WEAVE SPRINT
PAPER II · VOLUME SIX

MD and DNB psychiatry, theory revision

Clinical Psychiatry

Body, Impulse and the Therapies

The somatic-symptom, sexual and impulse-control disorders, and suicide. Then the psychotherapies, the clinical interview, the mental state and nosology.

Dr. Wilfred D'souza · Dr. Niharika Reddy

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WEAVE SPRINT · PAPER II

Clinical Psychiatry

THE WEAVE SPRINT SERIES

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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 final volume of the second paper gathers what remains, then turns to method. The disorders here are the ones that arrive through the body, desire and impulse, and they include suicide, which is not a diagnosis but is the question underneath many of them. The last chapter is how psychiatry treats and how it assesses, and it belongs at the end because it applies to everything before it.

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.

Contents

FRONT MATTER

Foreword 7

How to use this book 8

PART XI Somatic-Symptom, Sexual and Impulse-Control Disorders and Suicide 11

- Somatic symptom and related disorders 12
- Sexual dysfunctions, paraphilias and gender 54
- Psychosomatic medicine and consultation-liaison 103
- Impulse-control disorders 112
- Suicide and self-harm 118
- Apply and consolidate 166

PART XII Psychotherapies, Clinical Assessment, MSE and Nosology 188

- Psychotherapies: general and specific 189
- Psychiatric assessment and rating scales 283
- Nosology and cross-cutting clinical issues 326
- Apply and consolidate 381

BACK MATTER

Subject index 420

About the authors 427

PART XI

XI

Somatic-Symptom, Sexual and Impulse-Control Disorders and Suicide

Body, desire, impulse and self-harm: the somatic-symptom, sexual and impulse-control disorders, and suicide.

01 Somatic symptom and related disorders

02 Sexual dysfunctions, paraphilias and gender

03 Psychosomatic medicine and consultation-liaison

04 Impulse-control disorders

05 Suicide and self-harm

06 Apply and consolidate

PAPER II

Somatic-symptom, sexual, impulse-control disorders and suicide

Five sections . one complete notes document

This material gathers the somatic-symptom, sexual, impulse-control and suicide-related disorders into one document, by syndrome and by management. The first band is **the somatic symptom and related disorders**: somatic symptom disorder and the somatoform-to-SSD nosology shift with its positive psychological criterion, illness anxiety disorder, conversion or functional neurological symptom disorder placed on the spectrum, factitious disorder and malingering, and the management of medically unexplained symptoms. The second band is **the sexual dysfunctions, paraphilias and gender**: the normal sexual response cycle, the male and female sexual dysfunctions and their management, the paraphilic disorders, gender incongruence and the affirmative-care pathway, Dhat and the culture-bound presentations, and medication-induced sexual dysfunction. The third band is **psychosomatic medicine and consultation-liaison**, taught here as the psychosomatic concept with the service model and disease-specific aspects cross-referenced. The fourth band is **the impulse-control disorders**. The fifth band is **suicide and self-harm**, the high-stakes clinical core, written throughout with strict safe-messaging: the structured risk assessment and the balance of risk and protective factors, the management of the suicidal patient and collaborative safety planning, deliberate self-harm, prevention through means restriction and gatekeeper training, and the anti-suicidal pharmacology. The examinable skill is the safe, guideline-anchored assessment and management of each: the positive criterion behind a somatic presentation, factitious versus malingering, the first-line for erectile dysfunction, the affirming frame for gender incongruence, and the structured, compassionate assessment and safety planning of a person at risk.

HOW TO USE THESE NOTES

Read the five bands as one continuous account of how these disorders are assessed and managed. The **somatic symptom and related** band builds the nosology: the shift from the somatoform disorders to somatic symptom disorder with its positive psychological criterion, illness anxiety disorder, and the discrimination of the somatic disorders from factitious disorder and malingering by voluntariness and external incentive. The **sexual, paraphilias and gender** band teaches the sexual response cycle, the male and female dysfunctions and their guideline-anchored management, the paraphilic disorders, gender incongruence taught in the affirming ICD-11 frame with the Indian legal position, and Dhat as a culture-bound presentation. The **psychosomatic and consultation-liaison** band teaches the psychosomatic concept compactly. The **impulse-control** band teaches the disorders of urge and control. The **suicide and self-harm** band is the core: the structured risk assessment and the balance of risk and protective factors, the limits of individual-risk prediction, the compassionate non-judgemental assessment of self-harm, collaborative safety planning, and prevention through means restriction, all written with strict safe-messaging, stating the burden without method specifics and framing means restriction, help-seeking and safety planning positively. Every management recommendation is guideline-anchored, led by NICE for the self-harm and suicide pathway with the WHO LIVE LIFE frame, ISSM and BSSM for the sexual dysfunctions and WPATH SOC-8 for gender, on the where-to-treat, target-by-phase, modes-of-treatment spine; every named syndrome ends with a **Good to remember** box giving the criterion, the discriminator and the first step, and every named management step ends with one giving the principle and the first move. Figures declare one axis and code it in colour: **petrol** marks structure and the neutral case, **coral** marks the trap or the danger, and **marigold** highlights the number to hold; every suicide figure is conceptual and non-sensational, with no method depiction. The rating scales are reproduced as the actual instruments where the licence permits, the Columbia scale the key plate, credited to their sources, or typeset from their structure where it does not. Several boundaries are stated up front: conversion or functional neurological symptom disorder is taught in full in the Dissociative, conversion and anxiolytic/hypnotic pharmacology notes and cross-referenced here; the consultation-liaison service model and the disease-specific psychiatric aspects in the Consultation-liaison, geriatric and transcultural psychiatry notes; body dysmorphic disorder in the Anxiety, OCD and trauma-related disorders notes; and the deep antidepressant, antipsychotic and the lithium and clozapine pharmacology in the Mood disorders: pharmacotherapy notes and the Schizophrenia: management, antipsychotics and adverse effects notes. The somatic nosology, the factitious and malingering discrimination, the sexual and gender syndromes, Dhat, the impulse-control disorders and the whole suicide and self-harm band are owned and fully taught here. This is doctor-facing revision, so the full technical vocabulary is used, brand names lead with the Indian brand, and every dose, scale cut-off, criterion and legal provision is verified against a source or omitted and flagged.

Somatic symptom and related disorders

1 · Somatic symptom disorder and the somatoform nosology shift

This is the opening topic of a chapter that runs from the body that *complains* to the body that *desires*, then to the urge that *acts* and finally to the life that must be *protected*; the whole arc is

stitched together by one master mnemonic seeded here and paid off at consolidation. It opens with **somatic symptom disorder** because that entity is the product of the single largest reclassification in this part of the syllabus: the DSM-IV and ICD-10 **somatoform disorders**, a scattered family diagnosed by what could *not* be found on investigation, have collapsed forward into one positively defined diagnosis. Examiners test this **nosology shift** two ways, and you must be fluent in both: a straight "what replaced what" crosswalk, and a discrimination task where a vignette must be placed in the right modern category and defended against its neighbour.

How to use this page. Fix the three DSM-5-TR criteria first, then unpack Criterion B (the **positive psychological criterion**) because that clause carries most of the marks, then internalise the one conceptual break, that being **medically unexplained** is no longer a requirement, so a symptom may be fully medically explained and still qualify. After that, learn the ICD-10 family that was folded in, the DSM-5 specifiers, and the parallel ICD-11 move to **bodily distress disorder**; finish with the assessment scales and the guideline-anchored first moves in management. The cardinal error the chapter is built to prevent is calling this diagnosis "medically unexplained".

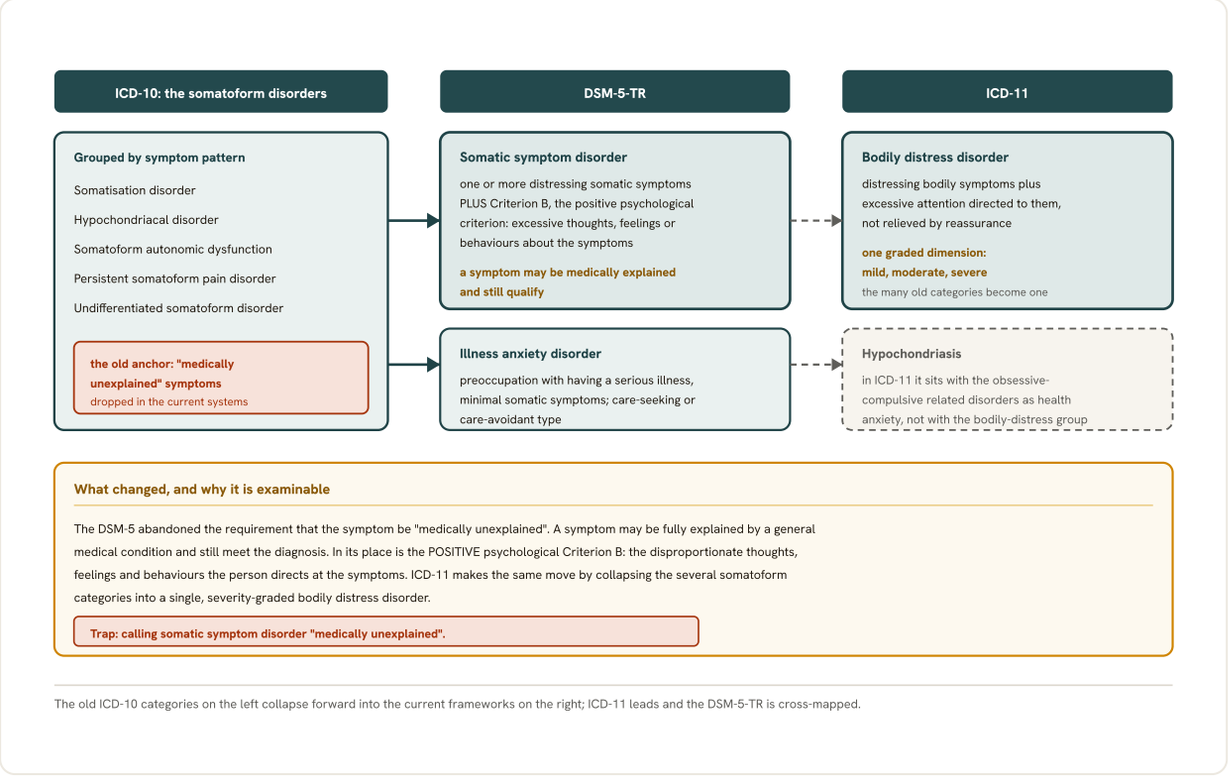


Fig 18.1 The somatic-symptom nosology shift. The ICD-10 somatoform disorders, grouped by the pattern of symptoms, collapse forward into a much simpler current picture. The DSM-5-TR replaces the whole group with somatic symptom disorder, which turns on a POSITIVE psychological criterion (excessive thoughts, feelings and behaviours about the symptoms) rather than on the symptom being medically unexplained, so a medically explained symptom may still qualify; hypochondriasis becomes illness anxiety disorder. ICD-11 goes further and folds the categories into a single, severity-graded bodily distress disorder, while placing hypochondriasis with the obsessive-compulsive related disorders as health anxiety. The examinable move, and the classic trap, is the retirement of "medically unexplained" in favour of the positive criterion.

Patient Health Questionnaire-15: Physical Symptoms

During the last 4 weeks, how much have you have been bothered by any of the following problems? Please place a check mark in the box to indicate your answer.

		Not bothered	Bothered a little	Bothered a lot
		0	1	2
1.	Stomach pain	☐	☐	☐
2.	Back pain	☐	☐	☐
3.	Pain in your arms, legs, or joints (knees, hips, etc)	☐	☐	☐
4.	Menstrual cramps or other problems with your periods [women only]	☐	☐	☐
5.	Headaches	☐	☐	☐
6.	Chest pain	☐	☐	☐
7.	Dizziness	☐	☐	☐
8.	Fainting spells	☐	☐	☐
9.	Feeling your heart pound or race	☐	☐	☐
10.	Shortness of breath	☐	☐	☐
11.	Pain or problems during sexual intercourse	☐	☐	☐
12.	Constipation, loose bowels, or diarrhea	☐	☐	☐
13.	Nausea, gas, or indigestion	☐	☐	☐
14.	Feeling tired or having low energy	☐	☐	☐
15.	Trouble sleeping	☐	☐	☐
TOTAL SCORE =				

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Source instrument available at http://www.phqscreeners.com/
Consortium version 12May2013. Available at http://www.rdc-tmdinternational.org/

The PHQ-15: 15 common somatic symptoms, each scored 0 to 2 over the last four weeks (total out of a possible 30); the bands are 0 to 4 minimal, 5 to 9 low, 10 to 14 medium and 15 to 30 high somatic-symptom burden.

PHQ-15 (Kroenke, Spitzer and Williams, 2002); PHQ family, no permission required to reproduce; free non-commercial educational use.

SSD-12 (SOMATIC SYMPTOM DISORDER - B CRITERIA SCALE)	STRUCTURE AND THE VERIFIED CUT-OFF
What it measures	the DSM-5 Criterion B psychological burden (the thoughts, feelings and behaviours directed at the symptoms), not the somatic symptoms themselves
Structure	12 items across three subscales (cognitive, affective, behavioural), each item scored 0 to 4
Total and cut-off	**out of a possible 48; the validated cut-off is 23 and above (Toussaint 2016); a lower primary-care threshold of 13 and above has been proposed (Cao 2020)**

SSD-12 (Toussaint et al, 2016); copyright the authors and Mapi Research Trust, permission required, so typeset here in summary with the verified cut-off rather than reproduced.

Fig 18.2 The somatic-symptom assessment scales. The PHQ-15 grades the burden of the somatic symptoms themselves: fifteen common complaints, each scored 0 to 2 over four weeks for a total out of a possible 30, banded 0 to 4 minimal, 5 to 9 low, 10 to 14 medium and 15 to 30 high. The SSD-12 measures the other half of the modern diagnosis, the positive Criterion B, rating the excessive thoughts, feelings and behaviours the person directs at the symptoms across twelve items for a total out of a possible 48, with a validated cut-off of 23 and above. The PHQ-15 is shown as its actual freely reproducible form; the SSD-12 is permission-required and is summarised from its verified structure.

1.1 Somatic symptom disorder: the three DSM-5-TR criteria

One entity, defined by symptoms plus a psychological response. Somatic symptom disorder (DSM-5-TR) is built on three criteria (DSM-5-TR 2022). **Criterion A** requires one or more somatic symptoms that are distressing or result in significant disruption of daily life; the symptom may be specific, such as localised pain, or non-specific, such as fatigue, and it may or may not accompany a diagnosable medical condition. **Criterion B** is the heart of the diagnosis: excessive thoughts, feelings or behaviours related to the somatic symptoms or the associated health concerns. **Criterion C** requires that, although any single symptom need not be continuously present, the *state of being symptomatic* is persistent, typically for more than six months. The suffering is authentic whether or not it is medically explained; the diagnosis rests on the person's disproportionate response to bodily symptoms, not on the symptoms being unfounded.

GOOD TO REMEMBER

- **Somatic symptom disorder (the diagnosis):** Criterion A, one or more distressing or disruptive somatic symptoms; Criterion B, excessive thoughts, feelings or behaviours about the symptoms (the positive psychological criterion); Criterion C, persistent symptomatic state, typically more than six months. The single discriminator from every predecessor diagnosis is that Criterion B, not the absence of a medical explanation, defines it.

1.2 Criterion B: the positive psychological criterion

Three ways the excessive response can show, any one of which suffices. The **positive psychological criterion** is met by at least one of three manifestations (DSM-5-TR 2022): first, *disproportionate and persistent thoughts* about the seriousness of one's symptoms; second, a *persistently high level of anxiety* about health or symptoms; third, *excessive time and energy* devoted to the symptoms or health concerns, such as repeated bodily checking, help-seeking and reassurance-seeking. Only one of the three is required for the diagnosis, though the count of them then drives the severity specifier. This is the criterion that shifts the diagnostic gaze from the investigation report to the patient's cognitive, affective and behavioural relationship with the body, which is exactly why it can be measured directly by a Criterion-B scale rather than by cataloguing negative test results.

PEARL

Hold Criterion B as **T-A-B**: excessive **T**houghts (disproportionate and persistent), high **A**nxiety about health, and excessive **B**ehaviour and time devoted to symptoms. Any one of the three, running alongside a distressing somatic symptom, is enough; the number present grades the severity.

RULE **Diagnose on the positive criterion, not on a normal work-up.** Somatic symptom disorder is established by the excessive thoughts, feelings and behaviours of Criterion B, present alongside a distressing somatic symptom; whether the symptom is medically explained is irrelevant to whether the criteria are met.

1.3 The cardinal break: "medically unexplained" is gone

A medically explained symptom can still qualify. The defining conceptual move of the shift is the deletion of the old **medically unexplained** symptoms requirement (DSM-5-TR 2022; Kaplan and Sadock CTP 2024). Under DSM-IV and ICD-10, a somatoform diagnosis demanded that the symptoms lack an adequate physical explanation, which forced clinicians into an unreliable and often adversarial hunt to *exclude* disease before they could name distress. DSM-5 abolished that. The diagnosis now turns on the presence of the positive psychological features, so a patient whose symptom is entirely accounted for by a genuine medical condition, an uncomplicated myocardial infarction, say, still meets criteria if their thoughts, anxiety and behaviour about that symptom are clearly excessive and disabling. Somatic symptoms without a medical explanation are, on their own, *not* sufficient for the diagnosis; the psychological response is what is required. This single change also dissolves the old mind-body dualism the somatoform label carried, letting the diagnosis sit comfortably alongside, rather than in place of, medical disease.

WORKED EXAMPLE

A man is fully rehabilitated after an uncomplicated myocardial infarction with a normal ejection fraction, yet several months on he remains housebound, checks his pulse dozens of times a day, has abandoned work and exercise, and cannot be reassured by repeated normal reviews. His chest symptoms are medically explained, but his response is grossly disproportionate; he meets Criterion A (distressing symptom), Criterion B (all three manifestations) and Criterion C (persistent), so he has somatic symptom disorder *with* established cardiac disease. Under the old rules he would have been un-diagnosable because nothing was "unexplained".

TRAP **Calling somatic symptom disorder "medically unexplained".** That is the abolished DSM-IV and ICD-10 criterion. The modern diagnosis is defined by the positive psychological criterion; a medically explained symptom with an excessive response qualifies, and an unexplained symptom without that response does not.

1.4 The forward collapse: what DSM-5 moved where

Many old boxes, one new home, with a few relocations. DSM-5 replaced the DSM-IV "somatoform disorders" chapter with "somatic symptom and related disorders", and folded most of the old members forward into somatic symptom disorder (Kaplan and Sadock CTP 2024). DSM-IV somatisation disorder, undifferentiated somatoform disorder and pain disorder are all now captured by somatic symptom disorder, the last of them by its predominant-pain specifier. Hypochondriasis was *split*: roughly three-quarters of former cases, those with prominent somatic symptoms, become somatic symptom disorder, and the remainder, with high health anxiety but few or no somatic symptoms, become the new illness anxiety disorder. Two members left the

chapter's core in different directions: conversion disorder was retained but renamed functional neurological symptom disorder, and body dysmorphic disorder migrated to the obsessive-compulsive and related disorders. Factitious disorder was, conversely, brought *into* this chapter. The positive signs and management of the conversion presentation are developed in the Dissociative, conversion and anxiolytic/hypnotic pharmacology notes, and body dysmorphic disorder on the obsessive-compulsive spectrum in the Anxiety, OCD and trauma-related disorders notes.

DSM-IV SOMATOFORM MEMBER	DSM-5-TR DESTINATION	THE ONE-LINE REASON
Somatisation disorder	Somatic symptom disorder	**Positive Criterion B replaces the multi-system symptom count**
Undifferentiated somatoform disorder	Somatic symptom disorder	**Same positive-criterion home, no symptom threshold to meet**
Pain disorder	Somatic symptom disorder, with predominant pain	**Becomes a specifier, not a separate diagnosis**
Hypochondriasis	Split: somatic symptom disorder / illness anxiety disorder	**Somatic symptoms present goes to the former; health anxiety with few symptoms to the latter**
Conversion disorder	Functional neurological symptom disorder (retained, renamed)	**Kept, because it still needs incompatibility with disease, not a psychological criterion**
Body dysmorphic disorder	Obsessive-compulsive and related disorders	**Repetitive checking and preoccupation place it on the OCD spectrum**

The forward collapse of the DSM-IV somatoform disorders into DSM-5-TR, with the two relocations shown in the nosology-shift diagram alongside (Kaplan and Sadock CTP 2024, DSM-5-TR 2022).

ICD-10 TO DSM-5: WHAT CHANGED

ICD-10 (F45) **kept a family of separate somatoform diagnoses**, each requiring symptoms not fully explained by physical disorder: somatisation disorder (F45.0), undifferentiated somatoform disorder (F45.1), hypochondriacal disorder (F45.2), somatoform autonomic dysfunction (F45.3) and persistent somatoform pain disorder (F45.4), with neurasthenia sitting nearby at F48.0. DSM-5 **discarded both the family structure and the medically-unexplained rule**, replacing the lot with one positively defined somatic symptom disorder (plus a separate illness anxiety disorder for the health-anxiety remnant). The old names still get tested because clinicians and ICD-10-using services still speak them, so you must read fluently in both the old family and the new single diagnosis.

1.5 The ICD-10 somatoform family that was folded in

Five members, each with its own discriminator. The ICD-10 F45 group is worth holding intact, both because ICD-10 is still in service and because the members are the classic viva names (ICD-10). Somatisation disorder (F45.0), historically Briquet syndrome, needs multiple, recurrent and

frequently changing physical symptoms across several body systems for at least two years, with refusal to accept reassurance and resulting social impairment. Undifferentiated somatoform disorder (F45.1) is the sub-threshold version, the same picture without the full symptom load or duration. Hypochondriacal disorder (F45.2) is a persistent preoccupation with the possibility of having one or more serious progressive physical disorders, the focus being on the feared *diagnosis* rather than the symptoms themselves. Somatoform autonomic dysfunction (F45.3) presents symptoms as though arising from an autonomically innervated organ, with objective autonomic arousal (palpitations, sweating, tremor, flushing) plus subjective organ-referred complaints; its cardiovascular subtype is the eponymous Da Costa syndrome or cardiac neurosis. Persistent somatoform pain disorder (F45.4) is severe, distressing pain not fully explained physiologically, arising with emotional or psychosocial conflict.

ICD-10 SOMATOFORM MEMBER	CORE REQUIREMENT	THE DISCRIMINATOR TO HOLD
Somatisation disorder (F45.0)	Multiple, changing, multi-system symptoms for at least two years	**Symptom multiplicity plus the two-year duration; Briquet syndrome**
Undifferentiated somatoform (F45.1)	Same picture below the full threshold	**Fewer symptoms or shorter than two years**
Hypochondriacal disorder (F45.2)	Preoccupation with having a serious disease	**Focus is the feared diagnosis, not the symptom itself**
Somatoform autonomic dysfunction (F45.3)	Organ-referred symptoms with objective autonomic arousal	**Autonomic signs plus a named organ system; Da Costa for the heart**
Persistent somatoform pain (F45.4)	Persistent severe pain with emotional or psychosocial conflict	**Pain is the whole presentation, tied to psychosocial context**

The ICD-10 F45 somatoform family, all now subsumed forward into somatic symptom disorder (or, for the health-anxiety type, into illness anxiety disorder) under DSM-5-TR (ICD-10).

GOOD TO REMEMBER

- **Somatisation disorder / Briquet syndrome (the ICD-10 diagnosis):** multiple, recurrent, frequently changing physical symptoms across several systems for at least two years, with refusal to accept reassurance; the discriminator from hypochondriacal disorder is that the focus is the symptoms, not the fear of a specific disease.
- **Somatoform autonomic dysfunction / Da Costa syndrome (the ICD-10 diagnosis):** objective autonomic arousal plus subjective symptoms referred to a single autonomically innervated organ system; the discriminator is the presence of true autonomic signs attached to a named organ.

1.6 The specifiers of somatic symptom disorder

Two descriptive specifiers and a severity grade counted from Criterion B. DSM-5-TR lets the diagnosis be qualified in three ways (DSM-5-TR 2022). The *with predominant pain* specifier (formerly the separate pain disorder) is used when the somatic symptoms predominantly involve pain. The *persistent* specifier marks a course characterised by severe symptoms, marked impairment and long duration, running beyond six months. Severity is then graded directly by how many of the Criterion-B manifestations are fulfilled: *mild* when only one is present, *moderate*

when two or more are present, and *severe* when two or more are present together with multiple somatic complaints or one very severe somatic symptom. This is a neat, examinable structure because severity is read off the positive psychological criterion itself rather than off symptom counts, which keeps the whole diagnosis anchored to Criterion B.

SEVERITY GRADE	CRITERION-B MANIFESTATIONS FULFILLED	ADDITIONAL REQUIREMENT
Mild	Only one	**None**
Moderate	Two or more	**None**
Severe	Two or more	**Plus multiple somatic complaints, or one very severe somatic symptom**

DSM-5-TR severity is graded from the count of Criterion-B manifestations, not from the number of somatic symptoms (DSM-5-TR 2022).

GOOD TO REMEMBER

- **Specifiers (the diagnostic qualifiers):** *with predominant pain* replaces the old pain disorder; *persistent* marks severe, impairing symptoms beyond six months; severity is mild (one Criterion-B feature), moderate (two or more), or severe (two or more plus multiple or one very severe somatic symptom). The rule to hold is that severity counts Criterion B, not symptoms.

1.7 The ICD-11 parallel: bodily distress disorder

ICD-11 made the same positive-criterion move under a different name. ICD-11 discarded the ICD-10 somatoform family and created the grouping "disorders of bodily distress and bodily experience", whose principal member is bodily distress disorder (6C20), sitting beside the newly introduced body integrity dysphoria (6C21) (ICD-11 CDDR; Kaplan and Sadock CTP 2024). The **icd-11 bodily distress** disorder is characterised by bodily symptoms that are distressing to the individual together with *excessive attention* directed toward them, shown as persistent preoccupation with the symptoms' severity or as repeated health-care contacts substantially in excess of what is medically necessary, and this attention persists despite appropriate examination, investigation and reassurance. Symptoms must be present on most days for at least several months, roughly three months or more. Like DSM-5, ICD-11 defines the disorder by these positive psychological features and *not* by the absence of a medical explanation, and it grades severity as mild, moderate or severe by impact on functioning. The two systems therefore converge on mechanism while differing on detail.

Where they still diverge. Two differences are examinable. First, the duration floor: DSM-5 speaks of a symptomatic state typically beyond six months, whereas ICD-11 sets its threshold at several months, giving the example of three months or more. Second, and more important, the health-anxiety patient is placed differently: DSM-5 keeps illness anxiety disorder *within* this chapter, whereas ICD-11 moves hypochondriasis *out*, into the obsessive-compulsive and related disorders, on the logic that its repetitive checking and reassurance-seeking are compulsion-like. In ICD-11 the bodily distress patient is preoccupied with the symptoms themselves and their

impact on life; the hypochondriasis patient is driven instead by the fear that the symptoms signify a serious progressive illness.

FEATURE	ICD-11	DSM-5-TR
Umbrella diagnosis	Bodily distress disorder (6C20)	**Somatic symptom disorder**
Defining basis	Distressing symptoms plus excessive attention	**Distressing symptoms plus excessive thoughts, feelings, behaviours (Criterion B)**
Medically-unexplained rule	Dropped	**Dropped**
Duration floor	Most days for at least several months (about three)	**Persistent state, typically beyond six months**
Health-anxiety type	Hypochondriasis, moved to obsessive-compulsive and related disorders	**Illness anxiety disorder, kept within this chapter**
Severity grading	Mild / moderate / severe by functional impact	**Mild / moderate / severe by Criterion-B count**

The ICD-11 to DSM-5-TR cross-map: convergent on the positive-criterion logic, divergent on duration and on where the health-anxiety patient sits (ICD-11 CDDR, DSM-5-TR 2022).

GOOD TO REMEMBER

- **Bodily distress disorder (the ICD-11 diagnosis):** distressing bodily symptoms with excessive attention (preoccupation with severity, or repeated medically unnecessary health-care contacts), persisting despite appropriate examination and reassurance, present on most days for at least several months (about three); graded mild, moderate or severe by functioning. The two discriminators to hold are that it is positively defined, not unexplained-based, and that ICD-11 hypochondriasis sits with the obsessive-compulsive and related disorders, not here.

1.8 Epidemiology and course

Common, female-predominant, and heavily concentrated in general medical settings. Population-based studies using DSM-5 criteria place the general adult prevalence of somatic symptom disorder at roughly 4 to 6 percent, well above the under-1-percent rate of the old, more restrictive DSM-IV somatisation disorder (DSM-5-TR 2022). The disorder is markedly commoner in general medical than in psychiatric settings: a twelve-month prevalence around 10 to 20 percent is plausible among primary-care attenders, rising to between 40 and 60 percent in services that specialise in psychosomatic or functional disorders. Women report more somatic symptoms than men, so the prevalence is higher in women. Onset is typically early, often in adolescence or before the age of thirty, and the course is characteristically chronic and fluctuating, its trajectory shaped by symptom number, age, degree of impairment and comorbidity; lower harm-avoidance and greater cooperativeness predict a shorter time to remission. Because these patients present to physicians rather than to mental-health services and may meet the suggestion of psychiatric referral with surprise or refusal, the disorder is easily missed and heavily over-investigated.

1.9 Assessment: the somatic-symptom scales

Two scales measure the symptom burden, one measures the positive criterion. Structured instruments grade severity and track change alongside the clinical interview; the reproduced forms sit in the accompanying scale plate, and only the verified bands matter here. The PHQ-15, the Patient Health Questionnaire-15, rates fifteen common somatic symptoms, each scored 0 to 2, summing to a total out of a possible 30, with cut-points at 5, 10 and 15 marking low, medium and high somatic-symptom severity (Kroenke and Spitzer). The SSS-8, the Somatic Symptom Scale-8, is its brief eight-item derivative, each item scored 0 to 4 over the past seven days, summing to a total out of a possible 32, banded as none-to-minimal (0 to 3), low (4 to 7), medium (8 to 11), high (12 to 15) and very high (16 to 32) (Gierk). Both of these read Criterion A, the somatic burden. The SSD-12, the twelve-item Somatic Symptom Disorder-B Criteria Scale, is different in kind: its twelve items, each 0 to 4 for a total out of a possible 48, measure the cognitive, affective and behavioural aspects of Criterion B itself, so it is the instrument that captures the positive psychological criterion rather than the symptoms. The clean pairing to remember is a symptom-burden scale (PHQ-15 or SSS-8) plus a Criterion-B scale (SSD-12).

15	16	4-6%
PHQ-15 HIGH-SEVERITY CUT-OFF (0 TO 30 SCALE)	SSS-8 VERY-HIGH BAND, LOWER BOUND (0 TO 32 SCALE)	SOMATIC SYMPTOM DISORDER, GENERAL-ADULT PREVALENCE

GOOD TO REMEMBER

- **PHQ-15 (the scale):** fifteen somatic symptoms, each 0 to 2, total out of a possible 30; cut-points at 5, 10 and 15 for low, medium and high somatic-symptom severity; it measures Criterion A, the symptom burden.
- **SSD-12 (the scale):** twelve items, each 0 to 4, total out of a possible 48; it measures Criterion B, the excessive thoughts, feelings and behaviours, and so is the direct read-out of the positive psychological criterion.

1.10 The guideline-anchored first moves in management

Physician-centred care first, psychological therapy next, drugs only for a comorbidity. Management is led by non-pharmacological, physician-centred care (IPS_CPG 2020, psychotherapies for somatoform disorders): build a therapeutic alliance, validate that the symptoms and the distress are real, restrict unnecessary investigations and referrals, treat any concurrent depression or anxiety early, and shift the focus from symptoms toward functioning, seeing stable patients about once every one to two months. Cognitive behaviour therapy is the first-line psychotherapy, targeting the catastrophic misinterpretation of bodily sensations and rebuilding activity, with a brief package of psychoeducation, relaxation and reattribution as an alternative first-line approach. The pharmacological rule is restrictive and heavily tested: do *not* prescribe anti-anxiety or antidepressant medicines for medically unexplained somatic complaints unless a specialist advises it (WHO mhGAP 2016); antidepressants are reserved for a genuinely comorbid depressive or anxiety disorder, or for a dominant chronic-pain component, where an SNRI such as duloxetine or a low-dose tricyclic such as amitriptyline is preferred for its analgesic action. Drugs supplement, and never replace, physician-centred and psychological care.

GOOD TO REMEMBER

- **Physician-centred care (the management step):** the guideline first-line (IPS_CPG 2020), being therapeutic alliance, validation of real symptoms, restriction of unnecessary tests and referrals, early treatment of comorbid mood or anxiety, and a shift toward functioning; the first move is the alliance, not a prescription.
- **Antidepressants in somatic symptom disorder (the drug principle):** the guideline rule (WHO mhGAP 2016) is not to prescribe anti-anxiety or antidepressant drugs for medically unexplained somatic symptoms unless a specialist advises; reserve them for comorbid depression or anxiety, or for a dominant chronic-pain component, where an SNRI (duloxetine) or low-dose amitriptyline is preferred.

MNEMONIC

SEED

The master mnemonic for the whole chapter, seeded here and reaped at consolidation. **S** is the *Somatic* room, somatic symptom disorder and bodily distress, where the body complains. **E** is *Eros*, the sexual dysfunctions and gender incongruence, where the body desires and identity is affirmed. **E** is the *Explosive urges*, the impulse-control disorders, where the urge acts. **D** is the *Defence of life*, suicide risk assessment, prevention and the protective, compassionate stance the chapter closes on. Four rooms, one house: S-E-E-D.

INDIA

Somatic presentation is the Indian norm rather than the exception: psychological distress is very commonly expressed and first brought to the clinician as bodily symptoms, so a large share of primary-care and general-hospital attenders sit in this diagnostic space, and the Indian evidence base is anchored by the IPS_CPG 2020 guideline on psychotherapies for somatoform disorders and by indigenous tools such as the Scale for Assessment of Somatic Symptoms (SASS). The most examinable India-specific presentation is the culture-bound Dhat syndrome, a somatic and anxious preoccupation attributed to perceived loss of vital fluid, which must be read through a cultural formulation rather than pathologised on its surface content; its wider transcultural frame and the consultation-liaison service model that most often meets these patients are developed in the Consultation-liaison, geriatric and transcultural psychiatry notes.

HOLD THIS

Somatic symptom disorder is diagnosed by the POSITIVE psychological criterion (Criterion B, excessive thoughts, feelings or behaviours about the somatic symptoms), not by the symptoms being medically unexplained, so a medically explained symptom can still qualify; DSM-5 collapsed the DSM-IV somatoform disorders into it, splitting hypochondriasis into somatic symptom disorder and illness anxiety disorder and renaming conversion as functional neurological symptom disorder, while ICD-11 made the parallel move to bodily distress disorder (6C20, positively defined, present on most days for at least several months) but sent its hypochondriasis to the obsessive-compulsive and related disorders.

2 · Illness anxiety disorder

Hypochondriasis, renamed and re-sorted. **Illness anxiety disorder** is the modern label for the health-anxious patient whose problem is the *fear of illness* rather than the *burden of symptoms*: a preoccupation with having or acquiring a serious illness, held with **minimal or no somatic symptoms** and a high level of **health anxiety**. It is what DSM-5 carved out of the old **hypochondriasis** once the term was retired for its stigma, and the examiner's favourite hook is the split it created: the same clinical tradition now flows into two boxes, illness anxiety disorder where the body is quiet and the mind is frightened, and somatic symptom disorder where distressing bodily symptoms dominate.

This note owns the diagnosis and the discrimination: the reconceptualisation of hypochondriasis, the DSM-5-TR criteria with the **care-seeking type** and **care-avoidant type** specifiers and the six-month duration, the ICD-11 position that kept the name and moved it onto the obsessive-compulsive spectrum, the sharp line against somatic symptom disorder, and the management, where the discipline of limited reassurance, first-line CBT, and treating comorbid anxiety and depression carries the whole load. The somatic symptom disorder that sits on the other side of the split is developed in the somatic symptom disorder topic in these notes; body dysmorphic disorder, its close obsessive-compulsive relative, is in the Anxiety, OCD and trauma-related disorders notes; and the wider consultation-liaison and transcultural frame is in the Consultation-liaison, geriatric and transcultural psychiatry notes.

2.1 The reconceptualisation of hypochondriasis

One old diagnosis, split in two. Because of the pejorative weight the word carried, DSM-5 removed the classical term hypochondriasis and redistributed its patients (Kaplan and Sadock 2024). The majority, roughly three-quarters, carry prominent bodily symptoms and are now diagnosed as somatic symptom disorder. The minority, about one in five (roughly 20%), have relatively minor somatic symptoms and are instead preoccupied with the fear that they will get sick or already harbour an undiagnosed disease; these become illness anxiety disorder. The line between the two boxes is simply the *severity of the somatic symptoms*.

ICD-11 kept the word but changed its home. ICD-11 retained the label hypochondriasis, added *health anxiety disorder* as an official alternative name, and, crucially, placed it not among the somatic disorders but within the obsessive-compulsive and related disorders grouping, on the strength of the shared phenomenology (intrusive health-related preoccupations plus repetitive checking or reassurance behaviours) and a similar treatment response (ICD-11 CDDR). In ICD-11 the presence of somatic symptoms is explicitly *not* an essential feature. The classic triad to name is **disease conviction**, **disease fear**, and **bodily preoccupation**.

RULE **Symptom load decides the box.** Prominent, distressing somatic symptoms mean somatic symptom disorder; a fear-of-illness preoccupation with minimal or no somatic symptoms and high health anxiety means illness anxiety disorder.

2.2 DSM-5-TR criteria and the two specifiers

The criteria to state. DSM-5-TR defines illness anxiety disorder as a preoccupation with having or acquiring a serious illness, in which somatic symptoms are *absent or only mild*; if a real medical condition or genuine risk is present, the preoccupation is clearly excessive or disproportionate (DSM-5-TR 2022). There is a high level of anxiety about health and the person is easily alarmed about their health status. They either perform excessive health-related behaviours (repeatedly checking the body) or show maladaptive avoidance (staying away from appointments and hospitals). The preoccupation has lasted at least six months, although the specific feared illness may change over that time, and it is not better explained by another mental disorder.

Then choose the specifier. DSM-5-TR asks the clinician to specify one of two behavioural phenotypes. In the care-seeking type, medical care (physician visits, tests and procedures) is frequently used. In the care-avoidant type, medical care is rarely used because contact with doctors and health information is itself frightening. The two look opposite at the surface yet spring from the same engine of health anxiety, which is the point examiners test.

DSM-5-TR CRITERION (ILLNESS ANXIETY DISORDER)	WHAT IT REQUIRES
A. Preoccupation	**Preoccupation with having or acquiring a serious illness**
B. Somatic symptoms	**Somatic symptoms absent or only mild; if a condition or risk exists, the worry is disproportionate**
C. Health anxiety	High anxiety about health; easily alarmed about personal health status
D. Behaviour	Excessive health-related behaviours (checking, reassurance-seeking) or maladaptive avoidance
E. Duration	**Illness preoccupation present at least six months (the specific feared illness may change)**
F. Exclusion	Not better explained by another mental disorder

The DSM-5-TR criteria for illness anxiety disorder; the discriminating pair is Criterion B (somatic symptoms absent or mild) and the six-month duration, then specify care-seeking type or care-avoidant type (DSM-5-TR 2022).

GOOD TO REMEMBER

- **Illness anxiety disorder (the syndrome):** preoccupation with having or acquiring a serious illness, with somatic symptoms absent or only mild, a high level of health anxiety, and either excessive health behaviours or maladaptive avoidance, present at least six months; the defining criterion is the fear-of-illness preoccupation on a body that is largely symptom-free, and the mandatory specifier is care-seeking type versus care-avoidant type.

2.3 ICD-11 hypochondriasis and its insight specifiers

The ICD-11 essential features. ICD-11 requires a persistent preoccupation or fear about the possibility of having one or more serious, progressive or life-threatening illnesses, accompanied by *either* repetitive and excessive health-related behaviours (repeated body-checking, exhaustive searching for information, repeated reassurance-seeking and multiple consultations) *or*

maladaptive avoidance related to health (avoiding medical appointments), with resulting significant distress or impairment (ICD-11 CDDR). The catastrophic misinterpretation of ordinary bodily sensations, for example reading a tension headache as a brain tumour, is the additional clinical hallmark.

Insight is coded, not assumed. ICD-11 attaches an insight specifier: *hypochondriasis with fair to good insight* (6B23.0), where the person can much of the time entertain that their belief may be untrue, and *hypochondriasis with poor to absent insight* (6B23.1), where they are convinced most or all of the time and, in a small minority, hold the belief with near-delusional conviction. Because insight can swing with the level of anxiety, it is judged over a period long enough to allow for fluctuation, a few days or a week. Onset is typically in early to mid-adulthood, and the course is chronic and relapsing.

FEATURE	ILLNESS ANXIETY DISORDER (DSM-5-TR)	HYPOCHONDRIASIS / HEALTH ANXIETY DISORDER (ICD-11)
Term retained	Renamed from hypochondriasis	**Term hypochondriasis kept; health anxiety disorder is the alternative name**
Classification home	Somatic symptom and related disorders	**Obsessive-compulsive and related disorders**
Somatic symptoms	Must be absent or only mild (Criterion B)	Not an essential feature; may be present or absent
Behavioural specifier	Care-seeking type / care-avoidant type	Excessive health behaviours or maladaptive avoidance built into the criteria
Insight specifier	Poor-insight / with-delusional-beliefs qualifiers	**Fair-to-good (6B23.0) vs poor-to-absent (6B23.1)**

The same construct across the two systems; the crunchy contrast is where it is filed, somatic-symptom-and-related in DSM-5-TR versus obsessive-compulsive-and-related in ICD-11, and whether somatic symptoms are required at all (DSM-5-TR 2022; ICD-11 CDDR).

GOOD TO REMEMBER

- **Hypochondriasis (ICD-11, health anxiety disorder):** persistent preoccupation or fear of having a serious, progressive or life-threatening illness plus *either* excessive health-related behaviours *or* maladaptive avoidance, causing distress or impairment; filed under obsessive-compulsive and related disorders, somatic symptoms are not required, and insight is coded as fair-to-good (6B23.0) or poor-to-absent (6B23.1).

2.4 Illness anxiety disorder versus somatic symptom disorder

The examiner's discriminator. Both patients are anxious about their health, so the split turns on the *weight of somatic symptoms*. In illness anxiety disorder the body is largely quiet: symptoms are absent or mild and the suffering is the fear itself, the conviction or dread of a disease not yet found. In somatic symptom disorder the patient carries one or more genuinely distressing somatic symptoms with disproportionate thoughts, feelings and behaviours about them; the symptoms drive the picture. DSM-5 also made somatic symptom disorder a *positive* psychological

diagnosis, resting on the excessive health-related thoughts, feelings and behaviours, rather than the old requirement that symptoms be medically unexplained.

DISCRIMINATOR	ILLNESS ANXIETY DISORDER	SOMATIC SYMPTOM DISORDER
Somatic symptoms	**Absent or only mild**	**One or more, prominent and distressing**
Core suffering	Fear of having or acquiring a disease	Burden of the symptoms and their meaning
Basis of the diagnosis	Health preoccupation despite reassurance	Positive psychological criterion (excessive thoughts, feelings, behaviours)
Behavioural axis	Care-seeking type or care-avoidant type	High health-related anxiety and effort directed at symptoms
Share of old hypochondriasis	About one in five (roughly 20%)	About three-quarters

Illness anxiety disorder against somatic symptom disorder; the one line to hold is that illness anxiety disorder is fear on a quiet body while somatic symptom disorder is a loud body (Kaplan and Sadock 2024; DSM-5-TR 2022).

TRAP **Do not diagnose on "medically unexplained".** Somatic symptom disorder now rests on a *positive* psychological criterion, not on symptoms being unexplained; a symptom can have a full medical explanation and the diagnosis still stand, and illness anxiety disorder is missed if you demand unexplained symptoms it does not require.

2.5 Epidemiology, comorbidity and course

Common and easily missed. Health anxiety is frequent: it may affect about **4% to 6%** of all patients, with primary-care rates around 3% to 7% (Kaplan and Sadock 2024), and DSM-5-TR puts the 6-month to one-year prevalence in ambulatory medical populations at roughly 2.2% to 8% (weighted mean about 3%), rising to nearly one-fifth in specialty clinics; it is about equally common in men and women (DSM-5-TR 2022). Onset is usually early to mid-adulthood, and identification is often delayed because these patients present to physicians rather than to mental-health services.

The company it keeps. Psychiatric comorbidity is the rule: depression in about **40%**, panic disorder in 10% to 20%, and generalised anxiety disorder in 5% to 10%, alongside obsessive-compulsive disorder (Kaplan and Sadock 2024). The course tends to be chronic and relapsing, with more than 60% still symptomatic after several years of follow-up. That chronicity, plus the fact that comorbid mood and anxiety often carry the distress, is exactly why the management targets the comorbidity as hard as the health anxiety.

PEARL

Two facts reframe the whole encounter. First, most of these patients sit in medical clinics, not psychiatric ones, so the diagnosis is made by whoever is willing to look past the presenting organ. Second, depression rides along in about four in ten, and it is frequently the treatable driver of the health anxiety, so screening for and treating a comorbid depressive or anxiety disorder is often the single most useful move.

2.6 Management: reassurance limits, CBT, treat the comorbidity

Reassurance is a trap if it is unlimited. The paradox of health anxiety is that reassurance relieves the fear for minutes and then feeds it, so that endless testing and "one more scan" become part of the disorder. The workable stance mirrors physician-centred care for somatic symptom disorder: a single trusted clinician, regular scheduled appointments that are not triggered by each new symptom, a genuine but *bounded* acknowledgement that the symptoms and fear are real, and a deliberate restraint on repeat investigations and referrals once an adequate work-up is done. Reassurance is offered once, clearly, and then the focus shifts from the question "am I ill" to living well despite the uncertainty.

CBT is first-line, and it is what works. Cognitive-behavioural therapy is the prototype, evidence-based first-line treatment, targeting the catastrophic misinterpretation of bodily sensations and the reassurance-seeking and checking that maintain the cycle (Kaplan and Sadock 2024; Barsky and Ahern 2004). India's own guidance is aligned: the IPS Clinical Practice Guidelines recommend, for hypochondriacal or illness-anxiety presentations, CBT with cognitive restructuring and exposure and response prevention as first line, with mindfulness-based cognitive therapy or acceptance and commitment therapy as second line (IPS_CPG 2020).

Medication treats the comorbidity, chiefly. Where a comorbid depressive or anxiety disorder is present, an SSRI is reasonable and the health anxiety often improves in parallel. The best single-drug evidence is for fluoxetine (Prozac), where a double-blind placebo-controlled trial at **20 to 80 mg per day** showed a moderate, well-tolerated benefit (Fallon and colleagues). The guideline caution to keep in view is that drugs are not started reflexively for medically unexplained somatic complaints without a clear comorbid indication or specialist advice (WHO mhGAP 2016); psychological care leads, and medication supplements it.

GOOD TO REMEMBER

- **First-line treatment (guideline):** CBT is the prototype first-line therapy; IPS_CPG 2020 specifies CBT with cognitive restructuring and exposure and response prevention first line for illness-anxiety presentations, with MBCT or ACT second line.
- **Reassurance principle:** unlimited reassurance and repeat testing maintain the disorder; offer a single trusted clinician, regular scheduled visits, a bounded validation of the distress, and restraint on further investigations once an adequate work-up is complete.
- **Pharmacotherapy (guideline):** an SSRI is used mainly for comorbid depression or anxiety; fluoxetine 20 to 80 (mg per day) has the best trial evidence; do not prescribe reflexively for medically unexplained symptoms without a clear indication (WHO mhGAP 2016).

COMMON TRAP

Chasing the fear with tests. Each new investigation buys a few minutes of calm and then raises the next question, deepening the care-seeking cycle and risking iatrogenic harm and doctor-shopping. The corrective is not to withhold care but to move from symptom-driven testing to scheduled, relationship-based follow-up, and to treat the health anxiety and any comorbid depression directly rather than through the radiology department.

6	~20%	20 to 80	3 to 8%
MINIMUM MONTHS OF PREOCCUPATION (DSM-5-TR)	OF OLD HYPOCHONDRIASIS NOW ILLNESS ANXIETY DISORDER	FLUOXETINE DOSE (MG PER DAY)	HEALTH ANXIETY IN AMBULATORY CARE

INDIA

Health anxiety fits the Indian care landscape closely. Most patients present to physicians and specialists rather than to psychiatry, and a fragmented, largely out-of-pocket fee-for-service system makes doctor-shopping and repeated investigation easy, so the **care-seeking type** is readily and iatrogenically reinforced by the very system meant to reassure. National guidance is clear and usable: the IPS Clinical Practice Guidelines anchor CBT with cognitive restructuring and exposure and response prevention as first line for illness-anxiety and hypochondriacal presentations (IPS_CPG 2020). The related culture-bound presentation of Dhat, and the wider transcultural handling of health anxiety, are developed in the Consultation-liaison, geriatric and transcultural psychiatry notes.

WORKED EXAMPLE

A 34-year-old man attends his fourth physician in six months, each time with a new fear, a heart attack, then a brain tumour, then bowel cancer, prompted by a normal sensation such as a skipped beat or a headache. Examinations and an extensive work-up are repeatedly normal, yet reassurance calms him only briefly before the next worry arrives, and he arranges further scans himself. He has no substantial ongoing bodily symptoms; the suffering is the dread. This is illness anxiety disorder, care-seeking type: preoccupation with acquiring a serious illness, somatic symptoms minimal, high **health anxiety**, over six months. Management is a single named clinician with scheduled visits, bounded reassurance, no further tests without a fresh indication, first-line CBT with exposure and response prevention, and screening for the comorbid depression that so often sits underneath.

HOLD THIS

Illness anxiety disorder is DSM-5's carve-out of hypochondriasis for the fear-of-illness patient whose body is quiet, preoccupation with having or acquiring a serious illness, somatic symptoms absent or mild, high health anxiety, at least six months, specify care-seeking type or care-avoidant type; somatic symptom disorder is the loud-body sibling with prominent symptoms and a positive psychological criterion; ICD-11 keeps the name hypochondriasis and files it under obsessive-compulsive and related disorders; and management is bounded reassurance plus first-line CBT with exposure and response prevention (IPS_CPG 2020), with an SSRI such as fluoxetine reserved for comorbid depression or anxiety.

3 · Conversion and functional neurological symptom disorder

The neurology-facing member of the family. **Conversion disorder**, renamed **functional neurological symptom disorder** in DSM-5, is the diagnosis given when a patient has a genuine neurological symptom, a motor, sensory or seizure-like disturbance, that is demonstrably *incompatible* with any recognised neurological disease. It sits on the **somatic spectrum** as the one condition defined not by how much the patient worries about a symptom but by an examination

finding, which is why examiners like it: the whole diagnosis turns on a sign you can elicit at the bedside. Across these notes the disorder is abbreviated fnd.

This note does one job, and does it precisely: it *places* functional neurological symptom disorder in the somatic nosology map, states the two shifts DSM-5 made (dropping the requirement for a preceding psychological stressor, and moving from a diagnosis of exclusion to a **positive signs** rule-in), and names the cardinal trap of the whole topic, missing an organic disease behind a presentation labelled "conversion". The actual bedside **positive signs** (Hoover's sign, the tremor entrainment test, the give-way weakness pattern) and the full management are taught in the Dissociative, conversion and anxiolytic/hypnotic pharmacology notes and are cross-referenced there rather than re-taught here. What follows is how to recognise the disorder and where it belongs. The term "conversion" is Charcot-era and psychoanalytic, the idea that unconscious conflict is "converted" into a bodily deficit; the modern label keeps the phenomenon and drops the theory.

3.1 Where it sits on the somatic spectrum, and the DSM versus ICD split

One disorder, two homes. The **somatic spectrum** groups conditions in which bodily symptoms dominate the presentation and are first met in medical rather than psychiatric settings. Within it, conversion / functional neurological symptom disorder is the pole defined by *loss or alteration of a function* (weakness, abnormal movement, sensory loss, non-epileptic attacks) rather than by distressing symptoms plus excessive health thoughts. Its neighbours on the somatic spectrum are these: somatic symptom disorder (positive distressing symptoms with disproportionate cognition), illness anxiety disorder (health anxiety with few or no symptoms), factitious disorder (deliberately produced signs, no external incentive) and, outside this chapter, body dysmorphic disorder, which belongs on the obsessive-compulsive spectrum and is developed in the Anxiety, OCD and trauma-related disorders notes.

The two classifications disagree on the address. This is a favourite discriminator. DSM-5-TR files the disorder inside *Somatic Symptom and Related Disorders* as functional neurological symptom disorder. ICD-11 instead places it among the *dissociative disorders*, as dissociative neurological symptom disorder (code 6B60), sitting beside dissociative amnesia and trance and possession disorders (ICD-11 CDDR). Both describe the same clinical picture, motor, sensory, seizure-like or speech symptoms not consistent with a recognised nervous-system disease; they simply differ on whether the mechanism is best framed as somatic or dissociative.

FRAMEWORK	NAME AND CODE	CHAPTER IT LIVES IN
DSM-5-TR	Functional neurological symptom disorder (conversion disorder)	**Somatic Symptom and Related Disorders**
ICD-11	Dissociative neurological symptom disorder (6B60)	**Dissociative Disorders**
ICD-10 (historical)	Dissociative (conversion) disorders (F44)	Neurotic, stress-related and somatoform disorders

The same disorder, two homes: DSM-5-TR keeps it on the somatic spectrum, ICD-11 files it under the dissociative disorders as 6B60, and the coexisting motor / sensory / seizure specifiers run in parallel across both.

3.2 The DSM-5-TR criteria and the two shifts

Four criteria, A to D. DSM-5-TR requires (A) one or more symptoms of altered voluntary motor or sensory function; (B) clinical findings that provide evidence of *incompatibility* between the symptom and recognised neurological or medical conditions; (C) the symptom is not better explained by another medical or mental disorder; and (D) it causes clinically significant distress or impairment, or warrants medical evaluation (DSM-5-TR 2022). Symptom-type specifiers name the presentation (with weakness or paralysis, abnormal movement, non-epileptic attacks or seizures, anaesthesia or sensory loss, speech or special-sensory symptoms), and course is specified as acute episode or persistent.

The two things DSM-5 changed, and both are examinable. First, it became a *rule-in* diagnosis: Criterion B demands positive evidence of incompatibility, so the disorder is no longer diagnosed by exclusion, no longer requires normal investigations, and can be made even in a patient who also has a recognised neurological disease. Second, DSM-5 *dropped the requirement for a preceding psychological stressor*. A stressor may be specified when present, but it is not necessary, precisely because an identifiable stressor is absent in up to **50%** of patients, and the diagnosis is not withheld for want of one.

RULE **Positive incompatibility, not normal scans.** The diagnosis rests on a positive examination finding of internal inconsistency (a sign present one way and gone another), never on "all the tests came back normal" or on the symptom looking bizarre; it is a rule-in diagnosis that can coexist with genuine neurological disease.

GOOD TO REMEMBER

- **Functional neurological symptom disorder (the syndrome):** altered voluntary motor or sensory function whose *defining* criterion is positive clinical evidence of incompatibility with recognised neurological disease (DSM-5-TR Criterion B); it is a rule-in, not an exclusion, diagnosis, needs no preceding stressor, and may be diagnosed alongside a real neurological disorder.

3.3 The positive signs, named here and taught elsewhere

What "incompatibility" looks like at the bedside. The demonstration is *internal inconsistency*: a deficit that changes when attention is redirected or when the same movement is tested a different way. The three the examiner wants named are Hoover's sign (functional hip-extension weakness that returns to normal power when the opposite hip is flexed against resistance), the tremor entrainment test (a functional tremor that entrains to, is suppressed by, or cannot copy a rhythm tapped by the other hand), and the give-way, or collapsing, weakness pattern (power that gives way suddenly rather than yielding smoothly). These, and the dissociative (non-epileptic) attack features, plus the full management, are worked through in the Dissociative, conversion and anxiolytic/hypnotic pharmacology notes; the point for this note is only that such **positive signs** exist and carry the diagnosis.

