALK TO THE WARD	The call as it actually arrives is limited to informing the psychiatrist to come and see the patient on a given bed number, which contains no question, so answering it accepts the whole diagnostic problem without knowing what was asked; the caller owes their identity, the patient's identifiers, any language difficulty, the location, the primary diagnosis and reason for admission, the psychiatric concern and the urgency, and should not initiate a call without examining the patient. Then comes the compulsory preparatory phase, which individual practice has no equivalent of: current diagnosis and treatment, all available papers rather than the summary handed over, past psychiatric history, direct communication with the treating consultant about what they want, the nursing observation, and word sent to a relative to attend. Nothing later recovers it.
URGENCY: THE BANDS, AND THE SCOPE LIMIT ON THEM	Five colour-coded bands with response windows, and the scope is the examinable half: the scale is an emergency-room instrument and not a standard for answering a ward call. Immediate response with security or police for weapons, violence or an attempt at self-destruction; four hours for clear intent, plan and arrangement to harm; twenty-four hours for intent without a plan or rapidly increasing confusion; seventy-two hours for mood disorder or psychosis without intent; four weeks for a known stable disorder needing follow-up. For an ordinary inpatient call no interval is established anywhere in this chapter. What exists is behavioural: respond in a timely way and tell the team the time frame you will attend in.
THE NOTE, AND THE QUESTION THAT REQUIRED A PSYCHIATRIST TO ATTEND	Six entries, and the second is the intellectual content: the diagnoses by current nosology, then the aetiology of the psychiatric picture against the medical illness, which is mutual causation, comorbidity or coincidence, then the interaction of the proposed psychiatric treatment with the ongoing medical treatment, the biopsychosocial background relevant to management, the immediate risk with any transfer decision, and any adjustment the treating team itself needs to make. Build the answer on the second, because each verdict sends the consult somewhere different: mutual causation makes the psychiatric problem part of the medical plan, comorbidity puts the weight on sequencing, coincidence may make continuity the honest recommendation. A diagnosis and a drug has skipped it.

ASK	HOLD
WHY WRITING IN THE FILE IS NOT THE END OF THE CONSULT	It is explicitly insufficient: beyond the note the psychiatrist should communicate directly with the treating consultant, at least by telephone, resolve the team's doubts, give the formulation and suggest a comprehensive plan. The conversation is the only moment at which the team can say your recommendation is impossible on their ward. Documentation is then deliberately doubled, in the primary team's records and in separate records kept by the psychiatrist, the first because a recommendation must live where it will be acted on tonight. Where a diagnosis is confirmed and drug treatment started, follow-up falls within a week at the latest, with outpatient follow-up after discharge obligatory; where no diagnosis was reached, the output is regular review with psychometric evaluation rather than a label asserted to close the episode. Review during the admission is required only from time to time, and no frequency is specified anywhere.
WHO KEEPS THE PATIENT WHEN THE WARD ASKS YOU TO TAKE THEM	The transfer request is the standing friction, and it is answered with criteria rather than a rule. Delirium continues on the medical ward with regular psychiatric observation and not on the ground of the behavioural disturbance itself, because the behaviour is the presentation of a medical emergency due to an underlying medical cause: moving the patient moves them away from the treatment that resolves it. A substance use disorder stays until the medical complications are stabilised. Depression, suicidality or psychosis with serious medical morbidity stays under psychiatric supervision and moves only in stable medical conditions. The job is to decline the transfer while accepting the work, and the setting is not a favour: the appropriate Government must provide mental health services at all general hospitals it runs or funds.
THE SIGNATURE, READ IN BOTH DIRECTIONS	The commonest thing you are called for is confusion with behavioural abnormality, and the first discrimination owed is between a neurocognitive disorder and a primary psychiatric condition presenting with behavioural disorganisation, which is also the thing most easily misfiled as psychiatric. Read the other direction with equal discipline: the psychiatric presentation a medical illness or its treatment produces, organised by system and by drug. Across specialties the recurring picture is stress, anxiety, depression and somatic distress, with depression running about 10 per cent in the community against up to 30 per cent in medical units. The entity itself belongs to the Stroke, TBI, delirium and focal brain syndromes notes.