Two old signs that do not carry it. La belle indifférence (a bland lack of concern about a disabling deficit) and the presence of "secondary gain" were once treated as diagnostic; both are non-specific, occur in organic disease too, and must *not* be used to make the diagnosis (DSM-5-TR 2022). The diagnosis is built on the overall clinical picture and the positive signs, not on a single feature and not on the patient's affect.

GOOD TO REMEMBER

- **Positive signs (the discriminator):** Hoover's sign, the tremor entrainment test and give-way weakness demonstrate internal inconsistency and rule the diagnosis in; la belle indifférence and "secondary gain" are non-specific and do not diagnose it. Full teaching sits in the Dissociative, conversion and anxiolytic/hypnotic pharmacology notes.

WORKED EXAMPLE

A 26-year-old woman develops sudden left-leg weakness after a family crisis and cannot lift the leg on the couch. On examination the strength of left hip extension is absent when tested directly but returns to full power the moment she flexes the opposite hip against your hand: a positive **Hoover's sign**. She is oddly untroubled by the disability. The positive sign rules the diagnosis in as functional neurological symptom disorder; the flat affect (la belle indifférence) is a footnote, not the evidence, and you still document a neurological screen because fnd can sit on top of real disease.

3.4 The cardinal trap: missing organic disease

The reassuring modern number, and why it does not license complacency. Eliot Slater's influential but methodologically flawed 1965 study suggested that up to two-thirds of patients labelled "hysteria" in fact had misdiagnosed neurological disease, and it wrongly persuaded a generation that the diagnosis was unsafe. The evidence since is very different: a systematic review pooling 27 outcome studies found a misdiagnosis rate of under **5%** from 1970 onward, in the era before MRI and video-telemetry (New Oxford Textbook of Psychiatry). Functional neurological symptoms are, in fact, the second commonest reason to see a neurologist, so a confident positive diagnosis is both possible and expected.

But the traps are specific and worth memorising. Comorbid neurological disease is common: around **one in five** patients with dissociative (non-epileptic) seizures *also* have epilepsy (DSM-5-TR 2022), so finding a functional attack never excludes a real one. Misreading true disease as fnd is most likely with an isolated gait disorder that examines normally on the couch, with frontal-lobe epilepsy (which can look odd and show a normal surface EEG), and with autoimmune encephalitis or the prodrome of a degenerative disease such as Parkinson's (New Oxford Textbook of Psychiatry). The discipline is to base the diagnosis on positive signs, and to re-examine if the picture becomes progressive.

TRAP **"Tests are normal, so it is conversion."** Missing organic disease behind a "conversion" label is the cardinal error; diagnose on positive incompatibility, remember functional and organic disease coexist (one in five non-epileptic-seizure patients also have epilepsy), and re-examine a progressive course.

4	5-15%	<5%	1 in 5
DSM-5-TR CRITERIA (A TO D)	OF NEUROLOGY-CLINIC PATIENTS HAVE FND	MISDIAGNOSIS RATE ON FOLLOW-UP SINCE 1970	NON-EPILEPTIC-SEIZURE PATIENTS ALSO HAVE EPILEPSY

INDIA

Conversion and dissociative presentations, pseudoseizures (dissociative attacks), functional weakness and possession or trance states, are among the commonest reasons a young or rural patient reaches Indian psychiatric services, often through a physician or neurologist first. ICD-11's placement of the disorder among the dissociative disorders, beside trance and possession disorder, fits this clinical reality well. The wider transcultural framing of possession and trance is developed in the Consultation-liaison, geriatric and transcultural psychiatry notes; the applied lesson here is to demonstrate the positive sign and rule out organic disease before attributing an attack to "hysteria" or a spiritual cause.

HOLD THIS

Conversion / functional neurological symptom disorder is a genuine neurological symptom shown by positive signs (Hoover's sign, tremor entrainment, give-way weakness) to be internally inconsistent and incompatible with recognised disease; DSM-5 made it a rule-in diagnosis and dropped the required stressor, ICD-11 files it as dissociative neurological symptom disorder (6B60) rather than on the somatic spectrum, and the cardinal trap is missing organic disease, so diagnose on the positive sign, not on normal scans, remembering that fnd and real neurological disease coexist.

4 · Factitious disorder and Munchausen syndrome

The one diagnosis defined by a deception. **Factitious disorder** is the intentional falsification or induction of physical or psychological signs and symptoms, driven not by any outside reward but by the internal need to occupy the **sick role**, to be seen and cared for as a patient. That single motive is what makes it examinable: it sits at the tip of a three-way spectrum of illness deception, distinguished from the unconscious somatic disorders on one side (where the symptom is not deliberately produced) and from malingering on the other (where the production is deliberate but the incentive is external). DSM-5 moved it into the somatic symptom and related disorders chapter precisely because these patients present with somatic complaints, most often first to the general physician.

How to use this page. Fix the DSM-5-TR criteria and the internal-versus-external incentive rule first, because that rule carries most of the marks. DSM-5-TR names two forms, factitious disorder imposed on self (historically **Munchausen syndrome**) and factitious disorder imposed on another (Munchausen by proxy); this note abbreviates them factitious imposed on self and factitious imposed on another. Then learn Munchausen syndrome as the severe chronic phenotype, factitious imposed on another as a form of child abuse whose first duty is safeguarding, and Ganser syndrome as a brief borderland name. The chapter closes on the therapeutic, non-punitive stance that management demands.

4.1 The core: intentional falsification, the sick role, no external incentive

Four criteria, A to D, for factitious imposed on self. DSM-5-TR defines factitious disorder imposed on self (F68.10) by four criteria (DSM-5-TR 2022): (A) falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception; (B) the individual presents to others as ill, impaired or injured; (C) the deceptive behaviour is evident even in the absence of obvious external rewards; and (D) it is not better explained by another mental disorder such as a delusional or psychotic disorder. The course is specified as a single episode or as recurrent episodes, the latter meaning two or more events of falsifying illness or inducing injury. The patient may feign symptoms (report chest pain that is not felt), simulate signs (manipulate a thermometer), or genuinely induce disease (self-inject a contaminant), and often carries a detailed, superficial medical vocabulary and a history of multiple procedures.

The whole diagnosis turns on Criterion C. The behaviour is conscious and goal-directed, but the goal is *internal*, the psychological gratification of being a patient, not money, drugs, disability or escape from duty. This is what separates it from malingering, and it is why the ICD codes it as a genuine mental disorder (6D50 imposed on self, 6D51 imposed on another) whereas malingering is not a disorder at all. Note the nuance that examiners like: the presence of some external reward does not automatically exclude factitious disorder, because the two can coexist, but the deception must be evident even when no external reward is on offer.

Symptom production

Conscious and deliberate in factitious disorder and malingering; unconscious in somatic symptom and conversion disorders.

Motivation

Internal, to assume the sick role, in factitious disorder; external and tangible in malingering; absent or unconscious in the somatic disorders.

Deception

Identified deception is required for factitious disorder (Criterion A); the somatic disorders involve no deception at all.

GOOD TO REMEMBER

- **Factitious disorder imposed on self (the syndrome):** intentional falsification or induction of signs or symptoms with identified deception (Criterion A), self-presented as ill (B), evident *even in the absence of obvious external rewards* (C, the defining criterion), and not better explained by another mental disorder (D); the internal motive is to occupy the sick role, coded 6D50 in ICD-11.

4.2 Factitious disorder versus malingering, and versus the unconscious somatic disorders

Two axes settle every vignette. Place the presentation on two questions: is the symptom produced *deliberately*, and is the motive *internal or external*. Somatic symptom disorder and conversion (functional neurological symptom disorder) answer "no" to deliberate production, the suffering is authentic and unwilled. Factitious disorder answers "yes, deliberate" and "internal motive" (the sick role). Malingering answers "yes, deliberate" and "external motive" (compensation,

narcotics, avoiding work or legal jeopardy). Only the middle column is defined by a lie told for its own psychological sake.

PRESENTATION	SYMPTOM PRODUCTION	MOTIVATION	STATUS
Somatic symptom / conversion disorder	Unconscious, not deliberate	None conscious; symptom is unwilled	**A mental disorder; genuine distress**
Factitious disorder	Intentional, with deception	Internal: to assume the sick role	**A mental disorder (ICD-11 6D50 / 6D51)**
Malingering	Intentional, with deception	External: money, drugs, escape from duty	**Not a disorder; a focus of clinical attention (ICD-11 QC30)**

The illness-deception spectrum: deliberate production plus internal motive is factitious disorder; deliberate production plus external reward is malingering; neither is present in the unconscious somatic disorders (DSM-5-TR 2022; Kaplan and Sadock CTP 2024).

RULE **Internal motive is factitious; external reward is malingering.** Both produce symptoms deliberately and deceptively; the discriminator is the pay-off, the psychological sick role versus a tangible external gain, and only factitious disorder is a mental disorder.

TRAP **Calling a factitious presentation "malingering."** Naming the deception is not enough; you must locate the motive. If there is no external incentive, the label is factitious disorder, not malingering, and the patient needs psychiatric care rather than discharge.

4.3 Munchausen syndrome: the severe, chronic, wandering form

The severe end of factitious imposed on self. Munchausen syndrome is the term Asher applied in his 1951 Lancet paper to the most chronic and dramatic patients, the "hospital addicts," "hospital hoboes" and "professional patients" who repeatedly simulate or induce disease for the sole purpose of obtaining medical attention. Two features beyond simple simulation define it: pseudologia fantastica, fluent, plausible, self-aggrandising lying in which the tale often contains a kernel of truth, and peregrination, the tendency to travel widely from hospital to hospital, discharging against advice and beginning the performance anew elsewhere. Antisocial traits are common, evidence of earlier surgery accumulates as multiple scars (the classic "gridiron abdomen"), and the mortality of severe induced disease is real.

But the commoner phenotype does not wander. A second, more prevalent form, sometimes called common or non-peregrinating factitious disorder, confines the behaviour to one locality and a narrow set of complaints. Its prototypical patient is younger, more often female, and frequently has a health-care background. The teaching point is that Munchausen syndrome is the memorable extreme, not the whole of factitious disorder, and the eponym is often wrongly stretched to cover every case.

4	2+	1951	1977
DSM-5-TR CRITERIA (A TO D), IMPOSED ON SELF	FALSIFICATION EVENTS DEFINE RECURRENT EPISODES	ASHER NAMES MUNCHAUSEN SYNDROME (LANCET)	MEADOW DESCRIBES IT BY PROXY (CHILD ABUSE)

WORKED EXAMPLE

A woman in her thirties presents to a fourth hospital in a year with dramatic haematemesis and a spellbinding account of nursing in a war zone; the notes are thin, the story shifts, and a laparotomy scar suggests earlier surgery elsewhere. No compensation claim, no controlled-drug request and no legal case are in play. Recurrent presentations, **pseudologia fantastica** and **peregrination**, with deception and no external reward, point to Munchausen syndrome (severe factitious imposed on self), not malingering, and she needs a psychiatric alliance rather than another endoscopy.

PEARL

The eponym is a double misnomer worth knowing. It honours Baron von Munchausen, the fictional teller of tall tales, so it captures the *storytelling* but not the *self-harm*; and because the label was so widely misapplied to milder cases, DSM-5-TR retired it in favour of the plain descriptor factitious disorder imposed on self. Reserve "Munchausen" for the chronic, peregrinating, pseudologia-rich extreme.

GOOD TO REMEMBER

- **Munchausen syndrome (the syndrome):** the severe chronic form of factitious imposed on self, its two discriminators being pseudologia fantastica (fluent self-aggrandising lies with a kernel of truth) and peregrination (wandering hospital to hospital); Asher, 1951; the commoner non-peregrinating phenotype is younger, more often female and health-care linked.

4.4 Factitious disorder imposed on another (Munchausen by proxy): abuse, not curiosity

The illness is fabricated in someone else. Factitious disorder imposed on another (F68.A; ICD-11 6D51), the entity Meadow named Munchausen by proxy in 1977, applies its four criteria to a perpetrator who falsifies or induces illness in a victim, most often a preverbal child, sometimes a dependent elder or disabled adult, and presents that victim to others as ill (DSM-5-TR 2022). The reward the perpetrator seeks is still internal, the vicarious sick role and the attention of clinicians, with no obvious external incentive. The single most tested fact is the direction of the diagnosis: **the perpetrator, not the victim, receives the diagnosis**, and the perpetrator is most commonly the mother. It is formally recognised as a form of abuse, and, like any physical abuse, the diagnosis does not depend on proving the caregiver's motive.

Safeguarding is the first and overriding step. The moment factitious imposed on another is suspected, protection of the victim outranks every diagnostic nicety: the induced illness itself can be lethal, and the child cannot self-report. Contemporaneous, factual documentation, separation of the fabricated history from verified findings, senior and multidisciplinary involvement and referral into the statutory child-protection pathway are the priorities. Confronting the caregiver alone, without safeguards in place, can escalate risk to the victim and is not the first move.

INDIA

Two India-specific realities matter. First, a fragmented, largely out-of-pocket, multi-provider health system with no unified medical record makes peregrination and repeated fresh presentations easy and hard to detect, so a suspicious index and a request for old records across facilities do real work. Second, when factitious imposed on another is suspected, safeguarding runs through India's child-protection framework: the child is a "child in need of care and protection" under the Juvenile Justice (Care and Protection of Children) Act 2015, with reporting to the Child Welfare Committee, alongside the consultation-liaison team that most often first meets these patients. The wider consultation-liaison service model is developed in the Consultation-liaison, geriatric and transcultural psychiatry notes.

GOOD TO REMEMBER

- **Factitious imposed on another / Munchausen by proxy (the syndrome):** falsification or induction of illness in another (usually a preverbal child), with deception and no obvious external reward; the perpetrator (commonly the mother), not the victim, receives the diagnosis; it is a recognised form of abuse, so safeguarding the victim is the first and overriding step (DSM-5-TR; Meadow, 1977).

4.5 Ganser syndrome: the factitious and dissociative borderland

The syndrome of approximate answers. Ganser syndrome, described by Ganser in the 1890s and historically labelled "prison psychosis," is defined by vorbeireden, the giving of approximate answers, responses that are wrong but wrong in a near-miss way that betrays that the question was fully understood (asked how many legs a horse has, the patient answers "three"). It classically runs with a clouded or twilight state, may carry conversion-like somatic features and pseudohallucinations, and is often followed by amnesia for the episode. It has never had a settled home, sitting at the borderland of dissociation, factitious behaviour and malingering; ICD-11 files it among the dissociative disorders, and it earns a place here because the approximate answer looks feigned yet, unlike malingering, seeks no external reward. It is grouped under the dissociative disorders as hysterical pseudodementia.

GOOD TO REMEMBER

- **Ganser syndrome (the syndrome):** the syndrome of approximate answers, vorbeireden, where replies are wrong but near-miss in a way that proves the question was understood, classically with a clouded/twilight state and historically seen in prison inmates ("prison psychosis"); it sits at the dissociative/factitious/malingering borderland and is classed by ICD-11 among the dissociative disorders.

4.6 Management: a therapeutic, non-punitive stance

No specific drug; treat the person, not the deception. There is no standard pharmacological treatment for factitious disorder itself; medication is directed only at a comorbid psychiatric disorder, such as a depressive, anxiety or personality disorder, or at the emotional distress that precipitated the illness behaviour (Kaplan and Sadock CTP 2024). The core of management is a stance: build a therapeutic alliance, adopt a supportive, face-saving and explicitly non-confrontational approach that addresses the patient's genuine emotional needs rather than the

fabricated ones, and steer toward psychiatric care without aggressive direct exposure. Because these patients split teams and generate intense negative feeling, care is coordinated through a multidisciplinary team with regular meetings to contain countertransference and reduce staff conflict, and iatrogenic harm is minimised by restricting unnecessary investigations and procedures.

Confrontation cautions. Blunt accusatory confrontation typically ruptures the alliance and drives the patient to abscond and re-present elsewhere, so it is avoided; when the deception is addressed it is done gently and truthfully. There is no role for the clinician's own deception either, no disguised placebos and no misrepresented tests; the double-bind manoeuvre (framing a treatment such that improvement is expected if the complaint is genuine, giving a face-saving exit) is a described technique to be used sparingly and honestly, never as a trap. Where the presentation is factitious imposed on another, this therapeutic stance is subordinate to safeguarding: protecting the victim comes first, always.

GOOD TO REMEMBER

- **Management of factitious disorder (the principle):** no specific drug treatment, treat only the comorbidity; the first line is a supportive, face-saving, non-confrontational therapeutic alliance, not exposure; coordinate through a multidisciplinary team, manage countertransference and splitting, minimise iatrogenic investigation, and for factitious imposed on another let safeguarding override everything (Kaplan and Sadock CTP 2024).

HOLD THIS

Factitious disorder is the deliberate, deceptive falsification or induction of signs or symptoms with an *internal* motive (the sick role) and *no* external incentive, which is exactly what separates it from malingering (external reward) and from the unconscious somatic disorders (no deliberate production); Munchausen syndrome is its severe wandering form (pseudologia fantastica plus peregrination), factitious imposed on another / Munchausen by proxy is a form of abuse in which the perpetrator, not the victim, is diagnosed and safeguarding comes first, and management is a non-confrontational therapeutic stance with no specific drug, treating only the comorbidity.

5 · Malingering and its differentiation from factitious disorder

This is the discrimination step of the somatic chapter, the point where every disorder met so far is separated by asking two questions rather than one: is the symptom *produced*, and if so, *why*. The genuine **somatic disorders** answer the first question with no, the symptom is real and not deliberately made; malingering and factitious disorder both answer yes, the symptom is feigned, and then part company on the second question, the motive. Examiners love this space precisely because it is a two-axis grid and a vignette can be walked through it cleanly, so the whole topic reduces to holding one figure in the head.

How to use this page. Fix malingering first, its definition, its status as a condition rather than a disorder, and the clinical pointers that raise suspicion. Then recall factitious disorder in a single frame so the contrast is sharp. Then learn the two discriminators the paper actually tests: the **voluntariness**-by-incentive grid that separates the two feigned conditions from each other and

from the genuine disorders, and the fuller five-way map that places somatic symptom disorder, illness anxiety disorder, conversion and these two side by side. The single error the whole topic is built to prevent is confusing factitious disorder, where no external incentive is present, with malingering, where one is.

Disorder	Core feature	Symptom production	External incentive	The discriminator
Somatic symptom d.	distressing somatic symptom(s) plus excessive thoughts, feelings or behaviours (Criterion B)	genuine, not feigned	**No**	the positive psychological criterion; the symptom may be medically explained
Illness anxiety d.	preoccupation with having a serious illness; minimal actual somatic symptoms	genuine, not feigned	**No**	the fear is of the illness, not the somatic burden
Conversion / FND	a neurological symptom incompatible with disease; positive signs on examination	not consciously feigned	**No**	positive functional signs (Hoover, entrainment); taught in the Dissociative notes
Factitious disorder	signs or symptoms deliberately produced or falsified	consciously feigned	**No** (internal sick role)	feigned but NO external gain; the motive is the sick role
Malingering	symptoms feigned or exaggerated	consciously feigned	**Yes** (external gain)	feigned WITH an external incentive; not a disorder

Read down the external-incentive column: it is the single line that separates factitious disorder (feigned, no external gain) from malingering (feigned, external gain).

Fig 18.3 The somatic and related disorders discriminated. Somatic symptom disorder and illness anxiety disorder are genuine, not feigned, and carry no external incentive; they are told apart by whether the problem is the symptom burden with a positive psychological criterion or a preoccupation with having an illness. Conversion or functional neurological symptom disorder is also not consciously feigned and is recognised by its positive signs on examination, taught in the Dissociative, conversion and anxiolytic/hypnotic pharmacology notes. The two feigned conditions are separated by one thing only: factitious disorder is feigned for the internal reward of the sick role with no external gain, whereas malingering is feigned for an external incentive and is not a mental disorder at all.

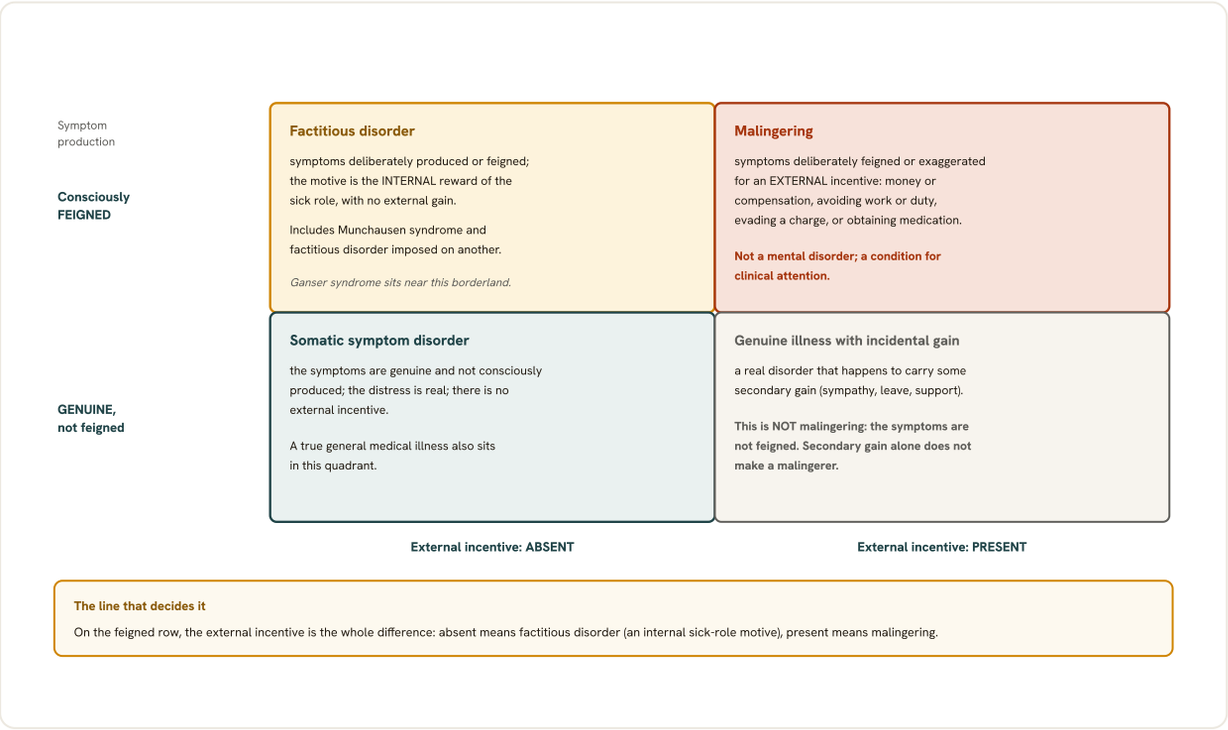


Fig 18.4 Feigning by incentive. Two questions place any of these presentations. First, are the symptoms consciously feigned or genuine? Somatic symptom disorder and a true medical illness are genuine and sit on the lower row; factitious disorder and malingering are feigned and sit on the upper row. Second, is there an external incentive? On the feigned row this is the entire distinction: factitious disorder is feigned for the internal reward of occupying the sick role, with no external gain, while malingering is feigned for an external incentive such as money, avoiding duty or evading a charge, and is not a mental disorder. The lower-right quadrant is the common trap: a genuine illness that carries some incidental secondary gain is not malingering, because nothing is being feigned.

5.1 Malingering: feigning driven by an external incentive

Not a disorder, a condition, defined by the motive behind the feigning. The essential feature of malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by an **external incentive** such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs (DSM-5-TR 2022; Kaplan and Sadock CTP 2024). Two features anchor it. First, the symptoms are under voluntary control and the **feigning** is conscious and deliberate; the person is aware of the presentation as a strategy. Second, and decisively, the motive is external: some tangible reward is sought, or some obligation avoided. Because of that motive it is coded in DSM-5-TR as Z76.5, a condition that may be a focus of clinical attention and expressly *not* a mental disorder. It may even be adaptive in the right context, the classic example being a captive who feigns illness while held by an enemy in wartime, which is why it is described neutrally as illness behaviour rather than psychopathology.

GOOD TO REMEMBER

- **Malingering (the condition):** intentional production of false or grossly exaggerated physical or psychological symptoms motivated by an **external incentive** (avoiding work or service, financial compensation, evading prosecution, obtaining drugs); coded Z76.5 as a condition for clinical attention, *not* a mental disorder. The single defining criterion is the external incentive; remove it and the label cannot stand.

5.2 The pointers that raise suspicion

Suspect, do not diagnose, on a combination of pointers. DSM-5-TR states that malingering should be *strongly suspected* when any combination of four features is present (DSM-5-TR 2022). These are a medicolegal context (the person is referred by an attorney, or self-refers while litigation or criminal charges are pending); a marked discrepancy between the claimed distress or disability and the objective findings; a lack of cooperation with the evaluation and with the prescribed treatment; and the presence of antisocial personality disorder. The word to hold is *suspected*: no single pointer confirms anything, and the diagnosis requires firm, documented evidence gathered across time, examiners and settings, with collateral information weighed carefully. The clinician's role here is medical, to assess the presentation and document inconsistency in a non-pejorative way, not to pronounce on honesty or fraud.

DSM-5-TR POINTER	WHAT IT LOOKS LIKE
Medicolegal context	**Attorney referral, or self-referral while litigation or criminal charges are pending**
Discrepancy	**Claimed stress or disability far exceeds the objective findings and observed behaviour**
Non-cooperation	**Poor engagement with the evaluation and with the prescribed treatment regimen**
Antisocial personality disorder	**Present as an associated feature (a pointer, not proof, and not a prerequisite)**

The four DSM-5-TR features that should raise suspicion of malingering; any combination warrants suspicion, none alone confirms it (DSM-5-TR 2022).

PEARL

Certainty in malingering is *graded, not binary*. The literature codes it along a ladder, indeterminate, then strongly suspected, then provisional, then probable, then deemed likely present, according to how far the pointers, associated features and collateral corroboration line up (Kaplan and Sadock CTP 2024). Genuine illness, by contrast, is consistent across examiners, contexts and even when the person is distracted; feigned illness tends to be inconsistent and shifting.

COMMON TRAP

Treating antisocial personality disorder as proof of malingering. It is only one associated pointer. Studies do *not* show that people with antisocial personality disorder malinger more often, or more successfully, than the general population, and mild symptom exaggeration or ordinary impression management is not malingering. A firm attribution needs converging, documented evidence, not a personality label.

SUBTYPES AND DETECTION INSTRUMENTS

Resnick's classical trichotomy (Resnick) names three forms: *pure malingering*, complete fabrication of a non-existent disorder; *partial malingering*, exaggeration of genuinely present symptoms; and *false imputation*, consciously attributing real symptoms to a false, unrelated cause. Structured aids to detection, used mainly in forensic assessment, include the SIRS (Structured Interview of Reported Symptoms), the M-FAST (Miller Forensic Assessment of Symptoms Test), the SIMS (Structured Inventory of Malingered Symptomatology) and the TOMM (Test of Memory Malingering); they support, but never replace, the clinical judgement built on collateral data.

5.3 Factitious disorder in one frame: feigned, but no external incentive

Deliberate deception with an internal motive, to be a patient. Factitious disorder imposed on self (F68.10) is defined by the falsification of physical or psychological signs or symptoms, or the induction of injury or disease, associated with identified deception; the person presents themselves to others as ill, impaired or injured; and, the decisive clause, the deceptive behaviour is evident *even in the absence of obvious external rewards*, and is not better explained by another mental disorder such as a psychotic illness (DSM-5-TR 2022). The symptoms are produced intentionally and consciously, exactly as in malingering, but the aim is internal: to occupy the sick role and receive care, attention and medical procedures. This is the classical **primary gain** of the sick role, not the tangible **secondary gain** of the malingerer. The diagnosis rests on objectively identifying the falsification, not on proving the inner motive. Its severe, chronic, wandering form is Munchausen syndrome, named for the Baron of tall tales, estimated at roughly five to ten percent of factitious cases; when the illness is fabricated or induced in another person, usually a dependent, it is factitious disorder imposed on another, and the perpetrator, not the victim, receives the diagnosis.

4	5	5-10%
DSM-5-TR MALINGERING POINTERS	CODED DEGREES OF CERTAINTY	MUNCHAUSEN SHARE OF FACTITIOUS CASES

GOOD TO REMEMBER

- **Factitious disorder imposed on self (the diagnosis, F68.10):** falsification of signs or symptoms, or induction of injury or disease, with identified deception; presents self as ill; the deception is present *even without obvious external rewards*; not better explained by another disorder. The one discriminator to hold is Criterion C, the absence of an external reward, which is exactly the axis that separates it from malingering.

5.4 Voluntariness by incentive: the factitious versus malingering grid

Two feigned conditions, told apart on one axis. Both malingering and factitious disorder are, by definition, deliberately produced, so **voluntariness** of symptom production is *shared* and cannot separate them; what separates them is the incentive. This is the whole of the **factitious versus malingering** discrimination: an external incentive present points to malingering (secondary gain, a reward or an avoided obligation), an external incentive absent points to factitious disorder (primary gain, the sick role itself). The genuine somatic disorders sit off this axis entirely, because their symptoms are not intentionally produced at all. The accompanying figure lays this out as a

two-by-two of intentional-or-not production against external-or-internal incentive; the same content is tabulated below (New Oxford Textbook of Psychiatry; DSM-5-TR 2022).

CONDITION	SYMPTOM INTENTIONALLY PRODUCED?	INCENTIVE PRESENT
Genuine somatic disorder (somatic symptom disorder, conversion)	No, involuntary and unintentional	**Neither; symptoms are not made to a purpose (secondary gain may coexist but is not the cause)**
Factitious disorder	Yes, intentional and conscious	**Internal only, the sick role (primary gain); external reward absent**
Malingering	Yes, intentional and conscious	**External incentive present, a tangible reward or avoided obligation (secondary gain)**

The voluntariness-by-incentive grid; production separates the genuine disorders from the two feigned conditions, and the external incentive separates malingering from factitious disorder (New Oxford Textbook of Psychiatry).

RULE **Same production, different incentive.** Malingering and factitious disorder are both consciously feigned; the discriminator is the external incentive, present in malingering (secondary gain), absent in factitious disorder (the internal sick role, primary gain).

5.5 The fuller somatic-disorders discriminator

Five neighbours placed on production and motivation. The examiner's synthesis extends the grid across the whole chapter, so that **somatic versus factitious** versus malingering can be read off two columns at a glance. Somatic symptom disorder carries genuine, not feigned, distressing symptoms with an excessive psychological response and no external incentive; illness anxiety disorder is genuine health fear on a largely quiet body; conversion, or functional neurological symptom disorder, is a genuine deficit whose *internal inconsistency* is demonstrated by positive signs rather than being deliberately produced. Factitious disorder is feigned with no external incentive, and malingering is feigned with an external incentive. The full bedside recognition of conversion, its positive signs and its management, is developed in the Dissociative, conversion and anxiolytic/hypnotic pharmacology notes, and body dysmorphic disorder, which belongs on the obsessive-compulsive spectrum, in the Anxiety, OCD and trauma-related disorders notes. The figure alongside renders this as the five-row discriminator map.

CONDITION	SYMPTOMS GENUINE OR FEIGNED	EXTERNAL INCENTIVE	THE ONE-LINE DISCRIMINATOR
Somatic symptom disorder	Genuine, not feigned	Absent	**Real distressing symptom plus excessive thoughts, feelings and behaviours (positive psychological criterion)**
Illness anxiety disorder	Genuine, not feigned	Absent	**Fear of having or acquiring illness on a quiet body; symptoms absent or mild**
Conversion / functional neurological symptom disorder	Genuine, not intentionally produced	Absent	**Positive signs of internal inconsistency (for example Hoover's sign) rule it in**
Factitious disorder	Feigned, intentionally produced	Absent	**Deception to occupy the sick role; primary gain, no external reward**
Malingering	Feigned, intentionally produced	Present	**External incentive drives the feigning; secondary gain**

The five-way somatic-disorders discriminator, keyed on symptom production and on motivation; the two feigned conditions split only on the external incentive (Kaplan and Sadock CTP 2024; New Oxford Textbook of Psychiatry; DSM-5-TR 2022).

GOOD TO REMEMBER

- **The discriminator (the synthesis):** ask production first, then motivation. Genuine somatic disorders are not intentionally produced. Of the two feigned conditions, factitious disorder has no external incentive (sick role, primary gain) and malingering has an external incentive (secondary gain). That single external-incentive axis carries the **differentiation**.

TRAP **Confusing factitious disorder with malingering.** Both are consciously feigned, so they feel alike; the difference is the external incentive. Factitious disorder has none (the motive is the sick role); malingering has one. Reading a compensation or medicolegal claimant as factitious, or a sick-role patient as a malingerer, inverts the whole grid.

INDIA

Malingering surfaces most in Indian medicolegal work, where it is examined rather than treated: disability and compensation certification, fitness assessments, and above all the malingered insanity defence, where a defendant may feign mental illness to influence criminal responsibility (Jiloha, Forensic Psychiatry, An Indian Perspective). Assessment leans on structured aids such as the SIRS, M-FAST, SIMS and TOMM alongside collateral history, and Indian professional guidance recognises malingering as one of the grounds on which a doctor may decline to continue a therapeutic relationship. The register throughout is medical and non-accusatory: the task is to document inconsistency and weigh evidence, not to brand a person dishonest, which also guards against the opposite error of dismissing a genuinely ill or culturally distressed patient, such as one presenting somatically, as a fraud.

HOLD THIS

Malingering and factitious disorder are both consciously feigned, so voluntariness of production does not separate them; the discriminator is the external incentive, present in malingering (secondary gain, coded Z76.5 as a condition and not a mental disorder, strongly suspected on the four DSM-5-TR pointers) and absent in factitious disorder (Criterion C, the deception persists without obvious external reward, the motive being the sick role and primary gain), while the genuine somatic disorders, somatic symptom disorder, illness anxiety disorder and conversion, are not intentionally produced at all, so the whole map reduces to two questions asked in order, is the symptom produced, and if so, for an external incentive or for the sick role.

6 · Body dysmorphic disorder and bodily distress

Two disorders, one abbreviation, opposite chapters. This short topic sits at the somatic/BDD boundary and its whole job is to keep two look-alikes apart. **Body dysmorphic disorder** is a preoccupation with a perceived defect in appearance and lives on the **obsessive-compulsive and related disorders** spectrum; **bodily distress disorder** is the ICD-11 label for the symptom-led somatic presentation that replaced somatoform disorder. Both get shortened to "BDD" in the wards and both were once filed as somatoform, which is exactly why examiners like the trap. Name each, place each, and know the one mapping the examiner wants: how ICD-11 bodily distress disorder lines up against DSM-5 somatic symptom disorder.

This is a naming and cross-reference note, not the full teaching. The complete work-up of body dysmorphic disorder, its phenomenology, comorbidity, suicidality and management, belongs with its obsessive-compulsive kin and is developed in the Anxiety, OCD and trauma-related disorders notes. The two somatic siblings that bracket it, somatic symptom disorder and illness anxiety disorder, are their own topics in these notes, and the wider transcultural frame, including Dhat as a culturally patterned bodily-distress presentation, is in the Consultation-liaison, geriatric and transcultural psychiatry notes.

6.1 Body dysmorphic disorder on the OCRD spectrum

A perceived flaw, not a real one. Body dysmorphic disorder is a preoccupation with one or more perceived defects or flaws in physical appearance that are *not observable or appear only slight to others* (DSM-5-TR 2022, Criterion A). The person performs repetitive behaviours (mirror

checking, excessive grooming, skin picking, reassurance seeking) or mental acts (comparing their appearance with others) in response to the concern (Criterion B), which causes clinically significant distress or impairment (Criterion C) and is not better explained by an eating disorder's concern with fat or weight (Criterion D). There is no duration threshold. Two riders matter: the muscle dysmorphia specifier (preoccupation that the build is too small or insufficiently muscular, seen mostly in men), and an insight specifier graded good-or-fair, poor, or absent insight with delusional beliefs, the last absorbing what older systems called delusional dysmorphophobia.

It migrated out of the somatic chapter. Historically dysmorphophobia was treated as a variant of hypochondriasis and filed with the somatoform disorders (Companion to Psychiatric Studies), which is the root of the confusion. DSM-5 and ICD-11 both moved it firmly onto the obsessive-compulsive and related disorders grouping (ICD-11 code 6B21), alongside hypochondriasis, olfactory reference disorder and hoarding, on the strength of the shared engine of intrusive preoccupation plus repetitive checking and reassurance. That placement on the OCRD spectrum is the single fact this note exists to fix. The full teaching, the bdd cross-reference for phenomenology, comorbidity and treatment, is carried in the Anxiety, OCD and trauma-related disorders notes.

RULE **Appearance, not illness, and OCRD, not somatic.** A preoccupation with a perceived *appearance* defect that others cannot see, driven by checking and comparing, is body dysmorphic disorder and it belongs on the obsessive-compulsive and related disorders spectrum, not among the somatic disorders.

GOOD TO REMEMBER

- **Body dysmorphic disorder (the syndrome):** preoccupation with one or more perceived defects or flaws in appearance that are unobservable or slight to others, plus repetitive behaviours (mirror checking, grooming, reassurance seeking) or mental acts (comparing with others), causing distress or impairment and not explained by an eating disorder; the defining criterion is the unobservable-defect preoccupation, the classic specifier is muscle dysmorphia, and its home is the OCRD spectrum (6B21), not the somatic chapter (DSM-5-TR 2022; ICD-11 CDDR).

6.2 Bodily distress disorder and its map to somatic symptom disorder

The ICD-11 replacement for somatoform. Bodily distress disorder (ICD-11 code 6C20) is the major ICD-11 change that swept away ICD-10's somatoform disorders. It is characterised by the presence of bodily symptoms that are distressing to the person and by an *excessive* level of attention directed toward those symptoms, which typically leads to repeated contact with health services (ICD-11 CDDR; Kaplan and Sadock 2024). Like DSM-5's construct, it is defined by *positive* psychological features, the distress and the excessive thoughts and behaviours, rather than by the old requirement that symptoms be medically unexplained. It is graded on a continuum as mild, moderate or severe by the impact on functioning, and it sits in the ICD-11 grouping "disorders of bodily distress and bodily experience" alongside the rare body integrity dysphoria.

The mapping the examiner wants. ICD-11 bodily distress disorder maps onto DSM-5 somatic symptom disorder: both are symptom-led, both rest on the positive psychological criterion, and

both replaced the medically-unexplained model. The two are easily held side by side. They are close cousins rather than identical twins, ICD-11 foregrounds the excessive attention and repeated healthcare contact, DSM-5 foregrounds disproportionate thoughts, feelings and behaviours, but for a one-line answer they are the same idea in two manuals.

AXIS	ICD-11 BODILY DISTRESS DISORDER (6C20)	DSM-5 SOMATIC SYMPTOM DISORDER
Replaces	**ICD-10 somatoform disorders**	**DSM-IV somatoform disorders**
Core feature	Distressing bodily symptoms plus excessive attention to them	Distressing somatic symptoms plus disproportionate thoughts, feelings, behaviours
Basis of diagnosis	**Positive psychological features, not absence of medical explanation**	**Positive psychological criterion, not medically unexplained**
Severity grading	Mild, moderate, severe by functional impact	Mild, moderate, severe; specify persistent, predominant pain
Grouping	Disorders of bodily distress and bodily experience	Somatic symptom and related disorders

ICD-11 bodily distress disorder against DSM-5 somatic symptom disorder; the one line to hold is that both are the symptom-led, positive-criterion successors to somatoform disorder (ICD-11 CDDR; DSM-5-TR 2022; Kaplan and Sadock 2024).

TRAP **"BDD" is not one thing.** Body dysmorphic disorder is an appearance-preoccupation on the OCRD spectrum; bodily distress disorder is the ICD-11 somatic-symptom successor to somatoform disorder. Same abbreviation, different chapters, do not let the letters merge them.

GOOD TO REMEMBER

- **Bodily distress disorder (the syndrome):** ICD-11 6C20, distressing bodily symptoms with an excessive level of attention directed to them and repeated healthcare contact, defined by positive psychological features rather than absence of a medical explanation and graded mild to severe; it is the ICD-11 replacement for somatoform disorder and maps onto DSM-5 somatic symptom disorder (ICD-11 CDDR; Kaplan and Sadock 2024).

6.3 Where each is taught, and the one management anchor

Route the reader, then give the anchor. Keep the full detail where it belongs: body dysmorphic disorder with its obsessive-compulsive relatives in the Anxiety, OCD and trauma-related disorders notes, and the symptom-led somatic disorders in the somatic symptom disorder and illness anxiety disorder topics here. For the one management fact worth carrying: body dysmorphic disorder is treated first-line with CBT that centres on exposure and response prevention, and where symptoms are moderate to severe an SSRI is added, used at the higher doses and the longer trial familiar from obsessive-compulsive disorder rather than the lower antidepressant doses of depression (NICE CG31; Maudsley Prescribing Guidelines). Bodily distress disorder is managed as its somatic siblings are, physician-centred care and psychological therapy first, with drugs reserved for a genuine comorbid depression or anxiety, developed in the somatic symptom disorder topic.

GOOD TO REMEMBER

- **Management anchor (guideline):** body dysmorphic disorder is first-line CBT with exposure and response prevention, adding an SSRI for moderate-to-severe illness at OCD-range higher doses and a longer trial (NICE CG31, obsessive-compulsive disorder and body dysmorphic disorder); bodily distress disorder follows the somatic pathway, physician-centred care and psychological therapy first, medication only for a comorbid mood or anxiety disorder.

INDIA

Bodily distress disorder fits the Indian clinic closely: symptom-led somatic presentations dominate general practice, and the ICD-11 positive-criterion frame is a better match than the old "medically unexplained" label for patients who present the body first. The culturally patterned bodily-distress presentation of Dhat, and its transcultural handling, are developed in the Consultation-liaison, geriatric and transcultural psychiatry notes. Body dysmorphic disorder is easy to miss here because it hides behind repeated requests for cosmetic and dermatological procedures rather than a psychiatric complaint, so the referral often arrives from the skin or surgery clinic, not from the patient naming a fear.

2.4%	13 to 15%	16 to 17
BODY DYSMORPHIC DISORDER POINT PREVALENCE, ADULTS (DSM-5-TR)	AMONG GENERAL COSMETIC SURGERY PATIENTS (DSM-5-TR)	MEAN AGE AT ONSET, BODY DYSMORPHIC DISORDER (YEARS)

HOLD THIS

Body dysmorphic disorder is an appearance-defect preoccupation on the OCRD spectrum (ICD-11 6B21, DSM-5 obsessive-compulsive and related disorders), unobservable or slight defect plus checking and comparing, muscle dysmorphia and insight specifiers, full teaching in the Anxiety, OCD and trauma-related disorders notes; bodily distress disorder is the different beast, ICD-11 6C20, the positive-criterion successor to somatoform disorder that maps onto DSM-5 somatic symptom disorder; same three letters, opposite chapters.

7 · Management of medically unexplained symptoms

This topic takes the somatic patient from diagnosis to a plan. **Medically unexplained symptoms** (MUS) are bodily complaints that persist without a physical disease that fully accounts for them; over decades the label has drifted from "somatization" through "medically unexplained symptoms" to "functional somatic symptoms" (Kaplan and Sadock CTP 2024). The examinable point is that the **management of medically unexplained symptoms** is *not* a hunt for the missing disease and *not* a prescription. It is a physician-led, relationship-based, psychological-first package in which drugs are held back deliberately. Get the order of moves right and you have the marks: physician-centred care first, structured psychological work next, and medication only for a genuine comorbidity.

How to use this page. Fix the guideline spine first, that being the Indian Psychiatric Society somatoform CPG (IPS_CPG 2020) and the WHO mhGAP OTH module (WHO mhGAP 2016), because both put non-pharmacological, physician-centred strategies as the first line and both restrict medication for the somatic symptoms themselves. Then learn the **reattribution** model as

the signature technique, the psychological evidence, the one restrictive drug rule, and the follow-up posture. Close with the functional somatic syndromes, which are managed on exactly these principles. The one cross-chapter link to keep is that the positive signs and specific management of a conversion presentation belong to the Dissociative, conversion and anxiolytic/hypnotic pharmacology notes.

Medically unexplained symptoms (MUS)
Distressing bodily symptoms not fully explained by a detectable physical disease; a description, not a single diagnosis.

Physician-centred care
A management stance in which one coordinating clinician builds an alliance, validates the distress, restrains testing, and shifts focus to functioning.

Reattribution
A brief structured technique that helps the patient re-link bodily symptoms to psychosocial stress, moving from cause to functioning.

7.1 Physician-centred care: the foundation of management

One coordinating clinician, one continuing relationship, and restraint. The guideline foundation is physician-centred care (IPS_CPG 2020; WHO mhGAP 2016): emphasise non-pharmacological strategies as the first line of treatment, and build management on a small number of durable moves. A single named clinician holds the case, so care stops fragmenting across specialists. That clinician establishes a **therapeutic relationship**, the alliance that carries every other step and is undermined by prescription-drug dependence, benzodiazepine dependence in particular, which the IPS CPG flags explicitly. The clinician validates that the symptoms and the distress they cause are real and not imaginary, restricts unnecessary diagnostic testing and specialist referrals to those with a clear medical indication such as abnormal vital signs, identifies and treats any concurrent anxiety or depression early, and shifts the clinical focus away from symptoms and toward functioning. WHO mhGAP adds two explicit "do not" moves that sit inside this foundation, that being not ordering further investigations without a clear indication and not giving vitamin injections or other ineffective treatments.

ELEMENT OF PHYSICIAN-CENTRED CARE	WHAT IT MEANS IN THE ROOM	WHY IT IS THE ACTIVE INGREDIENT
Single coordinating clinician	One named doctor holds and continues the case	**Stops fragmented care and repeated doctor-shopping**
Therapeutic relationship	A trusting, continuing alliance with the patient	**The vehicle every other step travels on**
Validate symptoms and distress	State plainly that the symptoms are real, not imagined	**Removes the felt need to keep proving illness**
Restrict testing and referrals	Investigate only on a clear medical indication	**Breaks the iatrogenic loop of chasing disease**
Treat comorbidity early	Screen and treat concurrent depression or anxiety	**Relieves a driver of the somatic burden itself**
Shift toward functioning	Target coping and function, not symptom eradication	**A realistic, sustainable goal that reduces distress**

The six elements of physician-centred care, the guideline-anchored first line for medically unexplained symptoms (IPS_CPG 2020, WHO mhGAP 2016), set out step by step here.

MNEMONIC

CARVES

The physician-centred foundation, the way it carves the plan out of the chaos. **C**oordinating clinician, one named doctor; **A**lliance, the therapeutic relationship; **R**estrict tests and referrals; **V**alidate the real symptoms and distress; treat **E**motional comorbidity early; **S**hift from symptoms to functioning. Six moves, no prescription among them.

RULE **Physician-centred care is the treatment, not the waiting room.** In MUS the coordinating clinician, the therapeutic alliance, validation and restraint on testing *are* the active first-line intervention (IPS_CPG 2020); the alliance is the first move, not the prescription.

GOOD TO REMEMBER

- **Physician-centred care (the management step):** the guideline first line (IPS_CPG 2020, WHO mhGAP 2016), being a single coordinating clinician, a therapeutic relationship, validation that the symptoms and distress are real, restriction of unnecessary tests and referrals, early treatment of comorbid mood or anxiety, and a shift toward functioning. The first move is the alliance, and non-pharmacological strategies lead.

7.2 The reattribution model

A brief four-stage technique that re-links body to mind. Reattribution is the classic structured method for MUS in primary and general-hospital care, originally taught by Goldberg and Gask, and it runs in four stages (AIIMS Consultation Liaison handbook 2020). The first stage is *feeling understood*: focused history, focused physical examination and supportive listening to build the alliance. The second stage *broadens the agenda*: give feedback, acknowledge the concerns, and pick up cues of underlying distress. The third stage is the *normalising link*: connect the bodily symptoms to psychosocial problems, negotiate that unnecessary tests and doctor-shopping will

be curtailed with the assurance that tests will be arranged if genuinely needed, and target improved functioning and reduced distress rather than complete symptom removal; scheduling regular follow-up here both strengthens the alliance and prevents the patient from generating a new symptom as a ticket to a new physician. The fourth stage *makes the change*: agree a management plan and negotiate the goals of treatment. The model is effective, feasible and acceptable in routine primary care.

REATTRIBUTION STAGE	TASK IN THE ROOM	THE MOVE TO HOLD
Feeling understood	Focused history and examination, supportive listening	**Build the alliance before anything else**
Broadening the agenda	Give feedback, acknowledge concerns, read distress cues	**Open the emotional agenda without confrontation**
Making the link	Normalise, connect symptoms to psychosocial stress	**Aim at functioning, curb needless testing**
Negotiating the plan	Agree a management plan and shared goals	**Convert insight into an actionable plan**

The four stages of the reattribution model, from feeling understood to negotiating a plan (AIIMS Consultation Liaison handbook 2020, after Goldberg and Gask), run in order here.

GOOD TO REMEMBER

- **Reattribution (the management step):** a brief four-stage technique, that being feeling understood (focused history and examination), broadening the agenda (feedback and distress cues), making the link (normalise symptoms to psychosocial stress, aim at functioning, curb needless testing), and negotiating the plan. The guiding principle is to move from proving or disproving disease to restoring function.

7.3 The psychological therapies: CBT, psychoeducation, relaxation, mindfulness

Cognitive behaviour therapy leads, with a brief package close behind. The structured psychological evidence is the substance of the plan once the alliance is set. Cognitive behaviour therapy for somatic presentations, the **cbt somatic** evidence base, is the first-line psychotherapy (IPS_CPG 2020): it targets the catastrophic misinterpretation of bodily sensations, adds relaxation and pleasurable, meaningful activities, and rebuilds functioning through behavioural activation and cognitive restructuring; sessions typically range from four to sixteen over roughly three months. Running alongside it as an alternative first-line approach is a brief intervention that bundles psychoeducation, relaxation therapy and reattribution training. Psychoeducation emphasises the *mechanism* of symptoms over their cause, acknowledges the symptoms as real, communicates normal clinical and test findings, elicits the patient's own explanatory model, and discusses the links between emotional stress and bodily sensation, optionally paired with a consultation letter to the referring physician. Relaxation therapy means progressive muscular relaxation and slow diaphragmatic breathing. For a hypochondriacal, illness-anxiety flavoured presentation the IPS CPG puts CBT with cognitive restructuring and exposure and response prevention first line, with mindfulness-based cognitive therapy or acceptance and commitment therapy as second line; for persistent somatoform pain it puts CBT plus biofeedback first line.

WORKED EXAMPLE

A woman in her thirties has had two years of shifting aches, fatigue and gut symptoms, three normal specialist work-ups and a growing conviction that "something is being missed". Rather than order a fourth panel, her one coordinating clinician validates the symptoms as real, restricts new testing to a clear indication, and starts reattribution: focused examination to feel understood, then a gentle link between symptom flares and a difficult caregiving load, then a shared plan of scheduled monthly reviews with a functioning goal of returning to part-time work. Referral for cognitive behaviour therapy targets her catastrophic reading of each new sensation. No antidepressant is started, because there is no comorbid depression and no dominant pain syndrome.

GOOD TO REMEMBER

- **Psychological therapy in MUS (the management step):** the guideline first line (IPS_CPG 2020) is cognitive behaviour therapy targeting catastrophic misinterpretation and rebuilding function, with an alternative brief package of psychoeducation, relaxation and reattribution; psychoeducation stresses mechanism over cause. For illness-anxiety presentations, CBT with cognitive restructuring and exposure and response prevention leads, mindfulness-based approaches second line.

7.4 The pharmacological rule: restraint first, drugs for the comorbidity

Do not medicate the somatic symptoms; medicate a genuine comorbidity. The single most testable management fact here is a "do not": under the WHO mhGAP OTH module, do NOT prescribe anti-anxiety or antidepressant medicines for medically unexplained somatic complaints unless advised by a specialist (WHO mhGAP 2016). Medication is not the first-line treatment of the somatic symptoms themselves. It becomes appropriate only when there is a genuinely co-existing depressive or anxiety disorder, or a dominant chronic-pain component. Where mood or anxiety comorbidity dominates, the **ssri somatic** question is answered by treating that disorder on its own merits, so an SSRI is reasonable. Where persistent pain dominates, the analgesic antidepressants are preferred: an SNRI such as duloxetine, typically **60 mg** once daily, or a low-dose tricyclic such as amitriptyline for its analgesic action. The evidence keeps drugs firmly in a supporting role: the Cochrane review of pharmacological interventions for somatoform disorders (Kleinstauber 2014) found only low to very-low-quality evidence that new-generation antidepressants reduce somatic symptoms, so drugs supplement, and never replace, physician-centred and psychological care. Polypharmacy is avoided, and side effects matter especially here because they can amplify symptom perception.

TRAP **Reflexively prescribing an antidepressant or anxiolytic for the somatic symptoms.** WHO mhGAP (2016) says do not, unless a specialist advises; reserve drugs for a genuine comorbid depression or anxiety disorder, or a persistent-pain component, and never as a substitute for physician-centred and psychological care.

GOOD TO REMEMBER

- **Medication in MUS (the drug principle):** the guideline rule (WHO mhGAP 2016) is not to prescribe anti-anxiety or antidepressant drugs for medically unexplained somatic symptoms unless a specialist advises. Reserve them for comorbid depression or anxiety, or for a dominant chronic-pain component, where an SNRI (duloxetine, typically 60 mg once daily) or a low-dose tricyclic (amitriptyline) is preferred; deep antidepressant pharmacology sits in the Mood disorders: pharmacotherapy notes.

7.5 Follow-up: shifting from symptoms to functioning

Scheduled, time-based reviews replace symptom-driven visits. The management does not end at the first plan; the follow-up posture is itself guideline content. WHO mhGAP asks the clinician to review the person in 2 to 4 weeks if symptoms do not improve or worsen, and to reconsider the protocol or consult a specialist if there is no improvement or repeated insistence on further investigation (WHO mhGAP 2016). The IPS CPG frames maintenance around encouraging functioning and coping, keeping stable patients on roughly one visit every 1 to 2 months, and educating patient and family that minor symptom variations are common and need not be attributed to new pathology (IPS_CPG 2020). The deep principle across both is that visits are scheduled by the calendar, not triggered by each new symptom, which is precisely what stops a fresh complaint becoming the only permit to be seen.

15	4	2-4
PHQ-15 HIGH-SEVERITY CUT-OFF (0 TO 30 SCALE)	STAGES OF THE REATTRIBUTION MODEL	MHGAP SYMPTOM-REVIEW WINDOW (WEEKS)

PEARL

Grade severity with a scale to pitch the intensity of care: the PHQ-15 rates fifteen common somatic symptoms, each scored 0 to 2, for a total out of a possible 30, with cut-points at 5, 10 and 15 marking low, medium and high burden. The reproduced PHQ-15 form sits with the somatic-symptom scales; here the high-severity cut-off, at 15, is the number to carry.

GOOD TO REMEMBER

- **Follow-up in MUS (the management step):** the guideline posture (WHO mhGAP 2016, IPS_CPG 2020) is calendar-scheduled review, reassess in 2 to 4 weeks if no improvement, keep stable patients to roughly one visit every 1 to 2 months, and educate that minor symptom variation is normal and not new disease. Time-based visits replace symptom-triggered ones.

7.6 The functional somatic syndromes: chronic fatigue syndrome, fibromyalgia, phantom limb pain

Named syndromes, same management principles. Several defined conditions sit close to MUS as functional somatic syndromes and are managed on the same physician-centred, psychological-first footing, with medication reserved for a pain or comorbidity component. Chronic fatigue syndrome is defined by severe, disabling mental and physical fatigue that is not relieved by rest and is worsened by exertion, persisting for at least several months and not explained by another condition; graded activity and cognitive behaviour therapy are the mainstay psychological

approaches (Shorter Oxford; New Oxford). Fibromyalgia is defined by chronic widespread pain with tenderness, fatigue, unrefreshing sleep and cognitive complaints; here an antidepressant with an analgesic action, an SNRI such as duloxetine, has an established role alongside exercise and CBT, illustrating the "pain component" exception to the drug rule (Stahl; Kaplan and Sadock CTP 2024). Phantom limb pain is pain experienced in a limb that has been amputated, distinct from localised stump pain, and it responds in part to the analgesic antidepressants and to graded, functionally oriented rehabilitation (Kaufman's Clinical Neurology for Psychiatrists; Kaplan and Sadock CTP 2024). Across all three, the trap is to keep re-investigating a settled functional diagnosis rather than treating it.

GOOD TO REMEMBER

- **Chronic fatigue syndrome (the syndrome):** severe, disabling fatigue not relieved by rest and worsened by exertion, for at least several months, unexplained by another condition; the discriminator is post-exertional worsening, and graded activity plus CBT lead.
- **Fibromyalgia (the syndrome):** chronic widespread pain with tenderness, fatigue and unrefreshing sleep; the discriminator is the widespread pain, and an analgesic antidepressant (an SNRI such as duloxetine) plus exercise and CBT is the standard approach.
- **Phantom limb pain (the syndrome):** pain felt in an amputated limb, distinct from stump pain confined to the injury; the discriminator is the referred location in the absent limb, managed with analgesic antidepressants and functionally oriented rehabilitation.

INDIA

Somatic presentation is the Indian norm rather than the exception: emotional distress is very commonly first brought to the clinician as bodily symptoms, so a large share of primary-care and general-hospital attenders sit in exactly this management space, and the Indian evidence base is anchored by the IPS_CPG 2020 guideline on psychotherapies for somatoform disorders and by indigenous tools such as the Scale for Assessment of Somatic Symptoms. The most examinable India-specific presentation is the culture-bound Dhat syndrome, a somatic and anxious preoccupation attributed to perceived loss of vital fluid; it is managed with the same physician-centred alliance, validation and psychoeducation rather than reflexive medication, and must be read through a cultural formulation rather than pathologised on its surface content. Its wider transcultural frame and the consultation-liaison service model that most often meets these patients are developed in the Consultation-liaison, geriatric and transcultural psychiatry notes.

HOLD THIS

The management of medically unexplained symptoms is physician-centred and psychological first: one coordinating clinician builds a therapeutic relationship, validates the real symptoms and distress, restricts unnecessary testing and referrals, treats comorbid depression or anxiety early, and shifts the focus from symptoms to functioning, with reattribution and CBT as the first-line psychological work; per WHO mhGAP, anti-anxiety or antidepressant drugs are NOT prescribed for the somatic symptoms themselves unless specialist-advised, and are reserved for a comorbid mood or anxiety disorder or a persistent-pain component (an SNRI such as duloxetine, or low-dose amitriptyline), while chronic fatigue syndrome, fibromyalgia and phantom limb pain are managed on the very same principles.

Sexual dysfunctions, paraphilias and gender

8 · The normal sexual response cycle

Learn the map before the malfunctions. The **sexual response cycle** is the physiological scaffold on which every sexual dysfunction is classified, so it is the first thing to fix before any of the disorders make sense. Both DSM-5-TR and ICD-11 name their sexual dysfunctions by the *phase of response that is disrupted*, which means the examiner who asks you to define hypoactive desire, erectile dysfunction, or premature ejaculation is really asking whether you can place each complaint on this cycle. The topic is small, high-yield, and almost entirely about three named models plus one piece of neuroanatomy.

This note owns the normal frame: the **masters and johnson** four-phase model with its refractory period, Helen Singer Kaplan's triphasic reformulation that added the **desire phase** and turned the cycle into a diagnostic map, Rosemary Basson's circular model of female response, and the autonomic wiring of erection and ejaculation. The dysfunctions themselves, their criteria, and their guideline-anchored management are developed in the sexual dysfunction topics of these notes; the culture-bound frame of Dhat and semen-loss anxiety sits in the Consultation-liaison, geriatric and transcultural psychiatry notes. Keep the whole discussion clinical and schematic, and lean on the accompanying figure of the response-cycle curves.

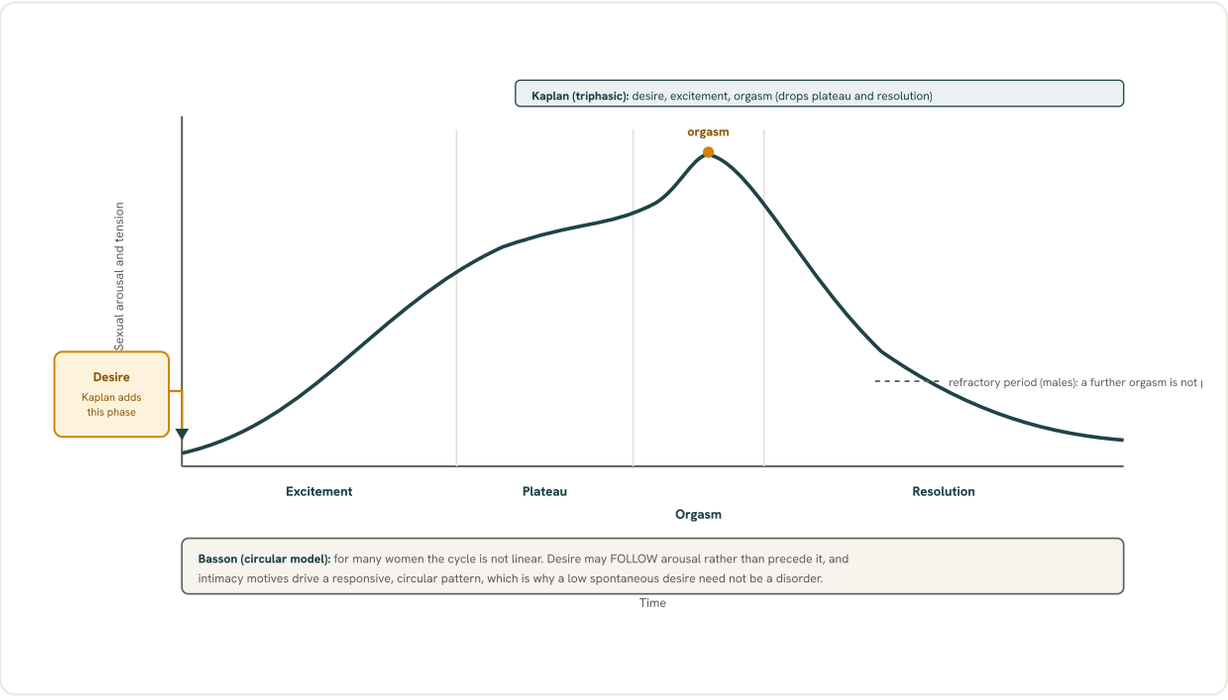


Fig 18.5 The normal sexual response cycle. Masters and Johnson described four sequential phases, drawn here as a single arousal curve: excitement, a sustained plateau, the orgasmic peak, and resolution, with a refractory period in males during which a further orgasm is not possible. Kaplan reframed the cycle as triphasic by adding an initial desire phase and collapsing plateau and resolution, which is the clinically useful version because it separates the desire, arousal and orgasm disorders. Basson's circular model captures a common female pattern in which desire is responsive, following arousal and intimacy rather than preceding them, so that a low level of spontaneous desire is not in itself a dysfunction. The figure is a neutral physiological schematic.

8.1 The Masters and Johnson four-phase model

Four sequential phases. From their laboratory observations, published as *Human Sexual Response* in 1966, Masters and Johnson described the human sexual response cycle as four sequential phases: **excitement**, **plateau**, **orgasm** and **resolution** (Kaplan and Sadock 2024). This is the **four-phase model**, and the two physiological engines running through it are vasocongestion (increased genital blood flow, giving erection in men and clitoral and vaginal engorgement with lubrication in women) and myotonia (rising skeletal and smooth-muscle tension). Excitement is the initial arousal and engorgement; plateau is the sustained high-arousal state just short of climax; orgasm is the brief peak that releases the accumulated tension; and resolution is the return to the unaroused baseline with a sense of well-being.

The refractory period is the sex difference to name. In men, resolution includes a refractory period, a recovery interval during which a further orgasm is physiologically not possible; it is short in youth and lengthens with age. Women characteristically have little or no true refractory period and can return to the orgasm phase with minimal delay, which is the physiological basis of multi-orgasmic capacity (Kaplan and Sadock 2024). That single asymmetry is the classic viva point and is exactly what the accompanying figure of the response-cycle curves is drawn to show.

PHASE (MASTERS AND JOHNSON)	CORE PHYSIOLOGICAL EVENTS
Excitement	**Onset of arousal: vasocongestion begins, penile erection, clitoral and vaginal engorgement with lubrication, breast and nipple changes, rising heart rate and blood pressure**
Plateau	Arousal sustained near its peak: testes elevate, the outer vaginal third forms the orgasmic platform, muscle tension and cardiorespiratory rate climb further
Orgasm	**Brief climax releasing sexual tension: rhythmic pelvic contractions, in men emission then ejaculation, in women rhythmic contraction of the orgasmic platform**
Resolution	**Return to baseline: detumescence and de-engorgement, well-being; men enter a refractory period, women may not**

The four-phase model of Masters and Johnson; the discriminating detail is the male refractory period in resolution, absent or minimal in women (Kaplan and Sadock 2024).

GOOD TO REMEMBER

- **Four-phase model (Masters and Johnson):** excitement, plateau, orgasm, resolution, driven by vasocongestion and myotonia; the defining sex difference is the refractory period in resolution, present in men and minimal or absent in women.

8.2 Kaplan's triphasic model and the desire phase

Kaplan added the mind before the body. Helen Singer Kaplan's 1979 reformulation, the **kaplan triphasic** model, collapsed the physiological cycle into three interdependent components and,

crucially, prefixed a psychological one: **desire**, **excitement** and **orgasm** (Kaplan and Sadock 2024). The addition of the desire phase mattered because Masters and Johnson had begun the cycle at excitement and so had no place for the many patients whose problem is an absence of sexual interest or drive before arousal is ever attempted. Desire is appetitive and centrally driven; excitement and orgasm are the peripheral, largely vascular and reflexive events that follow.

The triphasic model is a diagnostic map. Its enduring value is that each phase corresponds to a family of dysfunctions, which is why DSM-5-TR uses these phases as the basis for classifying the sexual dysfunctions (Kaplan and Sadock 2024). A desire-phase problem gives low libido (hypoactive sexual desire) or, at the other pole, hypersexuality; an excitement or arousal-phase problem gives erectile dysfunction in men and female arousal disorder; and an orgasm-phase problem gives anorgasmia or premature ejaculation. Localise the complaint to a phase and you have narrowed the differential before you have named a single criterion.

TRIPHASIC PHASE (KAPLAN)	NATURE OF THE PHASE	DYSFUNCTION WHEN DISRUPTED
Desire	**Central, appetitive drive and interest**	Hypoactive sexual desire; sexual aversion; hypersexuality
Excitement (arousal)	Peripheral vascular arousal (erection, engorgement, lubrication)	**Erectile dysfunction; female sexual arousal disorder**
Orgasm	Reflex peak and release of tension	**Anorgasmia (delayed or absent orgasm); premature ejaculation**

Kaplan's triphasic model as a map of the dysfunctions; the examiner's use of it is to place any presenting complaint on desire, excitement or orgasm (Kaplan and Sadock 2024; DSM-5-TR 2022).

RULE **The disrupted phase names the disorder.** Desire-phase failure means a desire disorder, excitement-phase failure means an arousal disorder such as erectile dysfunction, orgasm-phase failure means anorgasmia or premature ejaculation; classification follows the phase.

GOOD TO REMEMBER

- **Kaplan triphasic model:** desire, excitement, orgasm; the point of the model is that it adds the desire phase that Masters and Johnson omitted and maps each phase onto a family of dysfunctions, which is the framework DSM-5-TR adopts for classification.

8.3 Basson's circular model of female response

A circle, not a straight line. The linear models assume desire is spontaneous and always precedes arousal, an assumption that fits male experience better than female and risks over-diagnosing hypoactive desire in women (Kaplan and Sadock 2024). Rosemary Basson's circular model (2000), developed for female response, replaces the straight line with a loop that many women enter from a position of sexual neutrality, moved by a wish for emotional intimacy rather than by a spontaneous surge of drive. Willingness leads to sexual stimuli, arousal builds, and desire is then triggered by that arousal, so here desire can *follow* arousal rather than lead it. This is responsive desire, as opposed to the spontaneous desire the linear models presume.

Why it matters clinically. Basson's model reframes emotional satisfaction and relationship quality as drivers of the cycle, not incidental extras, and it normalises a pattern of desire that the linear models would misread as pathology. Although built around female response, its principles are now applied across sexes, and it is the reason a purely mechanistic, erection-and-orgasm account of a couple's difficulty so often misses the point.

PEARL

The single most testable idea from Basson is that arousal can precede desire. In her circular model a woman may begin from neutrality, choose to be receptive for intimacy, and only then, as arousal builds, experience desire. Reading that responsive pattern as a disorder of the desire phase is the commonest conceptual error at the bedside, and it is exactly what the model was written to correct.

8.4 The neurophysiology: point and shoot

Two autonomic divisions, two jobs. Erection is a parasympathetic event and ejaculation is a sympathetic one, and the whole of it is captured by the classic mnemonic point and shoot (Kaufman's Clinical Neurology for Psychiatrists). Excitatory descending impulses raise parasympathetic outflow from the sacral cord, which relaxes the smooth muscle of the genital arteries; the relaxed arteries dilate, blood flows in, and the result is penile erection in men and clitoral engorgement in women. At the tissue level the mediator is nitric oxide, released in the corpus cavernosum during arousal; it raises cyclic guanosine monophosphate, which produces the smooth-muscle relaxation and blood inflow that give the erection, and it is the enzyme that degrades that second messenger, phosphodiesterase-5, which the erectile-dysfunction drugs inhibit (Kaplan and Sadock 2024; Stahl).

Sympathetic outflow closes the sequence. With continued stimulation a predominantly sympathetic, thoracolumbar discharge produces emission (movement of seminal fluid into the posterior urethra) and then ejaculation, after which arterial tone returns and detumescence follows in resolution (Kaufman). The parasympathetic outflow for erection arises from the sacral cord at **S2 to S4** and the sympathetic outflow for emission and ejaculation from the thoracolumbar cord at **T11 to L2**; the somatic pudendal nerve (also S2 to S4) carries the erotic afferents and drives the rhythmic pelvic-floor contractions of the ejaculatory reflex. A failure of sympathetic bladder-neck closure diverts semen backwards, which is why sperm in a post-orgasm urine sample signals retrograde ejaculation.

MNEMONIC

POINT and SHOOT

Point is **P**arasympathetic and gives the erection (S2 to S4, acetylcholine, nitric oxide, arterial relaxation and inflow); **Shoot** is **S**ympathetic and gives emission and ejaculation (T11 to L2). The clinical payoff: sympathetic overdrive, as in anxiety, both softens erection and hurries ejaculation.

TRAP **Do not swap the autonomic assignments.** Erection is parasympathetic (point), not sympathetic; it is sympathetic overactivity, the physiology of anxiety, that abolishes erection and precipitates premature ejaculation, which is why performance anxiety is self-perpetuating.

GOOD TO REMEMBER

- **Autonomic control (point and shoot):** parasympathetic sacral outflow (S2 to S4) mediates erection via nitric oxide and cyclic guanosine monophosphate with smooth-muscle relaxation; sympathetic thoracolumbar outflow (T11 to L2) mediates emission and ejaculation; the pudendal nerve is the somatic afferent and ejaculatory-motor route.

8.5 Using the cycle in the clinic

The cycle is the sexual-history template. A good psychosexual history walks the phases in order and asks, for the patient and the partner, where the difficulty falls: is it a lack of interest before anything begins (desire), a failure to become or stay aroused (excitement), or a problem with climax and its timing (orgasm), with pain considered alongside (Kaplan and Sadock 2024). Because illnesses that cause pain, fatigue, vascular disease or hormonal deficiency and many medications each strike particular phases, phase-localisation immediately raises the organic differential as well as the psychological one. Erectile dysfunction, an excitement-phase vascular failure, is a recognised early marker of endothelial and cardiovascular disease, so the cycle is a screening prompt, not merely a taxonomy.

WORKED EXAMPLE

A man reports that his interest and arousal are intact and erections are firm, but climax arrives far sooner than he wishes. Walk the triphasic model: desire is normal, excitement is normal, and the problem is squarely in the orgasm phase, which localises the complaint to premature ejaculation rather than a desire or erectile disorder before a single management step is chosen. Reverse the pattern, so that interest is present but the erection will not form or hold, and you have moved one phase upstream to an excitement-phase disorder, erectile dysfunction, with its own vascular and organic differential. Localise first, name second.

INDIA

Indian teaching uses the same frame: it anchors the sexual dysfunctions to disturbance across the phases of the sexual response cycle, so the Masters and Johnson and Kaplan models are the standard Indian exam scaffold. The everyday clinical relevance is that orgasm-phase and desire-phase complaints, particularly premature ejaculation and low desire, dominate Indian psychosexual and andrology clinics, and they are frequently overlaid on the culture-bound anxiety of Dhat, in which normal physiology is misread through a fear of semen loss. Placing such a presentation on the cycle first, and reading the cultural meaning second, keeps the assessment grounded; the transcultural frame of Dhat is developed in the Consultation-liaison, geriatric and transcultural psychiatry notes.

4	3	S2 to S4	T11 to L2
MASTERS AND JOHNSON PHASES (EXCITEMENT, PLATEAU, ORGASM, RESOLUTION)	KAPLAN TRIPHASIC PHASES (DESIRE, EXCITEMENT, ORGASM)	PARASYMPATHETIC ERECTILE OUTFLOW (SACRAL)	SYMPATHETIC EMISSION AND EJACULATION OUTFLOW

HOLD THIS

Masters and Johnson gave four phases, excitement, plateau, orgasm and resolution, with a male-only refractory period; Kaplan's triphasic model added the desire phase to make desire, excitement and orgasm, and that phase map is how DSM-5-TR classifies the dysfunctions; Basson's circular model shows female desire can be responsive and follow arousal; and the wiring is point and shoot, parasympathetic sacral outflow (S2 to S4, nitric oxide) for erection and sympathetic thoracolumbar outflow (T11 to L2) for emission and ejaculation.

9 · Male sexual dysfunctions and their management

This topic sits at the *desire* and *arousal* hinge of the chapter, and it is examined as a hybrid: a short discrimination task that places a man's complaint in the right diagnostic box, then a longer, guideline-anchored management answer that most candidates under-prepare. The high-yield entity is **erectile dysfunction**, both because it is the commonest presentation the psychiatrist meets (as a side effect, a comorbidity of diabetes or vascular disease, or a primary complaint) and because its first-line drug treatment is one of the cleanest guideline positions in the syllabus. The consensus across the sexual-medicine bodies, the International Society for Sexual Medicine, the British Society for Sexual Medicine, and the operative urology guidelines, is uniform, so marks are lost only by getting a dose, a contraindication, or the testosterone principle wrong.

How to use this page. First fix the DSM-5-TR and ICD-11 map of the **male sexual dysfunctions** and the common criteria that gate every one of them; then learn erectile dysfunction properly, its definition, the organic against psychogenic split, and its meaning as a cardiovascular warning; then commit the stepwise management, first-line **PDE5 inhibitor** with its verified doses and the absolute nitrate rule, second-line injection or vacuum, third-line prosthesis, and the single testosterone principle that carries the classic trap. Finish with the **ejaculatory disorders** and hypoactive desire. The one error this page is built to prevent is starting long-term testosterone in a man whose testosterone is normal.

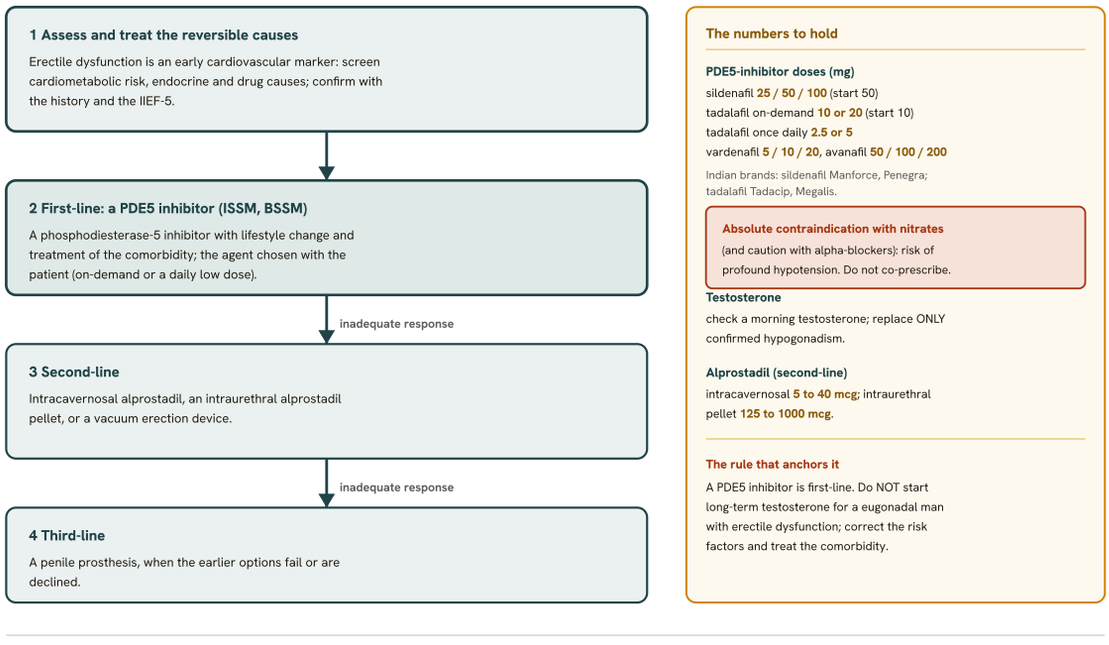


Fig 18.6 The erectile-dysfunction management algorithm. Because erectile dysfunction is often an early sign of vascular disease, the first step is to screen and treat the reversible cardiometabolic, endocrine and drug causes and to confirm the picture with the history and the IIEF-5. First-line treatment, anchored on the ISSM and BSSM guidance, is a phosphodiesterase-5 inhibitor alongside lifestyle change and treatment of the comorbidity, chosen with the patient as an on-demand agent or a daily low dose; the doses are held in the panel. A phosphodiesterase-5 inhibitor is absolutely contraindicated with nitrates. Where it fails or is unsuitable, second-line options are intracavernosal or intraurethral alprostadil or a vacuum device, and third-line is a penile prosthesis. Testosterone is checked and replaced only where hypogonadism is confirmed; empirical testosterone for a eugonadal man is a classic error.

IIEF-5 (SHIM), THE 5-ITEM SEXUAL HEALTH INVENTORY FOR MEN	SCORE BAND (OUT OF A POSSIBLE 25)
5 items on erectile function and satisfaction over the past 6 months, each scored 1 to 5; total out of a possible 25	22 to 25: no erectile dysfunction
higher total means better erectile function	17 to 21: mild
a brief screen and severity grade, not a diagnosis on its own	12 to 16: mild to moderate
tracks response to treatment over time	**8 to 11: moderate; 5 to 7: severe**

IIEF-5 / SHIM (Rosen et al, 1999); copyright the authors, permission required, so typeset here in summary with the verified severity bands rather than reproduced.

ASEX (ARIZONA SEXUAL EXPERIENCE SCALE)	INTERPRETATION
5 items: sex drive, arousal, erection or lubrication, ability to reach orgasm, and satisfaction from orgasm	each item scored 1 to 6; total out of a possible 30; higher means more sexual dysfunction
useful for tracking medication-induced sexual dysfunction across either sex	**clinically significant dysfunction if the total is 19 or more, OR any one item is 5 or more, OR any three items are 4 or more**

ASEX (McGahuey et al, 2000); University of Arizona, permission required, so typeset here in summary with the verified thresholds rather than reproduced.

Fig 18.7 The sexual-function rating scales. The IIEF-5, or Sexual Health Inventory for Men, is the brief erectile-function screen and severity grade: five items each scored 1 to 5 for a total out of a possible 25, banded from 22 to 25 (no dysfunction) down to 5 to 7 (severe). The Arizona Sexual Experience Scale is a short five-item measure usable across either sex and especially handy for tracking medication-induced sexual dysfunction, each item scored 1 to 6 for a total out of a possible 30, with clinically significant dysfunction flagged by a total of 19 or more, any single item of 5 or more, or any three items of 4 or more. Both are permission-required instruments and are summarised here from their verified structure and thresholds.

9.1 The DSM-5-TR and ICD-11 map of the male dysfunctions

Four male-relevant disorders, one shared set of gates. DSM-5-TR groups the male sexual dysfunctions into male hypoactive sexual desire disorder, erectile dysfunction (erectile disorder), premature ejaculation (premature or early ejaculation), and delayed ejaculation, alongside substance or medication-induced sexual dysfunction (Kaplan and Sadock CTP 2024; DSM-5-TR 2022). Whichever one you are diagnosing, the same qualifying criteria apply: the symptom must persist for at least six months, cause clinically significant distress, and not be better explained by a non-sexual mental disorder, relationship distress, another medical condition, or a substance. Erectile dysfunction, premature ejaculation and delayed ejaculation add a frequency gate on top of these, the symptom on roughly 75 to 100 percent of occasions; male hypoactive sexual desire disorder carries no frequency threshold in DSM-5-TR. Each is then coded as lifelong or acquired and as generalised or situational, and its severity is graded by the distress it causes. ICD-11 made the parallel move of lifting these out of the mental disorders chapter into a dedicated chapter, "Conditions related to sexual health", with gender-parallel dysfunctions (ICD-11).

DISORDER (DSM-5-TR)	CORE FEATURE	THE ONE THING TO ATTACH TO IT
Male hypoactive sexual desire disorder	Persistently deficient or absent sexual thoughts, fantasies and desire	**Measure morning testosterone; low desire correlates with low testosterone**
Erectile dysfunction (erectile disorder)	Difficulty obtaining or maintaining an erection, or reduced erectile rigidity	**Classify as organic, psychogenic or mixed; it is a cardiovascular marker**
Premature (early) ejaculation	Ejaculation within roughly one minute of penetration, sooner than wished	**On-demand dapoxetine is the only licensed first-line drug**
Delayed ejaculation	Marked delay, infrequency or absence of ejaculation	**Separate it from retrograde ejaculation, which is always organic**

The male sexual dysfunctions under DSM-5-TR, all gated by the shared six-month, distress and exclusion criteria, with the 75-to-100-percent frequency gate on every one except male hypoactive sexual desire disorder; ICD-11 places the parallel set in its sexual-health chapter (Kaplan and Sadock CTP 2024, DSM-5-TR 2022, ICD-11).

GOOD TO REMEMBER

- **The shared criteria (every male dysfunction):** at least six months, causing significant distress, not better explained by another disorder, relationship distress, a medical condition or a substance; then specify lifelong or acquired and generalised or situational. The symptom on about 75 to 100 percent of occasions is required for erectile dysfunction, premature ejaculation and delayed ejaculation, but not for male hypoactive sexual desire disorder. Missing the six-month and distress gates is the commonest under-diagnosis error.

9.2 Erectile dysfunction: definition and the organic, psychogenic, mixed split

One definition, three aetiological patterns. Erectile dysfunction is the persistent or recurrent inability to attain or maintain a penile erection sufficient for satisfactory sexual performance (Kaplan and Sadock CTP 2024). It is classified as psychogenic, organic, or mixed, and the split is drawn largely from the history. Psychogenic erectile dysfunction, driven by performance anxiety, relationship conflict or mood, tends to be situational and sudden in onset, and the man still has normal erections with masturbation, on waking, and during sleep. Organic erectile dysfunction is insidious, and erections are deficient in most contexts, nocturnal and masturbatory included. Organic causes are vascular (arterial insufficiency or venous leak), neurogenic, endocrine (hypogonadism, hyperprolactinaemia), medication-induced, or systemic; the vasculogenic type is the commonest organic aetiology, and antipsychotic and antidepressant contributions are a reversible cause the psychiatrist must actively exclude (developed in the Schizophrenia: management, antipsychotics and adverse effects notes and the Mood disorders: pharmacotherapy notes). Where doubt persists, nocturnal penile tumescence testing (erections during sleep) helps separate organic from psychogenic disease, since preserved sleep erections point away from an organic lesion.

RULE **The history sorts organic from psychogenic before any test.** Preserved morning, masturbatory and nocturnal erections with sudden, situational onset make organic disease negligible and the picture psychogenic; insidious onset with erections deficient in every context points organic and warrants a vascular and endocrine work-up.

GOOD TO REMEMBER

- **Erectile dysfunction (the diagnosis):** persistent inability to attain or maintain an erection sufficient for satisfactory performance, for at least six months, with distress; the defining discriminator is the organic, psychogenic or mixed classification, read first from preserved versus absent nocturnal and masturbatory erections.

9.3 Erectile dysfunction as a cardiovascular sentinel

The penis is a window on the arteries. Erectile dysfunction and cardiovascular disease share a pathophysiology of endothelial dysfunction, inflammation and low testosterone, and erectile dysfunction is independently associated with coronary heart disease, stroke and all-cause mortality (Kaplan and Sadock CTP 2024). The clinically load-bearing point is that vasculogenic erectile dysfunction in a younger man can be an early indicator of future cardiovascular disease, so these men should receive an appropriate cardiovascular risk assessment rather than a prescription alone. The epidemiology reinforces it: in the Massachusetts Male Aging Study the combined prevalence reached 52 percent, and after adjusting for age the strongest correlates were the classic vascular markers, hypertension, diabetes and heart disease. Among men with diabetes, roughly 50 to 75 percent develop erectile dysfunction, about three times the rate in non-diabetic men.

PEARL

Treat new-onset erectile dysfunction in a man under 50 as a reason to check blood pressure, fasting glucose or HbA1c, and lipids, not only to write for a tablet. The small penile arteries narrow before the larger coronaries, so the complaint can arrive years ahead of a cardiac event, which is exactly why the sexual-medicine guidelines fold cardiovascular risk stratification into the ED work-up.

9.4 Assessment: history, morning testosterone, the ISSM labs and the IIEF-5

Clinical diagnosis, targeted bloods, one screening scale. Diagnosis rests on the clinical presentation, not on laboratory values; the examination emphasises the nervous, vascular and genital systems, looking for signs of hypogonadism (small testes, gynaecomastia, sparse body and facial hair). The ISSM (International Society for Sexual Medicine) recommends a focused panel of fasting glucose, HbA1c, lipids and a morning total testosterone (Kaplan and Sadock CTP 2024). The morning sample matters because testosterone follows a diurnal peak; a low result must be confirmed on a repeat before it is called hypogonadism. The abridged International Index of Erectile Function, the five-item IIEF-5 or Sexual Health Inventory for Men, both screens for and grades erectile dysfunction; the reproduced instrument sits in the accompanying scale plate. A separate five-item scale, the ASEX (Arizona Sexual Experience Scale), is the tool of choice for tracking psychotropic-induced sexual dysfunction across a one-week window, scored so that a

higher total means more dysfunction (Clinical Methods in Psychiatry, AIIMS 2024; Maudsley Prescribing Guidelines).

IIEF-5 BAND (OUT OF A POSSIBLE 25)	INTERPRETATION
22 to 25	No erectile dysfunction
17 to 21	Mild
12 to 16	Mild to moderate
8 to 11	Moderate
5 to 7	Severe

The IIEF-5 (Sexual Health Inventory for Men) severity bands; the five items each score up to 5, so the total runs from 5 to 25, read against these cut-offs (see gaps). The typeset form is reproduced in the accompanying scale plate.

GOOD TO REMEMBER

- **The ED work-up (guideline-anchored, ISSM):** diagnosis is clinical; order fasting glucose, HbA1c, lipids and a morning total testosterone, confirm any low testosterone before acting on it, and use the IIEF-5 to grade severity, a total in the 22-to-25 band out of a possible 25 meaning no erectile dysfunction and 5 to 7 out of a possible 25 meaning severe.

9.5 First-line management: the PDE5 inhibitor

An oral PDE5 inhibitor plus risk-factor optimisation, for everyone without a contraindication. First-line treatment of erectile dysfunction is a phosphodiesterase-5 inhibitor combined with lifestyle and cardiovascular risk-factor management (ISSM; BSSM; EAU male sexual dysfunction; AUA 2018). All the oral agents are similarly effective, and choice turns on how the man wants to use them: sildenafil is the high-efficacy pick and tadalafil the tolerability pick with the longest window. Sildenafil is taken on-demand, roughly one hour before intercourse, with a recommended **50 mg** starting dose titrated between 25 and 100 mg; onset is 30 to 60 minutes and the window runs up to 12 hours, with absorption delayed by a high-fat meal. Tadalafil on-demand starts at **10 mg** (range 10 to 20 mg), acts from about 30 minutes, and gives the longest window of any agent, up to 36 hours, with the least food effect. Tadalafil also has a once-daily low-dose regimen, 2.5 or 5 mg with 5 mg preferred, which decouples dosing from sexual activity and is the only PDE5 inhibitor licensed for concurrent erectile dysfunction and lower-urinary-tract symptoms of benign prostatic hyperplasia at 5 mg once daily. Vardenafil (start 10 mg) and avanafil (start 100 mg, the fastest onset, taken 15 to 30 minutes before) complete the class.

AGENT	ON-DEMAND DOSE (MG)	ONSET AND WINDOW	DISTINGUISHING POINT
Sildenafil	25, 50, 100; start 50	30 to 60 min; up to 12 h	**High-efficacy pick; high-fat meal delays absorption**
Tadalafil (on-demand)	10, 20; start 10	from 30 min; up to 36 h	**Longest window; least affected by food**
Tadalafil (once-daily)	2.5 or 5 once daily; use 5	continuous, off the clock of sex	**Only PDE5 inhibitor licensed for ED with LUTS or BPH**
Vardenafil	5, 10, 20; start 10	from about 30 min	**Orally disintegrating form available**
Avanafil	50, 100, 200; start 100	fastest; take 15 to 30 min before	**Quickest onset of the class**

The oral PDE5 inhibitors, all first-line and similarly effective; the doses are the verified EAU and AUA 2018 figures (EAU male sexual dysfunction; AUA 2018).

25	50	5	30
IIEF-5 TOP SCORE, NO-ED BAND STARTS AT 22	SILDENAFIL ON-DEMAND START (MG)	TADALAFIL ONCE-DAILY DOSE (MG)	DAPOXETINE ON-DEMAND START (MG)

INDIA

The generics are widely marketed in India: sildenafil (Manforce, Penegra), tadalafil (Tadacip, Megalis), and, for premature ejaculation, dapoxetine (Duralast, Sustinex, also sold in sildenafil and tadalafil fixed-dose combinations). Keep the generic primary and confirm the exact product and strength locally; the sexual-medicine advice is that dapoxetine should not routinely be combined with a PDE5 inhibitor because of syncope risk.

MNEMONIC

PILLS → POKES & PUMPS → PROSTHESIS

The ED treatment ladder in order: oral **Pills** (PDE5 inhibitor) first, then the injection and vacuum second line (**Pokes and Pumps**), then the surgical **Prosthesis** third line. You climb only when the rung below fails or is declined.

GOOD TO REMEMBER

- **First-line ED drug (guideline-anchored, ISSM, BSSM, EAU, AUA 2018):** an oral PDE5 inhibitor plus risk-factor optimisation; sildenafil starts at 50 mg on-demand about one hour before, tadalafil at 10 mg on-demand or 5 mg once daily, and tadalafil is the only agent licensed for concurrent ED and benign prostatic hyperplasia.

9.6 The absolute nitrate contraindication

One combination you never allow. The concurrent use of any organic nitrate, nitric oxide donor, nicorandil, or a recreational nitrite with any PDE5 inhibitor is an absolute contraindication (EAU male sexual dysfunction; AUA 2018). Both act on the nitric-oxide, cyclic-GMP pathway, so the combination causes cyclic-GMP to accumulate and can precipitate profound, unpredictable

hypotension. Before prescribing, ask specifically about nitrate use for angina and about recreational nitrites. Alpha-blockers are a caution rather than an absolute bar and may be co-prescribed carefully, watching for postural hypotension.

COMMON TRAP

Forgetting to ask about a nitrate. A man on a nitrate for angina, or using a recreational nitrite, must never receive a PDE5 inhibitor; screening for nitrate use is a mandatory step, not an optional one, and no dose is "safe" in this combination.

GOOD TO REMEMBER

- **PDE5 inhibitor caution (guideline-anchored, EAU and AUA 2018):** any organic nitrate, nitric oxide donor, nicorandil or recreational nitrite is an absolute contraindication with any PDE5 inhibitor because of cyclic-GMP accumulation and profound hypotension; alpha-blockers are a relative caution only.

9.7 Second-line and third-line therapy

When the tablet fails or is contraindicated, step down the ladder. Second-line options are for men in whom oral therapy fails or is contraindicated (EAU male sexual dysfunction; AUA 2018). Intracavernosal alprostadil is the most effective injectable monotherapy, dosed at 5 to 40 micrograms and producing an erection within 5 to 15 minutes, with over 70 percent efficacy but needing in-office injection training; its risks are penile pain, priapism and fibrosis. An intraurethral alprostadil pellet (MUSE, 125 to 1000 micrograms, usually initiated at 500 micrograms) and topical alprostadil cream (200 to 300 micrograms) are alternatives with more limited data. A vacuum erection device is a non-invasive, drug-free choice for well-informed men, with variable satisfaction. Third-line therapy is a surgically implanted penile prosthesis (inflatable or semi-rigid), reserved for when less-invasive options fail or the man wants a definitive solution; it has the highest satisfaction of any ED treatment, over 90 percent, its main risks being mechanical failure and infection in about 2 to 3 percent.

LINE	OPTION	DOSE OR FORM	KEY POINT
Second	Intracavernosal alprostadil	5 to 40 micrograms	**Most effective injectable; erection in 5 to 15 min; needs training**
Second	Intraurethral pellet (MUSE)	125 to 1000 micrograms, start 500	**Alternative for men declining injection; data more limited**
Second	Topical alprostadil cream	200 to 300 micrograms	**Non-injection local option**
Second	Vacuum erection device	mechanical device	**Non-invasive, drug-free; satisfaction variable**
Third	Penile prosthesis	inflatable or semi-rigid implant	**Highest satisfaction, over 90 percent; infection about 2 to 3 percent**

The second-line and third-line ED ladder, entered when oral PDE5 inhibitors fail or are contraindicated; the full stepwise route is drawn in the accompanying figure (EAU male sexual dysfunction; AUA 2018).

GOOD TO REMEMBER

- **Second and third-line ED therapy (guideline-anchored, EAU and AUA 2018):** after oral failure, intracavernosal alprostadil (5 to 40 micrograms, the most effective injectable) or a vacuum device is second line, and a penile prosthesis, with the highest satisfaction of any treatment, is third line.

9.8 Testosterone: test, then treat only confirmed hypogonadism

Measure it, but do not treat a normal level. Measure a morning total testosterone in any man with erectile dysfunction, low desire, or clinical signs of hypogonadism, and treat only biochemically confirmed hypogonadism (EAU male sexual dysfunction; AUA 2018). In a genuinely hypogonadal man who has not responded to a PDE5 inhibitor, adding testosterone can improve the response, so the two are complementary in that specific setting. What you must not do is give empirical, long-term testosterone for erectile dysfunction to a man whose testosterone is normal: it will not fix a eugonadal man's erectile dysfunction and it exposes him to the risks of unnecessary androgen therapy. This is the single commonest examined error in the topic.

TRAP **Starting long-term testosterone in a eugonadal man with erectile dysfunction.** Testosterone helps only when a low level is confirmed on a morning sample; in a man with normal testosterone it does not correct erectile dysfunction and adds needless risk. Test first, treat only proven hypogonadism.

GOOD TO REMEMBER

- **Testosterone principle (guideline-anchored, EAU and AUA 2018):** check a morning total testosterone, treat only confirmed hypogonadism, use it to rescue a hypogonadal PDE5-inhibitor non-responder, and never give empirical long-term testosterone for erectile dysfunction in a eugonadal man.

9.9 The ejaculatory disorders and hypoactive sexual desire

Three more entities, each with a clean discriminator. **Premature ejaculation** is ejaculation, before or within roughly one minute of penetration, that occurs sooner than the man wishes and causes distress; DSM-5-TR grades it as mild (about 30 seconds to 1 minute), moderate (about 15 to 30 seconds), or severe (at the start of, or within about 15 seconds of, penetration). Its pharmacological management, on-demand dapoxetine as the only licensed first-line agent (started at 30 mg, maximum 60 mg, not more than once every 24 hours), off-label daily SSRIs, topical anaesthetics, and behavioural methods, is developed in full in the dedicated premature ejaculation and dapoxetine topic. **Delayed ejaculation** is a marked delay in, infrequency of, or absence of ejaculation despite adequate stimulation; the crucial separation is from retrograde ejaculation, in which semen passes backward into the bladder, which always has an organic cause (genitourinary surgery, autonomic neuropathy, alpha-blocker or anticholinergic drugs). Male hypoactive sexual desire disorder is persistently deficient or absent sexual thoughts and desire for at least six months with distress, and it prompts a check of testosterone, mood, relationship factors and medication.

GOOD TO REMEMBER

- **Premature ejaculation (the diagnosis):** ejaculation within about one minute of penetration, sooner than wished, with distress and control lost; graded mild, moderate or severe by latency, with on-demand dapoxetine the only licensed first-line drug.
- **Delayed and retrograde ejaculation (the discriminator):** delayed ejaculation is a marked delay or absence of ejaculation; retrograde ejaculation, semen passing into the bladder, is a separate, always-organic entity tied to genitourinary surgery, autonomic neuropathy, or alpha-blocker and anticholinergic drugs.
- **Male hypoactive sexual desire disorder (the diagnosis):** persistently deficient or absent sexual thoughts and desire for at least six months with distress; the first step is to measure a morning testosterone and screen mood, medication and relationship factors.

HOLD THIS

Erectile dysfunction is first-line an oral PDE5 inhibitor (sildenafil start 50 mg on-demand, tadalafil start 10 mg on-demand or 5 mg once daily); a nitrate in any form is an absolute contraindication, and you never start long-term testosterone in a man whose testosterone is normal.

10 · Female sexual dysfunctions and their management

This topic mirrors the male-dysfunction page but flips the emphasis: the diagnostic map is a little denser (a merger and a subsuming category the examiner loves), and the management answer is deliberately un-showy, because the pharmacology is thin and the marks live in the **biopsychosocial** and couple-based first line. The high-yield facts are the DSM-5-TR trio and their shared gates, the single biggest reclassification (desire and arousal merged into one female disorder), and the one management principle that the whole chapter turns on: in women, psychological, relational and physiotherapeutic approaches lead, and drugs are a narrow, licence-limited adjunct.

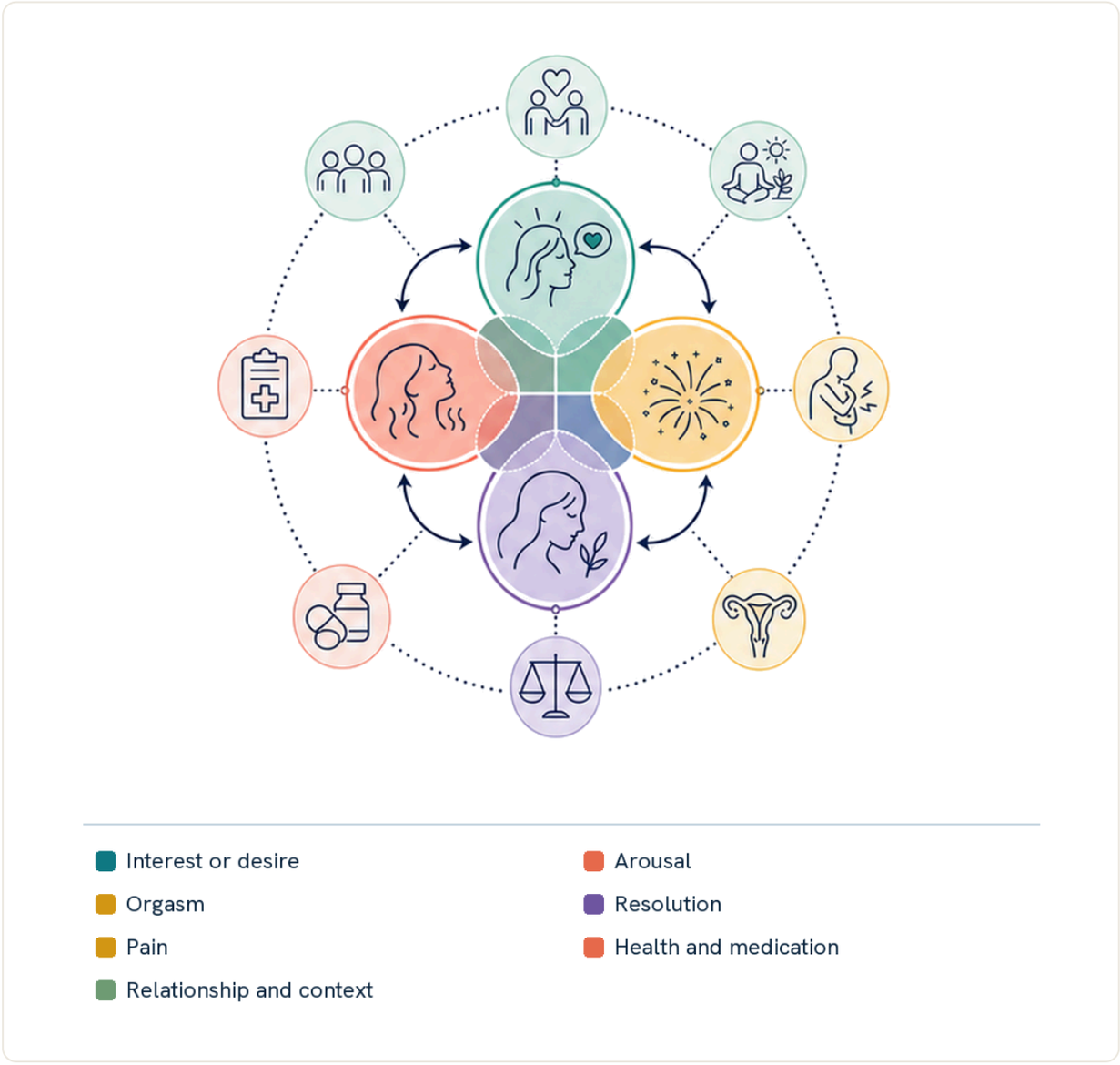


Fig 18.8 Female sexual response is non-linear and context-sensitive. Difficulties in interest, arousal, orgasm or pain may be shaped by physical health, medication, hormonal state and relational context.

How to use this page. First fix the DSM-5-TR and ICD-11 map of the female sexual dysfunctions; then take each of the three disorders in turn, learning the defining criterion and the one discriminator that keeps you out of trouble; then commit the multimodal management, biopsychosocial assessment, psychoeducation and sex therapy, the pelvic-floor and graded-dilator work that is specific to the pain-penetration disorder, local oestrogen for the menopausal cause of painful sex, and the two licensed drugs, which are covered fully in the dedicated flibanserin topic. The error this page is built to prevent is labelling painful sex psychogenic before an organic cause has been excluded.

10.1 The DSM-5-TR trio and the ICD-11 framing

Three female disorders, one shared set of gates, one big merger. DSM-5-TR recognises three **female sexual dysfunctions**: female sexual interest/arousal disorder, female orgasmic disorder, and genito-pelvic pain/penetration disorder (alongside substance or medication-induced sexual dysfunction, which is gender-neutral) (Kaplan and Sadock CTP 2024; DSM-5-TR 2022). The defining structural change from DSM-IV is that the old hypoactive sexual desire disorder and

female sexual arousal disorder were combined into a single interest-and-arousal category, on the evidence that low desire and low arousal co-occur so heavily in women that separating them is artificial. Whichever of the three you are diagnosing, the same qualifying gates apply: the symptom must persist for at least approximately six months, cause clinically significant distress in the woman herself, and not be better explained by a non-sexual mental disorder, severe relationship distress or partner violence, another medical condition, or a substance. Each is then specified as lifelong or acquired and graded mild, moderate or severe by distress. ICD-11 lifts the equivalent conditions out of the mental disorders chapter into a new chapter, "Conditions related to sexual health"; notably, and unlike DSM-5, ICD-11 does *not* merge desire and arousal, keeping hypoactive sexual desire dysfunction and female sexual arousal dysfunction as separate categories, with anorgasmia and a sexual pain-penetration disorder completing the female set (ICD-11).

DISORDER (DSM-5-TR)	CORE FEATURE	THE DISCRIMINATOR TO ATTACH
Female sexual interest/arousal disorder	Merged low desire and low arousal; at least three of six indicators	**A mere "desire discrepancy" with a partner is not the disorder**
Female orgasmic disorder	Marked delay, infrequency, absence, or reduced intensity of orgasm	**Clitoral-not-coital orgasm, and inadequate stimulation, are excluded**
Genito-pelvic pain/penetration disorder	Penetration difficulty, pain, fear of pain, or pelvic-floor tensing (any one of four)	**Subsumes vaginismus and dyspareunia; the only one with no generalized/situational specifier**

The three DSM-5-TR female sexual dysfunctions, each gated by the shared roughly-six-month, distress and exclusion criteria and specified lifelong or acquired; ICD-11 places the parallel set in its "Conditions related to sexual health" chapter but keeps desire and arousal apart (Kaplan and Sadock CTP 2024, DSM-5-TR 2022, ICD-11).

GOOD TO REMEMBER

- **The shared gates (every female dysfunction):** the symptom for at least approximately six months, causing clinically significant distress in the woman, not better explained by another mental disorder, severe relationship distress, a medical condition or a substance; then specify lifelong or acquired and grade by distress. The single biggest DSM-5 change is the merger of desire and arousal into one female disorder.

10.2 Female sexual interest arousal disorder, the merged desire and arousal disorder

At least three of six indicators, for at least approximately six months, with distress. Female sexual interest/arousal disorder requires a lack of, or significantly reduced, sexual interest or arousal shown by at least three of six indicators: reduced interest in sexual activity; reduced erotic thoughts or fantasies; no or reduced initiation and typical unreceptiveness to a partner's initiation; reduced excitement or pleasure during almost all (roughly 75 to 100 percent) encounters; reduced arousal to any internal or external erotic cues; and reduced genital or non-genital sensations during almost all encounters (DSM-5-TR 2022). Two diagnostic subtleties carry marks. First, a *desire discrepancy*, where a woman simply wants sex less often than her partner, is explicitly not sufficient for the diagnosis. Second, a lifelong lack of desire that is better

understood as an asexual identity is excluded. The concept of *responsive desire* matters clinically: many women do not begin an encounter with spontaneous desire but develop it once arousal is under way, so an assessment of the adequacy of sexual stimulation is part of the diagnosis, not an afterthought. Around 30 percent of women report chronic low desire, but only a fraction of those experience the personal distress the criteria demand.

RULE **Distress in the woman is the gate, not the frequency of sex.** Low desire, low arousal, or a mismatch with a partner is a disorder only when it persists for about six months and causes clinically significant distress in the woman herself; a desire discrepancy alone, or an asexual identity, is not female sexual interest/arousal disorder.

PEARL

Ask about **responsive desire** before you label a woman as having low desire. If desire reliably arrives once she is aroused with adequate, wanted stimulation, the problem may be the context, the stimulation or the relationship rather than a dysfunction, and the treatment is couple-based, not pharmacological.

GOOD TO REMEMBER

- **Female sexual interest arousal disorder (the merged desire and arousal disorder):** at least three of six Criterion A indicators of reduced sexual interest or arousal, for at least approximately six months, causing distress in the woman; a desire discrepancy with a partner and an asexual identity are both excluded, and the disorder combines the old hypoactive desire and female arousal diagnoses.

10.3 Female orgasmic disorder

Delay, infrequency, absence, or reduced intensity of orgasm on almost all occasions. Female orgasmic disorder, historically called inhibited female orgasm or anorgasmia, is a marked delay in, marked infrequency of, or absence of orgasm, or a markedly reduced intensity of orgasmic sensations, experienced on almost all (roughly 75 to 100 percent) occasions of sexual activity for at least approximately six months and causing distress (DSM-5-TR 2022; Kaplan and Sadock CTP 2024). Two exclusions do the discriminating. A woman who reaches orgasm with clitoral stimulation but not during penile-vaginal intercourse does *not* meet the criteria, because clitoral-dependent orgasm is a normal variant, not a disorder. And where orgasm difficulty is the result of demonstrably inadequate sexual stimulation, the diagnosis is not made even though the woman may still need help. The lifelong subtype, present since the woman first became sexually active, can be specified further as "never experienced an orgasm under any situation," which is the classic indication for the directed-masturbation programme. Internationally, roughly 10 percent of women report never experiencing orgasm across their lifetime.

GOOD TO REMEMBER

- **Female orgasmic disorder (the diagnosis):** marked delay, infrequency, absence or reduced intensity of orgasm on about 75 to 100 percent of occasions, for at least approximately six months, with distress; a clitoral-only (non-coital) orgasm and orgasm difficulty from inadequate stimulation are both excluded, and the lifelong "never orgasmed" subtype is the target for directed masturbation.

10.4 Genito-pelvic pain penetration disorder, subsuming vaginismus and dyspareunia

One category built from four complaints, any one of which qualifies. Genito-pelvic pain/penetration disorder gathers the two older diagnoses of vaginismus and dyspareunia into a single category defined by persistent difficulty with one or more of: vaginal penetration during intercourse; marked vulvovaginal or pelvic pain during penetration attempts; marked fear or anxiety about that pain; and marked tensing or tightening of the pelvic-floor muscles on attempted penetration, for at least approximately six months with distress (DSM-5-TR 2022). Because these four so often drive one another (fear leads to guarding, guarding to pain, pain to more fear), DSM-5-TR reasoned it was cleaner to combine them, though the split remains useful clinically. The single most important step is not psychiatric at all: somatic causes of painful sex must be actively excluded, because a substantial minority of women presenting to sex-therapy clinics have identifiable pelvic pathology.

Vaginismus (historical term)

Involuntary spasm or tensing of the pelvic-floor and perivaginal muscles that prevents or makes painful any vaginal penetration; now the "penetration/tensing/fear" pole of genito-pelvic pain penetration disorder.

Dyspareunia (historical term)

Recurrent or persistent genital pain before, during or after intercourse; DSM-5-TR notes roughly 15 percent of North American women report recurrent painful intercourse. Somatic causes must be ruled out first.

Genitourinary syndrome of menopause

Oestrogen-deficiency vulvovaginal atrophy causing dryness and dyspareunia in peri- and post-menopausal women; the leading organic driver of acquired painful sex, and the one with a specific, effective treatment.

TRAP **Calling painful sex psychogenic before excluding an organic cause.** Dyspareunia and the pain-penetration disorder demand a genital and pelvic examination first: genitourinary syndrome of menopause, infections, vulvodynia, endometriosis, episiotomy scarring and dermatoses all cause it, and up to a third of sex-clinic attenders with the complaint have pelvic pathology. Rule out the organ before you formulate the mind.

INDIA

In Indian sexual-medicine and psychiatry practice, genito-pelvic pain/penetration disorder frequently presents not as "painful sex" but as **non-consummation of marriage**, often as a couple, sometimes with the man's erectile difficulty layered on, and typically laden with cultural expectation and shame. Neither licensed female-desire drug (flibanserin, bremelanotide) is marketed in India, so Indian management leans even harder on psychoeducation, couple therapy, graded dilators and pelvic-floor work; local oestrogen preparations for menopausal atrophy are, however, readily available generically. Frame the assessment for the couple, non-judgementally, and rule out organic pathology early.