ASK	HOLD
REACTION AGAINST DISORDER, AND WHAT RIDES ON GETTING IT RIGHT	A psychological reaction to physical illness is universal and does not always reach morbid level, and separating reaction from disorder is the liaison task rather than a preliminary to it; patients referred here may not fulfil criteria for any mental disorder and still need support. The judgement is movement rather than content: whether the person is moving towards acceptance or is stuck, against their own premorbid history as comparator, with the further decision being whether drug treatment is needed or psychotherapy or a support group will do. The stake is adherence and the outcomes attached to it, taught directionally because no effect size for that chain is established anywhere in this chapter.
CAPACITY: A PRESUMPTION, THEN THREE ABILITIES JOINED BY "OR"	Capacity is presumed for every person including a person with mental illness, and the test is three abilities, to understand the relevant information, to appreciate any reasonably foreseeable consequence of the decision or of its absence, or to communicate the decision. The joiner carries the mark: the section prints them with "or", not with "and", so any one of them makes capacity out. Do not import the four-part functional schema of the international literature and do not add a limb about retaining information; neither is in this statute. The burden sits on the clinician who wishes to displace the presumption, and an unwise decision is not incapacity.
WHAT HAS TO HAVE HAPPENED BEFORE A CAPACITY FINDING MEANS ANYTHING	The information must have landed. It is to be given in simple language the person understands, or in sign language, or through visual aids, or by any other means that enables understanding, and on a medical ward that is the step most often skipped before a team records incapacity. Two boundaries decide reach: a general hospital is expressly inside the definition of a mental health establishment, so the Act follows you onto the surgical ward, while the test itself is written for decisions about treatment, admission or personal assistance. Extending it to a purely medical decision is an argument rather than a citation, and saying so is the answer.
THE ADULT OF SOUND MIND WHO SAYS NO, AND THE HOLE IN THE LAW	The highest authority is a 2018 Constitution Bench holding that a person who has come of age and is of sound mind has a right to refuse medical treatment, separated in terms from suicide, assisted suicide and euthanasia, so a competent refusal ending in death is not a psychiatric emergency. Quote it with its context, since the passage sits inside a discussion of the terminally ill and the persistently vegetative patient. Then name the gap plainly: no functional capacity test for an ordinary physical-treatment decision by a patient with no mental illness is established, and neither is who lawfully decides for such an adult who cannot decide. Reason by analogy, record that you are doing so, and do not import a foreign statute to fill it.

ASK	HOLD
WHEN TREATMENT CANNOT WAIT, AND THE CEILING ON IT	Any registered medical practitioner may give emergency treatment to a person with mental illness, at an establishment or in the community, subject to the nominated representative's consent where one is available, and only where it is immediately necessary to prevent death or irreversible harm, serious self-harm or harm to others, or serious damage to property flowing from the illness; the explanation extends it to transport to the nearest establishment for assessment. Three limits follow: nothing beyond what is directly related to the emergency, no electro-convulsive therapy under this power, and a ceiling of seventy-two hours or until assessment, whichever is earlier, extending to seven days only in a declared disaster. It is not a route for overriding a competent refusal.
THE RECORD'S OWN SHELF LIFE, AND WHAT THE WARD BELIEVES ABOUT RELATIVES	Capacity is decision-specific and time-specific, so a finding expires. The Act fixes an interval in one place only: where the representative consents during a supported admission the consent is recorded and capacity reviewed every seven days, and beyond thirty days on the expiry of every fortnight. No equivalent interval attaches to a one-off liaison opinion, which is what this topic is actually about, so the review interval is clinical judgement that has to be justified in the note. And the model is supported decision-making rather than substituted: a son who signs because it is quicker is the substituted model wearing the supported model's name.
THE TWO REFERRALS THE TEAM WANTS TAKEN OFF ITS HANDS	Medically unexplained symptoms and suspected fabrication arrive the same way, through a clinician out of investigations or out of patience, and in both the referral often follows the team's frustration rather than a change in the patient, which is itself part of the assessment. What the liaison psychiatrist owns is the general-hospital presentation, the documentation restraint and the team dynamics; the nosology of the somatoform and factitious disorders, the internal-versus-external incentive rule and the semen-loss presentation are taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. On the record, what was observed and what was alleged belong in different sentences with the source named for each, and what may lawfully be entered when deception is suspected but not established is not settled anywhere in this chapter.
THE SETTINGS WHERE THE CONSULT IS HARDEST AND THE DECISION LEAST REVERSIBLE	