GOOD TO REMEMBER

- **Genito-pelvic pain penetration disorder (subsuming vaginismus and dyspareunia):** persistent difficulty with any one of four (penetration, vulvovaginal or pelvic pain, fear of that pain, pelvic-floor tensing), for at least approximately six months with distress; it is the only female dysfunction with no generalized/situational specifier, and the first step is always to exclude an organic cause of the pain.

10.5 Biopsychosocial assessment and the multimodal management

Assess and treat biopsychosocially first; psychological and couple-based approaches lead. The ISSM (International Society for Sexual Medicine) and the general consensus frame female sexual dysfunction as biopsychosocial, so assessment and management run in parallel across relationship factors, mood and anxiety, medication effects, hormonal and genital contributors, and the woman's beliefs and knowledge about sex (ISSM; Kaplan and Sadock CTP 2024). Assessment is clinical, supported where useful by a rating instrument: the FSFI (Female Sexual Function Index), a nineteen-item scale across six domains, is the standard measure, with a validated cut-off at or below **26.55** flagging a woman at risk of sexual dysfunction (Rosen et al 2000; Wiegel et al 2005); the validated cut-off is carried in the text. Management is multimodal and stepwise: first, *psychoeducation* that corrects myths and reframes the response cycle; second, *treat the contributors*, which means optimising mood and anxiety, reviewing and where possible switching a culprit drug (antidepressant-induced dysfunction is developed in the Mood disorders: pharmacotherapy notes, and antipsychotic hyperprolactinaemia in the Schizophrenia: management, antipsychotics and adverse effects notes), and treating hormonal or genital pathology; third, *sex therapy*. The core behavioural method is sensate focus (Masters and Johnson), a graded programme of non-demand mutual pleasuring with intercourse initially interdicted, which lifts performance pressure and interrupts **spectatoring** (the anxious self-observation that sabotages arousal). Disorder-specific techniques layer on top: lifelong female orgasmic disorder is treated with directed masturbation, sometimes with a vibrator, plus Kegel exercises to build pelvic-floor awareness.

MODALITY	BEST SUITED TO	WHAT IT DOES
Psychoeducation	All three disorders	**Corrects myths, reframes the response cycle and responsive desire**
Treat the contributors	Acquired dysfunction of any kind	**Mood, anxiety, culprit drugs, hormonal and genital pathology**
Sensate focus (sex therapy)	Interest/arousal and orgasmic disorder, as a couple	**Non-demand pleasuring, intercourse banned early, ends spectatoring**
Directed masturbation and Kegels	Lifelong female orgasmic disorder	**Self-exploration to first orgasm; pelvic-floor awareness**
Pelvic-floor physiotherapy and graded dilators	Genito-pelvic pain/penetration disorder	**Desensitises penetration, retrains guarding; see 10.6**

The multimodal management of the female sexual dysfunctions, biopsychosocial and psychological-first; the full stepwise route is biopsychosocial-first (ISSM; Kaplan and Sadock CTP 2024).

3	6	26.55	100
FSIAD CRITERION A INDICATORS NEEDED, FROM A SET OF SIX	MONTHS MINIMUM DURATION FOR EVERY DYSFUNCTION	FSFI CUT-OFF FLAGGING FEMALE SEXUAL DYSFUNCTION	FLIBANSERIN BEDTIME DOSE (MG PER DAY)

MNEMONIC

PLISSIT

The escalating sex-therapy framework (Annon): **P**ermission (normalise and permit the sexual concern), **LI** Limited Information (targeted education), **SS** Specific Suggestions (concrete behavioural tasks such as sensate focus, dilators or directed masturbation), and **IT** Intensive Therapy (referral for in-depth psychotherapy). Most female sexual dysfunction is resolved at the first three, lighter levels, which is exactly why the drugs sit so far down the list.

GOOD TO REMEMBER

- **Multimodal management (guideline-anchored, ISSM, biopsychosocial):** assess and treat biopsychosocially, lead with psychoeducation, treat the contributors (mood, anxiety, culprit drugs, hormones), and use sensate focus as the core sex-therapy method, with directed masturbation for lifelong female orgasmic disorder; the FSFI (cut-off at or below 26.55) grades severity, and pharmacology is a narrow adjunct, not the first move.

10.6 The pain-penetration physiotherapy, local oestrogen, and the limited drug options

For pain and penetration, physiotherapy and graded dilators; for menopausal atrophy, local oestrogen; drugs are last and licence-limited. Genito-pelvic pain/penetration disorder has the most concrete physical management of the three: pelvic-floor physiotherapy and progressive vaginal trainers, in which the woman uses her own fingers or size-graduated dilators to desensitise penetration and unlearn the protective muscle guarding, ideally with a pelvic-floor physiotherapist, and combined with the psychological and sex-therapy work described above (Kaplan and Sadock CTP 2024). Where the driver is genitourinary syndrome of menopause, low-

dose local vaginal oestrogen (for example estriol or estradiol cream or pessary) is effective for the dryness and dyspareunia and is preferred over systemic hormone therapy for isolated urogenital symptoms (NICE NG23 menopause 2015; ISSM). Pharmacotherapy for low desire is genuinely limited: the two agents licensed anywhere, flibanserin (a 5-HT1A agonist and 5-HT2A antagonist, 100 mg once daily at bedtime) and bremelanotide (a melanocortin agonist, 1.75 mg subcutaneously on demand), are approved only for acquired, generalised hypoactive sexual desire disorder in *premenopausal* women, and both are covered in full, with their boxed warnings and cautions, in the dedicated flibanserin topic (Addyi FDA label 2015; Vyleesi FDA label 2019). PDE5 inhibitors are not established for female sexual dysfunction (results are inconsistent), and systemic testosterone for female low desire is off-label and unapproved in most jurisdictions; the overall pharmacological evidence base is weak, which is precisely why couple-based and psychological approaches remain the lead.

GOOD TO REMEMBER

- **Pain-penetration and oestrogen management (guideline-anchored):** genito-pelvic pain penetration disorder is treated with pelvic-floor physiotherapy and graded dilators plus the psychological work; menopausal dyspareunia (genitourinary syndrome of menopause) is treated with low-dose local vaginal oestrogen, preferred over systemic therapy for isolated urogenital symptoms (NICE NG23).
- **The limited drug options (guideline-anchored):** flibanserin (100 mg once daily at bedtime) and bremelanotide (1.75 mg subcutaneous, on demand) are licensed only for acquired, generalised hypoactive sexual desire disorder in premenopausal women; PDE5 inhibitors are not established and systemic testosterone is off-label. Full pharmacology sits in the dedicated flibanserin topic.

HOLD THIS

The female sexual dysfunctions are the DSM-5-TR trio, female sexual interest/arousal disorder (desire and arousal merged), female orgasmic disorder, and genito-pelvic pain/penetration disorder (vaginismus plus dyspareunia), each gated by about six months and distress; management is biopsychosocial-first (psychoeducation, sensate focus, dilators and pelvic-floor work, local oestrogen for menopausal painful sex), and the only licensed drugs treat premenopausal acquired generalised low desire alone.

11 · Dapoxetine and flibanserin

These two agents pair naturally as a compact pharmacology question: both are *repurposed serotonergic drugs licensed for a single sexual dysfunction*, one for the man and one for the woman, and each carries a small cluster of verified facts, a dose, a timing, a label restriction, and one signature caution, that the examiner can pull straight out. **Dapoxetine** is the short-acting, on-demand pill taken before sex for **premature ejaculation**; **flibanserin** is the daily bedtime pill taken for months for **hypoactive sexual desire disorder** in premenopausal women. Confuse their dosing rhythms and you lose the mark; hold the rhythm and the rest follows.

How to use this page. Learn each drug as a triad: what it is (mechanism and class), how it is dosed (the verified on-demand versus daily rhythm), and its one examinable caution. Then read the pair against each other, because the discriminator most often tested is the licensing restriction, on-

demand for **premature ejaculation** against acquired, generalised, **premenopausal** HSDD, and the single interaction that gets each drug into trouble.

11.1 Dapoxetine: the on-demand short-acting SSRI for premature ejaculation

The only agent licensed for on-demand treatment of premature ejaculation. Dapoxetine is a **short-acting SSRI** developed specifically for premature ejaculation, and it is the first and only drug approved for its **on-demand** treatment (Kaplan and Sadock CTP 2024; New Oxford Textbook of Psychiatry). The sexual-medicine and regulatory positions are uniform: an **on-demand SSRI** is the first-line pharmacological option for lifelong premature ejaculation (ISSM 2014; EAU male sexual dysfunction; AUA 2018), and the drug is licensed for this indication under the label recommendation of a **30 mg** starting dose taken **1 to 3 hours** before sexual activity (NICE ESNM40; Priligy SPC). It is titrated upward only if the starting dose is insufficient and tolerated, to a maximum **60 mg**, and it is never taken more than once every 24 hours. Benefit and risk are reappraised after the first 4 weeks or at least 6 doses.

Why the on-demand rhythm works. Unlike the long-acting SSRIs (paroxetine, sertraline, fluoxetine, citalopram), which delay ejaculation only when taken daily for a fortnight or more and are unsuitable as an as-needed drug, dapoxetine is absorbed and cleared rapidly, so a single pre-coital dose raises synaptic serotonin over the window that matters and then washes out. Its common adverse effects are the expected serotonergic ones, nausea, dizziness, headache and diarrhoea, together with an orthostatic, syncope-prone effect that drives its cardinal interaction rule (Priligy SPC). It is contraindicated in significant cardiac disease and in a history of mania or severe depression.

FEATURE	DAPOXETINE (VERIFIED)
Class	Short-acting, on-demand SSRI
Indication	Premature ejaculation (the only licensed on-demand agent)
Start dose (mg)	30, taken 1 to 3 hours before activity
Ceiling dose (mg)	60, only if 30 is insufficient and tolerated
Frequency	Not more than once every 24 hours
Review	Reappraise after 4 weeks or at least 6 doses
Signature caution	Do not combine with a PDE5 inhibitor (syncope); avoid in cardiac disease and in a mania or severe-depression history

Dapoxetine at a glance: the on-demand short-acting SSRI for premature ejaculation, with its verified label doses and the PDE5-inhibitor caution (ISSM 2014; NICE ESNM40; Priligy SPC).

PEARL

The pharmacokinetics are the point. A chronic SSRI blunts ejaculation through gradual receptor adaptation that takes days to build, which is why paroxetine and its peers must be taken every day off-label. Dapoxetine's rapid absorption and short half-life invert that logic: it acts within about an hour and clears quickly, so it can be swallowed only when needed, roughly 1 to 3 hours ahead. That single kinetic difference, not any special receptor trick, is what makes it the on-demand agent.

INDIA

Dapoxetine is heavily marketed in India: lead the generic, with Duralast and Sustinex the common brands, and it is also sold in sildenafil-dapoxetine and tadalafil-dapoxetine fixed-dose combinations. The verified caution runs against exactly those combinations, since the Priligy SPC advises against pairing dapoxetine with a PDE5 inhibitor because of syncope risk; keep the generic primary and confirm the exact product and strength locally before any prescribing use. Flibanserin has no established routine Indian presence, so it is examined as a name to recognise rather than a drug to prescribe here.

GOOD TO REMEMBER

- **Dapoxetine (guideline-anchored, ISSM 2014, NICE ESNM40, Priligy SPC):** the only agent licensed for on-demand premature ejaculation; a short-acting SSRI started at 30 mg taken 1 to 3 hours before activity, raised to a maximum 60 mg only if needed and tolerated, not more than once every 24 hours, and never combined with a PDE5 inhibitor because of syncope risk.

11.2 Flibanserin: the daily bedtime pill for premenopausal HSDD

A daily serotonergic agent for acquired, generalised HSDD in premenopausal women. Flibanserin (brand Addyi) is a 5-HT1A agonist and 5-HT2A antagonist that, in the prefrontal cortex, lowers serotonin while raising noradrenaline and dopamine activity; it was originally trialled as an antidepressant, failed, and was repurposed for desire (Kaplan and Sadock CTP 2024; Goodman and Gilman). It is one of the two FDA-approved agents (with bremelanotide) for acquired, generalised hypoactive sexual desire disorder (HSDD) in **premenopausal** women only, and its licensed dose is **100 mg** once daily at bedtime (Addyi FDA label 2015). Unlike dapoxetine it is a maintenance, not an as-needed, drug: it is taken every night for weeks, and it is discontinued after 8 weeks if there is no improvement.

Modest effect, three named cautions. The efficacy is real but modest, a small rise in satisfying sexual events and desire with reduced desire-related distress (Tasman; New Oxford Textbook of Psychiatry). Its adverse-effect and interaction profile is where marks sit: hypotension, syncope, somnolence, dizziness, nausea and dry mouth (Maudsley Prescribing Guidelines). The bedtime timing is deliberate, limiting daytime hypotension and sedation. It carries a boxed warning for severe hypotension and syncope with alcohol and with strong CYP3A4 inhibitors, so alcohol co-use and CYP3A4 interactions are the two cautions to state, alongside its CNS-depressant, sedating profile. Reassuringly, it appears safe in women already taking antidepressants (Maudsley Prescribing Guidelines).

FEATURE	FLIBANSERIN (VERIFIED)
Mechanism	5-HT1A agonist, 5-HT2A antagonist (lowers cortical serotonin, raises noradrenaline and dopamine)
Indication	Acquired, generalised HSDD in premenopausal women only
Dose (mg)	100 once daily at bedtime
Rhythm	Daily maintenance; stop at 8 weeks if no benefit
Effect size	Modest
Signature cautions	Alcohol and strong CYP3A4 inhibitors (hypotension, syncope); CNS depression and sedation

Flibanserin at a glance: the daily bedtime pill for premenopausal, acquired, generalised HSDD, with its modest effect and the alcohol, CYP3A4 and CNS-depression cautions (Addyi FDA label 2015; Maudsley Prescribing Guidelines).

GOOD TO REMEMBER

- **Flibanserin (guideline-anchored, Addyi FDA label 2015):** a 5-HT1A agonist and 5-HT2A antagonist for acquired, generalised HSDD in premenopausal women, dosed 100 mg once daily at bedtime, of modest effect, stopped at 8 weeks if no benefit; the examinable cautions are alcohol and strong CYP3A4 inhibitors (hypotension and syncope) plus its sedating, CNS-depressant profile.

11.3 Reading the pair: on-demand versus daily, and the label restrictions

Two rhythms, two label boxes, two cautions. The pair is designed to be discriminated. Dapoxetine is *on-demand and short-acting*, swallowed before a single act of sex for premature ejaculation, its trap being combination with a PDE5 inhibitor. Flibanserin is *daily and maintenance*, taken every bedtime for premenopausal HSDD, its trap being alcohol. The restriction most often tested on flibanserin is the population box: it is licensed only for *acquired* (not lifelong), *generalised* (not situational), *premenopausal* HSDD, so offering it to a postmenopausal woman or for a situational, relationship-bound loss of desire is off-label and off-target.

AXIS	DAPOXETINE	FLIBANSERIN
Target	Premature ejaculation (men)	**Acquired, generalised HSDD (premenopausal women)**
Class	Short-acting SSRI	**5-HT1A agonist, 5-HT2A antagonist**
Rhythm	On-demand, 1 to 3 hours before	**Daily, at bedtime**
Dose (mg)	30 start, up to 60 max	**100 once daily**
Signature caution	Not with a PDE5 inhibitor (syncope)	**Not with alcohol or strong CYP3A4 inhibitors (hypotension, syncope)**
Review point	After 4 weeks or 6 doses	**Stop at 8 weeks if no benefit**

The discrimination table for the pair; the contrast in dosing rhythm and licensed population is the highest-yield line, and the two kinetic profiles could hardly differ more (ISSM 2014; NICE ESNM40; Addyi FDA label 2015).

30	60	100	8
DAPOXETINE START DOSE (MG)	DAPOXETINE CEILING DOSE (MG)	FLIBANSERIN NIGHTLY DOSE (MG)	FLIBANSERIN REVIEW POINT (WEEKS)

RULE **The rhythm names the drug and the caution.** On-demand short-acting SSRI before sex means dapoxetine for premature ejaculation, caution the PDE5 inhibitor; daily bedtime 5-HT1A agonist for premenopausal, acquired, generalised HSDD means flibanserin, caution the alcohol.

TRAP **Prescribing flibanserin as an on-demand libido pill, or ignoring its label box.** It is a daily maintenance drug, not a pre-sex tablet, and it is licensed only for acquired, generalised HSDD in premenopausal women; offering it to a postmenopausal woman, for situational loss of desire, or without the alcohol and CYP3A4 warning is the classic error.

COMMON TRAP

Pairing dapoxetine with a PDE5 inhibitor. It is tempting when a man reports both premature ejaculation and erectile difficulty, and Indian fixed-dose combinations make it easy, but the Priligy SPC advises against the combination because of syncope risk. Treat the dominant complaint first and keep the two apart unless a specialist judges otherwise.

HOLD THIS

Dapoxetine is the on-demand short-acting SSRI for premature ejaculation, 30 mg (up to 60) taken 1 to 3 hours before sex and never with a PDE5 inhibitor; flibanserin is the daily bedtime 5-HT1A agonist / 5-HT2A antagonist for acquired, generalised, premenopausal HSDD, 100 mg nightly, of modest effect and never with alcohol.

12 · Paraphilic disorders

This topic is examined less on the exotic list of behaviours and more on one clean conceptual line: the difference between a **paraphilia**, an atypical sexual interest that is not in itself a disorder, and a **paraphilic disorder**, which the current nosology reserves for a paraphilia that

either causes the person *distress* or impairment or entails *harm*, or the risk of it, to another, usually non-consenting, person. Get that threshold right and most of the marks follow; miss it and you pathologise a private, harmless preference or, worse, treat a criminal charge as if the label alone made a diagnosis. The class also carries a genuine forensic and risk-assessment dimension the psychiatrist is asked to comment on, and a graded, guideline-anchored management answer that candidates rarely rehearse.

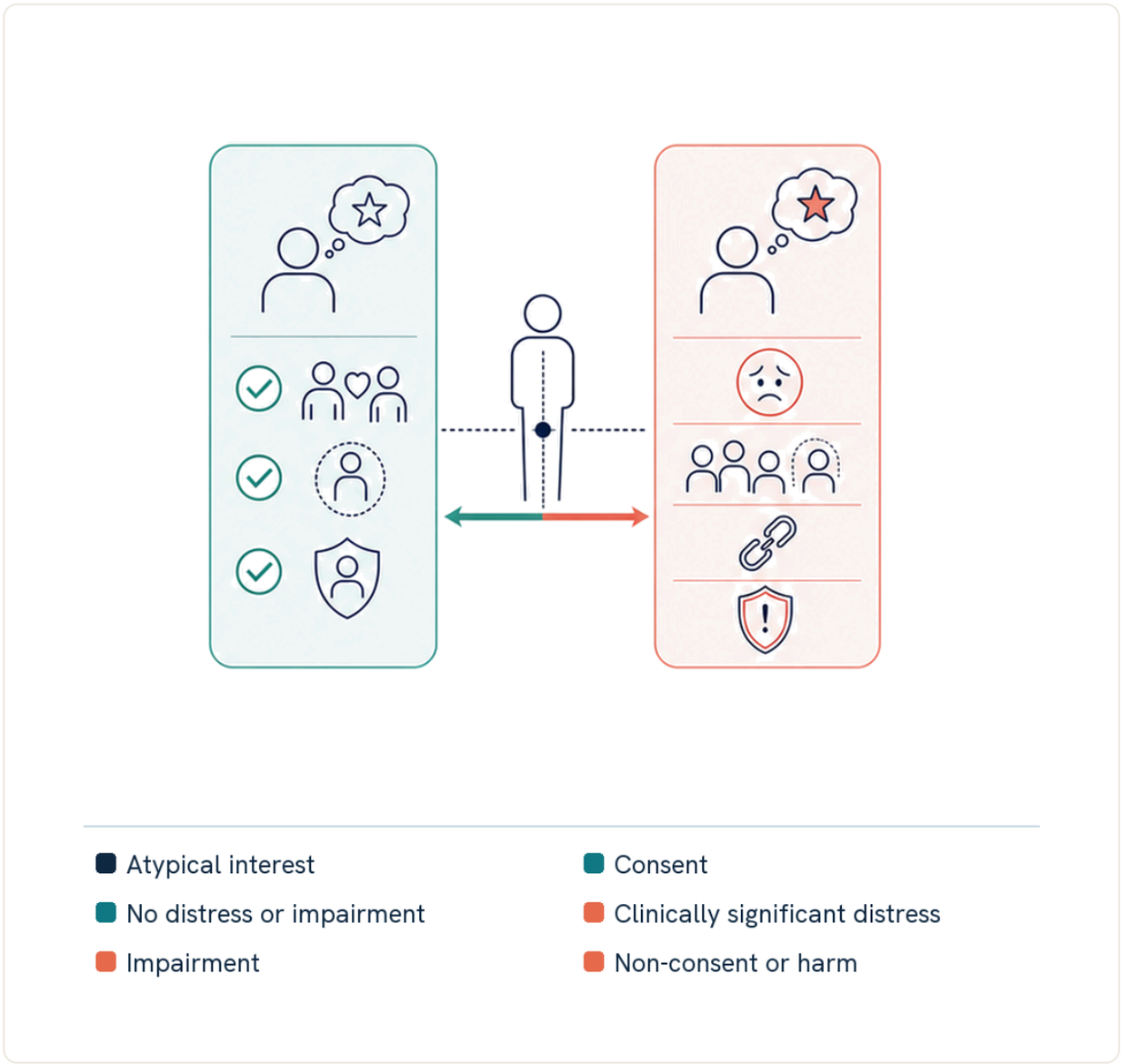


Fig 18.9 An atypical sexual interest is not by itself a disorder. A paraphilic disorder requires clinically significant distress or impairment, or behaviour involving a non-consenting person or substantial risk of harm.

How to use this page. First fix the paraphilia-against-disorder distinction and the shared criteria that gate every entity; then learn the eight named DSM-5-TR types and the sharp place where ICD-11 parts company; then the forensic frame, where the cardinal error is diagnosing from the offence rather than the sexual preference; and finally the **management of paraphilia**, psychological relapse-prevention first, with SSRIs and, for severe or high-risk cases, testosterone-lowering antiandrogen or GnRH-agonist treatment reserved for the top of the ladder. The combined map of the paraphilic and impulse-control classes is drawn in the accompanying figure

at the impulse-control block; refer to it there. The tone throughout is clinical, nosological, and non-graphic.

12.1 Paraphilia against paraphilic disorder: the consent, distress and harm threshold

An interest is not a disorder until it crosses a threshold. DSM-5 and DSM-5-TR define a paraphilia as "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (Kaplan and Sadock CTP 2024; DSM-5-TR 2022). The pivotal 2013 move was to separate that interest from the paraphilic disorder, defined as a paraphilia that is *currently causing distress or impairment to the individual*, or *a paraphilia whose satisfaction has entailed personal harm, or the risk of harm, to others*. In other words a paraphilia is a disorder only when criterion B is met: the person is distressed or impaired, or the interest is acted on with, or poses a risk to, a non-consenting person. This preserves the line between non-normative and pathological sexual behaviour without branding every unusual preference a mental illness. Across every named entity the shared gates are the same: the pattern is present for at least six months, and either causes clinically significant distress or impairment, or the urges have been acted on with a non-consenting person.

RULE **Distress, impairment, or harm to a non-consenting other is what makes a paraphilia a disorder.** The atypical interest alone is not diagnosable; you need criterion B, distress or impairment to the person, or personal harm or the risk of it to another who has not consented. Consent, distress and harm are the three words that carry the diagnosis.

GOOD TO REMEMBER

- **Paraphilic disorder (the defining criterion):** an intense, persistent atypical sexual interest present for at least six months that *either* causes the individual clinically significant distress or impairment *or* is acted on with, or risks harm to, a non-consenting person; without that criterion B threshold it is a paraphilia, not a disorder.

12.2 The named types, and where ICD-11 parts from DSM-5-TR

Eight named disorders in DSM-5-TR, grouped three ways. DSM-5-TR names eight specific paraphilic disorders, organised into anomalous *activity* preferences (voyeuristic disorder, exhibitionistic disorder, frotteuristic disorder), *algolagnic* disorders of pain and suffering (sexual masochism disorder and sexual sadism disorder), and anomalous *target* preferences (paedophilic disorder, fetishistic disorder, transvestic disorder), with residual "other specified" and "unspecified" categories replacing the old NOS label (Kaplan and Sadock CTP 2024; DSM-5-TR 2022). The activity-preference and sadism disorders require that the urges be acted on with a non-consenting person, or that they cause marked distress or impairment; the target-preference disorders can qualify on distress or impairment alone. Two age anchors are examined: for paedophilic disorder the individual must be at least 16 years of age and at least five years older than the prepubescent child, generally 13 years of age or younger; for voyeuristic disorder the individual must be at least 18 years of age. Course specifiers, "in a controlled environment" and "in full remission", apply to all except paedophilic disorder.

ICD-11 draws the line by consent, and drops three DSM entities. The ICD-11 "Paraphilic disorders" grouping is built explicitly around whether the arousal focus is on non-consenting others or on solitary or consenting behaviour. It lists exhibitionistic (6D30), voyeuristic (6D31), paedophilic (6D32), coercive sexual sadism (6D33) and frotteuristic (6D34) disorders, plus a catch-all for other paraphilic disorder involving non-consenting individuals (6D35), and a separate residual for paraphilic disorder involving solitary behaviour or consenting individuals (6D36), diagnosed only where there is marked distress and not merely because the behaviour is socially disapproved (ICD-11 CDDR). Crucially, ICD-11 *removed* fetishistic disorder, fetishistic transvestism and sadomasochism as named disorders, on the reasoning that private, consensual variants are not, by themselves, mental disorders. That DSM-keeps / ICD-drops split for fetishism and transvestism is a favourite discriminator.

DISORDER	CORE AROUSAL FOCUS	AGE OR DURATION ANCHOR	THE ONE THING TO ATTACH
Exhibitionistic disorder	Exposing one's genitals to an unsuspecting person	At least six months	**One of the three commonest offences in police records (with voyeurism and paedophilia)**
Voyeuristic disorder	Observing an unsuspecting person naked or in sexual activity	Individual at least 18 years of age	**The only paraphilia with a stated minimum age for the diagnosis**
Frotteuristic disorder	Touching or rubbing against a non-consenting person	At least six months	**Typically in crowded settings; from French "frotter", to rub**
Paedophilic disorder	Prepubescent child, generally 13 years of age or younger	Individual at least 16 years and at least five years older	**No course specifiers; the forensic core of the class**
Sexual sadism disorder	Physical or psychological suffering of another	At least six months	**ICD-11 names only the coercive, non-consenting form (6D33)**
Sexual masochism disorder	Being humiliated, beaten, bound or made to suffer	At least six months	**Often benign; asphyxiophilia is the dangerous specifier**
Fetishistic disorder	Non-living objects or a specific non-genital body part	At least six months	**Kept in DSM-5-TR; removed from ICD-11**
Transvestic disorder	Sexual arousal from cross-dressing	At least six months	**Kept in DSM-5-TR; removed from ICD-11. Not the same as gender incongruence**

The eight DSM-5-TR paraphilic disorders and their discriminators; ICD-11 retains only the five non-consenting-focused disorders plus two residual codes and drops fetishistic, transvestic and sadomasochism as named entities (Kaplan and Sadock CTP 2024; DSM-5-TR 2022; ICD-11 CDDR).

PEARL

Read the "in a controlled environment" and "in full remission" specifiers carefully. The absence of paraphilic behaviour in a prison or secure unit, where opportunity is removed, is *not* remission; it is simply a controlled environment. Full remission requires no acting on the urges with a non-consenting person and no distress or impairment for at least five years while in an *un*controlled setting, which is why a quiet custodial record cannot, on its own, be read as recovery.

GOOD TO REMEMBER

- **Exhibitionistic disorder (the criterion):** recurrent, intense arousal from exposing the genitals to an unsuspecting person for at least six months, acted on with a non-consenting person or causing distress or impairment; exhibitionism is one of the three commonest offences in police records.
- **Voyeuristic disorder (the discriminator):** arousal from observing an unsuspecting naked or sexually active person; the individual must be at least 18 years of age, the only paraphilia with a stated minimum diagnostic age, distinguishing it from adolescent curiosity.
- **Frotteuristic disorder (the criterion):** arousal from touching or rubbing against a non-consenting person, usually in a crowd, acted on or causing distress or impairment.
- **Paedophilic disorder (the criterion):** recurrent, intense arousal to a prepubescent child, generally 13 years of age or younger, with the individual at least 16 years of age and at least five years older than the child; it uniquely carries no course specifiers.
- **Fetishistic and transvestic disorder (the divergence):** both remain named DSM-5-TR disorders (objects or non-genital body parts; cross-dressing), but ICD-11 has removed them, treating private, consensual variants as non-disordered.

12.3 The forensic and risk-assessment dimension

A paraphilic disorder is a diagnosis; a sex offender is a legal category, and the two are not interchangeable. The term "sex offender" describes a person legally convicted of a sexual offence and says nothing about the presence or absence of a paraphilia; conversely a person with a paraphilia may never offend, obtaining gratification through fantasy alone (Kaplan and Sadock CTP 2024). The diagnosis rests on the individual's *sexual preference*, established through a comprehensive psychosexual evaluation, collateral history and, where used, objective measures, penile plethysmography (phallometry), visual reaction time and, in mandated settings, the sexual-history polygraph, since self-report is unreliable and there is no definitive test. Crossover between paraphilias is common, so a single presentation should prompt a review for the others. Risk is best estimated with structured actuarial instruments such as the Static-99R, which the evidence shows predict relative recidivism risk more accurately than unstructured clinical judgement, and clinicians must also weight the dynamic risk factors, deviant sexual interest, sexual preoccupation, poor self-regulation, intimacy deficits and offence-supportive attitudes.

TRAP **Diagnosing the paraphilia from the offence, or equating "sex offender" with a paraphilic disorder.** A man who has molested a child may have paedophilic disorder, but the same act can arise from intellectual disability, a manic episode, dementia or intoxication; you diagnose from the sustained pattern of sexual *preference*, not from the behaviour or the conviction alone.

WORKED EXAMPLE

A man is referred after exposing himself; he is distressed, describes a decade of recurrent urges to expose to unsuspecting strangers, and has acted on them repeatedly. That sustained pattern, with acting on the urges toward non-consenting others, supports exhibitionistic disorder. Contrast a first-ever episode of public undressing during a florid manic episode, with no prior deviant arousal: here the behaviour is a symptom of the mood disorder, and a paraphilic diagnosis would be wrong. Screen him for the other paraphilias, because crossover is the rule, and estimate risk with a structured actuarial tool rather than a gut impression.

12.4 Management principles: the graded, psychological-first ladder

The management of paraphilia is graded to severity and risk, and begins with psychological work. There is no evidence any paraphilic disorder can be "cured"; the realistic goal is control of behaviour and reduction of risk (New Oxford Textbook of Psychiatry). The World Federation of Societies of Biological Psychiatry (WFSBP) algorithm assigns treatment by severity: the less severe are managed with psychotherapy alone, while more severe or higher-risk presentations add pharmacotherapy on top (Kaplan and Sadock CTP 2024). The empirically supported psychological approach is structured cognitive-behavioural treatment, historically framed as relapse prevention, targeting the cognitive distortions (minimisations, justifications) and the offence cycle, and increasingly delivered through strength-based rehabilitation frameworks, the Good Lives Model and the Risk-Need-Responsivity model. Meta-analysis finds cognitive-behavioural treatment reduces reoffending more than didactic or purely psychodynamic work, and is comparable to antiandrogen treatment in effect; a non-judgemental, empathic therapist improves outcomes regardless of the programme's orientation.

MNEMONIC

PSYCHOTHERAPY → SSRI → ANTIANDROGEN → GnRH AGONIST

The WFSBP severity ladder for the management of paraphilia: cognitive-behavioural relapse-prevention for the less severe, an SSRI added as the first drug step, then a testosterone-lowering antiandrogen, and a long-acting GnRH agonist at the top for severe, treatment-refractory or high-risk cases. You climb only as severity and risk demand.

GOOD TO REMEMBER

- **Psychological management (guideline-anchored, WFSBP):** structured cognitive-behavioural relapse-prevention is first-line for less severe paraphilic disorders and the base of every plan; it targets cognitive distortions and the offence cycle, is comparable to antiandrogens in effect, and is now embedded in strength-based frameworks such as the Good Lives Model.

12.5 Pharmacological options: SSRIs, antiandrogens and GnRH agonists

Drugs work by dampening serotonergically driven urges or by lowering testosterone, and they escalate with severity. When medication is indicated, the first step is an SSRI, on the OCD analogy that enhanced central serotonergic tone reduces paraphilic arousal; it suits milder cases and those with prominent obsessive, compulsive urges, though the controlled evidence is limited

(Kaplan and Sadock CTP 2024). For more severe or higher-risk cases the strategy is to lower testosterone. The antiandrogens cyproterone acetate and medroxyprogesterone acetate are synthetic progestogens that reduce serum testosterone and thereby libido, erections and ejaculation; cyproterone acetate is used at **50 to 100 mg** per day and is licensed for male hypersexuality in some countries at 50 mg twice daily (Maudsley Prescribing Guidelines; Goodman and Gilman). At the top of the ladder, the long-acting GnRH agonists leuprolide and triptorelin produce a reversible chemical castration by exhausting the hypothalamic-pituitary axis; leuprolide is given as **7.5 mg** intramuscularly every month and triptorelin as 11.25 mg intramuscularly every 12 weeks, and they are generally better tolerated than the older antiandrogens (Maudsley Prescribing Guidelines; Kaplan and Sadock CTP 2024). Surgical castration is now nearly obsolete. All testosterone-lowering agents demand baseline and follow-up monitoring, testosterone, liver function, glucose and bone mineral density, given risks of osteopenia, weight gain, hyperglycaemia, gynaecomastia and, for cyproterone, meningioma.

STEP	AGENT	TYPICAL DOSE AND ROUTE	KEY POINT AND MONITORING
First drug	SSRI (e.g. sertraline, fluoxetine)	Standard antidepressant range, oral daily	**For milder or obsessive-type urges; evidence limited but low-risk**
Antiandrogen	Cyproterone acetate	50 to 100 mg oral, daily	**Lowers testosterone; watch LFTs, meningioma risk, feminisation**
Antiandrogen	Medroxyprogesterone acetate	Oral or intramuscular depot	**Progestogenic androgen-lowering; weight gain, glucose, thromboembolism**
GnRH agonist	Leuprolide	7.5 mg IM, monthly	**Chemical castration for severe or refractory cases; monitor bone density**
GnRH agonist	Triptorelin	11.25 mg IM, every 12 weeks	**Depot GnRH agonist; better tolerated than antiandrogens**

The pharmacological ladder for paraphilic disorders, escalated by severity and risk; doses are the verified Maudsley and Goodman and Gilman figures, and every testosterone-lowering agent needs testosterone, LFT, glucose and bone-density monitoring (Maudsley Prescribing Guidelines; Kaplan and Sadock CTP 2024; see gaps for paraphilia-specific dosing).

INDIA

The forensic frame is the genuine Indian anchor. Child sexual offences fall under the POCSO Act (Protection of Children from Sexual Offences Act, 2012), which also imposes a mandatory-reporting duty on the clinician, the practical face of the paedophilic-disorder risk assessment. Indian criminal law separately makes voyeurism a distinct statutory offence (introduced by the Criminal Law Amendment Act, 2013, and carried into the Bharatiya Nyaya Sanhita, 2023). India has *no* chemical-castration sentencing statute, and the Justice Verma Committee (2013) advised against castration as punishment, so testosterone-lowering treatment stays a consented clinical decision, not a court penalty. On availability, leuprolide is marketed in India as Lupride Depot and triptorelin as Decapeptyl; cyproterone acetate is available as an antiandrogen (confirm the exact standalone product and strength locally, see gaps). Keep the generic primary.

GOOD TO REMEMBER

- **Pharmacological management (guideline-anchored, WFSBP and Maudsley):** an SSRI is the first drug step for milder or obsessive-type urges; for severe or high-risk cases lower testosterone with an antiandrogen (cyproterone acetate at 50 to 100 mg per day) and, at the top, a long-acting GnRH agonist (leuprolide 7.5 mg IM monthly, triptorelin every 12 weeks), all with testosterone, LFT, glucose and bone-density monitoring; surgical castration is obsolete.

8	6	18	50 to 100
DSM-5-TR NAMED PARAPHILIC DISORDERS	MONTHS MINIMUM SYMPTOM DURATION	VOYEURISTIC DISORDER MINIMUM AGE (YEARS)	CYPROTERONE ACETATE DOSE (MG PER DAY)

HOLD THIS

A paraphilia becomes a paraphilic *disorder* only when it causes the person distress or impairment, or entails harm or the risk of harm to a non-consenting other, the consent-distress-harm threshold; you diagnose from the sexual preference, not the offence, and the management of paraphilia climbs from cognitive-behavioural relapse-prevention to SSRIs to testosterone-lowering antiandrogen or GnRH-agonist treatment for the severe and high-risk.

13 · Gender incongruence and gender-affirmative care

This is the topic where nosology and human rights meet, and the examiner wants to see that you can hold both. The single biggest fact is a reclassification: the eleventh revision of the international classification moved **gender incongruence** out of the mental disorders chapter altogether, so the modern, guideline-anchored position is that being transgender is *not* a mental illness. The management answer is not a drug at all but a stance, the gender-affirmative approach codified in the WPATH Standards of Care, and a clear sense of what the psychiatrist does and does not do within it. High-yield marks cluster on four things: the terminology (and the incongruence-versus-dysphoria distinction), the ICD-11 **depathologisation** contrasted with the DSM retention of a diagnosis, the affirmative-care pathway, and the Indian legal frame.

How to use this page. First fix the vocabulary, because half of the errors on this topic are vocabulary errors; then learn the two competing constructs, gender incongruence (the mismatch, no distress required) and gender dysphoria (the mismatch plus clinically significant distress); then

hold the two classifications side by side, ICD-11 having depathologised where DSM-5-TR retains a diagnosis; then anchor the affirmative-care pathway and the mental-health professional's bounded role; and finally the Indian statute. The one error this page is built to prevent is treating the identity itself as the pathology, when the guideline-anchored target of care is the distress, the comorbidity and the stigma, never the person's gender.

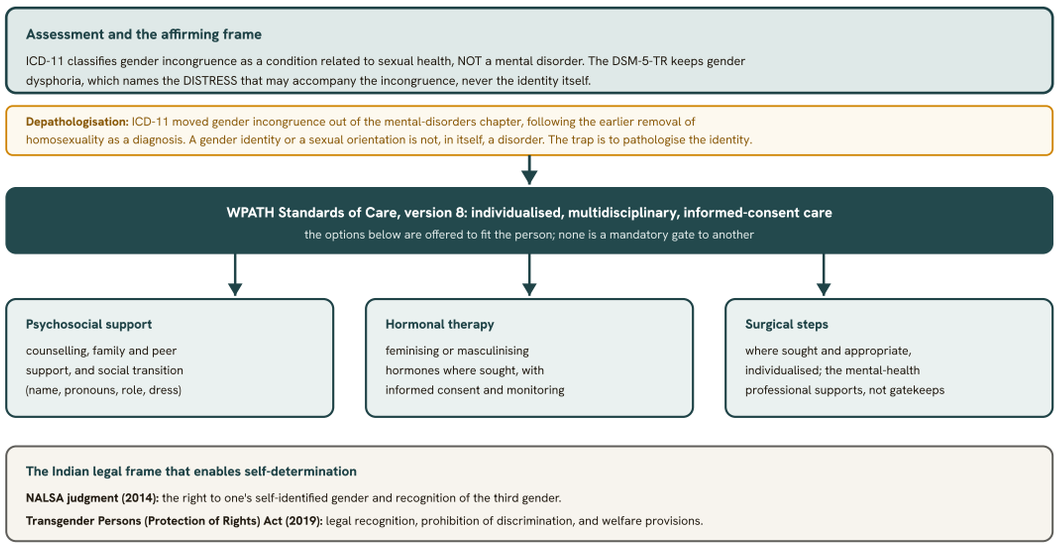


Fig 18.10 The gender-affirmative-care pathway. Care begins from an affirming frame: ICD-11 treats gender incongruence as a condition related to sexual health and not a mental disorder, having moved it out of the mental-disorders chapter just as homosexuality was removed as a diagnosis decades earlier, while the DSM-5-TR retains gender dysphoria to name the distress that may accompany incongruence rather than the identity itself. The WPATH Standards of Care, version 8, then set out an individualised, multidisciplinary, informed-consent model in which psychosocial support and social transition, hormonal therapy, and surgical steps are offered to fit the person, none a mandatory gate to another, and the mental-health professional supports rather than gatekeeps. In India this is underpinned by the NALSA judgment of 2014 and the Transgender Persons (Protection of Rights) Act of 2019.

13.1 The terminology: sex, gender identity and the umbrella terms

Separate sex, gender identity, gender expression and sexual orientation before anything else. The words are examined precisely, and conflating any two of them is the classic slip (Kaplan and Sadock CTP 2024). *Sex* refers to biological variables (genes, chromosomes, gonads, internal and external genital structures) that are male-typical or female-typical; sex assigned at birth is the sex recorded for an individual in infancy. *Gender* is the social category and role. Gender identity, a term coined by Robert Stoller in the mid-twentieth century, is a person's persistent inner sense of their own gender, which today is recognised as possibly male, female, both, in between or neither. Critically, gender identity says nothing about sexual orientation: whether a person experiences their gender as man or woman does not predict whom they are attracted to. Keep these four axes independent and most of the traps disappear.

Sex assigned at birth

The sex (male or female) recorded for a person at birth on the basis of observed anatomy; the reference point against which incongruence is later described.

Gender identity

A person's persistent internal sense of their own gender (Stoller); may be male, female, non-binary or another category, and is independent of sexual orientation.

Gender expression / gender role

The outward presentation of gender (dress, mannerisms, social role); the visible counterpart of the inner identity.

Transgender

Umbrella term (coined by Virginia Prince, early 1970s) for a person whose gender identity or expression differs from the sex assigned at birth; it is an identity, not a diagnosis.

Cisgender

A person whose gender identity aligns with the sex assigned at birth.

RULE **Identity is not orientation, and neither is a diagnosis.** Gender identity (who I am), gender expression (how I present), sex assigned at birth, and sexual orientation (whom I am drawn to) are four independent axes; being transgender or cisgender tells you nothing about a person's sexual orientation, and neither is, in itself, a disorder.

13.2 Gender incongruence versus gender dysphoria: where distress enters

Incongruence is the mismatch; dysphoria is the mismatch plus clinically significant distress. This one distinction earns marks repeatedly. **Gender incongruence** is a marked and persistent mismatch between a person's experienced or expressed gender and the sex assigned at birth. It is a description, not a pathology, and by itself it requires no distress. **Gender dysphoria** is the term the DSM uses for the aversive distress that *some* people with that incongruence experience; it is defined by the presence of clinically significant distress or impairment, and that distress, not the identity, is what a clinician treats (Kaplan and Sadock CTP 2024; DSM-5-TR 2022; ICD-11). The move from "gender identity disorder" to "gender dysphoria" in DSM-5 was deliberately made to strip the word "disorder" from the label and to shift clinical focus from identity to distress. Much of that distress is now understood through *gender minority stress*, the chronic strain of stigma, misgendering and discrimination, which is linked to elevated rates of depression, anxiety and suicidality; affirmation and the reduction of stigma are correspondingly protective. The population-level and public-health dimension of that suicide risk is developed in the Community psychiatry and public health notes; here the point is simply that distress is contingent and modifiable, not intrinsic to being transgender.

PEARL

A memorable way to hold the pair: **incongruence** is a noun of fact (the two do not match), **dysphoria** is a noun of feeling (and it hurts). You can have the first without the second, and a large proportion of transgender people do. The clinician's business is the second.

13.3 The ICD-11 depathologisation: out of the mental disorders chapter

ICD-11 renamed transsexualism as gender incongruence and moved it out of mental disorders entirely. This is the headline reform. In the eleventh revision (ICD-11), the WHO replaced "transsexualism" with gender incongruence and, for the first time, removed the diagnosis

from the Mental and Behavioural Disorders chapter, relocating it to a new chapter, "Conditions related to sexual health" (ICD-11; New Oxford Textbook of Psychiatry). This is the formal **depathologisation** of gender diversity: the reclassification keeps a diagnostic code, so that people can still access publicly funded and insured gender-affirming care, while explicitly stating that gender incongruence is *not* a mental disorder. The adolescent-and-adult category (gender incongruence of adolescence and adulthood, code HA60) requires a marked and persistent incongruence between experienced gender and assigned sex, shown by at least two of the four indicators (discomfort with one's sex characteristics, a desire to be rid of them, a desire for those of the experienced gender, and a desire to be treated as the experienced gender), continuously present for at least several months, and it cannot be assigned before the onset of puberty. Notably, unlike the DSM, ICD-11 requires *no* distress or dysfunction criterion at all.

GOOD TO REMEMBER

- **Gender incongruence, ICD-11 (the criterion anchor):** a marked, persistent mismatch between experienced gender and sex assigned at birth, at least two of the four indicators, continuously present for at least several months, not assignable before puberty; there is NO distress criterion. It sits in "Conditions related to sexual health," not the mental disorders chapter, so it is explicitly not a mental disorder.

13.4 The DSM-5-TR retention of gender dysphoria, and the contrast

DSM-5-TR keeps a diagnosis, gender dysphoria, gated by distress; ICD-11 does not. DSM-5-TR (DSM-5-TR) renamed gender identity disorder as gender dysphoria but, unlike ICD-11, retains it as a diagnosis within the manual. The adolescent-and-adult diagnosis requires at least two of the six criteria (a marked incongruence between experienced gender and one's sex characteristics, a strong desire to be rid of those characteristics, a desire for those of the other gender, a desire to be the other or an alternative gender, a desire to be treated as such, and a conviction of having the typical feelings of that gender), present for at least approximately six months, plus a mandatory Criterion B of clinically significant distress or impairment (DSM-5-TR 2022). There are four DSM diagnoses in the family (gender dysphoria in adolescents and adults, in children, other specified, and unspecified), with a "with a disorder of sex development" specifier and a "post-transition" specifier, the latter letting a person retain the diagnosis needed to access ongoing hormones after transition. The examiner's favourite contrast is captured below.

FEATURE	ICD-11 GENDER INCONGRUENCE	DSM-5-TR GENDER DYSPHORIA
Chapter placement	Conditions related to sexual health (moved OUT of mental disorders)	**Retained as a diagnosis within the manual**
Former name	Transsexualism	**Gender identity disorder**
Distress required?	No distress or dysfunction criterion	**Yes, Criterion B distress or impairment is mandatory**
Adult criteria threshold	At least two of the four indicators, several months	**At least two of the six, at least approximately six months**
Core stance	Explicit depathologisation of gender diversity	**Destigmatised label, but still a diagnosis**

The single highest-yield table on this topic: ICD-11 depathologises by relocation and needs no distress; DSM-5-TR destigmatises the label but keeps a distress-gated diagnosis (ICD-11; DSM-5-TR 2022; Kaplan and Sadock CTP 2024).

GOOD TO REMEMBER

- **Gender dysphoria, DSM-5-TR (the criterion anchor):** at least two of the six criteria for at least approximately six months, PLUS Criterion B clinically significant distress or impairment; formerly gender identity disorder, retained as a diagnosis (four sub-types) with "with a DSD" and "post-transition" specifiers. The distress is the gate; the identity is not.

13.5 The historical precedent: the depathologisation of homosexuality

Gender incongruence is following the road homosexuality already travelled: out of the manuals. The reclassification of gender incongruence is best understood as the second act of a story whose first act was the removal of homosexuality from psychiatric classification. The American Psychiatric Association removed homosexuality as a disorder from its diagnostic manual in **1973** (a residual "ego-dystonic homosexuality" category persisted for a time and was later dropped), and the WHO's ICD followed, with ICD-11 finally clearing all such orientation categories out (Kaplan and Sadock CTP 2024). The enduring principle is the one to quote in a viva: a sexual *orientation* is a normal human variation, not a disorder. Historically, gender-diverse presentations were conflated with homosexuality and both were pathologised; the modern separation of gender identity from sexual orientation, and the depathologisation of each in turn, is the same corrective applied twice. Framing gender incongruence this way signals to the examiner that you grasp the trajectory of the whole field, not just one diagnostic row.

MNEMONIC

ORIENTATION IS NOT A DISORDER

The line to carry from the homosexuality precedent into the gender discussion: what a person *is* (their orientation, their gender identity) is not the illness. Distress, comorbidity and the effects of stigma may need care; the identity does not. The two depathologisations, homosexuality first and gender incongruence second, rest on this single principle.

13.6 The WPATH SOC-8 gender-affirmative care pathway

The affirmative-care standard is individualised, multidisciplinary and informed-consent based, with a flexible staged transition. The reference framework for management is the World Professional Association for Transgender Health Standards of Care, eighth version (WPATH SOC-8 2022), which adopts the ICD-11 gender incongruence diagnosis and frames gender-affirmative care as individualised, multidisciplinary and grounded in informed consent, deliberately moving away from mental-health assessment as a universal gatekeeping hurdle while still recommending mental-health support where it is needed (WPATH SOC-8 2022; Kaplan and Sadock CTP 2024). The pathway is staged and flexible, not a rigid ladder: fully reversible steps (living as, and being socially recognised as, one's experienced gender, a *social transition*) usually precede partially reversible steps (gender-affirming hormone therapy) which precede irreversible surgical steps. Importantly, version 8 removed the older requirement for a minimum period of living in the experienced gender role before hormones, and it individualises timing rather than fixing minimum ages. For genital surgery, SOC-8 suggests at least **12 months** of continuous gender-affirming hormone therapy (unless contraindicated) and **two** referral letters documenting persistent gender incongruence and the capacity to give fully informed consent; for adolescents seeking puberty suppression, one criterion is that the young person has reached Tanner stage 2. The full staged route, from social transition through the hormonal and surgical options with the mental-health professional sitting alongside rather than as a gate, is drawn in the accompanying figure. Not every person wants or reaches every step, and that is by design.

TRAP **Pathologising gender incongruence instead of affirming it.** The examiner's cardinal error here is to treat the gender identity as the disorder and reach for something that tries to change it (so-called conversion or reparative efforts, which are ineffective, harmful and legislatively banned in many places). The affirmative stance is the standard of care: affirm the identity, and treat only the distress, the comorbidity and the effects of stigma.

8	12	2	2014
THE CURRENT WPATH STANDARDS OF CARE VERSION (SOC-8, 2022)	MONTHS OF CONTINUOUS GENDER-AFFIRMING HORMONE THERAPY WPATH SUGGESTS BEFORE GENITAL SURGERY	REFERRAL LETTERS WPATH SOC-8 ASKS FOR BEFORE GENITAL SURGERY	THE NALSA JUDGMENT YEAR, AFFIRMING SELF-IDENTIFIED GENDER IN INDIA

GOOD TO REMEMBER

- **WPATH SOC-8 pathway (the guideline anchor):** individualised, multidisciplinary, informed-consent affirmative care; a flexible staged transition running fully reversible (social) then partially reversible (hormones) then irreversible (surgery); version 8 dropped the minimum "real-life" duration before hormones; genital surgery is preceded by about 12 months of continuous gender-affirming hormones and two referral letters documenting persistent incongruence and capacity to consent.

13.7 The role of the mental-health professional (and the endocrine overview)

The psychiatrist assesses readiness and capacity, treats comorbidity and supports; the psychiatrist does not initiate hormones. Within affirmative care, the mental-health

professional's role is bounded and specific: assessment of the person's readiness and capacity to give informed consent, accurate diagnosis and treatment of any co-occurring mental illness (which does not by itself preclude transition but should be stabilised so it will not compromise a safe transition plan), psychoeducation, and psychosocial support (WPATH SOC-8 2022; Kaplan and Sadock CTP 2024). Hormone therapy can be initiated on a referral from a qualified mental-health professional or another suitably trained health professional able to assess incongruence, eligibility and readiness, but the prescribing itself is endocrinology-led. On the endocrine overview only (prescribing detail is out of scope and belongs to the endocrinologist): feminising therapy combines an oestrogen with an anti-androgen, and masculinising therapy uses testosterone, with the Endocrine Society Clinical Practice Guideline (2017) as the standard specialist, monitored reference (Endocrine Society 2017). The psychiatrist may co-monitor mood and adherence during hormone use, but does not start or titrate the regimen.

GOOD TO REMEMBER

- **Mental-health professional's role (the guideline anchor):** assess readiness and capacity for informed consent, diagnose and treat comorbid mental illness (stabilise, do not exclude), give psychoeducation and psychosocial support, and refer; the psychiatrist does NOT initiate or titrate gender-affirming hormones, which are endocrinology-led (feminising = oestrogen plus anti-androgen; masculinising = testosterone; Endocrine Society 2017).

13.8 The Indian legal frame: NALSA and the Transgender Persons Act

India recognises the self-identified gender and a third gender in law. The Indian frame is genuinely examinable and must be verified rather than paraphrased loosely. In the NALSA judgment (National Legal Services Authority v Union of India, Supreme Court, 15 April 2014), the court recognised transgender persons as a "third gender" and affirmed the constitutional right to self-identified gender. This was followed by statute: the Transgender Persons (Protection of Rights) Act, 2019 (the Transgender Persons Act) provides the framework for legal recognition of a transgender identity, prohibits discrimination in areas such as employment, education and healthcare, and sets out welfare provisions (NALSA 2014; Transgender Persons (Protection of Rights) Act 2019). India also has long-standing traditional third-gender communities, the hijra being the most widely known, which the two-spirit and hijra examples in the standard texts cite as evidence that a strict male/female binary is not culturally universal. For an Indian candidate, pairing the affirmative-care clinical stance with the NALSA judgment and the 2019 Act is the complete, high-scoring answer.

INDIA

Weave the legal frame into any Indian answer on this topic. The clinical stance (affirm, do not pathologise) and the legal stance now point the same way: the 2014 **NALSA judgment** gave transgender persons the right to self-identified gender and third-gender recognition, and the 2019 Transgender Persons (Protection of Rights) Act turned that into anti-discrimination and welfare law. Culturally, the hijra community is India's own long-standing third-gender tradition. The psychiatrist works within this frame, offering affirmative, non-judgemental care and appropriate referral, not gatekeeping and never conversion approaches.

GOOD TO REMEMBER

- **Indian legal frame (the statute anchor):** the NALSA judgment (Supreme Court, 15 April 2014) recognised a third gender and the right to self-identified gender; the Transgender Persons (Protection of Rights) Act, 2019 gives legal recognition, prohibits discrimination and provides welfare measures. Both are verified; quote them by name and year.

HOLD THIS

Gender incongruence is the mismatch between experienced gender and sex assigned at birth and is NOT a mental disorder (ICD-11 moved it to "Conditions related to sexual health," needing no distress); gender dysphoria is the DSM-5-TR term for the distress that only some experience; management is the WPATH SOC-8 individualised, informed-consent, gender-affirmative pathway (social, then hormonal, then surgical steps, hormones endocrinology-led) with the psychiatrist treating distress and comorbidity, not the identity, all within the Indian frame of the NALSA judgment (2014) and the Transgender Persons (Protection of Rights) Act, 2019.

14 · Dhat syndrome and culture-bound sexual presentations

This topic is the Indian examiner's favourite in the sexual-and-somatic band, and it is tested as a discrimination-and-management task rather than a memory dump. **dhat syndrome** is the presentation in which a young man attributes fatigue, weakness, anxiety and a range of somatic and sexual symptoms to the loss of semen, and the marks turn on recognising it as a **culture-bound** presentation, placing it correctly in the nosology, reading it through a cultural formulation, and managing the semen-loss belief without confronting it. It is the most examinable member of a small family of culturally shaped sexual presentations that examiners like to pair.

How to use this page. Fix the cardinal feature and the semen-loss attribution first; then the Ayurvedic cultural roots and the prevalence and comorbidity in the Indian and South Asian setting; then the nosological status as a cultural concept of distress and the cultural formulation the whole topic turns on; then the related **culture-bound sexual presentations**, koro chief among them; and finally the non-confrontational psychoeducational management. The complaint usually crystallises around **semen-loss anxiety** tied to masturbation and nocturnal emission, and the single error this page is built to prevent is reading a Dhat presentation without the cultural formulation.

14.1 Dhat syndrome: the semen-loss attribution

A cluster of symptoms pinned on the loss of semen. dhat syndrome is a term coined in South Asia about half a century ago to account for young men who attribute diverse symptoms to the loss of semen (DSM-5-TR 2022). Despite the name it is not, in the modern reading, a discrete disease but a culturally shaped presentation: the patient reports anxiety, fatigue, weakness, weight loss, poor concentration, multiple somatic complaints, low mood and sexual difficulty such as erectile dysfunction or premature ejaculation, and attributes them all to the passage of *dhat*, a whitish discharge he notices in urine or after defecation and believes to be semen. The cardinal feature is the anxiety and distress about the perceived loss of semen in the absence of any identifiable physiological dysfunction. The belief commonly carries marked guilt and dysphoria,

and it typically fastens onto masturbation and nocturnal emission as the feared sources of loss (Companion to Psychiatric Studies).

RULE **The attribution is the disorder, not the discharge.** What defines Dhat syndrome is the distressing belief that semen is being lost and is causing the symptoms; the whitish urinary discharge is usually normal, so the target of assessment and treatment is the semen-loss belief, not a genitourinary lesion.

GOOD TO REMEMBER

- **Dhat syndrome (the presentation):** diverse somatic, anxious, depressive and sexual symptoms that the patient attributes to the loss of semen (dhat), a whitish discharge in urine or after defecation that he believes to be semen; the defining feature is the distressing preoccupation with semen loss in the absence of an identifiable physiological cause, not any single somatic symptom.

14.2 The cultural roots and the Indian and South Asian context

An Ayurvedic belief that semen is a precious, finite essence. The attribution rests on an old and widely held sociocultural belief: semen is regarded as an extremely precious bodily substance, distilled from many drops of blood, so its loss is felt to drain vitality and to cause weakness and sexual failure. The idea connects to dhatu, the word for semen in Ayurveda, counted as one of seven essential bodily fluids whose balance is held to maintain health (DSM-5-TR 2022). Because the belief is culturally normative rather than idiosyncratic, Dhat presentations are common wherever it is shared. The figures from the **indian context** and the wider South Asian setting are striking: **64 percent** of men attending psychiatric clinics in India for sexual complaints, and **30 percent** of men attending general medical clinics in Pakistan, have been described with the concept (DSM-5-TR 2022). It is most often seen in young men from lower socioeconomic backgrounds, though middle-aged men are also affected, and a parallel concern about white vaginal discharge (the leukorrhea variant) forms the female counterpart. Depression and anxiety are frequent companions, and the classic teaching is that a Dhat presentation should prompt an active search for a comorbid depressive or anxiety disorder rather than being taken as a stand-alone complaint.

Dhat
the whitish urinary or post-defecation discharge the patient believes to be lost semen

Dhatu
semen in Ayurveda, counted among the seven essential bodily fluids whose balance is held to maintain health

Leukorrhea variant
the parallel female concept that attributes symptoms to the loss of white vaginal discharge

64%	30%	7
DHAT CONCEPT IN INDIAN PSYCHIATRIC SEXUAL-COMPLAINT ATTENDERS	DHAT CONCEPT IN PAKISTANI GENERAL-MEDICAL ATTENDERS	DHATU, THE ESSENTIAL BODILY FLUIDS OF AYURVEDA

INDIA

Dhat is one of the commonest ways sexual and general distress reaches the Indian clinic, and it sits at the meeting point of the somatic symptom disorders, the sexual dysfunctions and depression. The examiner's expectation is that you name it as a culture-bound presentation, read it through the cultural formulation, search for and treat the comorbid depression, anxiety or sexual dysfunction, and address the semen-loss belief with psychoeducation rather than dismissal. Its wider transcultural frame, alongside the other culture-bound presentations, is developed in the Consultation-liaison, geriatric and transcultural psychiatry notes.

14.3 A cultural concept of distress, not a discrete disorder: the cultural formulation

A cultural explanation of distress, held in the DSM-5-TR glossary rather than the disorder list. DSM-5-TR does not classify Dhat as a discrete disorder; it lists it among the cultural concepts of distress in the Section III chapter on culture and psychiatric diagnosis, and specifically as a cultural causal explanation, the semen loss being the culturally recognised cause to which a range of somatic and psychological symptoms are attributed (DSM-5-TR 2022; Clinical Methods in Psychiatry, AIIMS 2024). ICD-10 placed it, with koro and the other geographically localised presentations, among the other specified neurotic disorders as a culture-specific or culture-bound syndrome (ICD-10). The practical consequence is the same in both systems: the presenting symptoms map onto ordinary diagnoses, a somatic symptom disorder, an illness anxiety disorder, a depressive or anxiety disorder, or a sexual dysfunction, while Dhat names the cultural idiom through which they are expressed. This is why the assessment must run through a cultural formulation. The Cultural Formulation Interview, the person-centred protocol in the same DSM-5 chapter, elicits the patient's own definition of the problem, its perceived cause and context, and his coping and help-seeking, so that the semen-loss explanatory model is understood rather than overwritten (DSM-5-TR 2022).

TRAP **Reading a Dhat presentation without the cultural formulation.** Taken at surface value the semen-loss belief can be mislabelled as a delusion, or the discharge chased as an organic genitourinary disease; the cultural formulation reframes it as a shared explanatory model and redirects assessment to the comorbid depression, anxiety or sexual dysfunction beneath it.

GOOD TO REMEMBER

- **Dhat as a cultural concept of distress (the nosological status):** DSM-5-TR holds Dhat in the Section III glossary of cultural concepts of distress as a cultural causal explanation (semen loss as the perceived cause), not as a codeable disorder; ICD-10 placed it among the other specified neurotic disorders as a culture-bound syndrome. The first step is a cultural formulation, after which the presenting symptoms are coded as the ordinary depressive, anxiety, somatic-symptom or sexual diagnosis they represent.

14.4 Related culture-bound sexual presentations: koro

Genital retraction and the fear of death. The related **culture-bound sexual presentations** are worth naming because examiners pair them with dhat syndrome, and koro is the classic partner (DSM-5-TR 2022). Koro is an episode of sudden, intense anxiety that the penis, or in the female form the nipples, breasts or vulva, is shrinking or retracting into the body, accompanied by a

belief that this will prove fatal. It is reported across Asia including India, and notably in Southeast Asia, where it can spread rapidly through a community in epidemic form, often built on the same culturally elaborated fears about nocturnal emission and masturbation. The Chinese counterpart, shen-k'uei or kidney deficiency, attributes weakness and sexual symptoms to semen loss much as Dhat does. The discriminator to hold is the object of the fear: koro fixes on genital retraction and imminent death, Dhat on the draining loss of a vital fluid, and both differ from body dysmorphic disorder, whose preoccupation is with perceived ugliness rather than shrinkage or depletion (body dysmorphic disorder is developed on the obsessive-compulsive spectrum in the Anxiety, OCD and trauma-related disorders notes).

PRESENTATION	CORE ATTRIBUTION OR FEAR	THE DISCRIMINATOR
Dhat syndrome	Symptoms attributed to loss of semen (dhat) in urine	**Fear of depletion of a vital fluid; South Asian; comorbid depression and anxiety common**
Koro	Penis, or nipples, breasts and vulva, retracting into the body	**Fear of genital retraction and death; can occur in epidemics**
Shen-k'uei (kidney deficiency)	Weakness and sexual symptoms attributed to semen loss	**Chinese counterpart of the semen-loss concept**
Body dysmorphic disorder	Preoccupation with a perceived defect in appearance	**Fear of ugliness, not depletion or retraction; obsessive-compulsive spectrum**

The culture-bound sexual presentations separated by the object of the fear; body dysmorphic disorder is set beside them as the appearance-based contrast (DSM-5-TR 2022).

PEARL

Separate the three by the *object of the fear*: **Dhat** fears the *loss* of semen (depletion of a vital fluid), **koro** fears the *retraction* of the genitals into the body and death, and **body dysmorphic disorder** fears the *appearance* of the body (perceived ugliness). Loss, retraction, ugliness.

GOOD TO REMEMBER

- **Koro (the presentation):** sudden intense anxiety that the genitals (the penis, or the nipples, breasts or vulva in women) are retracting into the body, with a belief that death will follow; it can occur in epidemics. The discriminator is the fear of genital retraction and death, which separates it from body dysmorphic disorder (perceived ugliness) and from Dhat syndrome (perceived semen loss).

14.5 Non-confrontational psychoeducational management

Correct the myth, treat the comorbidity, never confront. Management of Dhat syndrome is non-pharmacological and non-confrontational first. The core is counselling and psychoeducation directed at gently correcting the misconception about semen loss: explain, in the patient's own explanatory language, that the whitish discharge is not a dangerous drain of vitality, that occasional masturbation and nocturnal emission are normal and harmless, and pair this with straightforward sex education to allay the specific fears. Cognitive behavioural techniques fold easily into this model, addressing the catastrophic beliefs about depletion and the checking and

reassurance-seeking they drive. The second, equally important step is to identify and treat any comorbidity by the usual means, a depressive or anxiety disorder, a sexual dysfunction, or a hypochondriacal concern, reserving an antidepressant for a genuine comorbid depression or anxiety rather than for the semen-loss belief itself. Throughout, the stance stays respectful of the cultural model: the aim is to reframe the belief collaboratively, not to dismiss or ridicule it, since confrontation ruptures the alliance and drives the patient away.

GOOD TO REMEMBER

- **Management of Dhat syndrome (the first step):** non-confrontational counselling and psychoeducation that corrects the semen-loss myth and normalises masturbation and nocturnal emission, combined with sex education and, where useful, cognitive behavioural techniques; then treat any comorbid depression, anxiety or sexual dysfunction by the usual means, reserving antidepressants for a genuine comorbidity, not for the belief itself. The first move is psychoeducation within the patient's cultural model, never confrontation.

HOLD THIS

Dhat syndrome is a culture-bound presentation, not a disease: the patient attributes anxiety, fatigue, weakness and sexual symptoms to the loss of semen (dhat, a whitish urinary discharge he believes to be semen), so DSM-5-TR holds it as a cultural concept of distress rather than a codeable disorder; read it through the cultural formulation, search for and treat the comorbid depression, anxiety or sexual dysfunction, and manage the semen-loss belief with non-confrontational psychoeducation, never by confronting or pathologising it.

15 · Medication-induced sexual dysfunction

Sexual dysfunction is one of the most common, most under-reported and most adherence-wrecking adverse effects in all of psychiatric prescribing. Patients rarely volunteer it, quietly stop the drug, and relapse; the examiner therefore wants you to *ask about it, attribute it correctly, and manage it by a guideline ladder rather than by simply stopping treatment*. Two drug classes dominate the answer. **Antidepressant-induced sexual dysfunction** is a **serotonergic** problem of desire, arousal and orgasm; **antipsychotic-induced sexual dysfunction** is largely a **prolactin** problem driven by dopamine blockade. The mechanism you name decides the management you offer.

How to use this page. Hold each class as a triad: the clinical picture (which functions fail, how prevalent, whether reversible), the mechanism (serotonin versus hyperprolactinaemia), and the verified management ladder (watchful waiting, **dose reduction**, **switch** to a lower-liability agent, then an **adjunct**). The deep receptor pharmacology behind each antidepressant sits in the Mood disorders: pharmacotherapy notes, and the full antipsychotic-by-antipsychotic prolactin and receptor profile in the Schizophrenia: management, antipsychotics and adverse effects notes; this page is the clinical syndrome and its management.

15.1 Antidepressant-induced sexual dysfunction: the clinical picture, prevalence and PSSD

A serotonergic triad of reduced desire, delayed or absent orgasm, and erectile difficulty. Selective serotonin reuptake inhibitor (SSRI) treatment lowers sexual function so reliably that the SSRI sexual side effects carry their own teaching profile, clustering into three failures: reduced

libido, delayed or absent orgasm (anorgasmia and delayed ejaculation), and erectile difficulty in men with reduced lubrication in women (Kaplan and Sadock CTP 2024; Maudsley Prescribing Guidelines). It is a class effect of serotonergic antidepressants and it is *largely dose dependent* and *generally fully reversible* on stopping (Maudsley Prescribing Guidelines). Prevalence is high but agent-dependent: treatment-emergent sexual dysfunction reaches 70 to 80 per cent with venlafaxine, citalopram, paroxetine and fluoxetine, and is lower, 25 to 45 per cent, with imipramine, phenelzine, duloxetine, escitalopram and fluvoxamine (Kaplan and Sadock CTP 2024).

Post-SSRI sexual dysfunction is the one to flag. In a minority the sexual symptoms persist despite stopping the drug, a state termed post-SSRI sexual dysfunction (PSSD): decreased libido, erectile dysfunction, delayed ejaculation, anorgasmia, vaginal dryness and, in men, genital numbness and pleasureless orgasm (Maudsley Prescribing Guidelines). Its prevalence and pathophysiology remain uncertain, one estimate putting the risk at **1 in 216** patients treated; diagnosis rests on the medication history, the onset and profile of symptoms and the exclusion of other causes, and no definitive treatment exists (Maudsley Prescribing Guidelines). Examine it as a name to recognise and a caution to counsel, not a syndrome to over-diagnose.

FUNCTION AFFECTED	ANTIDEPRESSANT-INDUCED PATTERN (VERIFIED)
Desire	**Reduced libido (serotonergic; also driven by the depression itself)**
Arousal	**Erectile difficulty in men; reduced lubrication in women**
Orgasm	**Delayed or absent orgasm, delayed ejaculation, anorgasmia (the most drug-specific)**
Course	**Largely dose dependent; generally fully reversible on stopping**
Persistent variant	**Post-SSRI sexual dysfunction (PSSD): symptoms continue despite discontinuation**

The antidepressant-induced sexual dysfunction picture: a serotonergic desire, arousal and orgasm triad, dose dependent and usually reversible, with PSSD as the persistent exception (Kaplan and Sadock CTP 2024; Maudsley Prescribing Guidelines).

GOOD TO REMEMBER

- **Antidepressant-induced sexual dysfunction (criterion-anchored, Maudsley Prescribing Guidelines):** a serotonergic triad of reduced desire, delayed or absent orgasm and erectile or lubrication difficulty; highest rates (70 to 80 per cent) with venlafaxine, citalopram, paroxetine and fluoxetine, largely dose dependent and generally fully reversible.
- **Post-SSRI sexual dysfunction / PSSD (criterion-anchored):** the defining feature is persistence of the sexual symptoms despite the antidepressant being discontinued; prevalence and mechanism uncertain, risk estimated near 1 in 216 treated, no definitive treatment, diagnosis by history and exclusion.

15.2 Managing antidepressant-induced sexual dysfunction: the strategy ladder

Confirm the cause, then climb the ladder. The Maudsley ladder is a sequence, not a menu (Maudsley Prescribing Guidelines Table on sexual adverse effects; Kaplan and Sadock CTP 2024). First, *rule out other causes*: compare sexual functioning on the antidepressant against functioning *before the antidepressant*, not before the depressive illness, since untreated depression itself lowers desire, and screen for alcohol or substance use, diabetes, vascular disease and other medications such as diuretics and beta-blockers. Then, where the depression is stable, work upward: **watchful waiting** for spontaneous tolerance, then dose reduction, then a **switch**, then an **adjunct**.

Watchful waiting is weak; switching is the well-supported move. Spontaneous remission occurs in only a small minority (roughly 5 to 10 per cent) and can take 4 to 6 months, so it is the least effective option and suits milder cases. Dose reduction to the lowest effective dose is reasonable once the patient is in full remission. A short planned *drug holiday* (missing a dose or two before planned intimacy) may help shorter-half-life agents but is useless for fluoxetine given its long half-life, and it risks discontinuation symptoms, reduced adherence and relapse, so it is used cautiously. The best-supported strategy, when mood is stable, is to switch to a lower-liability antidepressant: bupropion, mirtazapine, vortioxetine, agomelatine or moclobemide, with agomelatine, bupropion and vortioxetine carrying the best evidence (Maudsley Prescribing Guidelines).

Add-ons, where a switch is not wanted. In men with antidepressant-related erectile difficulty, adding a PDE5 inhibitor (sildenafil has the strongest evidence, tadalafil also works) improves function on randomised-trial evidence (Nurnberg, JAMA 2003). Add-on bupropion is used, chiefly in women at higher doses (300 mg per day), but its evidence is more modest and mixed (see gaps). Transdermal testosterone has randomised support in women with serotonergic-antidepressant-emergent low libido and in men on serotonergic antidepressants with low or low-normal testosterone.

STEP	WHAT TO DO	VERIFIED DETAIL
1. Confirm cause	Compare with function before the drug, not before the illness; exclude other causes	**Depression itself lowers desire; screen alcohol, diabetes, vascular disease, diuretics, beta-blockers**
2. Watchful waiting	Await spontaneous tolerance in milder cases	**Only 5 to 10 per cent remit; can take 4 to 6 months; least effective**
3. Dose reduction	Lower to the lowest effective dose	**Reserve for patients already in full remission**
4. Switch	Move to a lower-liability agent (mood stable)	**Bupropion, mirtazapine, vortioxetine, agomelatine, moclobemide; best evidence agomelatine, bupropion, vortioxetine**
5. Adjunct	Add an agent without switching	**PDE5 inhibitor for male erectile difficulty (sildenafil best evidence); add-on bupropion or testosterone in selected cases**

The verified management ladder for antidepressant-induced sexual dysfunction; the ordering, and the switch targets, are the highest-yield lines, ordered as a clear algorithm (Maudsley Prescribing Guidelines).

GOOD TO REMEMBER

- **Switch strategy (guideline-anchored, Maudsley Prescribing Guidelines):** where mood is stable, the well-supported move for antidepressant-induced sexual dysfunction is to switch to bupropion, mirtazapine, vortioxetine or agomelatine (best evidence: agomelatine, bupropion, vortioxetine), after first excluding depression itself as the cause and trying watchful waiting or dose reduction.
- **Add-on PDE5 inhibitor (guideline-anchored):** for antidepressant-related erectile difficulty in men, adding sildenafil (the best-supported PDE5 inhibitor) improves function on randomised-trial evidence; keep the antidepressant and add the PDE5 inhibitor rather than sacrificing a working mood response.

15.3 Antipsychotic-induced sexual dysfunction: hyperprolactinaemia and the prolactin ladder

Dopamine blockade, then raised prolactin. Sexual dysfunction is an adverse effect of most antipsychotics; individual susceptibility varies and the effect is usually reversible (Maudsley Prescribing Guidelines). Two linked mechanisms operate: antipsychotics decrease dopaminergic transmission, which itself lowers libido, and the same dopamine blockade raises prolactin by removing tonic inhibition of its release, producing **hyperprolactinaemia**. Prolactin elevation suppresses the hypothalamic-pituitary-gonadal axis, giving sexual dysfunction, menstrual disturbance, infertility, breast enlargement and galactorrhoea in both sexes, and rarely delusions of pregnancy; long-term risks are reduced bone mineral density and a possible increase in breast-cancer risk. Note the nuance: hyperprolactinaemia is *a key factor but may explain only about 40 per cent* of antipsychotic-related sexual dysfunction, the rest coming from anticholinergic effects (impaired arousal), peripheral alpha-1 blockade (erection and ejaculation problems in men) and sedation or weight gain (reduced desire).

The prolactin ladder ranks the culprits. The propensity of an antipsychotic to cause sexual dysfunction tracks its facility to raise prolactin: risperidone is the worst, then haloperidol, then olanzapine, then quetiapine, then aripiprazole (Maudsley Prescribing Guidelines). Aripiprazole, a partial dopamine agonist, is relatively free of sexual adverse effects as monotherapy and even improves function when patients are switched to it. Group the agents by prolactin: prolactin-raising (risperidone, paliperidone, amisulpride, sulpiride and the typicals) versus prolactin-sparing (aripiprazole first, then quetiapine, olanzapine, clozapine and the newer partial agonists). Before you blame the drug, exclude other causes of a raised prolactin: pregnancy, stress at venepuncture, hypothyroidism, renal impairment and prolactinoma, sampling early in the morning.

PROLACTIN LIABILITY	ANTIPSYCHOTIC (VERIFIED LADDER)
Highest (worst for dysfunction)	**Risperidone, paliperidone, amisulpride, sulpiride, first-generation antipsychotics such as haloperidol**
Intermediate to low	**Olanzapine, then quetiapine**
Prolactin-sparing (least)	**Aripiprazole (partial agonist), also clozapine, brexpiprazole, cariprazine, asenapine**

The prolactin ladder underlying antipsychotic-induced sexual dysfunction, risperidone worst and aripiprazole least (Maudsley Prescribing Guidelines).

GOOD TO REMEMBER

- **Antipsychotic-induced sexual dysfunction (criterion-anchored, Maudsley Prescribing Guidelines):** largely driven by hyperprolactinaemia from dopamine blockade, worst with risperidone and the typicals and least with aripiprazole; but prolactin explains only about 40 per cent, so also consider anticholinergic, alpha-1-blockade and sedative contributions, and exclude pregnancy, hypothyroidism and prolactinoma before attributing a raised prolactin to the drug.

15.4 Managing antipsychotic-induced sexual dysfunction: switch or aripiprazole adjunct

Two verified routes: switch down the ladder, or add low-dose aripiprazole. Where a prolactin-raising antipsychotic is driving the problem through hyperprolactinaemia, the first choice is to **switch** to a prolactin-sparing agent, aripiprazole first, or to a lesser extent quetiapine or olanzapine, remembering that any switch carries a risk of destabilising the illness (Maudsley Prescribing Guidelines). Where switching is not feasible, add low-dose aripiprazole to the existing treatment: it lowers prolactin in a dose-dependent way, 3 mg per day is effective and 6 mg per day more so, with higher doses unnecessary, and a 2022 network meta-analysis confirmed aripiprazole near 5 mg per day (and vitamin B6 at 600 mg per day) as effective. This aripiprazole adjunct is the standard way to normalise prolactin in patients kept on a raising agent such as haloperidol or risperidone long-acting injection. Dose reduction of the offending antipsychotic, and treating modifiable bone-health risks, sit alongside these.

ROUTE	INDICATION	VERIFIED DETAIL
Switch	Prolactin-raising agent is the driver and switching is feasible	**Move to a prolactin-sparing agent (aripiprazole first; quetiapine or olanzapine to a lesser extent); watch for relapse**
Aripiprazole adjunct	Must stay on the current antipsychotic	**Add aripiprazole 3 to 6 mg per day; lowers prolactin dose-dependently; 5 mg per day confirmed by 2022 network meta-analysis**
Exclude first	Before either route	**Rule out pregnancy, hypothyroidism, renal impairment and prolactinoma; sample prolactin in the early morning**

The two verified management routes for antipsychotic-induced hyperprolactinaemic sexual dysfunction, switch or aripiprazole adjunct, with the dose that matters (Maudsley Prescribing Guidelines).

GOOD TO REMEMBER

- **Aripiprazole adjunct (guideline-anchored, Maudsley Prescribing Guidelines):** where a prolactin-raising antipsychotic must be continued, adding aripiprazole 3 to 6 mg per day normalises prolactin dose-dependently (5 mg per day confirmed by 2022 network meta-analysis); the alternative first-line move is to switch to a prolactin-sparing agent, aripiprazole itself being the least offending.

15.5 Assessing it: baseline, the ASEX scale, and the common traps

Ask directly, and measure at baseline. Sexual dysfunction is far commoner than spontaneous reports suggest, so direct questioning or a rating scale beats waiting for the patient to volunteer it (Maudsley Prescribing Guidelines). The most examinable instrument is the ASEX (Arizona Sexual Experience Scale, McGahuey and colleagues), a brief five-item scale covering sex drive, arousal, penile erection or vaginal lubrication, ability to reach orgasm, and satisfaction from orgasm over one week; each item scores 1 to 6 so the total runs from 5 to 30 (out of a possible 30), with higher scores meaning worse dysfunction (Clinical Methods in Psychiatry, AIIMS 2024). Its practical value is a *baseline*: a score before the drug lets you attribute a later change to the medication rather than to the illness. The ASEX form sits on the sexual-function scale plate with the male sexual dysfunctions.

1 in 216	40%	3 to 6	5 to 30
PSSD RISK ESTIMATE (MAUDSLEY)	ANTIPSYCHOTIC SEXUAL DYSFUNCTION VIA RAISED PROLACTIN	ARIPIPRAZOLE ADJUNCT DOSE (MG PER DAY)	ASEX TOTAL RANGE (HIGHER IS WORSE)

INDIA

The add-on PDE5 inhibitor for antidepressant-related erectile difficulty in men is everyday practice here: lead the generic sildenafil, with Manforce and Penegra the common Indian brands, and tadalafil (Tadacip, Megalis) as the alternative; keep the generic primary and confirm the product and strength locally before prescribing. Risperidone and the typicals, the worst prolactin raisers, are among the most-used antipsychotics in Indian public practice, so hyperprolactinaemic sexual dysfunction and galactorrhoea are common bedside findings, and low-dose aripiprazole augmentation is a familiar fix. The ASEX itself is taught in the AIIMS Clinical Methods text as the standard bedside scale for drug-induced sexual dysfunction.

RULE **Switch or spare, do not just stop.** For medication-induced sexual dysfunction the guideline move is to confirm the cause, try watchful waiting or dose reduction, then switch to a lower-liability agent (bupropion, mirtazapine, vortioxetine or agomelatine for antidepressants; a prolactin-sparing antipsychotic or an aripiprazole adjunct for antipsychotics), never abrupt cessation that risks relapse.

TRAP **Blaming the drug without a baseline or a prolactin work-up.** Reduced libido may be the untreated depression, not the SSRI, unless you compare with function before the drug; and galactorrhoea on an antipsychotic must not be pinned on the drug before pregnancy, hypothyroidism and prolactinoma are excluded. A parallel error is trying a drug holiday with fluoxetine, whose long half-life makes it useless.

COMMON TRAP

Reflexively stopping the antidepressant or antipsychotic when a patient reports a sexual side effect. Abrupt cessation trades a manageable adverse effect for a relapse of depression or psychosis. The verified sequence is to confirm the drug is the cause, optimise the dose, and switch or augment within the guideline ladder while keeping the psychiatric illness treated.

HOLD THIS

Medication-induced sexual dysfunction splits by mechanism: for the antidepressant, rule out depression as the cause, try watchful waiting or dose reduction, then switch to bupropion, mirtazapine, vortioxetine or agomelatine (or add a PDE5 inhibitor in men); for the antipsychotic it is largely hyperprolactinaemia, worst with risperidone and the typicals and least with aripiprazole, so switch to a prolactin-sparing agent or add low-dose aripiprazole 3 to 6 mg per day.

Psychosomatic medicine and consultation-liaison

16 · The psychosomatic concept

This topic teaches the idea that the whole somatic band rests on, the **psychosomatic concept**: the position that mind and body are one system, so that emotional life can shape the onset, course and outcome of frank physical disease and, conversely, that physical illness reshapes the mind. It is the conceptual hinge of the chapter, sitting between the disorders where the body *complains* without disease (somatic symptom disorder) and the consultation-liaison service that

meets the medically ill patient at the bedside. Examiners test it in three predictable ways: define **psychosomatic medicine** and its modern diagnostic label, state the organising model (Engel's biopsychosocial frame), and list the classical psychosomatic illnesses with the theorist who named them.

How to use this page. Fix the terminology first, then learn the one formal diagnosis this concept carries in DSM-5-TR, that being **psychological factors affecting other medical conditions** (F54), and hold its cardinal discriminator from somatic symptom disorder: PFAOMC requires a *genuine* medical condition that psychological or behavioural factors are worsening. Then internalise the **biopsychosocial model** as the frame, sketch the stress-illness pathways at concept level (the neuroendocrine, autonomic and immune routes), and finish with the seven classical conditions. The service model and the disease-specific psychiatric aspects, the psycho-oncology, HIV, endocrine, cardiac, transplant and surgical or intensive-care work, are developed in the Consultation-liaison, geriatric and transcultural psychiatry notes; here we teach only the concept.

16.1 What "psychosomatic" means, and the field of psychosomatic medicine

One word, from two Greek roots, badly misused by the lay ear. The term derives from *psyche*, soul or mind, and *soma*, body, and refers literally to how the mind affects the body (Kaplan and Sadock CTP 2024). The popular misreading, that a psychosomatic complaint is imaginary or "all in the head", is precisely the error the concept exists to correct: the suffering and the disease are real, and the psychological contribution is to their course, not to their reality. Psychosomatic medicine is the subspecialty that studies and treats this mind-body interface in the medically ill. Its nomenclature has moved twice, and both moves are examinable. First, the American classification retired the older label psychophysiological disorders (also called psychosomatic disorders) in 1980 and replaced it with the descriptive diagnosis psychological factors affecting other medical conditions. Second, in 2017 the subspecialty itself was formally renamed consultation-liaison psychiatry to align the field's name with its actual bedside practice, though the historic term survives in the journals and societies (the American Psychosomatic Society, the journal *Psychosomatic Medicine*).

THE THREE LABELS, AND WHAT EACH ONE IS

Psychosomatic medicine is the *field* (now practised as consultation-liaison psychiatry). **Psychophysiological / psychosomatic disorders** was the old *nosological* term, deleted from DSM in 1980. **Psychological factors affecting other medical conditions (F54)** is the current *diagnosis* that replaced it. Do not conflate the field, the obsolete category and the live diagnostic code; a viva can ask for all three in one breath.

16.2 Psychological factors affecting other medical conditions (F54): the DSM-5-TR diagnosis

The concept's one formal home in the manual. Psychological factors affecting other medical conditions is the diagnosis given when psychological or behavioural factors adversely affect a real, diagnosed medical condition (DSM-5-TR 2022). It rests on three criteria. **Criterion A** requires that a medical symptom or condition, other than a mental disorder, is actually present. **Criterion B** requires that psychological or behavioural factors adversely affect that condition in at least one

of four ways (below). **Criterion C** requires that those factors are not better explained by another mental disorder, such as panic disorder, major depressive disorder or post-traumatic stress disorder. Severity is then graded in **four** steps by how much harm the psychological factor does, from mild through to extreme. The whole diagnosis turns on Criterion A: there must be an underlying general medical condition for the psychological factor to act upon, which is exactly what separates it from the somatic disorders where no such disease is required.

CRITERION B ROUTE	WORKED ILLUSTRATION
The factor influences the course of the condition (a close temporal link to its onset, exacerbation or delayed recovery)	**A stressful period immediately preceding an asthma exacerbation**
The factor interferes with the treatment of the condition	**Poor adherence to antihypertensive medication**
The factor constitutes an additional well-established health risk	**Continued smoking despite established chronic lung disease**
The factor influences the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating care	**Anxiety aggravating angina or an arrhythmia**

The four routes by which psychological or behavioural factors adversely affect a medical condition under Criterion B; any one route suffices (DSM-5-TR 2022).

Mild

Increases medical risk (for example, inconsistent adherence with antihypertensive treatment)

Moderate

Aggravates the underlying medical condition (for example, anxiety aggravating asthma)

Severe

Results in medical hospitalisation or an emergency-department visit

Extreme

Results in a severe, life-threatening risk (for example, ignoring the symptoms of a heart attack)

GOOD TO REMEMBER

- **Psychological factors affecting other medical conditions / F54 (the diagnosis):** Criterion A, a genuine non-psychiatric medical condition is present; Criterion B, psychological or behavioural factors adversely affect it by one of four routes (course, treatment, health risk, or pathophysiology); Criterion C, not better explained by another mental disorder; severity graded mild, moderate, severe or extreme. The single discriminator to hold is Criterion A, the requirement for a real underlying medical disease that the psychological factor worsens.

RULE **PFAOMC needs a real disease being worsened; somatic symptom disorder needs an excessive response to symptoms.** Diagnose psychological factors affecting other medical conditions only when a genuine medical condition (Criterion A) is present and psychological or behavioural factors are demonstrably harming its course, treatment, risk profile or pathophysiology.

TRAP **Reading PFAOMC as "the same as somatic symptom disorder".** They are mirror images: PFAOMC starts from a real medical condition made worse by the mind, whereas somatic symptom disorder starts from distressing bodily symptoms plus a disproportionate psychological response, with no medical disease required. The presence or absence of a genuine underlying condition sorts them.

16.3 The biopsychosocial model: the organising frame

Engel's answer to biomedical reductionism. The biopsychosocial model was developed and named by George Engel in **1977** as a deliberate alternative to the purely biomedical model of disease (developmental and general-medicine texts). Its fundamental purpose is anti-reductionist: it insists that biological, psychological and social domains all be accounted for in every case, regardless of how obviously "physical" a lesion appears, so that psychological and social contributors are never excluded by default. This is not a neutral mediator between three domains; it is a positive stance against biological, psychological and social reductionism alike, and it has since become the standard formulation frame across medicine, not psychiatry alone. For the psychosomatic concept it is the load-bearing frame: it is what lets a genuine coronary lesion, a depressive state and chronic occupational stress be held in one explanatory picture rather than forced into a single cause.

Biological domain

Genetic predisposition, neuroendocrine and physiological processes, the organ pathology itself and the drugs acting on it

Psychological domain

Mood, personality, coping style, health beliefs and behaviours, illness cognitions and the meaning of the illness to the person

Social domain

Family, work and financial context, social support, culture and access to care

PEARL

The biopsychosocial model is easy to *recite* and hard to *use*. In an exam formulation, do not list the three domains and stop; show the *interaction*, for example how a social stressor (job loss) drives a psychological state (depression) that changes a biological pathway (adherence and inflammation) to worsen a real disease. The interaction is the mark-earning part.

16.4 The stress-illness pathways, at concept level

Three biological roads from an emotion to an organ. The mechanism that gives the concept its credibility is that psychological stress reaches the body through well-mapped physiological systems, so the mind-body link is not mystical but neuroendocrine, autonomic and immune (Kaplan and Sadock CTP 2024; Tasman). The neuroendocrine road is the hypothalamic-pituitary-adrenal axis: perceived stress drives cortisol and other counter-regulatory hormones, which over time impair glucose handling, immune surveillance and healing. The autonomic road is sympathetic and adrenomedullary activation, releasing catecholamines that raise heart rate and blood pressure and can, in vulnerable coronary vessels, provoke ischaemia. The immune road is

captured by psychoneuroimmunology, the study of how psychological states, particularly depression and chronic stress, shift immune function and raise pro-inflammatory cytokines that are themselves implicated in cardiovascular and autoimmune disease. When these systems are activated repeatedly rather than briefly, the cumulative physiological cost is described as allostatic load, the wear-and-tear price of chronic adaptation. Hold the three roads by system, not by disease; the disease-specific detail belongs to the consultation-liaison chapter.

PATHWAY	PRINCIPAL MEDIATORS	ILLUSTRATIVE ORGAN CONSEQUENCE
Neuroendocrine (HPA axis)	Cortisol and counter-regulatory hormones	**Impaired glucose control, immunosuppression, delayed healing**
Autonomic (sympatho-adrenal)	Adrenaline and noradrenaline (catecholamines)	**Raised heart rate and blood pressure, coronary ischaemia in vulnerable vessels**
Immune (psychoneuroimmunology)	Pro-inflammatory cytokines, altered lymphocyte function	**Contribution to cardiovascular and autoimmune disease activity**

The three concept-level stress-illness pathways linking a psychological state to physical disease, each linking a psychological state to physical disease (Kaplan and Sadock CTP 2024; Tasman).

16.5 The classical psychosomatic conditions

Alexander's seven, and how the list outgrew them. Franz Alexander, styled the Father of Psychosomatic Medicine, originally described **seven** classical psychosomatic illnesses. His specificity hypothesis proposed that a specific unconscious emotional conflict, occurring in a person with a genetically predetermined vulnerable organ, produces a specific physical disease. The seven he named are the classic viva list, easiest to hold as the mnemonic below. The specificity hypothesis has not survived as a literal theory, but it seeded the field, and as biopsychosocial causation became clearer the roster of illnesses in which psychological factors matter grew until the list of psychosomatic illnesses is virtually endless. That expansion is exactly why the modern manual abandoned a fixed list of "psychosomatic diseases" for the general, mechanism-neutral diagnosis of psychological factors affecting other medical conditions.

ALEXANDER'S CLASSICAL PSYCHOSOMATIC ILLNESSES	SYSTEM
Bronchial asthma	**Respiratory**
Ulcerative colitis	**Gastrointestinal**
Peptic ulcer	**Gastrointestinal**
Neurodermatitis (atopic dermatitis)	**Dermatological**
Thyrotoxicosis	**Endocrine**
Rheumatoid arthritis	**Musculoskeletal or autoimmune**
Essential hypertension	**Cardiovascular**

The seven classical psychosomatic illnesses described by Franz Alexander, the anchor list for the specificity hypothesis.

MNEMONIC

PURE ANT

A study aid for Alexander's seven: **P**eptic ulcer, **U**lcerative colitis, **R**heumatoid arthritis, **E**ssential hypertension, **A**sthma (bronchial), **N**eurodermatitis, **T**hyrotoxicosis. Seven letters, seven organs; recite the mnemonic and name the theorist (Alexander) and his mechanism (the specificity hypothesis) alongside it.

GOOD TO REMEMBER

- **Alexander's classical psychosomatic illnesses (the anchor list):** bronchial asthma, ulcerative colitis, peptic ulcer, neurodermatitis, thyrotoxicosis, rheumatoid arthritis and essential hypertension (PURE ANT); the discriminator to attach is the specificity hypothesis, that a specific emotional conflict in a genetically vulnerable organ yields a specific disease, a theory now historical but foundational.
- **George Engel, 1977 (the model):** the biopsychosocial model, requiring the biological, psychological and social domains all be accounted for, is the organising frame of the psychosomatic concept and the standard formulation frame across medicine.

7	1977	4
ALEXANDER'S CLASSICAL PSYCHOSOMATIC ILLNESSES	ENGEL'S BIOPSYCHOSOCIAL MODEL	PFAOMC SEVERITY GRADES (DSM-5-TR)

INDIA

The psychosomatic concept is not a Western import for the Indian resident; the canonical Indian textbook is itself the source that names Franz Alexander the Father of Psychosomatic Medicine, sets out the specificity hypothesis and Engel's 1977 model, and lists the seven classical illnesses, so this is examined from the Indian syllabus directly. It also lands with unusual force in Indian practice, where psychological distress is very commonly first voiced as bodily symptoms and where most of these patients are met not in a psychiatry clinic but on a general-hospital ward through the consultation-liaison service; the wider transcultural frame of somatic idioms of distress, including the culture-bound presentations, is developed in the Consultation-liaison, geriatric and transcultural psychiatry notes.

HOLD THIS

The psychosomatic concept holds mind and body as one system: its live diagnosis is psychological factors affecting other medical conditions (F54), which requires a REAL medical condition (Criterion A) that psychological or behavioural factors adversely affect, and is therefore the mirror image of somatic symptom disorder, not a synonym; Engel's 1977 biopsychosocial model is its organising frame, the HPA, autonomic and immune systems are its mechanisms, and Franz Alexander's specificity hypothesis gave the seven classical illnesses (PURE ANT).

17 · Consultation-liaison psychiatry and the disease-specific aspects

The interface discipline, mapped here and taught elsewhere. **Consultation-liaison psychiatry** is the branch of clinical psychiatry that works at the border between psychiatry and the rest of medicine, seeing the psychological problems of patients who are physically ill and

advising the teams that look after them. It matters to the examiner as a named model of care and as a pattern: the same short list of psychiatric problems (delirium, depression, anxiety, self-harm-related presentations and substance withdrawal) recurs across every medical and surgical setting, and each physical illness carries its own psychiatric signature. This note is a compact map. It names the field, its service model and its disease-specific reach, and hands the full teaching to the canonical home.

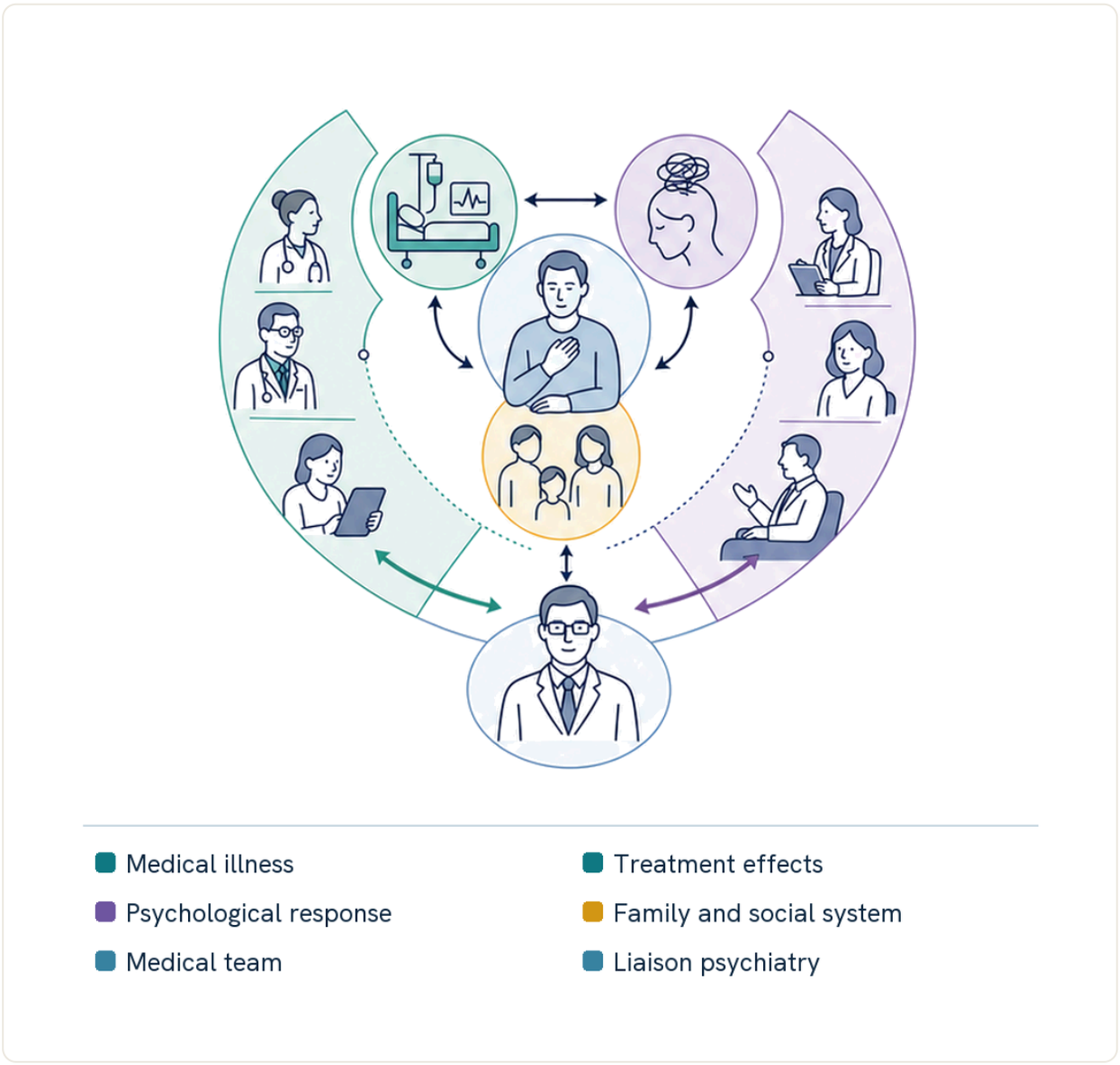


Fig 18.11 Consultation-liaison psychiatry connects medical illness and treatment effects with the patient's psychological response, mental state, family and social system while coordinating care with the medical team.

This is a naming and cross-reference note, not the full teaching. The principles of consultation-liaison psychiatry and the working service model, psycho-oncology and the psychiatric aspects of chronic medical illness, the psychiatric aspects of HIV, endocrine disease and cardiac disease, and the psychiatric aspects of organ transplantation and the surgical and critical-care settings are all developed in *the Consultation-liaison, geriatric and transcultural psychiatry notes*; the acute triage of an actively suicidal patient is in *the emergency psychiatry chapter*. What follows is only where each piece belongs and the one or two facts worth carrying across.

17.1 The principles of consultation-liaison psychiatry and the C-L service model

Consultation versus liaison. Lipowski, in 1971, defined the field as the clinical, teaching and research work of psychiatrists in the non-psychiatric parts of a general hospital. The two words name two activities. *Consultation* is patient-focused: a referral arrives, the psychiatrist answers a specific question and writes back. *Liaison* is team-focused: the psychiatrist teaches and works alongside the medical or surgical team so that psychological care is built into the ward, achieving **integration of care** rather than a single integrated clinician. Six service models are described worldwide, and which one a service runs is largely a question of resources. The commonest reasons a consult is requested are delirium, self-harm and suicide-related presentations, substance withdrawal, disturbed behaviour on the ward, an uncertain diagnosis and the psychological reaction to physical illness; the acute management of the actively suicidal patient is handled compassionately in *the emergency psychiatry chapter*.

C-L SERVICE MODEL	WHO OR WHAT IS THE FOCUS
Consultation model	**The patient is the focus; the consultant answers a specific referral question and hands back a note (the default model in India)**
Liaison model	The consultee and the clinical team are the focus; ongoing teaching and joint care integrate psychiatry into the ward
Bridge model	The C-L psychiatrist is embedded at a primary-care teaching site and trains primary-care physicians
Hybrid model	The psychiatrist sits as a member of a multidisciplinary team
Autonomous psychiatric model	The C-L psychiatrist is unaffiliated to any department and is hired directly by primary-health-care services
Postgraduate training model	A physician is trained in a mental-health setting for one to two years

The six C-L service models (AIIMS Handbook of Consultation-Liaison Psychiatry, 2020); India defaults to the consultation model, with the hybrid model emerging at tertiary centres.

RULE **Delirium until proven otherwise.** New behavioural or cognitive disturbance in a medical or surgical inpatient is delirium, the single commonest reason for a general-hospital psychiatric referral, until an organic cause is found and corrected; screen and treat the physical cause before reaching for a psychiatric label.

GOOD TO REMEMBER

- **The C-L service model (the organising principle):** consultation-liaison psychiatry (Lipowski, 1971) provides psychiatric consultation to the medically and surgically ill and liaises with the treating team, integrating care rather than taking it over; six service models run worldwide (consultation, liaison, bridge, hybrid, autonomous and postgraduate-training), and the first discipline on any referral is to answer the referral question and exclude delirium before attributing a new disturbance to psychiatric illness.

6	~20%	0.15-3.6%	79%
C-L SERVICE MODELS WORLDWIDE	DELIRIUM AMONG GENERAL-HOSPITAL INPATIENTS	INDIAN GENERAL-HOSPITAL REFERRAL RATE	UPPER PSYCHIATRIC-MORBIDITY RATE IN INPATIENT SAMPLES

INDIA

In India, consultation-liaison psychiatry is still practised largely as part of general adult psychiatry rather than a formal subspecialty, and general-hospital psychiatric referral rates are strikingly low, spanning roughly **0.15 to 3.6%** against the Western figure near **10%**. Formal C-L units exist at only a few centres such as AIIMS New Delhi, PGIMER Chandigarh and NIMHANS Bengaluru; most settings run the consultation model, with informal liaison delivered through the National Mental Health Programme and its District Mental Health Programme outreach. The examinable point is that scaling C-L care in a low-resource system starts with the consultation model, layering hybrid and collaborative-care models on as capacity grows.

17.2 Psycho-oncology, chronic medical illness, and the psychiatric aspects of HIV, endocrine disease and cardiac disease

Each illness has a psychiatric signature. **Psycho-oncology** covers the mental health of cancer patients and families: adjustment reactions, depression and demoralisation, anxiety around procedures and prognosis, delirium in advanced disease, and the communication and palliative-care skills that carry it. The psychiatric aspects of **chronic medical illness** are bidirectional, physical illness raising the risk of depression and anxiety while those disorders worsen adherence and outcome. The psychiatric aspects of HIV run from HIV-associated neurocognitive disorder through depression, mania and the neuropsychiatric effects of the infection and its treatment. Endocrine disease is the classic organic mimic: hyperthyroidism presents with anxiety, depression or mania and hypothyroidism with apathy, cognitive slowing, depression and the historical "myxoedema madness". In cardiac disease the link is prognostic, depression is both a risk factor for and a poor prognostic marker after coronary artery disease and myocardial infarction. Every one of these is developed in *the Consultation-liaison, geriatric and transcultural psychiatry notes*; the point to carry is the pattern, not the detail.

TRAP **Do not normalise depression in the physically ill.** Depression in the medically ill is common, more than twice general-population rates, and a poor prognostic marker in cardiac disease, so it is screened and treated, not written off as an understandable reaction to being unwell.

17.3 Organ transplantation, the surgical setting and the ICU

The high-stakes settings. Organ transplantation brings the psychiatrist in twice: before, for a structured evaluation of the candidate's capacity, adherence, substance use and psychosocial support, and after, for delirium, steroid-induced mood change and immunosuppressant neurotoxicity. The surgical setting turns on preoperative anxiety, postoperative delirium and questions of capacity and consent. The ICU is dominated by delirium, which is very common in critically ill and ventilated patients, alongside sedation-related states and the longer post-intensive-care syndrome of cognitive, mood and stress symptoms after discharge. These settings, and the disease-specific detail above, are taught in full in *the Consultation-liaison, geriatric and*

transcultural psychiatry notes; this note only fixes their address and the recurring theme that delirium is the thread running through all of them.

HOLD THIS

Consultation-liaison psychiatry (Lipowski) works at the medicine-psychiatry interface, providing consultation to the medically and surgically ill and liaising to integrate care through six service models (India mostly runs the low-referral consultation model); its disease-specific reach, psycho-oncology and chronic medical illness, the psychiatric aspects of HIV, endocrine disease and cardiac disease, and the transplantation, surgical and ICU settings, is developed in the Consultation-liaison, geriatric and transcultural psychiatry notes, and the working rule at the bedside is delirium-first, treat the depression, and hand back a clear, actionable note.

Impulse-control disorders

18 · The impulse-control disorders

This is a small, self-contained class that examiners love precisely because it is compact and rule-bound. An **impulse-control disorder** is defined by a single repeating engine: a failure to resist an impulse, drive or temptation to perform an act that is harmful to the person or to others, a rising sense of *tension or affective arousal* before the act, and *pleasure, gratification or relief* at the moment of doing it. Learn that tension-relief cycle once and it carries most of the marks across all four entities. The modern nosology regroups these behaviours: ICD-11 collects four named disorders under an ICD-11 impulse-control grouping, while DSM-5-TR scatters them, placing intermittent explosive disorder, pyromania and kleptomania in "Disruptive, impulse-control and conduct disorders" and handling compulsive sexual behaviour differently again.

How to use this page. Take each entity as a keyword with one defining criterion and one management line. Fix the shared tension-relief template first; then the four disorders, intermittent explosive disorder (impulsive aggression), kleptomania (impulsive stealing), pyromania (deliberate fire-setting) and compulsive sexual behaviour disorder; then the sharp discriminators that separate each from its "ordinary" mimic, and the graded, psychological-first management. The combined map of the paraphilic and impulse-control classes is drawn in the accompanying figure, which sits with this block; refer to it for how these entities relate to the paraphilias. The tone throughout is clinical and non-graphic.

MNEMONIC

TENSION → ACT → RELIEF

The shared engine of every impulse-control disorder: mounting *tension* or affective arousal, an impulsive *act* the person cannot resist, then *relief*, pleasure or gratification. Present this cycle and you have named what unifies intermittent explosive disorder, kleptomania, pyromania and compulsive sexual behaviour disorder, and what separates them from goal-directed, premeditated behaviour.

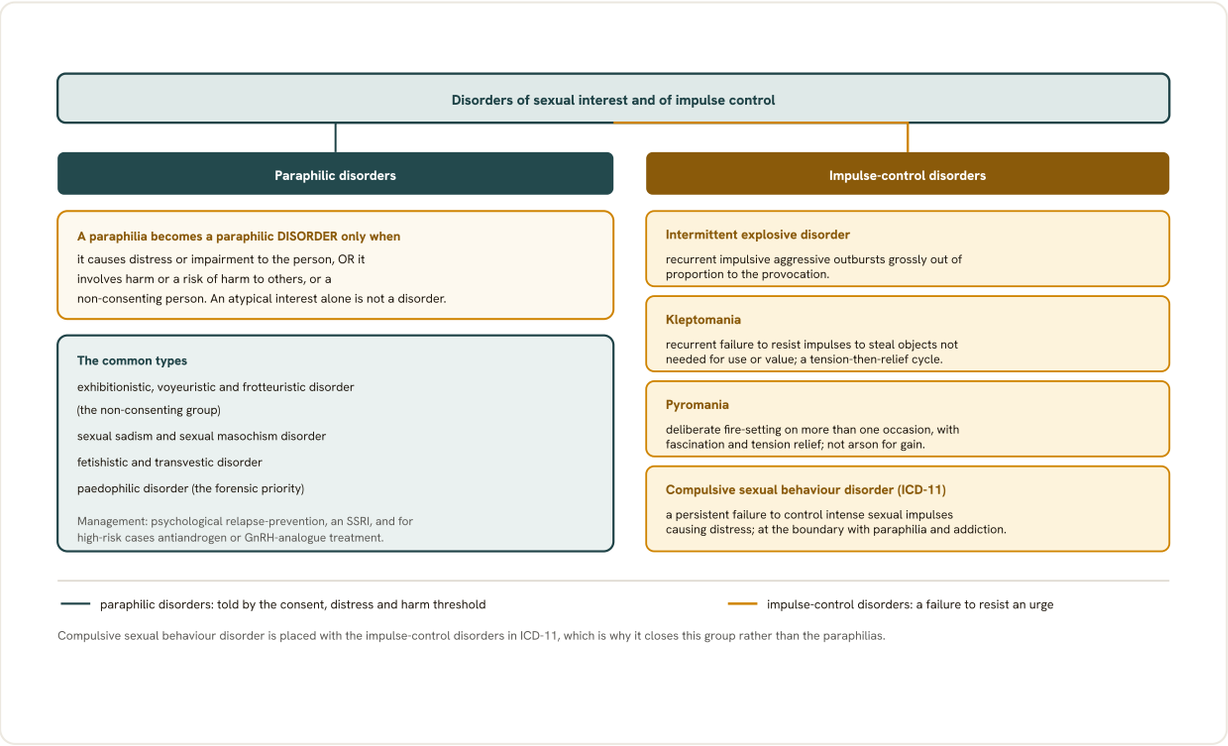


Fig 18.12 The paraphilic and impulse-control disorders. The two groups share a theme of behaviour driven by an urge, but they are recognised differently. A paraphilia becomes a paraphilic disorder only when it causes the person distress or impairment or entails harm or risk of harm to others or a non-consenting person, so an atypical interest by itself is not a disorder; the common types run from the non-consenting exhibitionistic, voyeuristic and frotteuristic disorders through sexual sadism and masochism, fetishistic and transvestic disorder, to paedophilic disorder as the forensic priority. The impulse-control disorders, intermittent explosive disorder, kleptomania and pyromania, are each a recurrent failure to resist an urge with a tension-then-relief cycle, and ICD-11 adds compulsive sexual behaviour disorder here, at the boundary with the paraphilias and with the addiction model.

18.1 Intermittent explosive disorder: impulsive aggression out of proportion to provocation

Recurrent, impulsive aggressive outbursts grossly out of proportion to the trigger. The core of intermittent explosive disorder is recurrent impulsive aggression, that is, aggressive outbursts that are impulsive or anger-based and grossly out of proportion, in intensity or duration, to the provocation (DSM-5-TR 2022; Kaplan and Sadock CTP 2024). DSM-5-TR operationalises the frequency two ways: verbal aggression (temper tantrums, tirades, verbal arguments) or non-damaging, non-injurious physical aggression occurring **twice weekly** on average over a 3-month period (Criterion A1), *or* three behavioural outbursts causing damage, destruction or physical injury within a 12-month period (Criterion A2). The magnitude is grossly out of proportion to the provocation (Criterion B); the outbursts are *not premeditated* and are not committed to achieve a tangible objective such as money, power or intimidation (Criterion C); and the chronological age is at least **6 years** (Criterion E). Outbursts have a rapid onset, little prodrome, and typically last under 30 minutes.