ASK	HOLD
THE PRE-TRANSPLANT OPINION, AND THE FOUR THINGS IT CANNOT CONTAIN	A pre-transplant psychiatric and psychosocial assessment is imperative for recipient suitability, and that is the whole of what is established. No domain list, no structured instrument, no separation of absolute from relative psychiatric contraindication, and no requirement of psychiatric evaluation under Indian transplantation law is grounded anywhere in this chapter, so an answer inventing a domain grid or an abstinence interval is inventing it. What is teachable is the form of the opinion and the dual-agency problem inside it: you are asked for a judgement that will decide access to an organ, by a team whose interests are not the patient's, about a living donor whose consent has to survive the family that produced it. Say what you can and name the rest as unsettled.
DIALYSIS: THE SYMPTOM OVERLAP, AND THE INDIAN NUMBER	Uraemic symptoms mimic and mask depressive ones, so the mechanism of under-detection is symptom overlap and the consequence is under-evaluation and under-treatment; the unit-level stressors named alongside it are physical, financial, occupational, social and dietary. The Indian measurement is worth its denominator: 282 maintenance-haemodialysis patients across four Mumbai centres, screened with a questionnaire read aloud in the patient's own language regardless of literacy, gave 21.28 per cent at the moderate threshold, and 29.13 per cent of women against 16.76 per cent of men. Public and private centres did not differ. Reading the instrument aloud is the methodological point, and it is what makes the denominator usable.
INTENSIVE CARE, AND THE SYNDROME AFTER IT	The term names three domains, physical, cognitive and mental health, and one qualifier does the work: the impairment must be new or worsening, so pre-existing impairment does not count and a baseline is required before the label can be used at all. It was agreed at a multidisciplinary stakeholders conference rather than derived from a cohort. Everything a candidate reaches for next is unavailable here: no duration criterion, no incidence figure, no instrument, nothing on whether it looks the same in Indian survivors, and no Indian follow-up clinic model. Name the construct, name its qualifier, and refuse the proportion.
CHRONIC INFECTION: THE CONSENT QUESTION IS STATUTORY, AND ITS TEXT IS NOT HERE	What is grounded is that the 2017 Indian Act on prevention and control of the infection exists and that its section 5 is headed informed consent for testing or treatment. What the section requires in operative terms, whether pre-test and post-test counselling are statutory components, what conditions attach and which modal verb it uses are not established, and the national counselling references were located and never read, so no step, interval or competency may be attributed to them. Every epidemiological figure is absent as well. Teach consent, disclosure, adherence, stigma and a clinic relationship that is built rather than improvised, and say the statutory detail is owed rather than known.

ASK	HOLD
THE CARDIAC AND RENAL INTERFACES, AS FIGURES WITH POPULATIONS	Depression runs 15 to 20 per cent in coronary artery disease and reaches a major episode in 20 per cent after myocardial infarction, while fewer than 15 per cent of those depressed in coronary disease are actually diagnosed, which is the recognition problem stated as a number rather than as a complaint. Post-infarct depression carries a 1.6 to 2.7 fold mortality risk and the relationship is bidirectional. In kidney disease depression is 22.8 per cent in advanced disease and cognitive impairment reaches 60 per cent. All of it is an Indian guideline reporting international evidence, not Indian primary data, and the head terms themselves are not all attested.
THE TWO PRESCRIBING SIGNALS, AND THE NEUROLOGICAL DOOR	Two constraints are named and neither carries a dose here. Physical treatment is relatively contraindicated within 30 days of unstable angina or infarction, with its procedural precautions taught where they belong. And citalopram in haemodialysis carries a raised risk of sudden cardiac arrest, greater than other agents of its class, with no effect size given anywhere. On the skin the severe cutaneous reactions are taught as an interface and as a duty to warn the patient and the attendants, deliberately without rates or onset windows, because the available tabulation disagreed with its own document's prose. Epilepsy arrives as a referral rather than as an entity and is taught in the Epilepsy and psychiatry notes.
WHAT CHANGES AT SEVENTY-EIGHT	
WHAT AGE CHANGES, AND WHAT IT LEAVES EXACTLY WHERE IT WAS	The skeleton does not move: history, physical examination, mental state examination and investigations, with the one shift being that comorbid physical illness now carries the weight the psychiatric history carries. Three domains are added to the history: sensory deprivation, a frailty review, and elder abuse, the last requiring a high index of suspicion rather than a complaint. Underneath sits the physiology that makes all of it matter: reduced reserve, so a small perturbation produces a disproportionate clinical effect. Two acts precede any score, and they are not politeness: the hearing aid and the spectacles go on before a single cognitive item is administered, because otherwise the item measures hearing.
NORMAL AGEING: WHAT DECLINES, WHAT HOLDS, AND THE COMMON CAUSE	The split is the teaching. Fluid abilities peak in the third decade and fall at about 0.02 standard deviations a year, while crystallised ability is stable or gradually improving at 0.02 to 0.003 standard deviations a year through the sixth and seventh decades, and vocabulary is resilient while conceptual reasoning, memory and processing speed decline at rates that differ between individuals. One change explains many findings: processing speed begins falling in the third decade and drags down scores in other domains, so a low score may be a speed artefact. Acquisition and free recall decline while recognition, temporal order and procedural memory hold, and confrontation naming stays level until about 70. No Indian norms exist for any of it.