CRITERION	AGGRESSION TYPE	FREQUENCY THRESHOLD
A1	Verbal, or physical without damage or injury	**Twice weekly on average, over a 3-month period**
A2	Physical, causing damage, destruction or injury	**Three outbursts within a 12-month period**

The two frequency routes to the intermittent explosive disorder diagnosis; either the frequent low-grade route (A1) or the infrequent destructive route (A2) satisfies Criterion A (DSM-5-TR 2022).

RULE **The aggression is impulsive, not instrumental.** Intermittent explosive disorder is diagnosed only when the outbursts are impulsive or anger-based and are not premeditated and not aimed at a tangible objective; that is what separates it from the proactive, predatory aggression of conduct disorder and antisocial personality disorder.

GOOD TO REMEMBER

- **Intermittent explosive disorder (the criterion):** recurrent impulsive aggressive outbursts grossly out of proportion to provocation, either verbal or non-injurious aggression twice weekly over a 3-month period, or three destructive or injurious outbursts within a 12-month period; not premeditated, not for tangible gain, age at least 6 years.

Management: serotonergic pharmacotherapy plus cognitive-behavioural work. Because low central serotonergic function is linked to impulsive aggression, the drug evidence centres on SSRIs, and fluoxetine carries the single positive double-blind, placebo-controlled trial in intermittent explosive disorder (Coccaro and colleagues), dosed into the standard antidepressant range up to **60 mg** per day; across five controlled trials SSRIs reduce impulsive aggression, though under a third of patients reach full remission (Kaplan and Sadock CTP 2024). Where impulsivity is high, mood-stabilising anticonvulsants, divalproex sodium and valproate, reduce aggressive acts, with the largest effect in the most impulsive patients; the deeper pharmacology sits in the Mood disorders: pharmacotherapy notes. On the psychological side, cognitive-behavioural therapy targeting anger, hostile appraisals and the outburst cycle has a positive randomised trial (McCloskey and colleagues, twelve weekly sessions, group and individual formats), with gains sustained at follow-up.

GOOD TO REMEMBER

- **Intermittent explosive disorder management (guideline and evidence-anchored):** an SSRI is the drug of choice, fluoxetine having the one positive controlled trial (up to 60 mg per day); anticonvulsant mood stabilisers such as divalproex suit high trait impulsivity; and manualised cognitive-behavioural therapy for anger and impulse control is the evidence-based psychotherapy.

18.2 Kleptomania: the impulse to steal what is not needed

Recurrent failure to resist stealing objects not needed for use or value. Kleptomania is the recurrent failure to resist impulses to steal objects that are *not needed for personal use or for their monetary value* (Criterion A); the individual feels a rising subjective tension before the theft (Criterion B) and pleasure, gratification or relief at the moment of committing it (Criterion C); and the stealing is not done to express anger or vengeance and is not a response to a delusion or hallucination (Criterion D) (DSM-5-TR 2022). This is **impulsive stealing** driven by the tension-relief cycle, not by want: the objects are typically of little value to a person who could have paid for them, and are often given away, discarded, hoarded or secretly returned. It is distinct from ordinary theft, which is goal-directed, planned, and motivated by the value or usefulness of the item.

TRAP **Reading everyday shoplifting as kleptomania.** Most theft is ordinary, planned and motivated by the object's value; kleptomania is rare and defined by stealing things the person does not need or want, driven by mounting tension and relief. Equally, do not miss it in reverse, a patient who steals trinkets they discard, feels shame and cannot stop, is not simply "a thief".

GOOD TO REMEMBER

- **Kleptomania (the criterion):** recurrent failure to resist impulses to steal objects not needed for personal use or monetary value, with rising tension before and gratification or relief after the theft, not for anger, vengeance or in response to a delusion; the tension-relief cycle and the pointlessness of the object separate it from ordinary, goal-directed theft.

Management: an opioid antagonist and cognitive-behavioural therapy. There is no licensed drug, and the controlled evidence is thin, but the standout pharmacological signal is the opioid antagonist naltrexone, which reduces the urge to steal and stealing behaviour in trial data, plausibly by dampening the reward and relief that reinforce the act; SSRIs give mixed results and are used on the obsessive-compulsive-spectrum rationale (Kaplan and Sadock CTP 2024). The evidence-based psychotherapy is cognitive-behavioural therapy, classically covert sensitisation and imaginal desensitisation to the urge.

GOOD TO REMEMBER

- **Kleptomania management (evidence-anchored):** the opioid antagonist naltrexone has the best pharmacological support for reducing stealing urges; SSRIs are second-line with mixed evidence; and cognitive-behavioural therapy, particularly covert sensitisation and imaginal desensitisation, is the psychotherapy of choice. No agent is formally licensed.

18.3 Pyromania: deliberate fire-setting with fascination and relief

Purposeful, repeated fire-setting driven by fascination, not gain. Pyromania is **deliberate fire-setting** on more than one occasion (Criterion A), preceded by tension or affective arousal (Criterion B), with a *fascination with, interest in, curiosity about or attraction to* fire and its situational contexts, its paraphernalia, uses and consequences (Criterion C), and pleasure, gratification or relief when setting fires or witnessing their aftermath (Criterion D) (DSM-5-TR 2022). The diagnosis is exclusionary: the fire-setting must *not* be done for monetary gain, as an expression of sociopolitical ideology, to conceal criminal activity, to express anger or vengeance, to improve one's circumstances, in response to a delusion or hallucination, or as a result of impaired judgement; and it is not diagnosed if better explained by conduct disorder, a manic episode or antisocial personality disorder (Criteria E and F). This is what separates pyromania from arson, which is fire-setting for an external purpose such as profit, revenge or concealment.

GOOD TO REMEMBER

- **Pyromania (the criterion):** deliberate, purposeful fire-setting on more than one occasion, with pre-act tension, a fascination with fire, and relief on setting or watching it; not for monetary gain, ideology, concealment, anger or in response to a delusion; the intrinsic fascination and tension-relief, and the absence of external motive, separate it from arson.

Management: psychological, with no established drug. There are no controlled trials and no approved medication for pyromania; scattered case reports of SSRIs, naltrexone, topiramate and mood stabilisers are inconclusive (Kaplan and Sadock CTP 2024). The mainstay is cognitive-behavioural therapy combined with fire-safety education, an approach with the best support, especially in younger fire-setters where structured cognitive-behavioural programmes outperform education alone.

GOOD TO REMEMBER

- **Pyromania management (evidence-anchored):** no drug is licensed and pharmacotherapy evidence is only anecdotal; the first-line and best-supported treatment is cognitive-behavioural therapy paired with structured fire-safety education, targeting the antecedents of fire-setting and the fascination that reinforces it.

18.4 Compulsive sexual behaviour disorder: the ICD-11 impulse-control entity

A persistent failure to control intense, repetitive sexual impulses, classed with the impulse-control disorders. Compulsive sexual behaviour disorder (ICD-11 code 6C72) is a persistent pattern of failure to control intense, repetitive sexual impulses or urges resulting in repetitive sexual behaviour, over an extended period, at least six months (ICD-11 CDDR). The behaviour becomes a central life focus to the neglect of health, care and responsibilities; the person makes repeated unsuccessful efforts to reduce it; continues despite adverse consequences (relationship, financial, legal or health) and even when deriving little satisfaction; and the pattern causes marked distress or significant impairment. It is the ICD-11 successor to ICD-10 excessive sexual drive, the older label for **hypersexuality**, and it is deliberately placed among the impulse-control disorders. DSM-5-TR, by contrast, does *not* recognise it; a proposed "hypersexual disorder" was rejected for DSM-5 for want of evidence.

PEARL

Two boundaries are the whole exam answer. Against *paraphilia*: in compulsive sexual behaviour disorder the sexual interest itself is typically normative and it is *control* that fails, whereas a paraphilia is defined by an *atypical arousal focus*. Against *addiction*: ICD-11 declined to call this a behavioural addiction, reserving that grouping for gambling and gaming alone, and located it with the impulse-control disorders instead, so "sex addiction" is not an ICD-11 diagnosis. Crucially, distress arising *only* from moral or religious disapproval of one's own sexual behaviour does not qualify.

GOOD TO REMEMBER

- **Compulsive sexual behaviour disorder (the criterion):** a persistent, at-least-six-month failure to control intense, repetitive sexual impulses producing repetitive sexual behaviour that becomes a central focus, resists control and continues despite adverse consequences or little satisfaction, causing marked distress or impairment; classed as an ICD-11 impulse-control disorder, not a paraphilia and not a behavioural addiction, and not diagnosed on moral or religious distress alone.

DISORDER	THE IMPULSE RESISTED AND FAILED	TENSION THEN RELIEF	THE DISCRIMINATOR FROM ITS "ORDINARY" MIMIC
Intermittent explosive disorder	Impulsive aggressive outburst	Yes; anger or arousal, then release	**Impulsive, not premeditated and not for tangible gain (versus conduct disorder or antisocial aggression)**
Kleptomania	Stealing an unneeded, low-value object	Yes; tension, then gratification or relief	**Object not needed for use or value (versus ordinary, goal-directed theft)**
Pyromania	Deliberate fire-setting	Yes; arousal, then relief on watching	**Fascination with fire, no external motive (versus arson for gain, revenge or concealment)**
Compulsive sexual behaviour disorder	Repetitive sexual behaviour	Often to modulate negative affect	**Control fails over a normative interest (versus a paraphilia's atypical arousal focus; not an addiction in ICD-11)**

The four ICD-11 impulse-control disorders share one engine, the tension-relief cycle, and each is separated from a common mimic by a single discriminator (DSM-5-TR 2022; ICD-11 CDDR; Kaplan and Sadock CTP 2024).

INDIA

The genuine Indian anchor is the medico-legal interface. Kleptomania, pyromania and impulsive aggression frequently surface in forensic settings, but the disorder is not, in itself, a legal defence: the insanity defence under Indian law, Indian Penal Code Section 84 (the M'Naughten rules, re-enacted in the Bharatiya Nyaya Sanhita 2023), acquits only where unsoundness of mind rendered the person incapable of knowing the nature of the act or that it was wrong or contrary to law. Most people with an impulse-control disorder retain that knowledge, so they are usually held criminally responsible for the theft, the fire-setting or the assault; the diagnosis bears on mitigation and sentencing, not automatic exculpation. The clinician's task is to distinguish the disorder from the crime (kleptomania from theft, pyromania from arson) and to say so honestly. Drug choices here, SSRIs, naltrexone and mood stabilisers, are the same generics used across the mood and obsessive-compulsive chapters; entity-specific Indian brand equivalents were not confirmable in the available sources, so the generic name stays primary.

4	6	3
ICD-11 NAMED IMPULSE-CONTROL DISORDERS	INTERMITTENT EXPLOSIVE DISORDER MINIMUM AGE (YEARS)	DESTRUCTIVE OUTBURSTS (PER 12-MONTH PERIOD, CRITERION A2)

HOLD THIS

Every impulse-control disorder is a failure to resist an impulse harmful to self or others, with **tension before and relief after**; ICD-11 names four, intermittent explosive disorder, kleptomania, pyromania and compulsive sexual behaviour disorder, and you diagnose each by the tension-relief cycle and the *absence* of an external, goal-directed motive, managing them psychologically first (cognitive-behavioural therapy) with an SSRI, fluoxetine or naltrexone as the drug adjunct.

Suicide and self-harm

19 · Suicide risk assessment

This is the topic on which the whole chapter closes, the *Defence of life* that the master mnemonic seeded at the outset, and it is examined as a skill rather than as a fact-list. The task is a **suicide risk assessment**: a compassionate, structured clinical interview that gathers the patient's suicidal thinking and behaviour, weighs the **risk factors** against the **protective factors** and the current mental state and social context, and then translates that synthesis into a plan for care and **safety**. It is emphatically *not* a numerical prediction of who will die, and the single most important idea on the page is that no instrument, and no clinician, can predict individual suicide reliably; the assessment exists to guide management, not to forecast an outcome.

How to use this page. Fix the vocabulary first (ideation, plan, intent, attempt, self-harm), then the two halves of the balance, the static and dynamic risk factors and the protective factors, then the framing of chronic against acute risk. After that, learn the three named aides in the way examiners want them, the Columbia Suicide Severity Rating Scale as the gold-standard structured interview, SAD PERSONS as a teaching aide with a stated limitation, and PHQ-9 item nine as a screen, and finally the two principles that bind the whole topic together: the limits of individual prediction, and the Indian statute that has recriminalised nothing and decriminalised the attempt. Throughout, hold the cardinal error the topic is built to prevent, treating a denied ideation as a cleared risk when the structured evaluation and the risk-and-protective balance say otherwise.

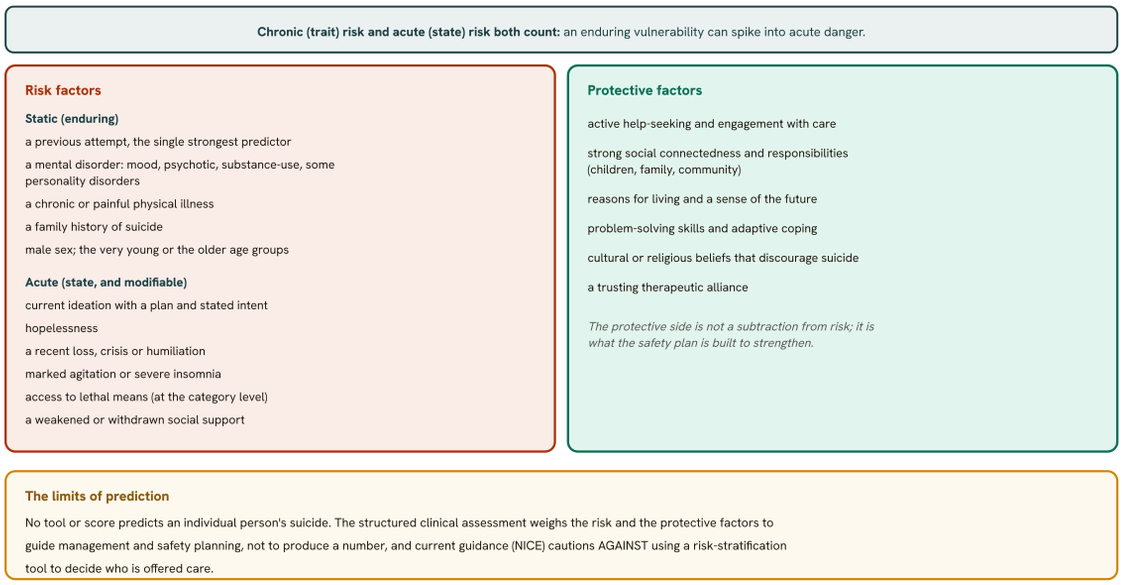


Fig 18.13 The balance of suicide risk and protective factors. A structured assessment weighs the two sides. The risk factors divide into static, enduring markers, of which a previous attempt is the single strongest, and acute, modifiable state factors such as current ideation with a plan and intent, hopelessness and a recent crisis, which is where intervention acts. The protective factors, from help-seeking and social connectedness to reasons for living and a therapeutic alliance, are not simply subtracted from risk; they are what a safety plan is built to strengthen. The decisive teaching point is the limit of prediction: no instrument forecasts an individual suicide, so the assessment guides care rather than generating a number, and current guidance discourages using a risk-stratification score to allocate treatment.

The Columbia Suicide Severity Rating Scale (C-SSRS): the screener structure

THE SCREENER ASKS, IN ESCALATING ORDER	WHAT IT MARKS
1. A wish to be dead, or to go to sleep and not wake up	ideation, lower
2. Non-specific active thoughts of ending one's life	ideation
3. Active thoughts with a general sense of acting, but no plan	ideation, rising
4. Active thoughts with some intention of acting	**high concern**
5. Active thoughts with a specific plan and intent	**highest ideation**
6. Behaviour: any preparatory act or attempt (asked of everyone)	**behaviour, highest**

Items 1 to 5 form an escalating ideation ladder and item 6 captures behaviour. The screener's own published triage points are: yes to item 1 or 2, low risk (behavioural-health referral at discharge); yes to item 3, moderate risk (behavioural-health consult); yes to item 4 or 5, high risk (patient safety precautions); yes to the behaviour item, high risk only if the behaviour fell within the past three months, otherwise moderate. The behaviour item is stated here in general terms, without method detail.

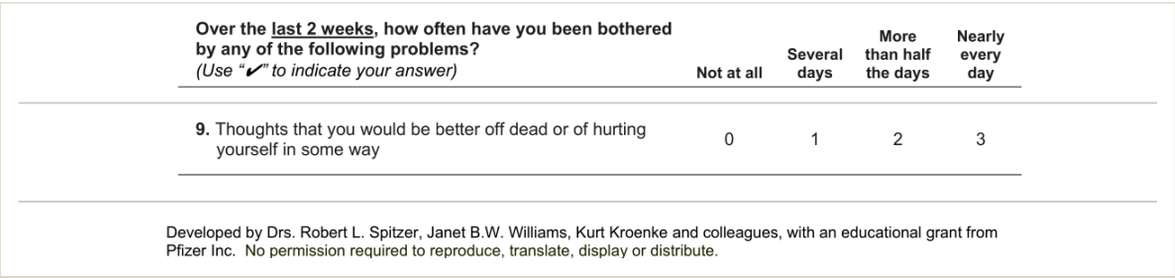
C-SSRS (Posner et al; Columbia Lighthouse Project); free for non-commercial clinical and research use with acknowledgement. Typeset here in structure only, safe-messaged, with the behaviour examples abstracted to "any preparatory act or attempt".

Fig 18.14 The Columbia Suicide Severity Rating Scale, shown as its structure. The screener walks up an ideation ladder, from a passive wish to be dead, through non-specific and then active thoughts, to active thoughts with intent and finally with a specific plan, and closes with a single behaviour question asked of everyone. It is used not to generate a number but to place where a person sits on that ladder: a positive answer at the second step already signals concern, and a positive answer higher up, or to the behaviour item, signals high risk needing immediate safety measures. It is presented here typeset and safe-messaged, with the behaviour examples abstracted so that no method detail appears.

SAD PERSONS: a teaching aide-memoire (out of a possible 10)

LETTER	ITEM (ONE POINT EACH)
S / A / D	male Sex; extremes of Age; Depression
P / E / R	Previous attempt; Ethanol or substance use; Rational thinking loss (psychosis)
S / O / N / S	Social supports lacking; Organised plan; No spouse or partner; Sickness (chronic illness)
Banding	**0 to 4 lower, 5 to 6 medium (consider admission), 7 to 10 high concern**

SAD PERSONS (Patterson et al, 1983). A teaching mnemonic, NOT a validated predictor of individual risk (Bolton 2012); use it to structure recall, never to clear a patient.



Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

PHQ-9 item 9 is the single suicidality-screen item, scored 0 to 3 over two weeks; any score of 1 or more is a positive screen that prompts a full risk assessment. It is a screen, not a risk assessment.

PHQ-9 (Kroenke, Spitzer and Williams); PHQ family, no permission required to reproduce; free non-commercial educational use.

BECK SUICIDE INTENT SCALE (SIS): INTENT BEHIND AN ACTUAL ATTEMPT	STRUCTURE AND BAND
Part 1, objective circumstances (8 items): isolation, timing, precautions against discovery, acting to gain help, final acts, active preparation, a note, and communication of intent	each item scored 0 to 2
Part 2, self-report (7 items): expectation of fatality, conception of lethality, seriousness, attitude to living or dying, premeditation, reaction to survival, stated purpose	each item scored 0 to 2; total out of a possible 30
rated for a person who HAS made an attempt (distinct from the ideation scales)	**a commonly used categorisation (Pierce 1977): 0 to 3 low, 4 to 10 medium, 11 or more high intent; Beck did not fix a validated cut-off**

Beck Suicide Intent Scale (Beck, Schuyler and Herman, 1974); copyright the authors, permission required, so typeset here in summary with the verified structure rather than reproduced.

Fig 18.15 The suicide-risk aides. SAD PERSONS is a ten-point mnemonic that helps a trainee remember the domains to ask about, banded 0 to 4 lower, 5 to 6 medium and 7 to 10 high concern; it is explicitly a teaching aide and not a validated predictor of an individual's risk, so it structures recall but never clears a patient. PHQ-9 item 9 is the single screening question for suicidality, positive at a score of 1 or more, which prompts, rather than replaces, a full assessment. The Beck Suicide Intent Scale is the instrument for a person who has already made an attempt, rating the objective circumstances and the self-reported intent across fifteen items for a total out of a possible 30, with the widely quoted Pierce bands recorded as a common categorisation rather than a Beck-validated cut-off. All are presented safe-messaged, without method detail.

19.1 The vocabulary of suicidality

Precise terms, arranged along a continuum from thought to act. A defensible assessment begins with clean definitions, because the examiner marks the discrimination between them and because muddled terms produce muddled clinical decisions (Kaplan and Sadock CTP 2024; Clinical Methods in Psychiatry, AIIMS 2024). **Suicidal ideation** is thinking about, considering or planning ending one's life, and it ranges from a passive wish to be dead to active, specific thoughts. A **plan** is a formulated method and set of circumstances for acting. **Intent** is the subjective determination to act on those thoughts, the will to die, and it is separable from both ideation and plan. A **suicide attempt** is a non-fatal, self-directed, potentially injurious act carried out with at least some intent to die. **Self-harm**, in the sense used by the self-harm guideline, is any act of self-injury or self-poisoning irrespective of intent or motive, so it is the broadest term and deliberately does not assume a wish to die; non-suicidal self-injury is the subset undertaken with no suicidal intent. The clinician's job is to place the patient on the continuum, ideation, then plan, then intent, then behaviour, because escalation along it is one of the things that raises acute concern.

GOOD TO REMEMBER

- **The suicidality continuum (the terminology):** ideation (passive wish to active thought) → plan (a formulated method) → intent (the will to act) → attempt (a self-directed potentially injurious act with some intent to die); self-harm is the umbrella term for any self-injury or self-poisoning regardless of intent, so it does not by itself imply a wish to die. The discriminator to hold is that intent is separable from ideation and plan and must be asked about in its own right.

19.2 What a structured evaluation is, and is not

A weighing interview, not a checklist score. The guideline-anchored method is a **structured evaluation** through a clinical interview that explores the patient's suicidal thinking and its history, the current mental state, the psychosocial context and the balance of risk and protective factors, and that arrives at a clinical judgement about care and safety (NICE-aligned, NG225 2022). It is structured in that it systematically covers the same domains every time so that nothing high-yield is missed, but it is not a tally of ticked boxes producing a risk number. Asking directly and calmly about suicidal thoughts is a core skill and, contrary to a persistent myth, does not plant the idea or increase risk; a graded set of questions, moving from low mood to thoughts that life is not worth living, to active thoughts, plan and intent, is the safe and validated way in. The cardinal trap sits precisely here: a patient may deny ideation, yet when the static and dynamic risk load is high and protective factors are thin, a bare verbal denial cannot be treated as a cleared risk. Denial is one data point among many, not the end of the assessment.

WORKED EXAMPLE

A man in his forties is seen after a recent attempt was medically managed. He now says, flatly, "no, I am not thinking of anything like that, I just want to go home." Against that single denial sits a strong static load (a prior attempt, current severe depression) and a heavy dynamic load (marked hopelessness, agitation, a job loss the week before, living alone), with few protective factors and poor engagement. Taking the denial at face value and discharging him would be the cardinal error. The structured evaluation, weighing the whole balance rather than the last sentence spoken, keeps him in active care with a collaborative safety plan; the denial is noted, not trusted as an all-clear.

TRAP **Treating a denied ideation as a cleared risk.** A verbal "no" does not neutralise a high risk-and-protective balance. When the structured evaluation shows heavy static and dynamic loading with thin protection, the denial is one data point; the assessment, not the last answer, governs the safety plan.

19.3 Static risk factors: the fixed background

Historical, slow-changing markers that set the baseline. Static (distal, largely unchangeable) risk factors describe the population a patient belongs to and raise the baseline against which the current state is read (Kaplan and Sadock CTP 2024). The single strongest of them is a *previous suicide attempt*; a prior attempt and a current major depressive episode are together described as the two strongest predictors of future suicide, and the first attempt materially raises the risk of a later one. Mental illness is the next great pillar: mood disorders (unipolar and, with the highest risk, bipolar), schizophrenia and other psychoses, and substance use disorders including alcohol all carry substantially elevated risk, and psychological-autopsy data find a diagnosable mental disorder in the large majority of those who die. Chronic, disabling or painful physical illness adds independently, especially when depression is also present. A family history of suicide or of psychiatric disorder raises risk, partly heritable and partly environmental. Demographic markers (for example male sex for completed suicide, older age, social isolation, single or bereaved status) are statistically real but weak in the individual case, which is exactly why they must never be used alone.

STATIC (DISTAL) RISK FACTOR	WHY IT RAISES BASELINE RISK	THE POINT TO HOLD
Previous suicide attempt	Strongest single historical predictor	**Prior attempt plus current depression are the two strongest predictors**
Mental illness	Mood disorder, psychosis, substance use disorder all elevate risk	**Bipolar and severe depression carry the highest mood-disorder risk**
Chronic pain or physical illness	Disabling, painful or fatal disease, amplified by depression	**Independent contributor, greatest when depression co-occurs**
Family history	Family history of suicide or psychiatric disorder	**Part heritable, part environmental transmission**
Demographics	Male sex (completion), older age, isolation, single or bereaved	**Statistically real but weak alone; never a stand-alone basis**

The static background factors that set baseline risk, mapped in the accompanying figure against the dynamic and protective factors (Kaplan and Sadock CTP 2024).

RULE **Prior attempt is the strongest static factor.** A previous suicide attempt, with current major depression, is among the two strongest predictors of future suicide; every assessment asks explicitly about past attempts and never discounts them because the method was medically minor.

19.4 Dynamic risk factors: the modifiable foreground

Current, changeable states that drive acute concern and are the levers of intervention. Dynamic (proximal, modifiable) factors are what shift a patient from their chronic baseline into a period of heightened risk, and because they can change they are where treatment acts (Kaplan and Sadock CTP 2024; NICE NG225 2022). *Hopelessness* is the pre-eminent dynamic factor, more tightly linked to eventual suicide than depressed mood itself, which is why it is asked about and rated directly. *Current suicidal ideation with a plan and stated intent* is the most immediate marker, and escalation along the ideation continuum is itself a warning. *Agitation, severe anxiety and insomnia* raise near-term risk, particularly in a depressive or mixed mood state. A *recent loss or interpersonal crisis* (bereavement, separation, humiliation, job or financial loss, legal trouble) commonly precedes an act. *Access to lethal means* is a dynamic factor named only at the category level, because reducing that access is one of the most effective things a clinician and family can do. *Social isolation and disconnection*, and recent discharge from inpatient or emergency care, complete the picture, the transition period after any care contact being a recognised window of elevated risk.

GOOD TO REMEMBER

- **Dynamic risk factors (the modifiable foreground):** hopelessness (the pre-eminent one), current ideation with plan and intent, agitation or severe anxiety and insomnia, a recent loss or crisis, access to means (named at category level only), isolation, and the high-risk period just after any care contact. The point to hold is that these are the treatable levers; the assessment targets them, and reducing access to means is framed positively as putting time and distance between a person and a crisis.

19.5 Protective factors: the other half of the balance

Reasons and connections that buffer risk and must be actively sought. A one-sided hunt for risk is a poor assessment; the protective factors are weighed alongside and are themselves things to strengthen (Kaplan and Sadock CTP 2024; Clinical Methods in Psychiatry, AIIMS 2024). The best-evidenced are *help-seeking* and a willingness to engage with care; *social connectedness and support*, a partner, family, friends or community; concrete *reasons for living*, which can be elicited directly and are the object of the Reasons for Living Inventory; *responsibilities to others*, notably dependent children; *religious or cultural beliefs* that frame suicide as unacceptable; and *active engagement with treatment* with a therapeutic alliance the patient values. Protective factors are not fixed either; they are dynamic, they can erode in a crisis, and part of management is deliberately building and mobilising them. Crucially, protection does not cancel risk arithmetically; a patient with strong reasons for living and a high acute risk is still at high acute risk, so protective factors qualify the plan rather than override the concern.

PEARL

Asking directly about suicide does *not* plant the idea or raise risk, a myth worth retiring on sight. A graded approach works best: start with mood, move to whether life feels worth living, then to active thoughts, then plan, then intent, and, just as deliberately, ask what has kept the person going, their reasons for living, so the interview surfaces the protective half of the balance rather than only the risk half.

19.6 Chronic and acute risk

Two time-frames, held separately, because they call for different responses. Risk is not a single dial; the useful clinical framing separates **chronic and acute risk** (Kaplan and Sadock CTP 2024). *Chronic (baseline) risk* is the long-standing, trait-like elevation carried by the static factors, a history of attempts, an enduring mental illness, a personality vulnerability; it changes slowly and is managed over the long term through treatment of the underlying disorder and durable supports. *Acute (state) risk* is the near-term elevation driven by the dynamic factors, a surge of hopelessness, an intensifying ideation, a fresh loss, agitation, intoxication; it changes fast and demands an immediate response. The two combine: a patient may be chronically high-risk yet acutely settled, or chronically moderate yet acutely dangerous because of a proximal crisis, and it is the person at chronic *and* acute elevation who is of greatest immediate concern. Documenting both, and stating what specifically has changed to raise the acute component, is what makes an assessment defensible and actionable.

DIMENSION	CHRONIC (BASELINE) RISK	ACUTE (STATE) RISK
Driven by	Static, trait-like factors	**Dynamic, modifiable factors**
Time-course	Slow-changing, long-standing	**Fast-changing, near-term**
Typical content	Past attempts, chronic illness, vulnerability	**Rising hopelessness, ideation with intent, recent crisis, agitation**
Response	Long-term treatment and durable support	**Immediate safety plan, closer care, mobilise supports**

Chronic and acute risk are documented as two separate axes; the person elevated on both warrants the most immediate response (Kaplan and Sadock CTP 2024).

19.7 The Columbia Suicide Severity Rating Scale (C-SSRS)

The gold-standard structured interview, an ideation-severity ladder plus a behaviour subscale. The Columbia Suicide Severity Rating Scale (C-SSRS; Posner and colleagues, 2011) is a clinician-administered interview widely regarded as the gold-standard instrument for assessing and monitoring suicidality, free for clinical use and available in many languages and versions (a lifetime-recent baseline version, a since-last-visit version for follow-up, and a brief screener for non-specialists) (Clinical Methods in Psychiatry, AIIMS 2024). Its power for the exam is its structure. The *ideation-severity subscale* is an ordered ladder of five levels of increasing severity: a wish to be dead; non-specific active suicidal thoughts; active thoughts with some general consideration of how one might act but no worked-out plan and no intent; active ideation with some intent to act but without a specific plan; and active ideation with both a specific plan and intent. A separate *behaviour subscale* records the spectrum of suicidal behaviour, from preparatory acts through interrupted and aborted attempts to an actual attempt, together with a general rating of its severity, and one further category captures self-injurious behaviour without suicidal intent. It structures the interview and tracks change over time; it does not, and is not meant to, output a probability that a given person will act.

C-SSRS IDEATION LEVEL	WHAT IT CAPTURES (NO METHOD SPECIFICS)	THE ESCALATION IT MARKS
Level one	Wish to be dead	**Passive; a wish not to be alive, without active thoughts**
Level two	Non-specific active suicidal thoughts	**Active thoughts of ending one's life, no method, plan or intent**
Level three	Active ideation with general thought of acting	**Some consideration of how one might act, no worked-out plan, no intent**
Level four	Active ideation with some intent	**Some intent to act, still without a specific plan**
Level five	Active ideation with plan and intent	**Both a specific plan and intent present; the top of the ladder**

The C-SSRS ideation-severity ladder, described without method detail; the full instrument is reproduced in the accompanying scale plate (Posner 2011; AIIMS Clinical Methods 2024).

GOOD TO REMEMBER

- **C-SSRS (the instrument):** the gold-standard clinician-administered interview for assessing and monitoring suicidality, comprising eleven categories in all, five ordered ideation-severity levels (from a wish to be dead up to active ideation with a specific plan and intent), five behaviour categories, and one for self-injurious behaviour without suicidal intent. The discriminator to hold is that it structures and tracks the assessment but is explicitly not a predictor of who will act.

19.8 SAD PERSONS and PHQ-9 item nine: two teaching aides

A mnemonic best used to teach, and a single screening item, each with clear limits. Two further aides appear in every viva, and each must be quoted with its caveat (Patterson and colleagues, 1983; Kroenke and Spitzer, 2001). The SAD PERSONS scale is a ten-item mnemonic of classic risk factors, scored out of a possible ten, devised as a memory aid and teaching tool. Its examinable weakness is decisive: it is *not* a validated predictor of individual suicide, it performs poorly at discriminating who will act, and it must never be used to decide who receives care or admission; it earns its place as a way to remember factors, not to grade risk. The PHQ-9 depression questionnaire carries item nine, which asks about "thoughts that you would be better off dead, or of hurting yourself in some way," scored 0 to 3 over the past two weeks. It is a widely used single-item screen: any endorsement is a positive flag that must trigger a full structured suicide risk assessment, but on its own it screens rather than assesses, and it neither confirms risk nor grades it. Both aides feed the interview; neither replaces it, and the reproduced forms sit in the accompanying scale plate.

MNEMONIC

SAD PERSONS

Sex (male), **A**ge (older), **D**epression; **P**revious attempt, **E**thanol or substance use, **R**ational-thinking loss (psychosis), **S**ocial supports lacking, **O**rganised plan, **N**o spouse (isolation), **S**ickness (chronic illness). Ten items, one point each, scored out of a possible ten. Hold it for what it is: a teaching aide that lists risk factors, explicitly not a validated instrument for predicting an individual's risk or for rationing care.

GOOD TO REMEMBER

- **SAD PERSONS (the aide):** a ten-item risk-factor mnemonic scored out of a possible ten; its defining limitation is that it is not validated to predict individual suicide and must not be used to allocate care, so it teaches factors rather than grades risk.
- **PHQ-9 item nine (the screen):** a single item on death and self-harm thoughts, scored 0 to 3 over two weeks; any positive answer mandates a full structured suicide risk assessment. It screens, it does not assess or grade risk.

19.9 The limits of individual-risk prediction

No instrument predicts individual suicide; the assessment guides care, it does not forecast. This is the intellectual centre of the topic and its most heavily tested principle. Suicide is, at the

level of the individual, a rare and fluctuating event, and the evidence is consistent that no scale, algorithm or clinical judgement reliably identifies which person will act; this is the **limits of prediction** (Kaplan and Sadock CTP 2024; NICE NG225 2022). Two practical consequences follow. First, risk-assessment and stratification *tools* must not be used to predict future suicide or self-harm, nor to decide who is offered treatment or admission; a global "low, medium, high" label must not drive clinical decisions. Second, the field has moved from prediction toward a prevention-oriented *suicide risk formulation*, which summarises the gathered data into four judgements that inform action rather than forecast an event: the patient's *risk status* (relative to a comparison group), their *risk state* (relative to their own baseline or other time-points), the *resources* they can draw on in crisis, and the *foreseeable changes* that could raise risk (Pisani, Murrie and Silverman 2016). The purpose of the assessment is to identify modifiable, treatable factors and to shape a safety-focused plan, not to generate a number.

FROM PREDICTION TO PREVENTION-ORIENTED FORMULATION

The traditional model sorted patients into low, medium and high risk and stopped there, which both over-labels and mis-directs care. The prevention-oriented formulation instead asks four action-linked questions, risk status, risk state, available resources and foreseeable changes, and uses the answers to build management and a collaborative safety plan. Stratifying into fixed categories to allocate care is discouraged precisely because it borrows a predictive authority the data do not support, while diverting attention from the modifiable factors that treatment can actually change.

GOOD TO REMEMBER

- **Limits of prediction (the governing principle):** no tool or clinician reliably predicts individual suicide; risk-stratification scores must not be used to predict or to ration care. The assessment identifies modifiable factors and drives a safety plan, and the field favours a prevention-oriented formulation (risk status, risk state, resources, foreseeable changes) over a low-medium-high label.

19.10 From assessment to safety: the management link

The assessment earns its keep only when it produces a safety plan and the right level of care. A risk assessment is a means to safety, not an end; the guideline-anchored next steps are a collaborative safety plan, means-restriction counselling framed positively, a disposition matched to need, and treatment of the driving disorder (NICE NG225 2022; WHO LIVE LIFE 2021). The Stanley-Brown Safety Planning Intervention is the standard collaborative tool, built *with* the person: recognise personal warning signs, use internal coping strategies, use social contacts and settings that provide distraction, identify people who can help, list professionals and crisis or helpline contacts, and make the environment safer by reducing access to means. Means restriction, counselled as putting time and distance between a person and a crisis and involving family where appropriate, is the single most robustly evidenced lever and is always framed positively and never punitively. The level of care, community follow-up, crisis-team involvement or admission, is matched to assessed need and safety, with rapid follow-up after any emergency contact because the transition period is high-risk. Where a driving disorder is present, its

treatment is itself anti-suicidal, and two agents carry specific evidence: lithium in mood disorders and clozapine in schizophrenia; their pharmacology, dosing and monitoring sit in the Mood disorders: pharmacotherapy notes and the Schizophrenia: management, antipsychotics and adverse effects notes, and the acute triage of the actively suicidal patient in crisis is developed in the emergency psychiatry chapter.

GOOD TO REMEMBER

- **Safety planning and means restriction (the management step):** the guideline first move after assessment (NICE NG225 2022) is a collaborative safety plan (the Stanley-Brown components) plus positively framed means-restriction counselling, then a level of care matched to need with rapid follow-up. Means restriction is the highest-yield lever; drugs treat the driving disorder (lithium in mood disorders, clozapine in schizophrenia, both with specific anti-suicidal evidence) and supplement, never replace, the plan.

19.11 India: the Mental Healthcare Act 2017 and the decriminalised attempt

The statute every Indian candidate must quote precisely. The pivotal Indian provision is Section 115 of the Mental Healthcare Act 2017 (VERIFIED against the Act and Indian Kanoon). It provides that any person who attempts to commit suicide is presumed, unless proved otherwise, to have severe stress, and shall not be tried or punished for it, effectively overriding the old Section 309 of the Indian Penal Code that had criminalised the attempt. The Act goes further and places a duty on the appropriate government to provide care, treatment and rehabilitation to a person under such severe stress, so as to reduce the risk of recurrence. The clinical translation is humane and examinable: a person who attempts suicide is presumed to be suffering, not offending, and is owed care rather than a charge. This reframes the clinician's role at the bedside toward compassionate assessment and safety planning, in keeping with the safeguarding, non-judgemental tone the whole topic demands.

INDIA

India carries a large share of the world's suicide deaths, and suicide is among the leading causes of death in young Indian adults, a burden that makes competent assessment a public-health priority; it is stated here without any reference to means. The legal frame is the anchor: **Section 115** of the Mental Healthcare Act 2017 decriminalised the attempt through a presumption of severe stress and a duty of care, superseding Section 309 of the Indian Penal Code, and this is reinforced by national helpline infrastructure such as Tele MANAS. The Indian Psychiatric Society endorses the shift from punishment to care. The population-level and public-health suicide-prevention deep dive, including the WHO LIVE LIFE strategy and gatekeeper programmes, is developed in the Community psychiatry and public health notes.

RULE **The attempt is decriminalised, not the person blamed.** Under Section 115 of the Mental Healthcare Act 2017 a person who attempts suicide is presumed to be under severe stress and shall not be punished, and the state owes them care to reduce recurrence.

5	10	4
C-SSRS IDEATION-SEVERITY LEVELS	SAD PERSONS ITEMS (SCORE OUT OF A POSSIBLE TEN)	PREVENTION-ORIENTED FORMULATION JUDGEMENTS

HOLD THIS

A suicide risk assessment is a compassionate **structured evaluation** that weighs static and dynamic risk factors against protective factors and separates **chronic and acute risk**, using the C-SSRS ideation ladder to structure the interview and PHQ-9 item nine to screen, while remembering that SAD PERSONS is only a teaching aide and that **no instrument predicts individual suicide**, so stratifying into low-medium-high to ration care is discouraged; the assessment exists to drive a collaborative safety plan and means restriction, a denied ideation is never a cleared risk, and in India the attempt is decriminalised by Section 115 of the Mental Healthcare Act 2017.

20 · Epidemiology and aetiology of suicide

This is a CORE topic in the suicide band, and it is examined as two linked demands: state the **epidemiology of suicide** responsibly, and explain the **aetiological models** that make sense of it. The marks turn on framing the burden without sensationalising it, knowing the demographic and clinical risk patterns, placing the Indian picture with its student and agrarian dimensions accurately, and holding the three complementary explanatory frames: the individual-level **stress-diathesis model** that integrates the field, Durkheim's sociological typology, and Joiner's interpersonal theory. Throughout, the register stays compassionate, non-judgemental and means-free.

How to use this page. Fix the vocabulary and the spectrum first; then the global **suicide burden** and who is most at risk; then the Indian context and the legal frame set by the Mental Healthcare Act; and finally the aetiology, working from the integrating stress-diathesis model out to the sociological and interpersonal theories. The one idea to carry off the page is that suicide is best read as an enduring vulnerability meeting an acute stressor, never as a simple reaction to circumstances.

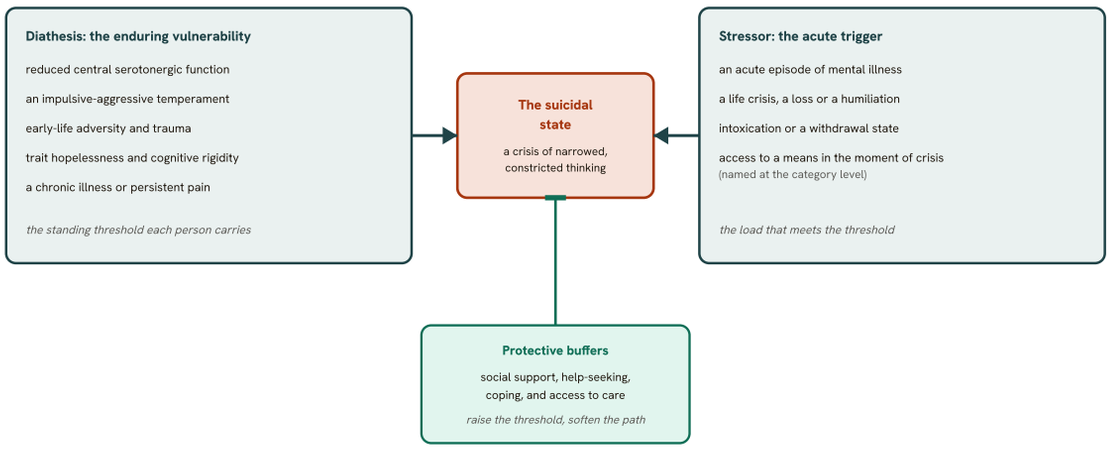


Fig 18.16 The stress-diathesis model of suicidal behaviour. Suicidal crises are best understood not as a simple product of a stressor but as the meeting of two things. Each person carries a standing diathesis, an enduring vulnerability made of reduced serotonergic function, impulsive-aggressive temperament, early adversity, trait hopelessness and chronic illness, which sets the threshold at which a crisis can occur. An acute stressor, an episode of illness, a loss or humiliation, or intoxication, then supplies the load that may meet that threshold, producing the suicidal state of narrowed, constricted thinking. Protective buffers, social support, help-seeking, coping and access to care, raise the threshold and soften the path. The model explains why an identical stressor tips one person and not another, and it shows where prevention and care can act, on the acute stressor and on the buffers.

20.1 The vocabulary and the spectrum of suicidal behaviour

Precise terms, because the examiner marks them. Suicidal phenomena form a spectrum, and the words are not interchangeable (Shorter Oxford Textbook of Psychiatry; Companion to Psychiatric Studies). Suicide is death caused by a self-directed act undertaken with at least some intent to die. Suicidal ideation ranges from a passive wish to be dead to active, planned thinking. A suicide attempt is a non-fatal self-directed act with some intent to die. Older literature used deliberate self-harm and parasuicide for intentional self-injury that need not carry a wish to die, and the acute triage of these presentations belongs to the emergency psychiatry chapter. The clinical point is that intent, not the medical severity of the act, defines where a presentation sits, and that the assessment stays needs-based and safety-focused rather than a graded checklist.

Suicidal ideation

thoughts of ending one's life, from a passive wish to be dead through to active planning

Suicide attempt

a non-fatal self-directed act carried out with some degree of intent to die

Suicide

death from a self-directed act undertaken with at least some intent to die

Deliberate self-harm

intentional self-injury that may or may not carry a wish to die; assessed for needs and safety, not by severity alone

20.2 The global suicide burden

A common, largely preventable cause of death. The **epidemiology of suicide** is examined first as scale. The World Health Organization reports that more than one in every hundred deaths worldwide is a suicide, and that suicide is the fourth leading cause of death among people aged 15 to 29 (WHO). More than three-quarters of suicides occur in low- and middle-income countries, so the **suicide burden** falls disproportionately on the settings with the least specialist provision (WHO; New Oxford Textbook of Psychiatry). The responsible way to state this in an exam is as a public-health problem that is common, unevenly distributed and amenable to prevention, keeping to counts and rates and never to method or graphic detail. The population and public-health approach to lowering these figures, including the highest-yield lever of reducing access to lethal means, is developed in the Community psychiatry and public health notes.

12	>1 in 100	4th	3
INDIA SUICIDE RATE PER 100,000 POPULATION (NCRB, 2021)	OF ALL DEATHS WORLDWIDE ARE SUICIDE (WHO)	LEADING CAUSE OF DEATH WORLDWIDE AT AGES 15 TO 29 (WHO)	COMPONENTS IN JOINER'S INTERPERSONAL THEORY

20.3 Who is most at risk: demographic and clinical patterns

Distal markers and the one proximal driver. Risk is patterned. Internationally more men die by suicide, while non-fatal self-harm is reported more often among women, a divergence usually called the gender paradox; part of the difference in case-fatality between groups reflects differences in the methods used and in help-seeking, which is one reason reducing access to lethal means is protective (Shorter Oxford; New Oxford). Risk rises at the extremes of adult age in many settings, and is higher among people who are unmarried, separated, widowed, socially isolated, unemployed or bereaved, and among those with chronic painful illness (Kaplan and Sadock CTP 2024). These are distal, largely fixed markers and they set the background rate. The single strongest proximal, and crucially modifiable, factor is active psychiatric illness: a mood disorder above all, and also alcohol and substance use, psychosis and personality disorder. Naming and treating that illness is where the epidemiology becomes clinical.

RULE **Treat the illness behind the statistic.** Active psychiatric illness, a mood disorder chief among them, is the strongest and most modifiable proximal risk factor for suicide; sociodemographic markers set the background rate, but the treatable target is the current disorder.

20.4 The Indian context

A rising rate, a young profile and a decriminalised act. India carries a large share of the global burden. Its national source is the National Crime Records Bureau (NCRB), whose annual Accidental Deaths and Suicides in India report is the primary dataset. The recorded suicide rate reached 12 per 100,000 (per lakh) population in 2021, up from about 10 per lakh in 2017, a steady year-on-year rise (NCRB, 2021). The majority of recorded deaths are among men, and the age profile skews young. Two dimensions are examined repeatedly and must be stated without sensationalising. The student dimension: NCRB records a marked and rising trend in suicides among students, widely linked to academic and examination stress. The agrarian dimension: the

farming sector, captured in NCRB's farmers and agricultural labourers category, is a recognised at-risk group tied to agrarian distress such as indebtedness and crop failure. The legal frame is a favourite: under Section 115 of the Mental Healthcare Act, 2017, a person who attempts suicide is presumed, unless proved otherwise, to be under severe stress and is not to be tried or punished, effectively overriding the old offence at Section 309 of the Indian Penal Code, and the appropriate government is placed under a duty to provide care and rehabilitation (Mental Healthcare Act 2017, Section 115).

INDIA

The Indian examiner expects three moves: the burden stated soberly from the NCRB source (a rate near 12 per lakh in 2021, up from about 10 per lakh in 2017), the two salient at-risk dimensions named (students, driven by examination and academic stress; and the farming sector, tied to agrarian distress), and the statute quoted precisely. Section 115 of the Mental Healthcare Act, 2017 decriminalises attempted suicide by presuming severe stress and directs the state toward care rather than punishment; the Indian Psychiatric Society has supported this reframing of the attempt as a signal of distress and a call for help.

GOOD TO REMEMBER

- **Section 115, Mental Healthcare Act, 2017 (the statute):** any person who attempts suicide is presumed, unless proved otherwise, to have severe stress and shall not be tried or punished, which in practice overrides Section 309 of the Indian Penal Code; the state carries a duty to provide care, treatment and rehabilitation. The first response to an attempt is compassionate assessment and care, not sanction.

20.5 Aetiological models: the stress-diathesis model as the integrating frame

An enduring vulnerability meeting an acute stressor. The **aetiological models** operate at three levels, and the individual-level frame that ties them together is the stress-diathesis model (associated with Mann and colleagues). It holds that suicidal behaviour arises when an acute state stressor acts on an enduring trait diathesis, and only when their combined load crosses a threshold (Kaplan and Sadock CTP 2024). The diathesis is the stable, trait-like vulnerability: a disposition to hopelessness and pessimism, impulsive-aggressive traits, a heritable component and the imprint of early-life adversity, associated at the biological level with reduced central serotonergic function. The stressor is the acute, state-dependent trigger: an episode of psychiatric illness, intoxication, or a humiliating interpersonal, financial or occupational crisis. The model earns its place because it explains what a stressor alone cannot: why the overwhelming majority of people exposed to severe adversity do not act, while the same stressor precipitates an act in a vulnerable individual. The accompanying figure sets the enduring diathesis and the acute stressor as two converging axes crossing a threshold, and it is the mental model to carry into any risk formulation.

TRAP **Reading a suicide as a simple reaction to circumstances.** Explaining an act by the precipitating stressor alone (a job loss, an exam failure, a relationship breakdown) misses the enduring diathesis and, with it, the treatable psychiatric illness that amplifies it; the stress-diathesis frame keeps both the vulnerability and the modifiable disorder in view.

GOOD TO REMEMBER

- **Stress-diathesis model (the defining structure):** suicidal behaviour emerges when an acute state stressor (a psychiatric episode, intoxication, a life crisis) acts on an enduring trait diathesis (hopelessness, impulsive-aggressive traits, reduced central serotonergic function, early adversity) and their combined load crosses a threshold. The discriminator from a purely social account is the enduring, trait-level vulnerability, which is why most people under severe stress do not act.

20.6 Sociological and interpersonal models: Durkheim and Joiner

The social frame: Durkheim's two axes. The sociological level was set by Durkheim, whose 1897 monograph argued that suicide rates track two social forces: the degree of social integration and the degree of social regulation (Shorter Oxford; Companion to Psychiatric Studies). Too little or too much of each yields a type. Low integration produces egoistic suicide, in a person cut off from the group and its shared meanings; excessive integration produces altruistic suicide, in which the self is sacrificed for the group or a cause. Low regulation, when the normative bonds that guide behaviour break down in times of upheaval, produces anomic suicide; excessive, oppressive regulation produces fatalistic suicide. The enduring value of the model is that it explains suicide as a social fact whose rate rises and falls with social conditions, not only as an individual event.

DURKHEIM TYPE	SOCIAL FORCE	THE DEFINING CONDITION
Egoistic	Integration	**Too little integration: the person is detached from the group and its shared meanings**
Altruistic	Integration	**Too much integration: the self is sacrificed for the group or a greater cause**
Anomic	Regulation	**Too little regulation: normative bonds break down amid social or economic upheaval**
Fatalistic	Regulation	**Too much regulation: life is over-controlled by oppressive rules or blocked futures**

Durkheim's four types arranged on the two axes of social integration and social regulation, each as a deficiency or an excess (Shorter Oxford; Companion).

PEARL

Hold Durkheim as a two-by-two: the *integration* axis gives **egoistic** (too little) and **altruistic** (too much); the *regulation* axis gives **anomic** (too little) and **fatalistic** (too much). Every type is a deficiency or an excess of one of the two forces.

The interpersonal frame: Joiner's desire and capability. At the psychological level, Joiner's interpersonal theory, the Interpersonal-Psychological Theory of Suicide, proposes that the desire to die arises from two interpersonal states: thwarted belongingness, the sense of being disconnected, excluded or alienated, and perceived burdensomeness, the belief that one is a burden on others (Kaplan and Sadock CTP 2024; DSM-5-TR 2022). Desire alone, however, is not enough for a serious attempt; the theory adds acquired capability, a fearlessness about pain, injury and death that is built up through repeated exposure to painful or provocative experiences. A near-lethal attempt requires all three: the desire (thwarted belongingness plus perceived burdensomeness) and the capability. The framework is clinically useful because it separates the wish from the ability to act, and because belongingness and burdensomeness are addressable in therapy.

MNEMONIC

DESIRE + CAPABILITY

Joiner's interpersonal theory needs both to converge on a serious attempt. DESIRE = thwarted **B**elongingness + perceived **B**urdensomeness (the two B's); CAPABILITY = the **acquired capability** to enact lethal self-harm, built by habituation to pain and fear. Wish plus ability, not wish alone.

GOOD TO REMEMBER

- **Durkheim's typology (the two axes):** suicide rates track social integration (egoistic = too little, altruistic = too much) and social regulation (anomic = too little, fatalistic = too much); each of the four types is a deficiency or excess of one force.
- **Joiner's interpersonal theory (the three components):** the desire to die comes from thwarted belongingness plus perceived burdensomeness, and a serious attempt additionally requires acquired capability (fearlessness about pain and death); all three must converge, which is why desire without capability, or capability without desire, does not produce a lethal act.

HOLD THIS

Suicide is an enduring diathesis (trait vulnerability: hopelessness, impulsive-aggressive traits, reduced serotonergic function, early adversity) meeting an acute stressor (a psychiatric episode above all, intoxication, or a life crisis) and crossing a threshold; epidemiology tells you who is at risk (men, the socially isolated, the young in India, students and those in agrarian distress, and anyone with active psychiatric illness), Durkheim explains the social rate through integration and regulation, and Joiner explains the individual act as desire (thwarted belongingness plus perceived burdensomeness) meeting acquired capability.

21 · Management of the suicidal patient and safety planning

This is the CORE management topic of the chapter, and it is examined as a sequence of clinical moves rather than a single fact. The **management of the suicidal patient** begins the moment the person is in the room: an engaging, non-judgemental relationship, a structured assessment that weighs risk against protective factors rather than a predictive score, a collaborative **safety plan**, a disposition matched to need, treatment of the disorder that is driving the risk, and active follow-up through the vulnerable weeks that come after. Get the order and the principles right

and the marks follow; the guideline spine here is NICE (NICE NG225 2022), which frames every step around compassion, needs and safety.

How to use this page. Fix the NICE position first, because it is the lead guideline and it sets two rules that reorganise older teaching: assess needs and safety through a person-centred interview, and do *not* use risk-stratification scores to predict future suicide or to decide who is offered care (NICE NG225 2022). Then learn the collaborative Safety Planning Intervention as the signature intervention, means restriction counselling framed positively, the level-of-care decision, the disorder-directed and anti-suicidal pharmacology, and the follow-up posture. The India anchor to carry is Section 115 of the Mental Healthcare Act, 2017. The acute triage of the person who is actively suicidal in the emergency room is developed in the emergency psychiatry chapter, and the population-level prevention deep dive sits in the Community psychiatry and public health notes. Throughout, the tone is safeguarding and the burden is stated without any reference to method.

Therapeutic stance

The engaging, warm, non-judgemental clinical posture that makes honest disclosure and collaboration possible; the vehicle every other step travels on.

Safety planning

A collaborative, prioritised written plan the person can use in a crisis, co-produced with the clinician; the Stanley-Brown Safety Planning Intervention.

Means restriction counselling

Working with the person and family to reduce access to lethal means, framed positively as putting time and distance between the person and a crisis.