ASK	HOLD
COMPREHENSIVE ASSESSMENT AS A PROCESS RATHER THAN A QUESTIONNAIRE	It is an interdisciplinary and multidimensional process for frail or vulnerable older people, not an event and not a synonym for the specialty, and its product is a problem list, goal-driven interventions and one coordinated plan spanning treatment, rehabilitation, support and long-term care. Its five domains are physical conditions, mental health, functioning, social circumstances and environment, and note where cognition sits: one item inside the mental-health domain, beside mood, anxiety and fears, which is the whole argument against equating geriatric assessment with a cognitive score. The core team is a doctor who need not be a geriatrician, a nurse, an occupational therapist, a physiotherapist and a social worker, and the plan must state explicit goals, who is responsible, and a review timeline.
FALLS: THE SCREEN, THE STRATIFICATION AND THE ONE MEASURED THRESHOLD	Case-finding is opportunistic and cheap: in lower and middle income settings, everyone aged 60 and over, at any clinical encounter, at least annually, asked about falls in the past twelve months. Stratification then decides the work: low risk gets education and exercise and annual reassessment because low risk is not no risk, intermediate gets strength and balance work or physiotherapy, and high risk is offered a multifactorial assessment to inform individualised interventions. One threshold is measured rather than asserted: gait speed below 0.8 metres per second over a four-metre walk, with a timed-up-and-go alternative of over 15 seconds whose fall-risk evidence the guideline itself calls mixed. The component recommendations do not carry equal evidence, and vision, hearing, pain, depression and nutrition rest on expert opinion.
PRESCRIBING AT SEVENTY-EIGHT: DIRECTIONS, THEN FRACTIONS, NEVER MILLIGRAMS	The pharmacology is taught as direction and not as percentage: renal and hepatic clearance fall, volume of distribution rises for lipid-soluble drugs, half-life lengthens, and sensitivity is altered and usually increased. Body composition drives the first half, since total body water and lean mass fall while fat rises relatively, so water-soluble agents reach higher serum levels and lipid-soluble ones linger. Renal decline is neither uniform nor consistent, and creatinine is unreliable because muscle mass has fallen too. Only two dosing quantities are established, both fractions: an antidepressant at half the adult starting dose and half the adult target dose, and an antipsychotic reduced by 25 to 50 per cent. No milligram figure and no cumulative maximum exists for any of it.

ASK	HOLD
THE HAZARDS THAT CARRY A NUMBER, AND THE THREE THAT CARRY NONE	Two thresholds are printable. Specialist referral for hyponatraemia falls at a serum sodium below 125, the risk sitting in the first weeks of treatment in the elderly and frail with no number of weeks stated, and deprescribing review is triggered above five medications, which is a trigger for a review and not a permitted ceiling. Against them, three examinable absences: the anticholinergic load must be totalled across every ongoing drug as a crucial cause of delirium, with no instrument and no score named; no numeric threshold for the corrected interval and no age-specific cap; and geriatric-specific management strategies have not been evaluated.
SLEEP: THE CHANGES HAPPENED BEFORE THE PATIENT GOT OLD	The six changes are advanced timing, shorter nocturnal sleep, more naps, more awakenings, more time awake at night and less slow-wave sleep, and the timing of the change is the mark: they occur mostly between young and middle adulthood and are largely unchanged among healthy older adults after 60. Wake after sleep onset rises 10 minutes per decade, valid between 30 and 60 years only, and the stage-proportion shifts are not significant above 60 in healthy older people. The circadian phase advances by about an hour across sleep timing, temperature, melatonin and cortisol together. So none of this explains a new complaint at seventy-eight, and using it to do so is the error the section exists to stop.
WHY A HYPNOTIC IS THE WRONG REFLEX	Because the excess is comorbidity rather than age. Insomnia symptoms run about 50 per cent in older adults, yet in those in excellent health prevalence resembles that in younger people, so the complaint points at medical and psychological comorbidity; self-reported poor sleep quality reaches 50 to 60 per cent with the review's own caution that it is not necessarily ageing alone. The drug history is half the assessment, on figures that are explicitly not Indian: about 90 per cent of those aged 65 and over take prescription drugs and more than a third take over five. Older adults also under-report poor sleep, so the complaint you hear understates the problem.
ELDER ABUSE: HOW IT ARRIVES, AND THE ACT THAT MUST APPEAR IN THE NOTE	Nobody arrives complaining of it. It arrives as a fall, a confusional episode, weight loss, poor adherence, an admission the family is unusually keen on, or a discharge that keeps being deferred, each with an ageing explanation already to hand. The definition to quote treats it as acts of omission resulting in harm or threatened harm to the health or welfare of an older person, and say in the same breath that acts of commission are conventionally included, because as printed the definition narrows the subject. The instruction that is actually marked is procedural: the patient is interviewed separately and given time and reassurance. The named screen is a caregiver abuse screen with no item count, no cut-off and no validation data attached to it anywhere.

ASK	HOLD
THE SAFEGUARDING ANSWER HAS TWO HALVES, AND ONLY ONE IS LAW	There is no elder-abuse-specific mandatory reporting duty in the 2007 senior citizens Act, and no provision of the child-protection kind obliging any person or professional to report suspected abuse. Scope that negative correctly: it concerns this Act, and a general duty to inform the police of certain offences binds a psychiatrist as it binds anyone, though its text, section number and modal verb are not established here. What the Act supplies instead is a route, not a report: an application by the senior citizen, or by any other person or organisation authorised by him where he is incapable, or the Tribunal taking cognizance on its own motion, a power and not a duty. The directive half is professional: where safety may be compromised during the stay or after discharge, a report to the police must be made.
THE LATE-LIFE PRESENTATIONS THAT MISLEAD	
DEMENTIA IN AN OLDER REFERRAL: WHAT THIS CHAPTER OWES AND WHAT IT DOES NOT	It owes the frame, not the entity: why a family or a ward asks for help, the behavioural picture as the reason the call was made, and the wider assessment the diagnosis sits inside. The disease, its subtypes, its investigation and its treatment are taught in the Dementias and neurocognitive disorders notes, and the cognitive screening instruments belong there too. Three things a candidate expects to find here are not available anywhere in this chapter and should not be improvised: any prevalence or incidence for later life, any figure for how that rises with age, and any Indian measure of diagnostic delay or of old-age psychiatric service provision. Say the scale of the problem is not quantified here rather than borrowing a number that sounds right.
LATE-ONSET DEPRESSION: THE PRESENTATION THAT MISLEADS, AND THE MODAL THAT MUST SURVIVE	The mask is somatic and cognitive and the vascular contribution is part of the picture, but the discriminating question is whether an episode has occurred before rather than any age threshold, because no age cut-off defining late onset is established and neither is the proportion of late-life presentations that are first episodes. Current Indian guidance holds that age influences which antidepressant is chosen, with agents of one class possibly less effective and another possibly more suitable in older adults: the modal is may, twice, and strengthening it into a recommendation is the error. Prescribing runs start low and go slow, at half the adult starting and target dose, watching hyponatraemia and falls. Agent selection and switching sit in the Mood disorders: pharmacotherapy notes.

ASK	HOLD
A FIRST PSYCHOSIS LATE IN LIFE: EXCLUSIONS BEFORE ANYTHING ELSE	The exclusion list is the answer and it is long: affective psychosis, delirium, the dementias, medication-induced states from anticholinergics and antihistaminergics at higher doses, steroids, dopamine agonists, antimalarials, antiretrovirals, opioid analgesics, fluoroquinolones and cardiac agents, substance-induced states, and severe nutritional and endocrine disorders. Neuroimaging is indicated, and the emphasised trigger is a first episode after 60, with no modality or sequence named. Management changes because the patient is old rather than because the illness differs: first-line choice is driven by lower anticholinergic burden and lower sedation to prevent falls, starting 25 to 50 per cent lower, avoiding anticholinergic co-prescription, with more frequent metabolic monitoring. Where the paraphrenia label sits in any classification is not asserted.
DELIRIUM AT SEVENTY-EIGHT: THE INDIAN FIGURE, AND WHAT IT DOES NOT EXTEND TO	In elderly attenders screened at Indian emergency medical outpatient settings, delirium was the commonest diagnosis at 34.1 per cent, against dementia at 9.5 per cent and any axis-one disorder at 47.4 per cent, with both delirium and dementia commoner above 70. Ageing is the predisposition rather than the cause, through the listed age-related risk factors, which carry no weight, ranking or effect size, and through multimorbidity and polypharmacy, with more than three medications listed separately as a risk factor. Delirium superimposed on dementia is named and its discriminating features are not given. Nothing about outcome after the episode is quantified, and sundowning has no quotable definition.
PSEUDODEMENTIA: AN ASYMMETRY OF CONSEQUENCE, NOT OF FREQUENCY	The discrimination matters because the two errors are not equivalent: a depressive illness read as a dementia loses a treatable condition, while a dementia read as depression costs a trial of treatment and a review date. That asymmetry is the whole argument, and it is made on the order of clinical work rather than on relative frequency, because no figure exists for how often an apparent dementia in later life proves to be a depressive illness, in India or anywhere, and none for how long the treated interval usually takes to settle it. So the answer is an act with an owner and a date rather than a probability. The comparison table itself, with its features, is taught in the Dementias and neurocognitive disorders notes.
WHOSE EXPLANATION REACHED THE ROOM FIRST, AND THE END OF LIFE	