Disposition

The level-of-care decision that matches the setting (community follow-up, crisis team, or admission) to assessed need and safety.

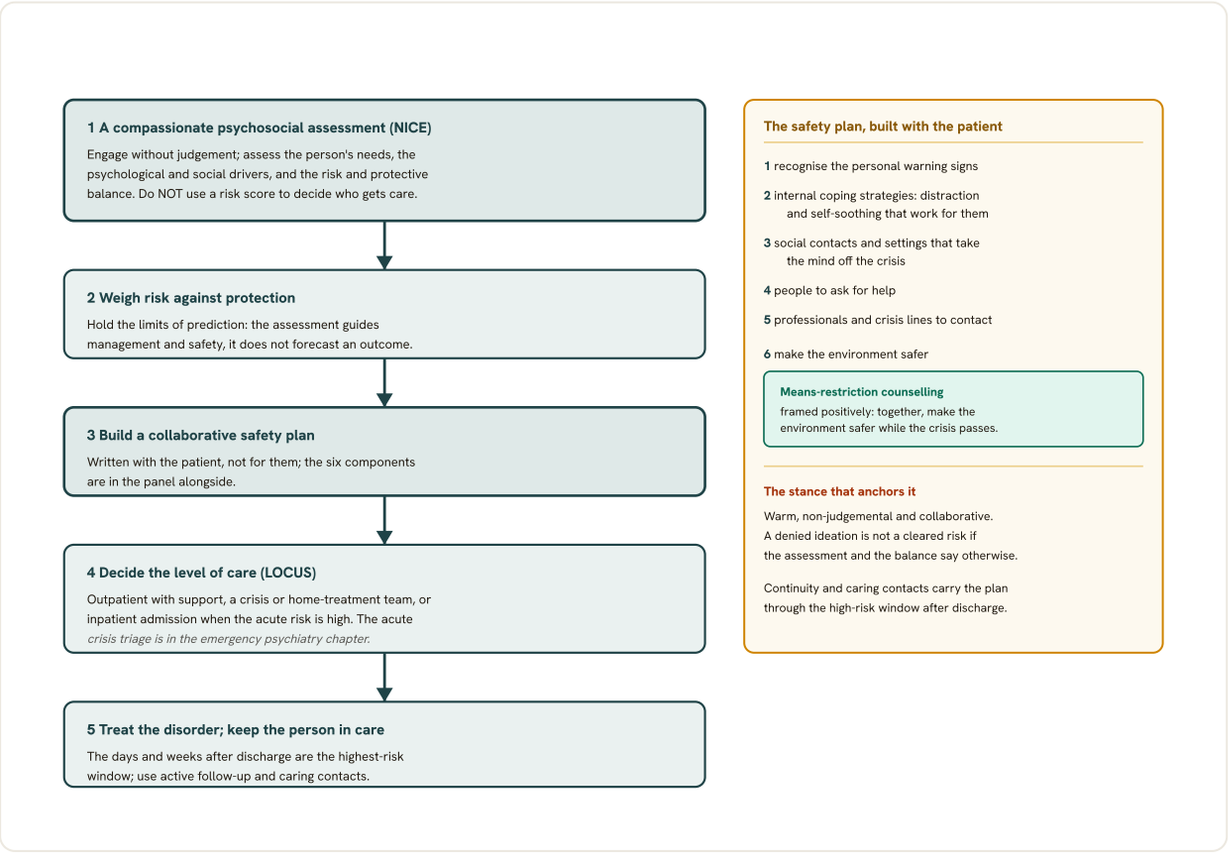


Fig 18.17 The management of the suicidal patient and safety planning. The pathway is anchored on a compassionate, non-judgemental psychosocial assessment, in the NICE tradition, that maps the person's needs and the drivers of their distress rather than reducing them to a risk score; guidance is explicit that a stratification score should not decide who receives care. The clinician then weighs the risk and protective balance, holding the limits of prediction, and builds a safety plan with the patient across its six components, from recognising warning signs to internal coping, social and professional contacts, and making the environment safer through means-restriction counselling framed positively. The level of care follows, from outpatient support through a crisis team to admission when acute risk is high, with the acute crisis triage taken up in the emergency psychiatry chapter. Because the period after discharge is the highest-risk window, active follow-up and caring contacts carry the plan forward.

21.1 The therapeutic stance: engage before you assess

A compassionate, non-judgemental relationship is the first intervention, not the preamble.

The guideline foundation is that every person presenting after self-harm or with suicidal thoughts receives a compassionate, non-judgemental, needs-based assessment, regardless of the apparent medical seriousness of the act (NICE NG225 2022). The **therapeutic stance** means sitting with distress without recoiling from it, asking about suicidal thoughts directly and calmly (asking does not plant the idea), validating the pain that drives the thoughts, and conveying that help is possible. This stance is itself protective: it reduces the shame that keeps people from disclosing, and it is the precondition for an honest account of ideation, intent and access to means. NICE is explicit that the assessment is an intervention in its own right, an opportunity for engagement rather than a bureaucratic risk-scoring exercise. The clinician who leads with warmth gets the information the assessment depends on; the clinician who leads with a checklist often does not.

RULE **Engagement is the intervention, not the waiting room.** The compassionate, needs-based assessment is itself therapeutic (NICE NG225 2022); asking directly about suicidal thoughts does not increase risk, and the honest disclosure it earns is what every later step depends on.

GOOD TO REMEMBER

- **Therapeutic stance (the management step):** the guideline first move (NICE NG225 2022) is a compassionate, non-judgemental, needs-based assessment offered to everyone, whatever the medical severity of the act; ask about suicidal thoughts directly and calmly, treat the assessment as an engagement opportunity, and build the alliance before anything else.

21.2 Structured assessment and risk formulation, not a predictive score

Weigh risk against protective factors and current state; do not stratify to ration care. The examinable pivot of modern practice is that individual-level prediction of suicide is poor, risk fluctuates, and no tool reliably identifies who will act (NICE NG225 2022). The clinician therefore builds a **risk formulation** through a structured interview that weighs static and dynamic risk factors against protective factors, current mental state, intent and access to means, and the social context, and that arrives at a clinical judgement of current risk rather than a fixed low, medium or high label. NICE is unambiguous: do not use risk-assessment or stratification scales to predict future self-harm or suicide, and do not use their scores to determine who is offered treatment or admission. Structured instruments still have a role as aids to a thorough interview: the C-SSRS (Columbia Suicide Severity Rating Scale) is regarded as the gold-standard structured tool for assessing and monitoring suicidal ideation and behaviour, with five ideation levels of increasing severity (Clinical Methods in Psychiatry, AIIMS 2024); the older SAD PERSONS acronym scale and the ninth item of the PHQ-9 are screening aids; and SAFE-T (the Suicide Assessment Five-Step Evaluation and Triage) offers a five-step framework for structuring the interview and the disposition. All support, and none replace, the clinical formulation.

INSTRUMENT	WHAT IT IS	VERIFIED USE AND CAUTION
C-SSRS	Structured scale with five ideation levels of increasing severity, plus behaviour items	**Gold-standard aid (AIIMS 2024); supports, never replaces, the interview**
SAD PERSONS	Ten-item acronym-based screen, historically used in the emergency room	**A prompt only, not a substitute for clinical evaluation (AIIMS CL 2020)**
PHQ-9, the ninth item	Single screening item for thoughts of being better off dead or of self-harm	**A positive item triggers fuller assessment, never a decision on its own**
SAFE-T	Suicide Assessment Five-Step Evaluation and Triage framework	**Structures interview and disposition; a scaffold, not a predictive score**

Structured instruments as aids to the interview, with the NICE caution that scores must not predict risk or ration care (NICE NG225 2022); the reproduced forms sit with the suicide-risk assessment scales.

TRAP **Reading a denied ideation as a cleared risk.** A flat denial does not clear risk when the risk-and-protective balance, the collateral history and the mental state point the other way; formulate from the whole picture, and never let a global scale score or a single answer make the disposition (NICE NG225 2022).

GOOD TO REMEMBER

- **Risk formulation (the management step):** the guideline principle (NICE NG225 2022) is a structured, person-centred interview that weighs risk against protective factors, current state, intent and access to means, producing a clinical formulation rather than a predictive category; do not use stratification scores to predict or to ration care. The C-SSRS is the gold-standard structured aid but never a substitute for the interview.

21.3 Collaborative safety planning: the Safety Planning Intervention

Six prioritised steps the person can use in a crisis, co-produced not prescribed. The signature intervention is the Safety Planning Intervention (the Stanley-Brown Safety Plan), developed collaboratively for anyone at moderate to high risk when hospitalisation is not clinically indicated (Kaplan and Sadock CTP 2024; NICE NG225 2022). It is a written, personalised, prioritised ladder that the person moves down as distress rises: recognise personal warning signs; use internal coping strategies alone; draw on social contacts and settings that provide distraction; reach out to people who can be asked for help; contact professionals and crisis or helpline services; and make the environment safer by reducing access to lethal means. The plan is co-produced, kept where the person can find it, and reviewed and updated over time. Crucially it is a clinical instrument, not a promise: a signed no-suicide or no-harm contract has no evidence base and can falsely reassure the clinician, whereas the safety plan gives the person concrete, ranked actions and gives the clinician a structured way to involve family and services.

COMPONENT	WHAT IT LOOKS LIKE IN THE PLAN	THE POINT OF THIS RUNG
Recognise warning signs	The person's own thoughts, images, moods and situations that precede a crisis	**Catch the crisis early, at the person's own first signal**
Internal coping strategies	Things the person can do alone to take their mind off the crisis	**Self-soothing tried before anyone else is contacted**
Social contacts and settings	People and places that provide healthy distraction	**Distraction, not disclosure, at this rung**
People to ask for help	Family or friends the person can tell they are in crisis	**The first human help, when self-management is not enough**
Professionals and crisis contacts	Clinicians, crisis lines, helplines and emergency services	**The professional safety net, with numbers to hand**
Making the environment safer	Means restriction counselling, framed positively, with the person and family	**Time and distance between the person and a crisis**

The six components of the Safety Planning Intervention, a ranked ladder from internal coping to professional help ending in a safer environment (Stanley-Brown; NICE NG225 2022), laid out in the accompanying figure.

MNEMONIC

WISE-PS

The Safety Planning Intervention as a ranked ladder. **W**arning signs the person recognises; **I**nternal coping strategies used alone; **S**ocial contacts and settings for distraction; **E**nlist people to ask for help; **P**rofessional and crisis contacts; make the environment **S**afer through means restriction counselling. Six rungs, climbed only as far as each crisis needs.

RULE **A safety plan is a collaborative clinical act, not a contract.** The six-step Safety Planning Intervention is co-produced and works because the person descends a ranked ladder that ends in a safer environment; a signed no-suicide contract is not evidence-based and is not a substitute.

GOOD TO REMEMBER

- **Safety Planning Intervention (the management step):** the guideline-anchored intervention (Stanley-Brown; NICE NG225 2022; Kaplan and Sadock CTP 2024) is a collaborative, prioritised, written plan with six components, that being warning signs, internal coping, social contacts and settings for distraction, people to ask for help, professional and crisis contacts, and making the environment safer through means restriction. It is co-produced for moderate to high risk when admission is not indicated, and it replaces the discredited no-suicide contract.

21.4 Means restriction counselling: framed positively

Reduce access to lethal means, and frame it as time and distance, never as blame. The sixth rung of the safety plan is its own high-yield step. **Means restriction counselling** is a collaborative conversation about reducing access to lethal means, framed positively as putting time and distance between the person and a crisis so that an intense, often short-lived suicidal impulse can pass safely (NICE NG225 2022). The clinician works with the person, and where appropriate with family or carers, to make the immediate environment safer, at the category level of reducing access to lethal means rather than dwelling on any specific method. This is deliberately non-judgemental and non-alarming; it is offered as a shared act of care, not an accusation or a restriction imposed from outside. At the population level the same principle is the single highest-yield, most robustly evidenced suicide-prevention lever (WHO LIVE LIFE 2021), which is why the individual conversation matters so much; the population and public-health treatment of means restriction is developed in the Community psychiatry and public health notes.

GOOD TO REMEMBER

- **Means restriction counselling (the management step):** the guideline principle (NICE NG225 2022; WHO LIVE LIFE 2021) is to reduce access to lethal means, framed positively as putting time and distance between the person and a crisis, worked out collaboratively with the person and family and kept at the category level. It is the sixth safety-plan component and, at the population level, the highest-yield prevention lever.

21.5 Disposition: matching the level of care to need

Community, crisis team, or admission, decided by need and safety, not by a score. The **disposition** is the level-of-care decision, and it is matched to assessed need and safety rather than to a stratification label (NICE NG225 2022). The lowest-restriction option that keeps the person safe is preferred: outpatient management with a safety plan and social support where risk can be contained; a crisis resolution and home treatment team for intensive community support when risk is higher but hospitalisation can be avoided; and inpatient admission, voluntary wherever possible, when acute risk is high and cannot be managed safely in the community. Every step in the pathway includes rapid follow-up after any emergency contact and an active, documented handover, because the transition between services is itself a period of elevated risk. Where a person at imminent risk lacks capacity or declines care, admission may proceed under the relevant provisions of the Mental Healthcare Act, 2017. The acute triage of the person who is actively suicidal in crisis, the immediate **crisis intervention** in the emergency room, belongs to the emergency psychiatry chapter.

LEVEL OF CARE	WHEN IT FITS	THE SAFEGUARD THAT MUST TRAVEL WITH IT
Outpatient with support	Risk containable in the community, safety plan in place, supports available	**Rapid review and a documented follow-up appointment**
Crisis resolution / home treatment team	Higher risk needing intensive daily support, admission avoidable	**Frequent contact and a clear escalation route**
Inpatient admission	Acute risk high, cannot be kept safe in the community	**Voluntary where possible; least restriction that keeps the person safe**

The disposition ladder, from outpatient support to admission, chosen by assessed need and safety and not by a stratification score (NICE NG225 2022); sketched in the figure alongside.

WORKED EXAMPLE

A man in his forties is brought in by his wife after an episode of self-harm following job loss. Rather than reach for a scale score, the clinician spends the first minutes building rapport, then formulates: prominent hopelessness and recent loss on one side, a supportive spouse, help-seeking and no current intent on the other. Together they build a safety plan, moving through the man's own warning signs, a few internal coping steps, his brother as a first contact, and a crisis line; the last rung is a calm, positive conversation with the couple about making the home environment safer. Because risk is judged containable and support is strong, the disposition is outpatient management with a review within a few days and a crisis number in hand, rather than admission.

GOOD TO REMEMBER

- **Disposition (the management step):** the guideline principle (NICE NG225 2022) is to match the level of care, that being outpatient with support, a crisis or home-treatment team, or inpatient admission, to assessed need and safety at the least restriction that keeps the person safe; ensure rapid follow-up and an active handover at every transition, and take the immediate emergency-room crisis intervention to the emergency psychiatry chapter.

21.6 Treat the underlying disorder, and the anti-suicidal agents

The most durable risk reduction is treating the disorder that drives the risk. Suicidal risk usually sits on a treatable psychiatric disorder, most often a mood disorder, a psychotic illness, or a substance use disorder, and vigorous treatment of that disorder is central to management. Two agents carry a specific anti-suicidal effect that goes beyond simply treating the episode. Lithium reduces the risk of suicide and of death from any cause in mood disorders; the meta-analysis by Cipriani and colleagues, pooling 48 randomised controlled trials, established this signal, which is at least partly distinct from control of the mood episode itself (Cipriani 2013 BMJ), making lithium a specific reason to favour it in mood disorders carrying suicide risk. Clozapine is the only antipsychotic with a specific anti-suicidal indication; the International Suicide Prevention Trial showed it superior to olanzapine in reducing suicidal behaviour in schizophrenia and schizoaffective disorder at high risk (InterSePT, Meltzer 2003). Ketamine and intranasal esketamine produce a rapid, short-term fall in suicidal ideation as an adjunct within comprehensive care (the ASPIRE programme), but an effect on completed suicide is not established. The deep pharmacology of these agents lives elsewhere: lithium in the Mood disorders: pharmacotherapy notes, and clozapine in the Schizophrenia: management, antipsychotics and adverse effects notes.

AGENT	POPULATION AND EVIDENCE	WHAT TO HOLD
Lithium	Mood disorders; Cipriani 2013 BMJ, pooling 48 randomised trials	**Cuts suicide and all-cause death; effect partly independent of mood control**
Clozapine	Schizophrenia and schizoaffective disorder at high risk; InterSePT, Meltzer 2003	**Only antipsychotic with a specific anti-suicidal indication; beat olanzapine**
Ketamine / esketamine	Depression with acute suicidal ideation; the ASPIRE programme	**Rapid, short-term fall in ideation only; no proven effect on completed suicide**

The three anti-suicidal agents and the strength of their evidence; doses and full pharmacology sit in the mood and schizophrenia chapters, cross-referenced above.

GOOD TO REMEMBER

- **Lithium (the anti-suicidal drug):** reduces suicide and all-cause mortality in mood disorders, an effect partly distinct from mood control (Cipriani 2013 BMJ, 48 trials); favour it where a mood disorder carries suicide risk. Deep pharmacology in the Mood disorders: pharmacotherapy notes.
- **Clozapine (the anti-suicidal drug):** the only antipsychotic with a specific anti-suicidal indication, superior to olanzapine in high-risk schizophrenia and schizoaffective disorder (InterSePT, Meltzer 2003). Deep pharmacology in the Schizophrenia: management, antipsychotics and adverse effects notes.
- **Esketamine (the anti-suicidal drug):** rapid, short-term reduction in ideation as an adjunct (the ASPIRE programme); a reduction in completed suicide is not established, so it supplements rather than replaces comprehensive care.

21.7 Follow-up and continuity: the high-risk period after discharge

The weeks after an emergency contact or discharge are the most dangerous, so follow-up must be active. Management does not end at the plan or the discharge letter. Transitions between services and the period soon after discharge from inpatient care carry markedly elevated risk, so continuity of care with a prompt, actively arranged follow-up is essential rather than optional (NICE NG225 2022). The clinician ensures a named follow-up is booked before the person leaves, that the safety plan travels with them, and that the handover to community services is explicit and closed-loop. A low-cost, well-recognised adjunct in this window is the use of **caring contacts**, brief, non-demanding follow-up messages or letters that simply convey that the service is thinking of the person and remains available; they are offered as a supportive supplement to, not a replacement for, active clinical follow-up. The aim across the whole period is to keep the person connected to care exactly when disengagement is most dangerous.

6	5	4	115
SAFETY PLANNING INTERVENTION COMPONENTS	C-SSRS IDEATION LEVELS	WHO LIVE LIFE INTERVENTIONS	MENTAL HEALTHCARE ACT 2017 SECTION DECRIMINALISING THE ATTEMPT

PEARL

The post-discharge window is where a good inpatient stay is either consolidated or lost. Book the follow-up before discharge, send the safety plan out with the person, and treat any missed appointment in this window as a signal to reach out actively rather than to wait; caring contacts are the cheap, humane way to hold the thread.

GOOD TO REMEMBER

- **Follow-up and continuity (the management step):** the guideline posture (NICE NG225 2022) is that the period after an emergency contact or discharge is high-risk, so arrange prompt, active follow-up with an explicit closed-loop handover, send the safety plan with the person, and use caring contacts as a supportive adjunct. Disengagement is most dangerous exactly here, so continuity is a safety intervention.

21.8 India: Section 115 of the Mental Healthcare Act, 2017

The attempt is decriminalised, and severe stress is presumed. The India anchor for this topic is a statute, not a scale. Under Section 115 of the Mental Healthcare Act, 2017, any person who attempts suicide is presumed, unless proved otherwise, to have severe stress, and shall not be tried and punished for the attempt; this provision effectively overrides the older Section 309 of the Indian Penal Code (Mental Healthcare Act, 2017, Section 115). The same section places a duty on the appropriate government to provide care, treatment and rehabilitation to a person who has attempted suicide, to reduce the risk of a recurrence. For the clinician this reframes the encounter decisively: the person who has attempted suicide is a patient in severe distress owed care, not an offender, and the entire management sequence in this topic follows from that stance. The wider burden of suicide in India is substantial and is a public-health priority; it is stated here without any reference to method, and the population-level response is taken up in the Community psychiatry and public health notes.

INDIA

Section 115 of the Mental Healthcare Act, 2017 is the single most examinable India point on this topic: a person who attempts suicide is presumed, unless proved otherwise, to be under severe stress and shall not be tried or punished, effectively overriding Section 309 of the Indian Penal Code, and the government carries a duty to provide care, treatment and rehabilitation. The Indian Psychiatric Society has supported this decriminalisation. Read every suicidal presentation through this lens, that being distress owed care rather than conduct to be judged.

GOOD TO REMEMBER

- **Section 115, Mental Healthcare Act, 2017 (the statute):** a person who attempts suicide is presumed, unless proved otherwise, to have severe stress and shall not be tried or punished, effectively overriding Section 309 of the Indian Penal Code; the government has a duty to provide care, treatment and rehabilitation. The defining point is decriminalisation with a presumption of severe stress.

HOLD THIS

The management of the suicidal patient runs as a sequence: an engaging, non-judgemental therapeutic stance; a structured assessment that weighs risk against protective factors and current state, a formulation rather than a predictive score (and never a stratification score to ration care, NICE NG225 2022); a collaborative six-step Safety Planning Intervention ending in positively framed means restriction counselling; a disposition matched to need across outpatient support, crisis team, or admission; vigorous treatment of the underlying disorder, with lithium reducing suicide in mood disorders (Cipriani 2013 BMJ) and clozapine the only antipsychotic with a specific anti-suicidal indication (InterSePT, Meltzer 2003); and active follow-up through the high-risk post-discharge weeks with caring contacts. In India, Section 115 of the Mental Healthcare Act, 2017 presumes severe stress and decriminalises the attempt.

22 · Deliberate self-harm

This is the topic where a compassionate stance and a guideline become the same thing. Deliberate self-harm is any intentional self-poisoning or self-injury, carried out irrespective of motive and

irrespective of the degree of suicidal intent, so the term deliberately spans the person who wished to die, the person who did not, and every ambivalent state between. The examiner tests two moves: the clean *discrimination* between self-harm, non-suicidal self-injury and a suicide attempt, and the *management* that flows from a single landmark guideline. That guideline is NICE NG225 (Self-harm: assessment, management and preventing recurrence, 2022), and it reframed the field so decisively that the whole of **self-harm management** can be reconstructed from its two central positions: every episode earns a full, needs-based psychosocial assessment, and risk-stratification scores must never be used to predict future self-harm or to decide who receives care.

How to use this page. Fix the vocabulary first, then the relationship between self-harm and suicide (any self-harm raises future suicide risk, whatever the apparent medical seriousness), then the NICE NG225 stance as the lead: a **compassionate non-judgemental**, needs-based psychosocial assessment for every presentation, no risk score used to ration treatment, a collaborative safety plan, the carefully stated harm-minimisation debate, and continuity of care. Throughout, safe-messaging is absolute: the burden and the risk are stated without any reference to method, and access to means is named only at the category level. The accompanying management-and-safety-planning algorithm, drawn at the management topic, also maps the self-harm pathway, so this page refers to it generically rather than redrawing it.

22.1 What deliberate self-harm is, and what it is not

An umbrella term that spans intent, not a synonym for a suicide attempt. The defining feature of self-harm is that it is intentional self-poisoning or self-injury *regardless* of the person's motive or the degree of suicidal intent (NICE NG225 2022; Kaplan and Sadock CTP 2024). This is why the guideline prefers the bare term "self-harm" to the older "deliberate self-harm (DSH)": it refuses to assume a wish to die and refuses to grade the act by its apparent medical seriousness. Sitting inside that umbrella are two narrower ideas held apart by intent. Non-suicidal self-injury (NSSI) is intentional self-inflicted injury to the body undertaken with the expectation that it will cause only minor physical harm and with no intent to die, a distinct entity coded in the ICD-11 (MB23.E); it is frequently a means of regulating unbearable affect rather than an attempt to end life. A *suicide attempt*, by contrast, is a self-directed, potentially injurious act carried out with at least some intent to die, however ambivalent. The clinician's first task is therefore not to label the method but to establish where on this intent-spanning field the person stands, because that is what the assessment, never the score, then addresses.

TERM	DEFINING FEATURE	THE DISCRIMINATOR TO HOLD
Deliberate self-harm (self-harm)	Intentional self-poisoning or self-injury, irrespective of motive or suicidal intent	**The umbrella term; does not, by itself, imply a wish to die**
Non-suicidal self-injury (NSSI)	Self-inflicted bodily injury with the expectation of only minor harm and no intent to die (ICD-11 MB23.E)	**The subset explicitly without suicidal intent, often to regulate affect**
Suicide attempt	A self-directed, potentially injurious act with at least some intent to die	**Intent to die is present, however ambivalent or fleeting**

The terminology of self-harm, arranged by the single axis of suicidal intent; the umbrella and its two subsets separate cleanly on that axis (NICE NG225 2022; ICD-11 CDDR).

GOOD TO REMEMBER

- **Deliberate self-harm (the definition):** intentional self-poisoning or self-injury irrespective of motive or degree of suicidal intent, so it is the broadest term and spans intent rather than assuming it. The discriminator to hold is that NSSI is the intent-free subset (ICD-11 MB23.E, expectation of only minor harm, no wish to die) while a suicide attempt carries at least some intent to die; the act is never graded by its apparent medical seriousness.

22.2 The relationship to suicide

Self-harm and suicide are neither identical nor safely separable: any self-harm raises future suicide risk. The two are distinct in the moment, because self-harm can occur with or without suicidal intent, yet they are bound together over time (NICE NG225 2022; New Oxford Textbook of Psychiatry). The examinable principle is that any episode of self-harm, including an episode with no suicidal intent at the time, is among the strongest markers of later suicide, and the risk of suicide is substantially elevated in the period immediately after a presentation. This has an immediate clinical consequence that the guideline insists upon: the apparent medical triviality of an act carries no reassurance about future risk, so a superficial injury or an apparently minor act is not a lesser presentation and must not be triaged as one. A history of prior self-harm is likewise one of the strongest static risk factors weighed in any suicide risk assessment, a link developed in the assessment topic. The safeguarding reading is the humane one: a person who has harmed themselves has signalled distress and elevated risk, and is owed a full assessment and active care rather than a rapid discharge.

RULE **Any self-harm raises future suicide risk, whatever the method or medical seriousness.** An episode with no suicidal intent still marks elevated future risk; the triviality of the act never justifies a lesser response, and every presentation earns a full assessment.

GOOD TO REMEMBER

- **Self-harm and suicide (the relationship):** self-harm occurs with or without suicidal intent and is distinct from a completed attempt in the moment, yet any self-harm, including non-suicidal episodes, is among the strongest predictors of subsequent suicide and the risk is highest soon after a presentation. The point to hold is that apparent medical seriousness does not grade future risk.

22.3 The NICE NG225 lead: a needs-based psychosocial assessment for every episode

The single first move, for every presentation, is a compassionate needs-based psychosocial assessment. The leading position of NICE NG225 (2022) is that every person presenting after an episode of self-harm should receive a full **psychosocial assessment**, carried out in a compassionate non-judgemental manner, regardless of the apparent medical seriousness of the act and regardless of whether they are seen in an emergency department, in primary care or on a ward. The assessment is *needs-based*, not risk-scored: it explores the person's own needs, the psychological and social factors that drove and surround the episode (the precipitants, the mental state, the relationships, the losses, the supports), and the risks to their safety, and it does so as an engagement, not an interrogation. NICE is explicit that this assessment is itself therapeutic, an intervention in its own right rather than a gate to one, because being heard without judgement is what re-establishes safety and the willingness to accept help. This is the anchor of self-harm management, and every downstream step (the safety plan, the level of care, the aftercare) is built on it.

RULE **Every episode gets a full compassionate psychosocial assessment (NICE NG225).** Whatever the apparent medical seriousness and wherever the person is seen, the needs-based assessment of needs, psychosocial factors and safety is the guideline first move, and it is itself therapeutic.

PEARL

Treat the psychosocial assessment as an intervention, not a triage form. NICE NG225 frames the compassionate, unhurried, non-judgemental conversation as therapeutic in itself: it validates distress, rebuilds engagement, and is often the moment a person first accepts help. Asking directly and calmly about self-harm and suicidal thoughts does not plant the idea or raise risk, a myth worth retiring on sight.

GOOD TO REMEMBER

- **The psychosocial assessment (the management step, NICE NG225 2022):** a compassionate non-judgemental, needs-based assessment for every episode covering the person's needs, the psychological and social factors, and the risks, given regardless of the medical seriousness of the act. The guideline principle to hold is that it is itself an intervention, not a gateway that screens people out of care.

22.4 The critical position: risk-stratification tools must not gate care

Do not use a risk score to predict future self-harm, and never to decide who is offered treatment. This is the position on which NICE NG225 (2022) most sharply broke with earlier practice, and it is the single most heavily tested point in the topic. Risk-assessment and stratification tools and scales must not be used to predict future self-harm or suicide, and must not be used to determine who is offered treatment, admission or discharge. A global label of "low", "medium" or "high" risk must not drive any clinical decision, because such instruments perform poorly at identifying who will act at the individual level and, used as a gate, they systematically deny care to people who need it. What replaces the score is the person-centred assessment of the preceding subtopic: the individualised weighing of needs, psychosocial factors and safety. The

instruments may still have narrow uses, for structuring a conversation or prompting domains, but the moment a number is used to ration care the guideline has been broken.

APPROACH	WHAT IT DOES	NICE NG225 VERDICT
Needs-based psychosocial assessment	Weighs the person's needs, psychosocial context and safety, individually, every episode	**Endorsed as the standard for every presentation**
Risk-stratification tool or global score	Sorts the person into low, medium or high to predict future self-harm	**Must not be used to predict, nor to decide who is offered care or admission**

The reframe at the centre of NICE NG225: a needs-based assessment governs care, a stratification score never does (NICE NG225 2022).

TRAP **Using a risk-stratification score to withhold care.** Reading a "low risk" label off a scale and discharging on the strength of it is the cardinal error NICE NG225 forbids; the score does not predict the individual, and it must never decide who is offered treatment.

COMMON TRAP

A young person is seen after a first episode of self-harm, appears calm, and a stratification tool returns a "low" global score. Discharging on that number, without the compassionate needs-based assessment, is exactly the practice NICE NG225 was written to end: the calm presentation and the low score neither predict future risk nor address the psychosocial drivers of the episode. The person is instead offered a full psychosocial assessment, a collaborative safety plan and active follow-up. The number never governs the disposition.

GOOD TO REMEMBER

- **Risk-stratification tools (the critical NICE NG225 position):** do not use risk-assessment or stratification scores to predict future self-harm or suicide, and do not use them to decide who is offered treatment or admission. A low-medium-high label must not drive care; a person-centred assessment of needs and safety does. The trap to hold is treating a "low risk" score as a licence to discharge.

22.5 Safety planning and access to help

A collaborative safety plan, built with the person, plus positively framed means-restriction counselling. After the assessment, the guideline first move is a collaborative safety plan developed *with* the person, together with clear, concrete information on how to get help during a crisis (NICE NG225 2022). The standard structure is the Stanley-Brown Safety Planning Intervention, whose components map directly onto self-harm: recognise personal warning signs; use internal coping strategies; use social contacts and settings that provide distraction; identify people who can be asked for help; list professionals and crisis or helpline contacts; and make the environment safer by reducing access to means. Means restriction is named only at the category level and is always framed positively and collaboratively, as putting time and distance between the person and a crisis rather than as a punitive removal, and family or carers are involved where

appropriate. The plan is a living document, revisited and revised, not a form signed once, and giving the person a real route to help between contacts is part of what makes it work.

GOOD TO REMEMBER

- **Safety planning (the management step, NICE NG225 2022):** build a collaborative safety plan with the person (the Stanley-Brown components) and give clear crisis-access information; counsel on reducing access to means, framed positively as time and distance from a crisis, involving carers where appropriate. The guideline principle to hold is that the plan is collaborative and revisited, and means restriction is named only at the category level, never punitively.

22.6 The harm-minimisation debate, stated carefully

Harm minimisation is an adjunct considered only within a wider plan, for people who continue to self-harm, and its evidence and ethics remain contested. For a person who continues to self-harm despite treatment, an individualised harm-minimisation approach, aimed at reducing the frequency, severity and impact of episodes, may be *considered* as one part of a wider, individualised plan (NICE NG225 2022). It is never a first-line or stand-alone intervention, and it is offered only after, and alongside, a proper assessment and the attempt to treat the underlying difficulties. The guideline is careful, and so must the candidate be: the overarching aim always remains reducing and ultimately stopping self-harm, and the evidence base and the ethics of harm minimisation are genuinely contested, so it is stated as a considered, bounded option rather than an endorsed strategy. In an exam answer the safe formulation is to name it, place it firmly as an adjunct for continuing self-harm within a broader plan, and flag the contested evidence, without specifying techniques.

GOOD TO REMEMBER

- **Harm minimisation (the contested adjunct, NICE NG225 2022):** consider it only as part of a wider individualised plan for people who continue to self-harm, never as first-line or stand-alone; the aim stays reducing and stopping self-harm, and the evidence and ethics are contested. The principle to hold is that it is a bounded adjunct, not an endorsed strategy, and it is stated without specifying techniques.

22.7 Continuity of care, aftercare and the self-harm-focused intervention

The period after an episode is high risk; continuity of care and active handover are protective. Self-harm management does not end at the safety plan. NICE NG225 (2022) emphasises continuity of care and follow-up after every episode, because transitions between services, the move from an emergency department to community care, from a ward to home, from one team to another, are recognised periods of elevated risk that demand an active, named handover rather than a passive referral. Rapid follow-up after any emergency contact and a clear, agreed plan for who is responsible are the protective moves. Beyond immediate aftercare, the guideline supports offering a psychological intervention specifically tailored to self-harm, and, for adults with recurrent self-harm and emotional dysregulation, dialectical behaviour therapy has the strongest evidence; the specific modality and session structure are taken from the guideline itself and are flagged here rather than fixed. Where a driving disorder underlies the self-harm, treating it is part of care, and two agents carry specific anti-suicidal evidence, lithium in mood

disorders and clozapine in schizophrenia, whose pharmacology, dosing and monitoring sit in the Mood disorders: pharmacotherapy notes and the Schizophrenia: management, antipsychotics and adverse effects notes; the acute triage of the actively suicidal patient in crisis is developed in the emergency psychiatry chapter, and the population and public-health suicide-prevention deep dive in the Community psychiatry and public health notes.

GOOD TO REMEMBER

- **Continuity and aftercare (the management step, NICE NG225 2022):** ensure continuity of care and rapid follow-up after every episode, and treat every service transition as a high-risk period needing an active named handover. Offer a psychological intervention tailored to self-harm, with dialectical behaviour therapy best evidenced for adults with recurrent self-harm and emotional dysregulation; treat any driving disorder, using the anti-suicidal evidence for lithium and clozapine held in the mood and psychosis chapters.

22.8 India: the decriminalised attempt and the duty of care

A person who self-harms is presumed to be under severe stress and is owed care, not a charge. The Indian frame for any self-harm or attempt is Section 115 of the Mental Healthcare Act 2017 (verified against the Act and Indian Kanoon). It provides that any person who attempts to commit suicide is presumed, unless proved otherwise, to have severe stress, and shall not be tried or punished for the attempt, effectively overriding the old Section 309 of the Indian Penal Code that had criminalised it. The Act goes further, placing a duty on the appropriate government to provide care, treatment and rehabilitation to reduce the risk of recurrence. The clinical translation is exactly the safeguarding stance the whole topic demands: a person who has harmed themselves is suffering, not offending, and the bedside response is compassionate assessment and safety planning, not judgement. India carries a large share of the world's suicide burden, and self-harm is a common emergency presentation, a burden stated here without any reference to means; the Indian Psychiatric Society endorses the shift from punishment to care.

INDIA

The anchor is **Section 115** of the Mental Healthcare Act 2017: the attempt is decriminalised through a presumption of severe stress and a duty of care, superseding Section 309 of the Indian Penal Code. The clinical stance follows directly, compassionate assessment and a collaborative safety plan rather than a charge, reinforced by national helpline infrastructure such as Tele MANAS. The burden is real and large but is stated without method, in keeping with safe-messaging, and the population-level prevention strategy sits in the Community psychiatry and public health notes.

GOOD TO REMEMBER

- **Section 115, Mental Healthcare Act 2017 (the statute, India):** a person who attempts suicide is presumed to be under severe stress and shall not be punished, overriding Section 309 of the Indian Penal Code, and the state owes them care to reduce recurrence. The principle to hold is that self-harm is met with care, not criminal liability.

2022	0	2017
NICE NG225, THE LEADING SELF-HARM GUIDELINE	RISK-STRATIFICATION SCORES THAT MAY PREDICT SELF-HARM OR RATION CARE	MENTAL HEALTHCARE ACT, SECTION 115 (ATTEMPT DECRIMINALISED)

HOLD THIS

Deliberate self-harm is intentional self-poisoning or self-injury irrespective of intent, so it spans NSSI (no wish to die) and the suicide attempt alike, and any self-harm raises future suicide risk whatever its medical seriousness; **NICE NG225** makes the management a single stance, a compassionate non-judgemental needs-based **psychosocial assessment** for every episode, no risk-stratification score ever used to predict self-harm or to decide who is offered care, a collaborative safety plan with positively framed means restriction, harm minimisation only as a contested adjunct, and active continuity of care, while in India Section 115 of the Mental Healthcare Act 2017 presumes severe stress and owes the person care rather than a charge.

23 · Suicide prevention

This topic asks you to lift the gaze from the single patient to the population: not *how do I assess this person*, but *what actually lowers the suicide rate of a community*. The marks turn on holding one organising frame, the World Health Organization's **WHO LIVE LIFE** guide, and its four evidence-based interventions; on placing each intervention on the right tier of a three-level public-health model; on knowing which single lever carries the strongest evidence; and on stating the Indian frame, the **National Suicide Prevention Strategy** and the decriminalising statute, accurately. Throughout, the register stays compassionate, non-judgemental and free of any method detail, and **means restriction** is framed positively as putting time and distance between a person and a crisis.

How to use this page. Fix the public-health scaffold first (the three tiers and the universal, selective and indicated classification); then load the WHO LIVE LIFE four interventions as the spine; then the highest-yield population lever, means restriction; then the community tier (gatekeeper training, crisis lines and responsible media reporting) and the individual and pharmacological tiers; and finally the Indian national frame. The population and public-health deep dive, including the epidemiology behind these levers, is developed in the Community psychiatry and public health notes; this page is the prevention framework itself. The one idea to carry off the page is that the biggest gains in **suicide prevention** come not from better individual prediction but from population-level action that reduces access to lethal means.

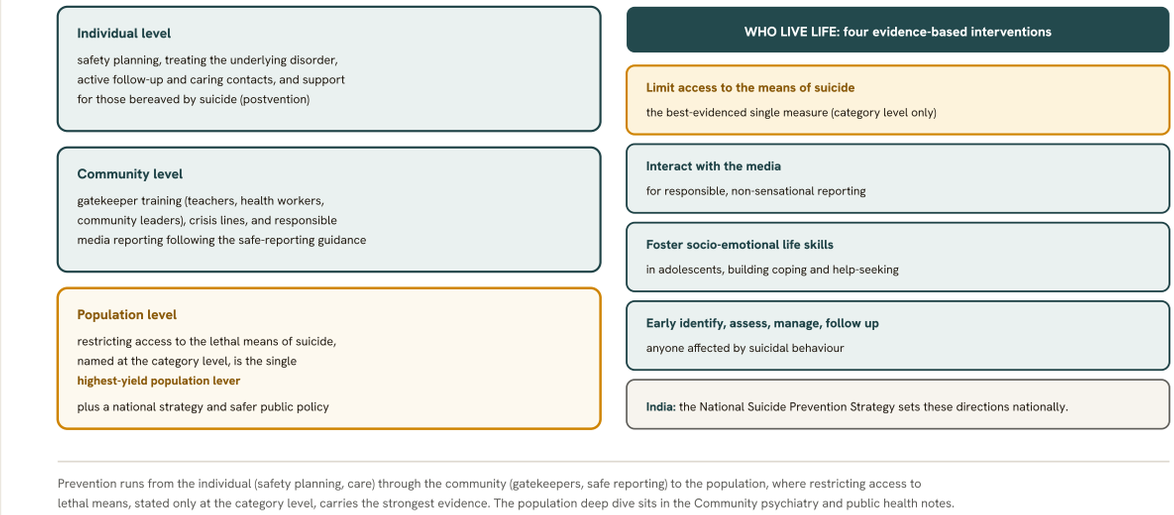


Fig 18.18 Suicide prevention. Prevention works across three levels. At the individual level it is safety planning, treatment of the disorder, active follow-up and caring contacts, and support for those bereaved. At the community level it is gatekeeper training, crisis lines and responsible, non-sensational media reporting. At the population level, restricting access to the lethal means of suicide, named only at the category level, is the single highest-yield lever, alongside a national strategy. The WHO LIVE LIFE framework gathers the four best-evidenced interventions, limiting access to means, engaging the media, fostering socio-emotional life skills in adolescents, and early identification and follow-up, and India expresses these through its National Suicide Prevention Strategy. The wider population and public-health treatment sits in the Community psychiatry and public health notes.

23.1 Prevention as a public-health task: the three tiers

From the clinic to the population. Because individual-level prediction of who will act is poor, prevention is best organised as a public-health task working across three tiers at once (New Oxford Textbook of Psychiatry; Kaplan and Sadock CTP 2024). The **individual tier** works with people already at risk or already affected: structured assessment, collaborative safety planning, follow-up and, above all, treating the underlying illness. The **community tier** works with at-risk groups and settings: gatekeeper training, crisis helplines, school-based life-skills programmes and responsible media reporting. The **population tier** works with everyone: reducing access to lethal means, reducing stigma, and the surveillance and strategy that underpin them. A complementary classification, borrowed from Gordon and used throughout the field, is universal, selective and indicated prevention: universal reaches a whole population regardless of risk (a canonical example is regulating access to hazardous means); selective targets a higher-risk subgroup (adolescents, farming communities); indicated targets identified individuals already showing warning signs. The two schemes map onto each other, and the examiner rewards the candidate who can place any given intervention correctly on the grid.

TIER	WHO IT TARGETS	EXEMPLAR INTERVENTIONS
Individual (indicated)	People already at risk or affected	**Structured assessment, collaborative safety planning, follow-up, treating the underlying disorder**
Community (selective)	At-risk groups and settings	**Gatekeeper training, crisis helplines, school life-skills, responsible media reporting**
Population (universal)	The whole population	**Means restriction (the highest-yield lever), stigma reduction, national strategy and surveillance**

The three-tier public-health model of prevention, aligned with the universal, selective and indicated classification (New Oxford; Kaplan and Sadock CTP 2024).

23.2 The WHO LIVE LIFE frame: four evidence-based interventions

The spine of every prevention answer. The World Health Organization LIVE LIFE implementation guide sets out four evidence-based interventions, and naming all four in order is the reliable way to structure an essay (WHO LIVE LIFE, 2021). They are: **L**imit access to the means of suicide; **I**nteract with the media for responsible reporting of suicide; foster socio-emotional **L**ife skills in adolescents; and **E**arly identify, assess, manage and follow up anyone affected by suicidal thoughts and behaviours. These four are supported by four foundational pillars (situation analysis, multisectoral collaboration, awareness-raising and capacity-building), underpinned in turn by adequate financing, surveillance, and monitoring and evaluation. The frame is deliberately cross-sectoral: it reaches beyond the health system into agriculture, media, education and regulation, which is precisely why it can move a population rate that clinical services alone cannot.

LIVE LIFE INTERVENTION	WHAT IT MEANS	TIER AND EVIDENCE
Limit access to means	Regulation reducing population access to lethal means	**Population; highest-yield, most robustly evidenced**
Interact with the media	Promote responsible, safe reporting; counter contagion	**Community; addresses the Werther effect**
Foster life skills	School-based socio-emotional and coping-skills programmes	**Universal, adolescent-directed**
Early identification and follow-up	Detect, assess, manage and actively follow up those affected	**Individual and clinical; gatekeeper-supported**

The four WHO LIVE LIFE interventions, each mapped to its prevention tier (WHO LIVE LIFE, 2021).

MNEMONIC

LIVE LIFE = LIMIT · INTERACT · LIFE-skills · EARLY

The four WHO interventions in order: **LIMIT** access to the means; **INTERACT** with the media for responsible reporting; foster **LIFE-skills** in adolescents; and **EARLY** identify, assess, manage and follow up. Four interventions on four pillars.

4	10%	1/3	48
WHO LIVE LIFE EVIDENCE-BASED INTERVENTIONS	NATIONAL SUICIDE PREVENTION STRATEGY TARGET REDUCTION IN SUICIDE MORTALITY BY 2030 (INDIA)	WHO GLOBAL TARGET REDUCTION IN THE SUICIDE RATE BY 2030	RANDOMISED TRIALS POOLED IN THE LITHIUM ANTI-SUICIDAL META-ANALYSIS (CIPRIANI, 2013)

GOOD TO REMEMBER

- **WHO LIVE LIFE (the four interventions):** Limit access to the means of suicide; Interact with the media for responsible reporting; foster socio-emotional Life skills in adolescents; Early identify, assess, manage and follow up. The guideline principle is that these four population and community levers, not better individual prediction, produce the largest fall in the suicide rate.

23.3 Means restriction: the single highest-yield lever

The one intervention with the strongest evidence. Of the four, restricting access to the means of suicide is the most robustly evidenced and highest-yield population-level intervention (WHO LIVE LIFE, 2021; New Oxford). It works because many suicidal crises are acute and ambivalent: putting time and distance between a person and a readily available lethal means allows the crisis to pass, and substitution to an equally lethal alternative is often incomplete. Canonical, method-free examples taught at the policy level are the regulation of highly hazardous pesticides in agriculture, limiting the pack sizes of commonly available over-the-counter medicines, and securing recognised structural hotspots with barriers. The accompanying figure sets the three prevention tiers in three levels with means restriction at the population base carrying the greatest population impact, and it is the mental model to reproduce. The full population and public-health case for this lever, with its epidemiological evidence, is developed in the Community psychiatry and public health notes.

RULE **Reducing access to lethal means is the highest-yield lever.** Across the whole toolkit, population-level means restriction has the strongest and most consistent evidence for lowering the suicide rate; it is the intervention to name first when asked what works.

TRAP **The substitution myth.** Assuming that a person prevented from one means will simply and inevitably find another is not borne out by the evidence; because crises are often transient and ambivalent, restricting access reduces deaths rather than merely displacing them.

GOOD TO REMEMBER

- **Means restriction (the guideline principle):** reducing population access to lethal means is the single highest-yield, most robustly evidenced suicide-prevention intervention (WHO LIVE LIFE, 2021). It is framed positively, as putting time and distance between a person and a crisis, and it acts at the population tier where clinical services cannot reach.

23.4 The community tier: gatekeeper training, crisis lines and responsible media

Widening the net beyond the clinic. The community tier equips non-specialists and shapes the information environment. Gatekeeper training equips frontline non-specialists (teachers, primary-care staff, community and religious leaders, helpline volunteers) to recognise warning signs and refer people at risk; it reliably improves skills and is highly acceptable in schools and workplaces, though a direct effect on completed suicide is harder to demonstrate and it works best as one component of a layered programme (Savita Malhotra; Dulcan). Crisis helplines and telephone or text lines provide accessible, immediate support at the point of distress. Responsible media reporting follows established safe-reporting guidance: avoid prominent or repetitive coverage, omit method and location detail, avoid framing suicide as a solution or romanticising it, and instead signpost help. This matters because sensational reporting can drive imitation, the Werther effect of copycat suicide, whereas coverage that models coping and recovery can be protective, the Papageno effect (New Oxford; Shorter Oxford). The acute triage of a person in active crisis who reaches these services belongs to the emergency psychiatry chapter.

PEARL

Hold the two named media effects as a mirror pair: the **Werther effect** is harm from irresponsible, sensational reporting (imitation and contagion); the **Papageno effect** is protection from responsible reporting that models coping and help-seeking. Responsible media reporting is the deliberate move from Werther toward Papageno.

GOOD TO REMEMBER

- **Gatekeeper training (the guideline role):** train non-specialists to identify and refer people at risk; it improves recognition and is highly acceptable, and it supports the early-identification intervention of WHO LIVE LIFE, but is delivered as part of a layered programme rather than as a stand-alone guarantee of reduced deaths.
- **Responsible media reporting (the guideline principle):** follow safe-reporting guidance (no method or location detail, no sensationalising or romanticising, signpost help); it shifts the population effect of coverage from the harmful Werther effect toward the protective Papageno effect.

23.5 The individual tier and the pharmacological prevention levers

Care, safety planning and the disorder-specific drugs that lower risk. At the individual tier, prevention means the early identification, assessment, management and active follow-up of people affected, with a collaboratively built safety plan (the Stanley-Brown Safety Planning Intervention components: warning signs, internal coping strategies, social contacts, people and professionals to call, and making the environment safer by restricting access to means) and rapid follow-up after any crisis contact, since transitions between services are a period of raised risk.

Two drugs carry a specific, evidence-based anti-suicidal effect and so act as pharmacological prevention levers. Lithium reduces the risk of suicide in people with mood disorders, a signal at least partly distinct from control of the mood episode itself, shown in the meta-analysis by Cipriani and colleagues pooling **48** randomised trials (BMJ, 2013); its full pharmacology is in the Mood disorders: pharmacotherapy notes. Clozapine is the only antipsychotic with a specific anti-suicidal indication, established by the International Suicide Prevention Trial in schizophrenia and schizoaffective disorder at high risk (InterSePT; Meltzer, 2003); its full pharmacology is in the Schizophrenia: management, antipsychotics and adverse effects notes. Treating the underlying disorder, and choosing an agent with an anti-suicidal signal where one exists, is itself prevention.

GOOD TO REMEMBER

- **Lithium (the guideline evidence):** favour lithium in a mood disorder carrying suicide risk; it reduces suicide and all-cause mortality versus placebo across 48 pooled randomised trials (Cipriani, BMJ 2013), an anti-suicidal effect at least partly independent of mood control.
- **Clozapine (the guideline indication):** clozapine is the only antipsychotic with a specific indication for reducing recurrent suicidal behaviour, in schizophrenia and schizoaffective disorder, established by the InterSePT trial (Meltzer, 2003).

23.6 The Indian national frame: strategy and statute

A first national strategy and a decriminalised act. India's prevention frame has two pillars the examiner expects. The first is the National Suicide Prevention Strategy, announced by the Ministry of Health and Family Welfare in 2022 as the country's first such strategy, with the stated goal of reducing suicide mortality by **10%** by 2030 against a 2019 baseline (a modest target beside the WHO Comprehensive Mental Health Action Plan aim of a **one-third** reduction in the suicide rate by 2030). Its actions are staged as immediate (within 1 to 3 years: advocacy for responsible media reporting, reducing access to a commonly used agrarian means through pesticide regulation, and strengthening surveillance and the mental-health workforce), intermediate (within 4 to 7 years: integrating mental health into general health care, training helpline workers, and reducing workplace stressors) and long term (within 8 to 10 years: destigmatisation, safer agricultural alternatives, and embedding well-being in education). The second pillar is the statute: under Section 115 of the Mental Healthcare Act, 2017, a person who attempts suicide is presumed, unless proved otherwise, to be under severe stress, and shall not be tried or punished, which effectively overrides the old offence at Section 309 of the Indian Penal Code, and the government carries a duty to provide care and rehabilitation. The Indian Psychiatric Society has supported this reframing of an attempt as a signal of distress and a call for help rather than a crime.

INDIA

Three moves win the Indian answer. Name the National Suicide Prevention Strategy (Ministry of Health and Family Welfare, 2022; the first national strategy) with its headline goal, a 10% reduction in suicide mortality by 2030. Quote Section 115 of the Mental Healthcare Act, 2017 precisely: attempted suicide is presumed to arise from severe stress and is not punished, overriding Section 309 of the Indian Penal Code, with a state duty of care. And weave in the two Indian dimensions the strategy targets, the agrarian sector (means regulation and safer farming) and students and adolescents (well-being curricula and life skills), consistent with the WHO LIVE LIFE emphasis on cross-sectoral action.

GOOD TO REMEMBER

- **National Suicide Prevention Strategy (the policy anchor):** India's first national strategy (Ministry of Health and Family Welfare, 2022); goal is a 10% reduction in suicide mortality by 2030 against a 2019 baseline, staged across immediate, intermediate and long-term actions spanning health, agriculture, media and education.
- **Section 115, Mental Healthcare Act, 2017 (the statute):** any person who attempts suicide is presumed, unless proved otherwise, to have severe stress and shall not be tried or punished (overriding Section 309 of the Indian Penal Code); the state must provide care, treatment and rehabilitation. The first response to an attempt is compassionate care, not sanction.

HOLD THIS

Prevention works in tiers (individual, community, population); the WHO LIVE LIFE guide gives the four evidence-based interventions (Limit access to means, Interact with the media for responsible reporting, foster Life skills, Early identify and follow up); of these, means restriction is the single highest-yield population lever; and the Indian frame is the National Suicide Prevention Strategy (2022, a 10% reduction goal by 2030) sitting on Section 115 of the Mental Healthcare Act, 2017, which decriminalises the attempt and mandates care.

24 · The neurobiology of suicidal behaviour

This is a short, high-yield topic that supplies the biological half of the picture built elsewhere in the chapter: it names the substrate of the enduring vulnerability, the **diathesis**, on which an acute stressor acts. Kaplan frames the **neurobiology of suicide** around a small number of recurring findings, and the examinable ones are three: a reduced central **serotonergic** function (indexed classically by low cerebrospinal-fluid 5-HIAA and tied to impulsive-aggressive and suicidal behaviour), a dysregulated stress axis (the **HPA axis**), and a set of emerging polyamine and inflammatory signals. The thread that binds them is the stress-diathesis (stress-vulnerability) model: these are trait-level, largely cross-diagnostic vulnerability markers, not tests that predict who will act (Kaplan and Sadock CTP 2024; New Oxford Textbook of Psychiatry).

How to use this page. Learn the serotonergic finding first, because it is the single most consistent and most examined; then the HPA-axis stress-response finding and what post-mortem study adds; then the newer polyamine and inflammatory signals and how the whole set constitutes the biological diathesis. The one idea to carry off the page is that these markers describe an enduring vulnerability and have limited value for predicting an individual, so the clinical task remains the

compassionate, structured assessment, and the tone throughout stays safeguarding and non-sensational.

24.1 Reduced central serotonergic function

The most consistent biological finding in the field. A decreased, dysregulated central serotonergic system in people who die by suicide and in those who attempt it, seen regardless of the psychiatric diagnosis, is a very strong correlate of suicidal behaviour and is described as one of the most consistent neurobiologic findings in psychiatry (Kaplan and Sadock CTP 2024). The classic in-vivo marker is a low concentration of the main serotonin metabolite, 5-HIAA (5-hydroxyindoleacetic acid), in the cerebrospinal fluid; central serotonergic function is also probed by the neuroendocrine fenfluramine challenge test and by PET of prefrontal metabolism (Tasman Psychiatry). Crucially, decreased central serotonin metabolism maps more tightly onto trait impulsive-aggression than onto any specific disorder: low CSF 5-HIAA is associated with impulsive, aggressive behaviour and with more medically serious, determined attempts, so it behaves as a trait vulnerability that raises the likelihood of an act when an acute episode and adverse circumstances coincide (Kaplan and Sadock CTP 2024).

MARKER OR METHOD	WHAT IT INDEXES	THE POINT TO HOLD
CSF 5-HIAA	The principal serotonin metabolite in cerebrospinal fluid	**Low CSF 5-HIAA marks reduced central serotonergic function and tracks impulsive-aggression**
Fenfluramine challenge	Prolactin response to a serotonin-releasing probe	**A blunted response signals reduced serotonergic responsiveness**
PET of prefrontal metabolism	In-vivo prefrontal serotonergic and metabolic activity	**Reduced prefrontal serotonergic and metabolic response**
Post-mortem 5-HT2A binding	Receptor-level change in the prefrontal cortex	**Altered 5-HT2A binding in the prefrontal cortex of those who died by suicide**

The measures of central serotonergic function used to demonstrate the core neurobiological finding; these findings form the diathesis axis of the stress-diathesis model (Tasman Psychiatry; Kaplan and Sadock CTP 2024).