ASK	HOLD
THE UMBRELLA TERM, AND WHY PSYCHIATRY HAS TO GO AND COLLECT IT	The current framework replaced the old roster heading with an umbrella holding three kinds of cultural concept, a syndrome, an idiom of distress and an explanation, and their definitions and the reasons for the change belong to the Psychotherapies, clinical assessment, MSE and nosology notes. What this chapter owns is the move from the concept to the clinic. The examinable point is that the three are not interchangeable: a syndrome is a cluster of features, an idiom is a way of expressing distress that need not indicate any disorder, and an explanation is a claim about cause. Answering with a list of exotic names has answered the superseded question.
THE CULTURALLY SHAPED PRESENTATION: NOT THE ROSTER, THE ROUTE	What is asked for is how the patient arrived, what has been tried and who advised it, what the family holds the cause to be, what else may sit behind it, and how the explanation is negotiated. The route is documented: information reaches such patients through friends, relatives, colleagues, roadside advertisements, lay magazines and traditional practitioners, and the cures they expect run from indigenous medicines, herbs and dietary interventions to injections, tonics and marriage. The boundaries leak both ways: a syndrome classically indexed to one country presented in two Indian cases reaching an obsessive-compulsive clinic after the family noticed it, and in another an obsessive-compulsive disorder emerged only on an unscheduled review. What is behind the presentation is the question.
THE FORMULATION, THE IDIOM AND THE MODEL: NAME THEM, THEN ROUTE THEM	Name both instruments, say where in an assessment each belongs, give the address, and print no counts: the outline's domains, the interview's questions and sections, and the supplementary modules are owned by the Psychotherapies, clinical assessment, MSE and nosology notes, and so are the definitions of an idiom of distress and an explanatory model and the eliciting questions that go with them. What this chapter adds is the clinical use. An idiom translated into a symptom loses the meaning that made it worth eliciting, and an explanatory model recorded and then not acted on has collected information and wasted it. The full instrument is seldom completed in clinic time, which is a statement about the encounter and not a licence to skip the enquiry.
MIGRATION, AT INDIAN SCALE AND WITH THE INDIAN OUTCOME MISSING	The official rate is 28.9 per cent and it is almost two different phenomena: 10.7 per cent of men against 47.9 per cent of women, with marriage accounting for about 86.8 per cent of female migration and employment for 22.8 per cent of the male, so who moves and why differs by sex before any outcome is discussed. The two questions generating the strategies are whether the person maintains their own identity and whether they maintain relations with the wider society, giving assimilation, separation, integration and marginalisation. No Indian outcome estimate for internal migrants exists, and current Indian guidelines carry nothing on migration or acculturation at all.

ASK	HOLD
THE ONE MEASURED INDIAN STUDY OF A HEALING SITE: WHAT IT DID	A single temple, 31 people, of whom 29 had a non-affective psychosis, so the study says nothing about common mental disorders or distress states. The exposure was residence with a relative in attendance, a fifteen-minute morning prayer and no ceremony performed for any individual's recovery, with no psychopharmacological or other somatic treatment at any point, over a stay of a mean of six weeks, range one to twenty-four. The rating-scale total fell from 52.9 to 42.9, a reduction the authors call nearly twenty per cent. Cost to the family was nil, and physical restraint was not used at this site though the paper records that it is at many others.
WHAT THAT STUDY DOES NOT LICENSE ANYONE TO SAY	The design is uncontrolled, single-site, unblinded, with the same rater at both assessments and no comparison group, and the authors call their own findings only suggestive. The caregiver rating was an unblinded judgement by the relatives who brought the person and stayed: 22 improved and 3 recovered, which accounts for 25 of the 31, and what happened to the remaining six is not stated. Their bar on generalising is explicit, not to other regions and not to other healing temples in the same region. The finding that matters clinically is about access: a government primary health centre stood in the same village and had been consulted by one of the thirty-one. The route to care is a question to ask, never a finding about belief.
THE REACTION TO A CANCER DIAGNOSIS, AND THE GROUP THAT IS LARGEST	The trajectory as stated runs shock and disbelief, anger, depression, loss and grief, and the diagnosis most often made is the one candidates reach for last: adjustment disorder is the commonest psychiatric syndrome in cancer patients. The Indian denominator is one tertiary inpatient sample of 384, in which 41.7 per cent had any psychiatric disorder, 22.6 per cent an adjustment disorder and 10.9 per cent a major depressive episode. No Indian community or advanced-disease prevalence exists to set beside it, and fear of recurrence, body image, sexual difficulty and financial distress carry no Indian magnitude at all.
COLLUSION: GRADED RATHER THAN BINARY, AND THE BIND STATED BOTH WAYS	It has three axes, who is kept in the dark, what is withheld, and whether it is partial or complete, and its triggers are the move from curative to palliative intent and the entry of death into the conversation; the paper's own line is that it may be a conspiracy of lopsided communication as much as one of silence. In India nearly one half of patients are unaware of their own diagnosis or treatment, while among those who already knew, 71 per cent wanted the truth, 81 per cent of relatives wanted to be told and 77 per cent did not want the patient told. Say the benefit side too: it may defend the person from harm and minimise concern about the future, against obstructed autonomy and lost trust. Working through it is a sequence, reasons first, then a no-disclosure-without-consent contract, then the patient's actual awareness, then being present when they first speak openly.

ASK	HOLD
RECOGNITION IN ADVANCED DISEASE, AND THE INSTRUCTION THAT SURVIVES COMORBIDITY	The direction is treat: pharmacotherapy remains indicated alongside medical comorbidity, on an umbrella review spanning 27 comorbid medical conditions against placebo, with a psychological arm supported for conditions such as coronary heart disease and neurological disorders. Hold the qualifier in the same sentence, since response tends to be poorer when comorbid, with the magnitude nowhere quantified. Delirium is the third presentation and it was 6.5 per cent of that same Indian inpatient sample. What is not established here: how the confounded somatic criteria should be handled, which brief screen is defensible in a breathless patient, and what constrains the choice of agent near the end.
GRIEF, AND THE PROTOCOL THAT WAS BUILT FOR THE WRONG NUMBER OF PEOPLE	The standard frameworks assume a dyad, whereas in Indian practice the patient is almost always accompanied, so more than one relative is included and the key relative is chosen by the patient's view of who that is rather than by volume or by your guess. The mechanism that makes concealment a clinical problem after the death, and not only before it, is that business left unattended before a death obstructs grief resolution in the survivors afterwards, and unchecked collusion leaves patients morbidly anxious and lowers the threshold for pain and nausea. Nothing about the after-death tasks is grounded here, and neither is any interval or risk stratification for bereavement follow-up.
DEMORALIZATION, AND THE LINE THE LAW ACTUALLY DRAWS	The core is hopelessness, loss of meaning and existential distress, ending in a desire to die, and the construct is proposed as separable from depression rather than demonstrated to be common: no proportion who are demoralized without being depressed is available, and the scale is named only, with its item count, subscales, format, cut-offs and revision all ungrounded. The legal boundary is where answers overreach. Active euthanasia is impermissible, on the basis that no statute permits it, while the passive form is withdrawal or withholding of measures that artificially prolong life, and the directions on advance directives operate as judicial directions until Parliament legislates, not as legislation.
THE SAME ENCOUNTER, PERFORMED ALOUD UNDER OBSERVATION	
A STATION SCORES THE ACT, NOT THE KNOWLEDGE BEHIND IT	That single sentence separates a station from a viva: in a viva, saying what you would do is the performance; in a station it is an admission that you did not do it. Six things exist before you arrive, five of them written: the place in the blueprint, the instruction at the door, the brief the patient carries, the material handed over, the marking schedule, and the standard it is read against. Read the instruction for its task verb before its clinical content, because the verb names the product due when time ends: take a focused history, elicit and describe, explain to, assess. Marking runs in two layers at once, an itemised schedule and one overall judgement, and neither alone is sufficient. Information is released on request, so silence is yours to fill.

ASK	HOLD
THE ARITHMETIC THAT DECIDES THE RESULT	Three conditions, all conjunctive: at least 40 per cent in each theory paper, at least 50 per cent in aggregate across the four, and at least 50 per cent in the practical, so failing any one fails the whole and a strong practical repairs nothing. The per-paper floor is the new element, absent from the superseded state ordinance whose rule was half the marks in each of two heads only. A station's marks sit inside the same practical line as your long case, because the practical is expressly composed of the clinical, the objective structured component and the viva voce. No grace mark is permitted in either head. Scripts are valued twice, a third valuation follows a difference of 15 per cent or more of the paper total, and there is no revaluation afterwards.
WHAT IS MANDATORY, AND THE FOUR THINGS NOTHING FIXES	The obligation is real and its vehicle is not settled: the notification of 16 December 2024 provides that an objective structured clinical examination or a short case shall be included from the ensuing examinations, and the clause is disjunctive on its face. It reaches candidates admitted before the rules were made because the university records a clarification that the 2023 regulations apply to all students appearing in the forthcoming examination, irrespective of admission year. Four things are established by no instrument: how many stations, how long one runs, what one is worth, and whether the requirement will be met by stations or by a short case. Numbers circulate for all four and are somebody's local arrangement. The board is at least four examiners, two of them external, one from outside the state.
LONG CASE AND SHORT CASE, AND THE MARKS NOBODY HAS PUBLISHED	The national provision is one long case and two short cases. Around it the current scheme is four papers, ten questions each, ten marks a question, with a 300-mark practical including 20 for the thesis and a 100-mark viva voce. What a long case or a short case is now worth is unpublished, because the division inside the practical is referred elsewhere, and the superseded ordinance's split is not carried forward to fill the hole. Equal marks per question means equal minutes per question, and the paper duration is not stated by the instrument that fixes the structure.
THE DEMONSTRATION, AND WHATEVER IS PUT IN FRONT OF YOU WITHOUT WARNING	Administration of a scale or a bedside test is an observed performance rather than a recitation: what is said to the patient before it starts, how timing is managed, what is reported aloud, and how a refusal is handled without abandoning the task. Whether such a demonstration is called for as a thing of its own, in what time and against what weighting, is established by nothing. The oral covers subject knowledge, investigative procedures, therapeutic technique and other aspects, and case reports, charts, specimens, slides and imaging are expressly examinable, with questions on instruments stated to be asked. How many such questions, how long for one, and what share of the viva they carry is not stated anywhere.

ASK	HOLD
BREAKING BAD NEWS AS AN EXAMINED ACT	Six steps, in the order the source prints them: setting, the patient's perception, an invitation from the patient to be given information, the knowledge itself, exploring and sympathising with emotion, then strategy and summary, with four objectives, to gather information, transmit it, provide support and elicit collaboration. Give the ethical frame both ways, because a one-sided answer loses half the marks: withholding on the presumption that the patient cannot cope may not always be justified against autonomy, and insensible disclosure may harm the patient and the relationship. One figure is printed only as a guard against transposition: the 13.6 per cent trained is an Iranian faculty and resident sample, and no Indian equivalent exists.

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Every specific in this chapter is bound to one of the sources below, and the count is the number of claim rows each carried. 23 of those rows are statutory and were read at the primary Act on India Code rather than from any textbook's summary of it, because a stale or paraphrased section changes what a clinician is legally obliged to do. Doses were read at current regulatory labelling, and each carries its own source receipt naming the regulator, the product, the label version and the retrieval date. 40 row(s) are recorded at partial confidence and 0 as a declared gap: a declared gap is a correct answer here, and no number has been supplied to fill one. The must-have-papers cross-check was NOT performed for this Paper III chapter, because the paper lists do not yet exist in the intel index; for Paper III the topic bank plus the syllabus scaffolding is the completeness authority. This table records provenance, not proof: it says where each specific came from, not that the chapter's prose uses it correctly, which the content pass and the ship review test.

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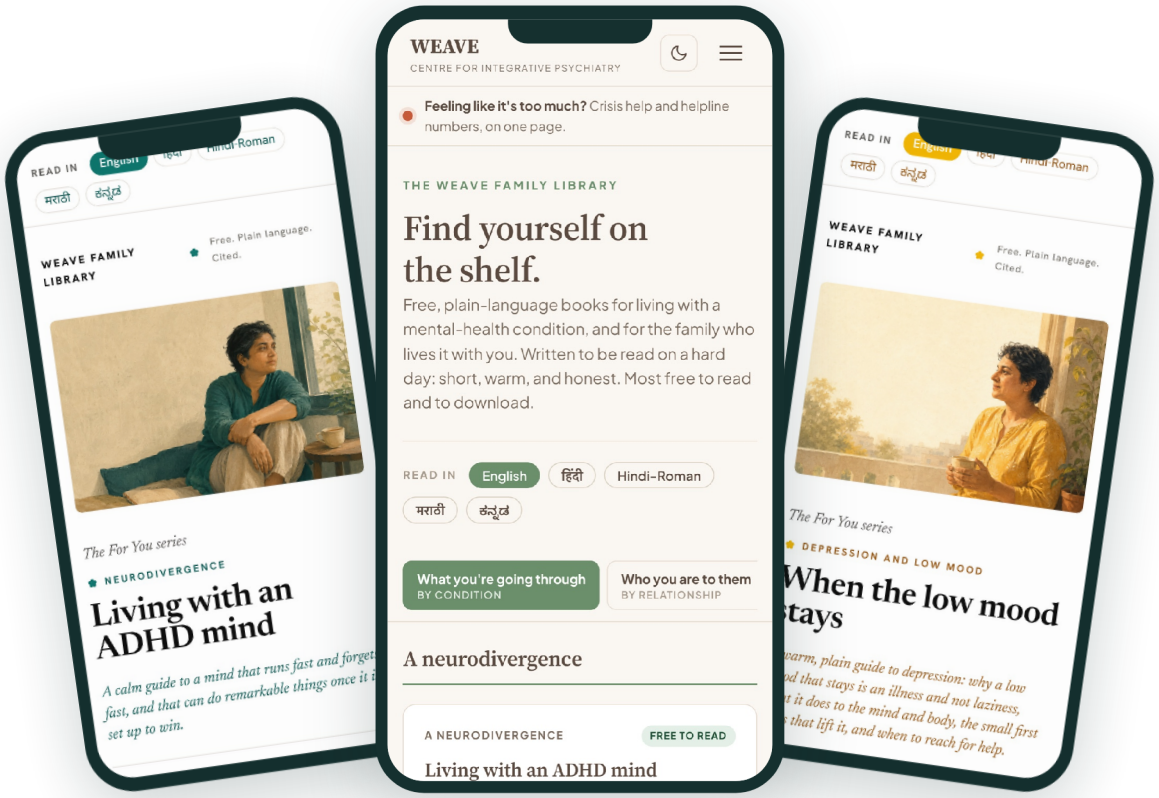
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