RULE **Serotonergic hypofunction is the trait signal, not a diagnostic one.** Reduced central serotonergic function, indexed by low CSF 5-HIAA, is the most consistent biological correlate of suicidal behaviour and is cross-diagnostic, binding to impulsive-aggressive traits rather than to any single disorder.

GOOD TO REMEMBER

- **Reduced central serotonergic function (the core finding):** a decreased, dysregulated serotonergic system, marked by low CSF 5-HIAA and probed by the fenfluramine challenge and prefrontal PET, is one of the most consistent neurobiologic findings and correlates with suicidal behaviour irrespective of diagnosis. The discriminator to hold is that it is a trait-level marker tied to impulsive-aggression, more so than to any specific psychiatric disorder.

24.2 HPA-axis dysregulation: the stress response

The stress-response pathway that links life adversity to biology. The most studied pathway after the serotonergic one is the stress-response pathway mediated by the HPA axis (hypothalamic-pituitary-adrenal axis); disruption of this axis with altered glucocorticoid activity may increase the risk for suicidal behaviour (Kaplan and Sadock CTP 2024). The robust, exam-ready form of the finding is that HPA-axis hyperactivity, reflected in an abnormal dexamethasone suppression test (that is, non-suppression of cortisol), is a robust predictor of future completed suicide, primarily among patients in a major depressive episode. Post-mortem brain study of people who died by suicide adds the anatomy and the downstream chemistry: significant alterations in the prefrontal cortex and hippocampus (regions of emotion regulation and executive function), altered 5-HT2A binding, decreased BDNF (brain-derived neurotrophic factor, a neuroprotective signal), and dysregulated glutamatergic and GABA signalling. Taken together, the HPA-axis and neuroplasticity findings show how an enduring stress-response vulnerability is written into the brain.

TRAP **Reading a biomarker as a clinical predictor for the individual.** An abnormal dexamethasone suppression test or a low CSF 5-HIAA describes group-level risk and enduring vulnerability; these findings have limited practical value in the individual case, so the clinical decision still rests on the structured risk-and-protective assessment, never on a biological test.

GOOD TO REMEMBER

- **HPA-axis dysregulation (the stress-axis finding):** hyperactivity of the HPA axis, shown as cortisol non-suppression on the dexamethasone suppression test, is a robust predictor of future completed suicide, primarily in mood disorder; post-mortem study adds prefrontal and hippocampal change, altered 5-HT2A binding and reduced BDNF. The discriminator is that it is a stress-response vulnerability marker, robust at the group level yet of limited use for predicting an individual.

24.3 Polyamine and inflammatory signals, and the diathesis synthesis

The newer signals, and how the biology assembles into a diathesis. Beyond serotonin and cortisol, two emerging areas complete the compact picture. Changes in the polyamine system are reported alongside the serotonergic and HPA-axis changes as candidate substrates that make some individuals more vulnerable to suicidal behaviour (New Oxford Textbook of Psychiatry). Separately, a growing literature links inflammation, depression and suicide, drawing attention to neuroinflammation and the microbiome, and GABAergic signalling is a further active area (Kaplan and Sadock CTP 2024). Overlaying all of these, epigenetic mechanisms are the bridge from experience to biology: childhood adversity can alter, through DNA methylation and histone modification, the genes governing neurotrophic signalling and neurotransmission, and this is how early environment loads the diathesis. Assembled, the serotonergic hypofunction, the dysregulated HPA axis and these newer signals are precisely what the stress-diathesis (stress-vulnerability) model calls the diathesis: an enduring, partly heritable, partly experience-shaped trait vulnerability on which an acute stressor acts to produce an act (Kaplan and Sadock CTP 2024). Where a driving disorder is present, its treatment is itself anti-suicidal, and two agents

carry specific evidence whose pharmacology sits elsewhere: lithium in mood disorders, in the Mood disorders: pharmacotherapy notes, and clozapine in schizophrenia, in the Schizophrenia: management, antipsychotics and adverse effects notes.

INDIA

The biology gives a compassionate reading of the Indian statute. Because a suicidal act needs an enduring diathesis for an acute stressor to act upon, "severe stress" is a signal of suffering rather than of choice, which is exactly the presumption written into Section 115 of the Mental Healthcare Act 2017: a person who attempts suicide is presumed, unless proved otherwise, to be under severe stress and is not to be punished, and the state owes them care. The neurobiology and the law point the same way, toward assessment and care, not blame.

2	3	5-HT2A
STRESS-DIATHESIS COMPONENTS: AN ACUTE STRESSOR ACTING ON AN ENDURING DIATHESIS	CORE SYSTEMS STUDIED: SEROTONERGIC, HPA AXIS, NEUROPLASTICITY	THE SEROTONIN RECEPTOR ALTERED IN THE PREFRONTAL CORTEX POST-MORTEM

HOLD THIS

The neurobiology of suicidal behaviour is the biological **diathesis** of the stress-diathesis model: a reduced central **serotonergic** function (low CSF **5-HIAA**, tied to impulsive-aggression and cross-diagnostic, the single most consistent finding) plus a dysregulated **HPA axis** (cortisol non-suppression on the dexamethasone suppression test predicting completed suicide in mood disorder), with newer polyamine, inflammatory and epigenetic signals, all describing an enduring trait vulnerability that has limited value for predicting the individual, so care rests on the structured assessment, not a biological test.

25 · Anti-suicidal pharmacology

Why this topic sits apart. Almost every effective psychiatric drug lowers suicide risk indirectly, by lifting the depression, settling the mania or quietening the psychosis that drove the risk. The examinable heart of **anti-suicidal pharmacology** is narrower and sharper: two agents, and only two, carry a specific, trial-level anti-suicidal effect that is at least partly *distinct* from their control of the mood episode or the psychosis, and each maps to a single disorder group. Lithium reduces suicide and self-harm in mood disorders (Cipriani 2013 BMJ), and clozapine reduces recurrent suicidal behaviour in schizophrenia and schizoaffective disorder (InterSePT, Meltzer 2003, and an FDA indication). A third strand, ketamine and esketamine, is the emerging rapid option for suicidal ideation. The topic then closes on post-attempt management, the ordered clinical response after an act.



Fig 18.19 Anti-suicidal care is layered: establish immediate safety, make a collaborative safety plan, treat the underlying syndrome, reduce access to lethal means, mobilise support, ensure rapid follow-up and use evidence-based medication or somatic treatments when indicated.

How to use this page. Hold the set as two "specific-signal" drugs plus one "emerging" drug, then the ordered post-attempt sequence. For each drug learn three things: the disorder it applies to, the trial or evidence that anchors it, and the one line that names its status (a class effect for lithium, the only antipsychotic so indicated for clozapine). The deep pharmacology, the doses, serum levels and monitoring, lives in the mood-disorder and schizophrenia chapters and is cross-referenced here; this page is about the anti-suicidal *effect* and its evidence. Safe-messaging holds throughout: the discussion stays at the level of risk, evidence and care, never method.

25.1 Two specific signals against a disorder-directed background

Treating the disorder is itself anti-suicidal; two drugs add more. The default and most important principle is that reducing suicide risk pharmacologically means treating the underlying disorder effectively, because an untreated mood episode or active psychosis is itself the main driver of risk (Kaplan and Sadock CTP 2024). The examinable exception is that two agents carry a dedicated anti-suicidal effect that sits over and above symptom control and is tied

to one disorder group each: lithium in mood disorders and clozapine in schizophrenia and schizoaffective disorder. A third, newer strand, ketamine and esketamine, gives a rapid but short-term effect on suicidal ideation rather than on completed suicide. These two specific signals stand against the disorder-directed background so the exception is not mistaken for the rule.

AGENT	DISORDER GROUP	ANCHORING EVIDENCE	STATUS TO STATE
Lithium	Mood disorders (unipolar and bipolar)	Cipriani 2013 BMJ meta-analysis, 48 RCTs	**A class effect specific to lithium, not shared by other mood stabilisers; reduces suicide and death from any cause**
Clozapine	Schizophrenia and schizoaffective disorder	InterSePT (Meltzer 2003), 2-year RCT versus olanzapine	**The only antipsychotic with an anti-suicidal FDA indication; reduces recurrent suicidal behaviour**
Ketamine and esketamine	Major depression with acute suicidal ideation	ASPIRE programme (esketamine)	**Emerging adjunct; rapid, short-term fall in ideation, no proven effect on completed suicide**

The examinable core of anti-suicidal pharmacology: two specific signals plus one emerging option, each read as disorder, evidence, and status (Cipriani 2013 BMJ; InterSePT, Meltzer 2003; ASPIRE).

RULE **Only two agents carry a specific anti-suicidal signal.** Beyond treating the disorder, only lithium (in mood disorders) and clozapine (in schizophrenia and schizoaffective disorder) have a dedicated, trial-level anti-suicidal effect; for each, name the trial and the status.

TRAP **Assuming the benefit is class-wide.** Lithium's anti-suicidal effect is not reproduced by valproate, lamotrigine or carbamazepine, and clozapine's is not reproduced by other antipsychotics; InterSePT's comparator olanzapine is an effective drug yet was inferior, so do not assume any mood stabiliser or any antipsychotic delivers the same protection.

25.2 Lithium: the anti-suicidal effect in mood disorders

Lithium lowers suicide in mood disorders, and it behaves as a class-specific property. The lithium anti-suicidal effect is the best-established in the field. The meta-analysis by Cipriani and colleagues (BMJ 2013;346:f3646) pooled 48 randomised controlled trials and found that lithium reduced the risk of suicide and the risk of death from any cause compared with placebo, across unipolar and bipolar mood disorders (Cipriani 2013 BMJ). Two points make it examinable. First, the anti-suicidal signal is at least partly *distinct* from control of the mood episode itself, so it is a reason to favour lithium specifically when a mood disorder carries suicide risk, not merely a by-product of better mood control. Second, it looks like a **class effect of lithium**, seen with lithium and not clearly shared by the other mood stabilisers, which is why the choice of the mood stabiliser can matter for risk. The proposed substrate is a dampening of impulsive aggression, consistent with the serotonergic diathesis of suicidal behaviour, but the effect is claimed on the

outcome evidence, not on a mechanism. The deep pharmacology, the therapeutic range, monitoring and toxicity, belongs to the Mood disorders: pharmacotherapy notes; here the point is the effect and the trial that anchors it.

PEARL

The word to hold is *distinct*. If lithium only prevented suicide by preventing relapse, any equally good mood stabiliser would match it, but they do not. The anti-suicidal effect tracks lithium specifically and is partly separable from episode control, which is exactly why it changes the prescribing calculus in a mood disorder with suicide risk rather than being a footnote to relapse prevention.

GOOD TO REMEMBER

- **Lithium anti-suicidal effect (evidence-anchored, Cipriani 2013 BMJ):** lithium reduces the risk of suicide and of death from any cause in mood disorders, pooled across 48 randomised controlled trials; the effect is at least partly distinct from mood-episode control and is a class effect specific to lithium, not shared by the other mood stabilisers, so it favours lithium where a mood disorder carries suicide risk. Deep pharmacology in the Mood disorders: pharmacotherapy notes.

25.3 Clozapine: recurrent suicidal behaviour in schizophrenia

Clozapine reduces recurrent suicidal behaviour in schizophrenia, and it is the only antipsychotic licensed for it. The clozapine persistent suicidality data come from the International Suicide Prevention Trial (InterSePT; Meltzer et al, Archives of General Psychiatry 2003;60:82-91). It was a double-blind randomised comparison that enrolled roughly 980 patients with schizophrenia or schizoaffective disorder judged to be at high suicide risk, assigned them to clozapine or to olanzapine, and followed them for up to 2 years. Clozapine was superior in delaying recurrent suicidal behaviour, with fewer clozapine-treated patients requiring hospitalisation or rescue intervention to prevent suicide (InterSePT, Meltzer 2003). This underpins the FDA-approved indication for reducing the risk of recurrent suicidal behaviour in schizophrenia and schizoaffective disorder, the only antipsychotic to hold such an indication. As with lithium, the effect appears partly distinct from control of the positive symptoms, so a persistent suicide risk in schizophrenia is itself a recognised reason to move to clozapine. The deep pharmacology, the titration and the mandatory haematological monitoring, belongs to the Schizophrenia: management, antipsychotics and adverse effects notes.

GOOD TO REMEMBER

- **Clozapine persistent suicidality (guideline-anchored, InterSePT, Meltzer 2003, and the FDA indication):** clozapine reduces recurrent suicidal behaviour in schizophrenia and schizoaffective disorder, shown in the InterSePT 2-year randomised trial where it outperformed olanzapine, and it is the only antipsychotic FDA-indicated for reducing suicide risk. Persistent suicidality in schizophrenia is a recognised reason to move to clozapine; deep pharmacology and monitoring in the Schizophrenia: management, antipsychotics and adverse effects notes.

25.4 Ketamine and esketamine: the emerging rapid option

A rapid, short-term effect on suicidal ideation, not a proven effect on completed suicide. Ketamine and intranasal esketamine (Spravato) produce rapid, short-lived reductions in suicidal ideation, often within hours, which is what makes them of interest when ideation is acute (Kaplan and Sadock CTP 2024; Maudsley Prescribing Guidelines). Esketamine has been studied specifically in major depressive disorder with acute suicidal ideation or behaviour (the ASPIRE programme). The honest reading of the evidence is that it supports a rapid effect on *ideation*, as an adjunct within comprehensive care, whereas a reduction in completed suicide has not been established. So it functions as a bridge, buying time while definitive treatment and safety planning take hold, and never as a stand-alone answer to risk.

GOOD TO REMEMBER

- **Ketamine and esketamine (guideline-anchored, ASPIRE programme):** a rapid, short-term reduction in suicidal ideation, studied for esketamine in major depression with acute suicidal ideation or behaviour; it is an adjunct within comprehensive care that buys time, not a proven reducer of completed suicide and not a stand-alone treatment.

25.5 Post-attempt management: the ordered response

An ordered sequence, not a single drug. Post-attempt management is the structured response after an act, and it is examined as a sequence. First comes medical stabilisation of the physical consequences to medical fitness; only then, once the person is medically fit, a compassionate, non-judgemental psychosocial assessment of needs, context and safety, which every episode warrants regardless of the apparent medical seriousness of the act (NICE NG225 2022). This feeds a collaborative safety plan with means-restriction counselling framed positively, and, running underneath all of it, treatment of the underlying disorder, which is the main pharmacological lever against future risk and where the two specific agents above may enter. A recurring pitfall the guideline names is using a risk-stratification score to decide who is offered care; risk is assessed to guide a needs-based, collaborative response, not to ration it. The acute triage of the actively suicidal patient in crisis is covered in the emergency psychiatry chapter, and the population-level, public-health side of prevention in the Community psychiatry and public health notes.

STEP	THE ACTION	THE PRINCIPLE
Medical stabilisation	Treat the physical consequences of the act to medical fitness first	**Life and physical safety precede any psychiatric disposition**
Psychosocial assessment	Compassionate, non-judgemental assessment of needs, context and safety, every episode	**Needs-based, never a risk score (NICE NG225 2022)**
Safety plan and means counselling	Build a collaborative safety plan; counsel on reducing access to lethal means	**Means restriction is the highest-yield step, framed positively**
Treat the underlying disorder	Optimise treatment of the driving disorder; consider lithium or clozapine where indicated	**Effective disorder treatment is itself anti-suicidal**

The post-attempt management sequence, medical stabilisation then needs-based psychosocial assessment, safety planning and disorder treatment, with those post-attempt steps set in order (NICE NG225 2022).

INDIA

The statute frames post-attempt management compassionately. Under Section 115 of the Mental Healthcare Act, 2017, a person who attempts suicide is presumed, unless proved otherwise, to be under severe stress, and is not to be tried or punished, with a duty on the government to provide care, treatment and rehabilitation to reduce the risk of recurrence (Mental Healthcare Act 2017, Section 115). The clinical sequence and the law point the same way, toward assessment and care rather than blame. Both specific agents are available and used in India: lithium is inexpensive and widely prescribed, and clozapine is available with the mandatory haematological monitoring, so the anti-suicidal evidence is directly actionable here. The Indian Psychiatric Society position aligns with this care-first, means-restriction framing.

GOOD TO REMEMBER

- **Post-attempt management (guideline-anchored, NICE NG225 2022):** an ordered response, medical stabilisation of the physical consequences first, then a compassionate, non-judgemental psychosocial assessment of needs and safety in every episode, a collaborative safety plan with positively framed means-restriction counselling, and treatment of the underlying disorder, which is itself the main anti-suicidal lever. A risk-stratification score must never decide who is offered care. Acute crisis triage is in the emergency psychiatry chapter.

48	2	1
RANDOMISED TRIALS POOLED IN THE CIPRIANI LITHIUM META-ANALYSIS	INTERSEPT FOLLOW-UP (YEARS)	ANTIPSYCHOTIC WITH AN ANTI-SUICIDAL INDICATION (CLOZAPINE)

HOLD THIS

Beyond treating the disorder, only two drugs carry a specific anti-suicidal effect: **lithium** reduces suicide and all-cause death in mood disorders (Cipriani 2013 BMJ, 48 RCTs; a class effect specific to lithium) and **clozapine** reduces recurrent suicidal behaviour in schizophrenia and schizoaffective disorder (InterSePT, Meltzer 2003; the only antipsychotic so FDA-indicated); ketamine and esketamine cut ideation rapidly but not completed suicide; and post-attempt management runs medical stabilisation, then a needs-based psychosocial assessment and positively framed safety plan, then treatment of the underlying disorder.

Apply and consolidate

26 · Worked cases

This is the topic on which the whole chapter is *closed*, the point where the four rooms of the master mnemonic, the body that complains, the body that desires, the urge that acts and the life that must be protected, are walked through as reasoning rather than recited as fact. Everything before this page taught entities in isolation; here five **worked examples** put them back into the clinic, because the examiner rarely asks "define" and almost always asks "here is a patient, place them and defend the next step". A vignette is marked on two moves, the discrimination that names the frame and the guideline-anchored step that follows from it, so each case below is reasoned through both.

How to use this page. Read each case as a two-part act: first the diagnostic or discrimination reasoning that fixes the frame, then the management or safety step that the frame demands, with the cardinal error the case is built to catch called out in the open. The order tracks the arc, a somatic-symptom work-up, then the produced-symptom discrimination, then an erectile-dysfunction management case, then a gender-incongruence affirmative-care case, and finally a suicide-risk-assessment-and-safety-planning case, the last written under strict safe-messaging, with no method detail anywhere and a compassionate, safeguarding register throughout.

26.1 A somatic-symptom-disorder work-up

case: a woman in her late thirties has attended gastroenterology, cardiology and general medicine repeatedly over roughly eight months with abdominal pain, palpitations and fatigue; the investigations have been normal each time, yet she spends hours reading about serious illness, checks her pulse many times a day, has cut back her work, and cannot be settled by a normal review. She arrives at psychiatry surprised to be referred, insisting the trouble is physical.

The reasoning. Place her against the three DSM-5-TR criteria for somatic symptom disorder (DSM-5-TR 2022). Criterion A is met, there are distressing, disrupting somatic symptoms. Criterion C is met, the symptomatic state has persisted well beyond six months. The load-bearing move is Criterion B, the **positive psychological criterion**: her disproportionate and persistent thoughts about seriousness, her high health anxiety, and the excessive time and behaviour devoted to symptoms are all present, and any one of the three would suffice. The diagnosis is therefore secured by what she does and feels about the symptoms, not by the symptoms being

unexplained; even were an explanatory condition later found, the excessive response would still qualify her. Grade the burden with the PHQ-15 (fifteen items, each scored 0 to 2, a total out of a possible 30) and read Criterion B directly with the SSD-12 (a total out of a possible 48); the totals run out of a possible 48.

RULE **Diagnose on the positive criterion, not on a normal work-up.** Somatic symptom disorder is established by the excessive thoughts, feelings and behaviours of Criterion B alongside a distressing somatic symptom; whether the symptom is medically explained does not decide it.

WORKED EXAMPLE

The wrong turn is a fresh battery of tests to "reassure" her, which teaches the body to keep speaking. The right first move is physician-centred: a single named clinician, brief scheduled visits at a fixed interval rather than symptom-triggered ones, explicit validation that the symptoms and the distress are real, restriction of unnecessary investigation and referral, early treatment of any comorbid depression or anxiety, and a steady shift of the conversation from symptoms toward functioning. Cognitive behaviour therapy is the first-line psychotherapy, targeting the catastrophic reading of bodily sensations (IPS_CPG 2020). Drugs are not started for the somatic symptoms themselves.

GOOD TO REMEMBER

- **Somatic symptom disorder (the diagnosis):** Criterion A, distressing somatic symptoms; Criterion B, excessive thoughts, feelings or behaviours about them (the positive psychological criterion); Criterion C, a persistent symptomatic state beyond six months. The single discriminator is that Criterion B, not the absence of a medical explanation, defines it.
- **Physician-centred care (the management step):** the guideline first-line (IPS_CPG 2020), being a therapeutic alliance, validation of real symptoms, restriction of unnecessary tests and referrals, early treatment of comorbid mood or anxiety, and a shift toward functioning; the first move is the alliance, and antidepressants are not prescribed for medically unexplained somatic symptoms unless a specialist advises (WHO mhGAP 2016), reserved instead for a comorbid depressive or anxiety disorder or a dominant chronic-pain component.

If a conversion element sat within her presentation its bedside positive signs and management would be worked in the Dissociative, conversion and anxiolytic/hypnotic pharmacology notes; the consultation-liaison service model that most often meets such patients, and the transcultural reading of a Dhat-type presentation through a cultural formulation, are developed in the Consultation-liaison, geriatric and transcultural psychiatry notes.

26.2 A somatic-versus-factitious-versus-malingering discrimination

case: a man is referred with recurrent, dramatic and shifting symptoms that never quite match the objective findings, and the team is split on whether he is genuinely unwell, making himself unwell, or putting it on for a reason. The whole discrimination reduces to two questions asked in order: is the symptom *produced*, and if so, *why*.

The reasoning. The first question separates the genuine somatic disorders, whose symptoms are not intentionally produced, from the two feigned conditions, where they are. The second

question then splits the feigned pair on the incentive. If this man carries a pending compensation or medicolegal claim, shows disability far exceeding the objective findings, and is poorly cooperative with assessment and treatment, an **external incentive** is present and the frame is malingering, coded Z76.5 as a condition for clinical attention and expressly not a mental disorder; DSM-5-TR says it is *strongly suspected*, never confirmed, on any combination of its four pointers (DSM-5-TR 2022). If instead he consciously falsifies or induces signs, seeks procedures and admissions, and no external reward is in view, so that the motive is simply to occupy the sick role, the frame is factitious disorder imposed on self (F68.10), whose Criterion C is precisely that the deception persists in the absence of obvious external rewards. Voluntariness of production is shared by both feigned conditions and so cannot tell them apart; only the external incentive can.

THE PRESENTATION	SYMPTOM INTENTIONALLY PRODUCED?	EXTERNAL INCENTIVE
Genuine somatic symptom disorder	No, not intentionally produced	**Absent; the distress is real and the response excessive**
Factitious disorder (F68.10)	Yes, consciously feigned	**Absent; the motive is the sick role (primary gain)**
Malingering (Z76.5)	Yes, consciously feigned	**Present; a tangible reward or an avoided obligation (secondary gain)**

The voluntariness-by-incentive grid applied to the case; production separates the genuine disorder from the two feigned conditions, and the external incentive separates malingering from factitious disorder (New Oxford Textbook of Psychiatry; DSM-5-TR 2022).

TRAP **Confusing factitious disorder with malingering.** Both are consciously feigned, so they feel alike; the difference is the external incentive, present in malingering, absent in factitious disorder. Reading a compensation claimant as factitious, or a sick-role patient as a malingerer, inverts the whole grid.

GOOD TO REMEMBER

- **The discriminator (the criterion anchor):** ask production first, then motivation. Genuine somatic disorders are not intentionally produced; of the two feigned conditions, factitious disorder has no external incentive (the sick role, primary gain, Criterion C) and malingering has one (secondary gain, coded Z76.5, strongly suspected on the four DSM-5-TR pointers, not a disorder). The single external-incentive axis carries the differentiation, and the register stays medical and non-accusatory, documenting inconsistency rather than branding dishonesty.

26.3 An erectile-dysfunction management case

case: a man in his early fifties with type 2 diabetes and hypertension reports gradually worsening difficulty attaining and maintaining an erection across all contexts, including reduced early-morning erections, for the past several months, and is distressed by it. He asks for "the tablet".

The reasoning. The history sorts aetiology before any test: an insidious onset with erections deficient in every context, nocturnal and masturbatory included, points to organic, most likely vasculogenic, erectile dysfunction rather than a psychogenic pattern (Kaplan and Sadock CTP 2024). Two consequences follow. First, in a man with vascular risk factors the complaint is a

cardiovascular sentinel, the small penile arteries narrowing before the coronaries, so he needs a proper cardiovascular risk assessment, blood pressure, fasting glucose or HbA1c and lipids, and not a prescription alone. Second, measure a morning total testosterone and confirm any low result on a repeat before calling it hypogonadism. Grade severity with the five-item IIEF-5: the total runs from 5 to 25, read as no erectile dysfunction (22 to 25), mild (17 to 21), mild to moderate (12 to 16), moderate (8 to 11) and severe (5 to 7), out of a possible 25; the bands run out of a possible 25.

The management. First-line for a man without a contraindication is an oral PDE5 inhibitor plus lifestyle and risk-factor optimisation (EAU male sexual dysfunction; AUA 2018). All the oral agents are similarly effective, so choice turns on how he wants to use them: sildenafil (Manforce, Penegra) is the high-efficacy pick, taken on-demand about one hour before, starting at **50 mg**; tadalafil (Tadacip, Megalis) is the tolerability pick with the longest window, on-demand from **10 mg** or a once-daily **5 mg** that decouples dosing from sex. Before any prescription, screen specifically for nitrate use, because any organic nitrate, nitric oxide donor, nicorandil or recreational nitrite with any PDE5 inhibitor is an absolute contraindication (cyclic-GMP accumulation and profound hypotension); alpha-blockers are a caution only. If oral therapy fails or is contraindicated, second-line is intracavernosal alprostadil or a vacuum device, and third-line a penile prosthesis. Where an antidepressant or antipsychotic is contributing, that reversible cause is addressed as in the Mood disorders: pharmacotherapy notes and the Schizophrenia: management, antipsychotics and adverse effects notes.

ORAL PDE5 INHIBITOR	ON-DEMAND START (MG)	THE POINT TO HOLD
Sildenafil (Manforce, Penegra)	50	**High-efficacy pick; onset 30 to 60 min, window up to 12 h; a high-fat meal delays absorption**
Tadalafil (Tadacip, Megalis)	10 on-demand, or 5 once daily	**Longest window, up to 36 h; the only agent also licensed for erectile dysfunction with benign prostatic hyperplasia, at 5 mg once daily**
Vardenafil	10	**Orally disintegrating form available**
Avanafil	100	**Fastest onset; taken 15 to 30 min before**

The first-line oral PDE5 inhibitors, all similarly effective, with the verified EAU and AUA 2018 starting doses; units are carried in the header (EAU male sexual dysfunction; AUA 2018).

The trap to close. Because he has diabetes and low-ish energy, the tempting error is empirical, long-term testosterone. Measure it, but treat only biochemically confirmed hypogonadism; testosterone can rescue a genuinely hypogonadal PDE5-inhibitor non-responder, but it will not fix a eugonadal man's erectile dysfunction and only adds androgen risk.

GOOD TO REMEMBER

- **Erectile dysfunction (the diagnosis):** persistent inability to attain or maintain an erection sufficient for satisfactory performance; the defining discriminator is the organic, psychogenic or mixed classification, read first from preserved versus absent nocturnal and masturbatory erections, with vasculogenic disease a cardiovascular warning.
- **First-line erectile-dysfunction drug (guideline-anchored, EAU and AUA 2018):** an oral PDE5 inhibitor plus risk-factor optimisation; sildenafil starts at **50 mg** on-demand about one hour before, tadalafil at **10 mg** on-demand or **5 mg** once daily; any nitrate in any form is an absolute contraindication, and empirical long-term testosterone is never started in a man whose testosterone is normal.

26.4 A gender-incongruence affirmative-care case

case: a young adult, assigned male at birth, has experienced herself as female persistently since adolescence and comes seeking recognition, support and onward referral; her low mood and anxiety are driven largely by family rejection, misgendering and fear of discrimination, not by the gender identity itself.

The reasoning. The affirming frame is the whole answer. Gender incongruence, the marked and persistent mismatch between experienced gender and sex assigned at birth, is not a mental disorder; ICD-11 moved it out of the mental disorders chapter into "Conditions related to sexual health", and it carries no distress criterion at all (ICD-11). Gender dysphoria is the DSM-5-TR term for the clinically significant distress that only *some* people with that incongruence experience, and it is that distress, understood largely as gender minority stress, that is the target of care, never the identity. So the clinician affirms who she is and treats the distress, the comorbid depression and the effects of stigma.

The pathway. Management is a stance codified in the eighth version of the Standards of Care, WPATH SOC-8 (2022): individualised, multidisciplinary and informed-consent based, with a flexible staged transition running fully reversible (social) then partially reversible (hormonal) then irreversible (surgical) steps, and mental-health support offered where needed rather than as a universal gate. The psychiatrist's role is bounded and specific: assess readiness and capacity to give informed consent, diagnose and treat comorbid mental illness (stabilise it, do not use it to exclude her), give psychoeducation and psychosocial support, and refer. The psychiatrist does not initiate or titrate gender-affirming hormones, which are endocrinology-led (feminising therapy combines an oestrogen with an anti-androgen; Endocrine Society 2017).

RULE **Affirm the identity; treat only the distress.** Gender incongruence is not the pathology. The guideline-anchored target of care is the dysphoria, the comorbidity and the effects of stigma, and so-called conversion or reparative efforts are ineffective, harmful and outside the standard of care.

GOOD TO REMEMBER

- **Gender incongruence (the criterion anchor, ICD-11):** a marked, persistent mismatch between experienced gender and sex assigned at birth, at least two of the four indicators, present for at least several months, not assignable before puberty, and with NO distress criterion; it sits in "Conditions related to sexual health", so it is explicitly not a mental disorder. Gender dysphoria is the DSM-5-TR distress-gated term for the suffering only some experience.
- **Affirmative-care pathway (the guideline anchor, WPATH SOC-8 2022):** individualised, multidisciplinary, informed-consent care with a flexible social-then-hormonal-then-surgical transition; the psychiatrist assesses readiness and capacity, treats comorbidity, supports and refers, and does not initiate hormones (endocrinology-led).

INDIA

The clinical and legal stances now point the same way. In the NALSA judgment (National Legal Services Authority v Union of India, Supreme Court, 15 April 2014) the court recognised transgender persons as a third gender and affirmed the right to self-identified gender; the Transgender Persons (Protection of Rights) Act, 2019 then gave statutory recognition, prohibited discrimination in employment, education and healthcare, and set out welfare provisions. India also has its own long-standing third-gender tradition in the hijra community. The psychiatrist works within this frame, offering affirmative, non-judgemental care and appropriate referral, and never conversion approaches.

26.5 A suicide-risk-assessment-and-safety-planning case

case: a person is seen in acute distress after a recent crisis, a job loss and a relationship breakdown in the same fortnight, against a background of a current depressive episode and a past attempt in the history. This case is written under strict safe-messaging: no method is named anywhere, access to means is spoken of only at the category level, and the register stays compassionate and safeguarding throughout.

The reasoning. The task is a structured evaluation, a compassionate clinical interview that systematically covers the same domains every time, not a checklist score. Move gently along the continuum, from low mood to whether life feels worth living, to active thoughts, plan and intent, and, just as deliberately, ask what has kept the person going. Asking directly does not plant the idea. Then weigh the two halves of the balance. The static load is heavy here, a previous attempt with a current major depressive episode being together among the two strongest predictors of future suicide. The dynamic load is what has surged, hopelessness (the pre-eminent dynamic factor), a fresh interpersonal and financial crisis, agitation and isolation, with access to lethal means considered only at the category level. Against these sit the protective factors to seek out and strengthen, help-seeking, family support, concrete reasons for living and responsibilities to others. Hold chronic and acute risk as two separate axes; the person elevated on both warrants the most immediate response. Structure the interview with the Columbia Suicide Severity Rating Scale (C-SSRS), whose ideation subscale is an ordered ladder of five levels of increasing severity, and screen with PHQ-9 item nine; remember that SAD PERSONS is only a teaching aide, and that no instrument or clinician reliably predicts individual suicide, so a low-medium-high label must never be used to ration care.

TRAP **Treating a denied ideation as a cleared risk.** A bare verbal "no" does not neutralise a high risk-and-protective balance. When the structured evaluation shows heavy static and dynamic loading with thin protection, the denial is one data point, not an all-clear; the assessment governs the plan, not the last sentence spoken.

The management link. The assessment earns its keep only when it produces a plan. Build a collaborative Stanley-Brown Safety Planning Intervention *with* the person: recognise personal warning signs, use internal coping strategies, use social contacts and settings that provide distraction, identify people who can help, list professionals and crisis or helpline contacts, and make the environment safer by reducing access to lethal means, the last framed positively as putting time and distance between a person and a crisis, involving family where appropriate. Match the level of care, community follow-up, crisis team or admission, to assessed need, and arrange rapid follow-up, because the transition after any care contact is a high-risk window. Treating the driving disorder is itself anti-suicidal, and two agents carry specific evidence, lithium in mood disorders and clozapine in schizophrenia, developed in the Mood disorders: pharmacotherapy notes and the Schizophrenia: management, antipsychotics and adverse effects notes; the acute triage of the patient in crisis is developed in the emergency psychiatry chapter, and the population-level prevention deep dive in the Community psychiatry and public health notes.

WORKED EXAMPLE

Taking this person's eventual "I just want to go home" at face value and discharging would be the cardinal error, because the whole balance, not the last answer, is heavily loaded. The defensible course keeps them in active care, documents chronic and acute risk separately and states what has changed acutely, mobilises the protective factors, and produces a written collaborative safety plan with positively framed means-restriction counselling and a rapid follow-up appointment. The denial is noted, not trusted as an all-clear.

GOOD TO REMEMBER

- **Structured suicide risk assessment (the principle anchor):** a compassionate structured interview that weighs static against dynamic risk factors and protective factors, separates chronic from acute risk, structures with the C-SSRS ideation ladder (five levels) and screens with PHQ-9 item nine; no tool predicts individual suicide, so stratifying into low-medium-high to ration care is discouraged, and a denied ideation is never a cleared risk.
- **Safety planning and means restriction (the management step, NICE-aligned NG225 2022):** the first move after assessment is a collaborative Stanley-Brown safety plan plus positively framed means-restriction counselling, then a level of care matched to need with rapid follow-up; means restriction is the highest-yield lever, and drugs treat the driving disorder (lithium, clozapine) and supplement, never replace, the plan.

INDIA

India carries a large share of the world's suicide deaths, and suicide is among the leading causes of death in young Indian adults, a burden stated here without any reference to means and one that makes competent, compassionate assessment a public-health priority. The legal anchor is Section 115 of the Mental Healthcare Act 2017: a person who attempts suicide is presumed, unless proved otherwise, to be under severe stress, and shall not be tried or punished, effectively overriding Section 309 of the Indian Penal Code, and the state owes them care and rehabilitation to reduce recurrence. National helpline infrastructure such as Tele MANAS and the Indian Psychiatric Society position reinforce the shift from punishment to care.

25	50	30	5
IIEF-5 TOP SCORE (NO ED FROM 22 UP)	SILDENAFIL ON-DEMAND START (MG)	DAPOXETINE ON-DEMAND START (MG)	C-SSRS IDEATION-SEVERITY LEVELS

HOLD THIS

Read every vignette in two moves, the discrimination that names the frame and the guideline step that follows: somatic symptom disorder turns on the POSITIVE psychological criterion and is managed physician-centred; the produced-symptom pair splits only on the external incentive (present in malingering, absent in factitious disorder); erectile dysfunction is first-line an oral PDE5 inhibitor (sildenafil **50 mg** on-demand, tadalafil **10 mg** on-demand or **5 mg** once daily) with nitrates absolutely contraindicated and testosterone only for confirmed hypogonadism; gender incongruence is affirmed, not pathologised, along the WPATH SOC-8 pathway within the NALSA judgment and the Transgender Persons Act 2019; and the suicidal patient gets a structured assessment weighing risk against protection, never a predictive score, with a collaborative safety plan and positively framed means restriction, remembering that a denied ideation is not a cleared risk and that Section 115 of the Mental Healthcare Act 2017 decriminalised the attempt.

27 · Consolidation

The whole chapter now stands in front of you, and this closing topic is not new content but the machinery that turns reading into recall. The examination does not reward the candidate who has *read* the somatic, sexual, impulse and suicide block; it rewards the one who can, cold and under pressure, name the positive criterion that defines a somatic symptom disorder, split factitious from malingering on a single axis, place a sexual complaint on the response cycle and reach for the first-line drug, state that being transgender is not an illness, and run a compassionate structured suicide assessment. Those retrievals are what this topic drills. The single most robust finding in the science of learning is that **active recall** (pulling an answer out of an empty page) and **retrieval practice** (repeatedly testing yourself rather than re-reading) beat every passive method for durable memory, so the design here is deliberately answer-sparse: prompts first, and the answers held elsewhere in the chapter so you must fetch them.

Why it matters, and what this note owns. This note owns three things: the master **mnemonic** that ties the chapter together, paid off from where it was seeded at the somatic-symptom-disorder opener; a set of answer-free prompt lists for **active recall** across the somatic nosology and its positive criterion, the factitious-versus-malingering discriminator, the sexual response

cycle and the erectile-dysfunction first-line, the gender-incongruence depathologisation, and the suicide risk-assessment principles and safety planning; and a whole-chapter **synthesis map** you are meant to **redraw from memory**. It re-derives no criterion, dose or cut-off of its own; every figure quoted here is a pointer back to the topic that verified it. The deep antidepressant and lithium anti-suicidal pharmacology lives in the Mood disorders: pharmacotherapy notes, the clozapine anti-suicidal pharmacology in the Schizophrenia: management, antipsychotics and adverse effects notes, and the transcultural frame of Dhat in the Consultation-liaison, geriatric and transcultural psychiatry notes. The synthesis map that carries the whole block is drawn in the accompanying figure, framed cover-the-branches so it can be used as a retrieval test.

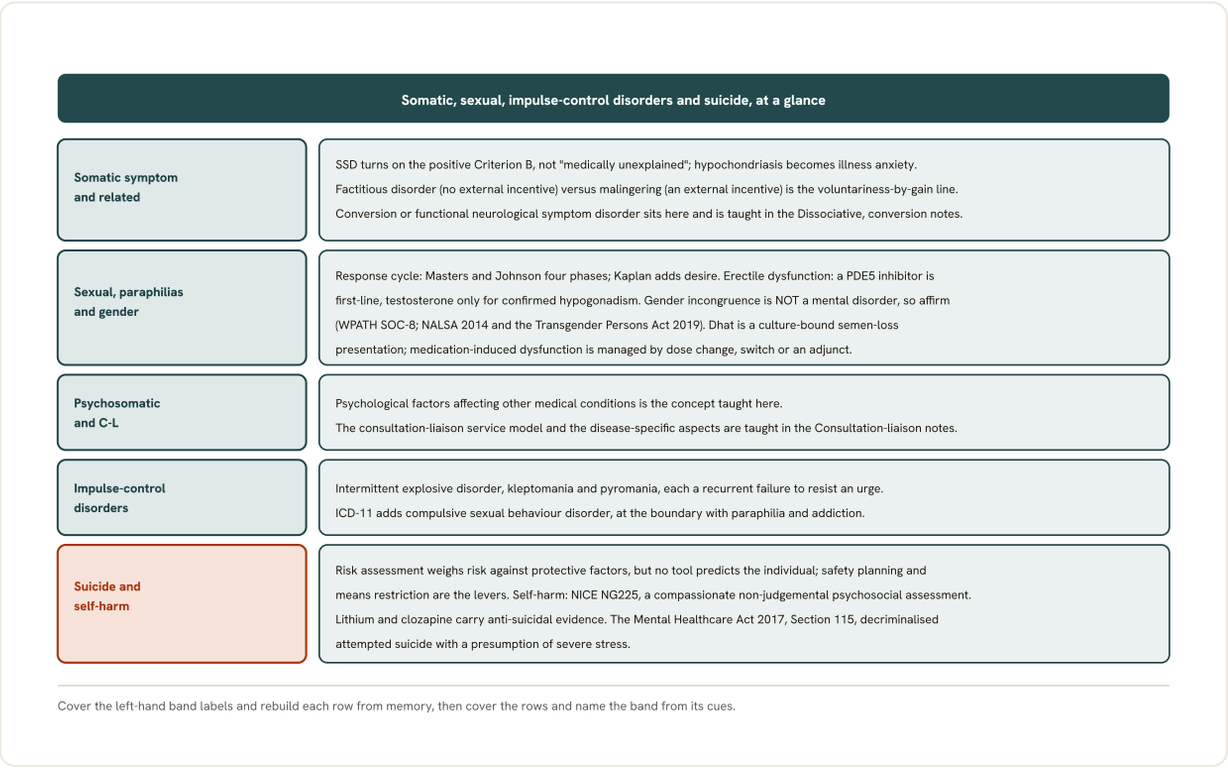


Fig 18.20 The chapter at a glance. Read across each band once, then use the map for retrieval: cover the left-hand labels and rebuild each row from its cues, then cover the rows and name the band. The somatic band turns on the positive Criterion B and the voluntariness-by-incentive line that separates factitious disorder from malingering. The sexual and gender band holds the response cycle, the phosphodiesterase-5 inhibitor as first-line for erectile dysfunction, the affirming frame for gender incongruence with its Indian legal basis, and Dhat. The psychosomatic and consultation-liaison band is the concept taught here with the service model cross-referenced. The impulse-control band gathers the disorders of urge. The suicide and self-harm band is the core: assessment that guides rather than predicts, safety planning and means restriction, the compassionate NICE stance to self-harm, the anti-suicidal evidence for lithium and clozapine, and the decriminalisation of attempted suicide under the Mental Healthcare Act.

27.1 The master mnemonic, paid off: SEED

Seeded at the opener, closed here. The chapter opened by seeding the master mnemonic **"SEED"** at somatic symptom disorder, and this is where it is reaped, because its four letters are the four rooms of a single house, arranged as the body moves from complaint to desire to urge to the protection of life. **S** is the *Somatic* room, where the body *complains*: somatic symptom disorder and the ICD-11 bodily distress disorder, with factitious disorder and malingering standing at its far door. **E** is *Eros*, where the body *desires* and identity is *affirmed*: the sexual dysfunctions and gender incongruence. **E** is the *Explosive urges*, where the urge *acts*: the impulse-

control disorders, each running the mounting-tension-then-relief arc. **D** is the *Defence of life*, the protective, compassionate stance the chapter closes on: suicide risk assessment, safety planning and prevention. If you can name the four rooms and walk their contents without looking, you hold the spine of the whole chapter.

MNEMONIC

SEED

The chapter master mnemonic, paid off. **S** = the *Somatic* room (the body complains): somatic symptom disorder defined by the positive psychological criterion, ICD-11 bodily distress disorder, and the feigned pair, factitious disorder and malingering, at the door. **E** = *Eros* (the body desires, identity is affirmed): the sexual dysfunctions mapped on the response cycle, and gender incongruence, which is not a mental illness. **E** = *Explosive urges* (the urge acts): the impulse-control disorders and their tension-then-relief arc. **D** = the *Defence of life*: compassionate, structured suicide risk assessment and collaborative safety planning. Four rooms, one house: S-E-E-D.

27.2 Active-recall prompt list: the somatic room, the positive criterion and the feigned pair

Cover the answers and pull each one. This is a **retrieval practice** list, not a summary. For each prompt below, say aloud (or write) the discriminator before you check it against the topic that verified it. The point is the effort of retrieval: the harder the pull, the stronger the trace.

- **The positive criterion.** Prompt: what now defines somatic symptom disorder, and what was abolished? (Answers in the somatic-symptom-disorder topic: Criterion B, the excessive *Thoughts, Anxiety and Behaviour* about the symptoms, is the defining **positive psychological criterion**; the old "medically unexplained" requirement is gone, so a medically explained symptom with an excessive response still qualifies, and severity is counted from Criterion B, not from the number of symptoms.)
- **The forward collapse.** Prompt: where did the DSM-IV somatoform family go? (Somatisation, undifferentiated and pain disorder folded into somatic symptom disorder; hypochondriasis split into somatic symptom disorder and illness anxiety disorder; conversion retained as functional neurological symptom disorder; body dysmorphic disorder migrated to the obsessive-compulsive spectrum. The positive signs of conversion are in the Dissociative, conversion and anxiolytic/hypnotic pharmacology notes, and body dysmorphic disorder in the Anxiety, OCD and trauma-related disorders notes.)
- **The ICD-11 parallel.** Prompt: the ICD-11 name and its logic? (Bodily distress disorder, code 6C20, distressing symptoms plus excessive attention, positively defined and not unexplained-based, present on most days for at least several months; ICD-11 sends its hypochondriasis to the obsessive-compulsive and related disorders.)
- **Factitious versus malingering.** Prompt: both are feigned, so what tells them apart? (Both are consciously produced, so voluntariness is shared and cannot separate them; the discriminator is the *external incentive*. Malingering has one, secondary gain, coded Z76.5 as a condition and not a mental disorder, strongly suspected on the four DSM-5-TR pointers; factitious disorder

has none, the motive being the sick role and primary gain, its severe wandering form being Munchausen syndrome. The genuine somatic disorders are not intentionally produced at all.)

RULE **Read production, then incentive.** The whole somatic room reduces to two questions asked in order: is the symptom intentionally produced, and if so, for an external incentive (malingering, secondary gain) or for the sick role (factitious disorder, primary gain); the genuine somatic disorders answer the first question with no.

GOOD TO REMEMBER

- **The somatic room (the criterion anchors):** somatic symptom disorder is defined by the positive Criterion B (excessive thoughts, feelings and behaviours), not by being medically unexplained; ICD-11 makes the same move as bodily distress disorder (6C20). The feigned pair separate only on the external incentive, present in malingering (Z76.5, not a disorder) and absent in factitious disorder (the sick role); a denied external motive does not turn a compensation claimant into a factitious patient.

27.3 Active-recall prompt list: the Eros room, the response cycle, the ED first-line and the depathologisation

Localise first, then treat, then affirm. This room holds a schematic model, one clean first-line drug position, and one reclassification. Retrieve each before checking it against its topic.

- **The response cycle.** Prompt: the three named models and the wiring? (Masters and Johnson gave four phases, excitement, plateau, orgasm and resolution, with a male-only refractory period; Kaplan's triphasic model added the desire phase to make desire, excitement and orgasm, and that phase map is how DSM-5-TR classifies the dysfunctions; Basson's circular model shows female desire can be responsive and follow arousal; the wiring is point and shoot, parasympathetic sacral outflow at **S2 to S4** for erection and sympathetic thoracolumbar outflow at **T11 to L2** for emission and ejaculation.)
- **The disrupted phase names the disorder.** Prompt: which phase gives which complaint? (A desire-phase failure gives hypoactive desire; an excitement-phase failure gives erectile dysfunction; an orgasm-phase failure gives anorgasmia or premature ejaculation. Localise to a phase and the differential is narrowed before a criterion is named.)
- **The erectile-dysfunction first-line.** Prompt: the first-line drug, the two doses, the one absolute contraindication, the testosterone rule? (An oral PDE5 inhibitor plus risk-factor optimisation; sildenafil starts at **50 mg** on-demand about one hour before, tadalafil at **10 mg** on-demand or **5 mg** once daily; any nitrate in any form is an absolute contraindication; test a morning testosterone and treat only confirmed hypogonadism, never long-term testosterone in a eugonadal man. The ladder is Pills, then Pokes and Pumps, then Prosthesis.)
- **Premature ejaculation.** Prompt: the only licensed first-line drug and its dosing rule? (On-demand dapoxetine, started at **30 mg**, taken one to three hours before, maximum 60 mg, not more than once every 24 hours; it should not routinely be combined with a PDE5 inhibitor because of syncope risk.)

- **The gender depathologisation.** Prompt: the headline reclassification, the DSM contrast, and the management stance? (ICD-11 renamed transsexualism as gender incongruence and moved it out of the mental disorders chapter to "Conditions related to sexual health," needing no distress criterion; DSM-5-TR keeps gender dysphoria, gated by Criterion B distress; management is not a drug but the affirmative-care pathway, individualised and informed-consent based, with the psychiatrist treating distress and comorbidity, never the identity.)

GOOD TO REMEMBER

- **Erectile dysfunction first-line (guideline-anchored, ISSM, BSSM, EAU, AUA 2018):** an oral PDE5 inhibitor plus risk-factor optimisation is first-line for every man without a contraindication; sildenafil (Manforce, Penegra) starts at 50 mg on-demand, tadalafil (Tadacip, Megalis) at 10 mg on-demand or 5 mg once daily; a nitrate is an absolute contraindication, and long-term testosterone is never started for a eugonadal man. Premature ejaculation is first-line on-demand dapoxetine (Duralast, Sustinex), started at 30 mg.
- **Gender incongruence (the criterion anchor and stance):** a marked, persistent mismatch between experienced gender and sex assigned at birth is *not* a mental disorder; ICD-11 relocated it out of the mental disorders chapter with no distress criterion, DSM-5-TR retains gender dysphoria gated by distress, and management is the WPATH SOC-8 individualised, informed-consent, gender-affirmative pathway. The discriminator to hold is that the target of care is the distress, the comorbidity and the stigma, never the person's gender.

27.4 Active-recall prompt list: the defence of life, risk assessment and safety planning

A weighing skill, held with a safeguarding tone. This is the room the chapter closes on, and it is examined as a skill, not a fact-list. Retrieve each principle before checking it against the suicide risk-assessment topic, and keep the register compassionate throughout: the assessment exists to guide care and safety, never to forecast an outcome or to allocate blame.

- **The structured evaluation.** Prompt: what is it, and what is it not? (A compassionate **structured evaluation** that weighs static and dynamic risk factors against protective factors and the current mental state, and separates chronic from acute risk; it is not a checklist score or a numerical prediction. Asking directly and calmly about suicidal thoughts is a core skill and does not plant the idea.)
- **The three named aides.** Prompt: the gold standard, the teaching aide, and the single screening item? (The C-SSRS is the gold-standard clinician-administered interview, its ideation subscale an ordered ladder of five levels; SAD PERSONS is only a teaching aide scored out of a possible ten, explicitly not validated to predict individual risk or to ration care; PHQ-9 item nine is a single screening item that, if endorsed, mandates a full structured assessment.)
- **The limits of prediction.** Prompt: the governing principle? (No tool or clinician reliably predicts individual suicide, so risk-stratification scores must not be used to predict or to ration care; the field favours a prevention-oriented formulation of four judgements, risk status, risk state, resources and foreseeable changes, over a low-medium-high label.)
- **Safety planning and means restriction.** Prompt: the guideline first move after assessment? (A collaborative Stanley-Brown Safety Planning Intervention built with the person, plus

means-restriction counselling framed positively as putting time and distance between a person and a crisis, then a level of care matched to need with rapid follow-up. Reducing access to lethal means, named only at the category level, is the single most robustly evidenced lever, and where a driving disorder is present its treatment is itself anti-suicidal, lithium in mood disorders and clozapine in schizophrenia.)

TRAP **Treating a denied ideation as a cleared risk.** A verbal "no" does not neutralise a high risk-and-protective balance; when the structured evaluation shows heavy static and dynamic loading with thin protection, the denial is one data point among many, and the assessment, not the last sentence spoken, governs the safety plan.

GOOD TO REMEMBER

- **Suicide risk assessment and safety planning (guideline-anchored, NICE NG225 2022, WHO LIVE LIFE 2021):** weigh static and dynamic risk factors against protective factors and separate chronic from acute risk; use the C-SSRS ideation ladder to structure and PHQ-9 item nine to screen, and remember no instrument predicts individual suicide, so stratifying to ration care is discouraged. The first move after assessment is a collaborative Stanley-Brown safety plan plus positively framed means restriction, the highest-yield lever; drugs (lithium, clozapine) treat the driving disorder and supplement, never replace, the plan.

INDIA

The Indian thread runs through every room and is worth carrying as one line at consolidation. In the Somatic room, distress is very commonly first brought to the clinician as bodily symptoms, so the culture-bound Dhat presentation must be read through a cultural formulation rather than pathologised on its surface, its transcultural frame sitting in the Consultation-liaison, geriatric and transcultural psychiatry notes. In the Eros room, the generics are familiar Indian brands, sildenafil (Manforce, Penegra), tadalafil (Tadacip, Megalis) and dapoxetine (Duralast, Sustinex), and gender-affirmative care is reinforced in law by the 2014 NALSA judgment, which recognised a third gender and the right to self-identified gender, and the Transgender Persons (Protection of Rights) Act, 2019. In the Defence-of-life room, India carries a large share of the world's suicide deaths, a burden stated here without any reference to means, and Section 115 of the Mental Healthcare Act 2017 decriminalised the attempt through a presumption of severe stress and a duty of care, superseding Section 309 of the Indian Penal Code; the Indian Psychiatric Society endorses the shift from punishment to care.

27.5 The whole-chapter synthesis map, framed cover-the-branches

Build the house, then redraw it blind. The strongest single revision act for this block is to **redraw from memory** a **synthesis map** that hangs every entity off its SEED room. The map has four rooms: the *Somatic* (the body complains), *Eros* (the body desires and identity is affirmed), the *Explosive urges* (the urge acts), and the *Defence of life* (the life protected). From each room hang its disorders, and from each disorder hang the one anchor to pull cold, its criterion, its discriminator or its first-line. The accompanying figure draws this map; use it as a retrieval test by covering all the branches and regenerating them, then uncovering to score yourself, exactly the cover-the-branches method that makes **retrieval practice** work.

SEED ROOM	WHAT HANGS FROM IT	THE ONE ANCHOR TO PULL COLD
S · Somatic (the body complains)	Somatic symptom disorder, illness anxiety, bodily distress disorder, conversion; factitious disorder and malingering at the door	**The positive psychological criterion (Criterion B), then production-before-incentive for the feigned pair**
E · Eros (the body desires, identity affirmed)	The response-cycle phases and their dysfunctions, erectile dysfunction, premature ejaculation, gender incongruence	**The disrupted phase names the disorder; ED first-line is a PDE5 inhibitor; gender incongruence is not a mental illness, so affirm**
E · Explosive urges (the urge acts)	The impulse-control disorders, each running the tension-then-relief arc	**Mounting tension relieved by the act, the ego-syntonic urge distinguishing them**
D · Defence of life (the life protected)	Suicide risk assessment, safety planning, prevention	**Weigh the whole balance not the last sentence; means restriction framed positively; the attempt is decriminalised**

The four-room SEED synthesis map, framed cover-the-branches; each room's single anchor is the fact to regenerate before uncovering the row (verified against the individual chapter topics, drawn in the accompanying figure).

How to use it. First pass: cover everything but the four room-names and list the disorders under each. Second pass: for each disorder, cover the anchor and pull it. Third pass: recite the one first-line or discriminator per room. A branch you cannot regenerate is a branch to re-read in its own topic; a branch you can is one you can leave. Repeated over spaced sittings, the map converts the chapter from something you recognise into something you can produce.

5	15	50
C-SSRS IDEATION-SEVERITY LEVELS	PHQ-15 HIGH-SEVERITY CUT-OFF (0 TO 30 SCALE)	SILDENAFIL ON-DEMAND START DOSE (MG)

PEARL

The whole chapter collapses to four rooms and four anchors. The *Somatic* room turns on the positive criterion and the production-before-incentive grid; *Eros* turns on the response-cycle phase and the clean PDE5-inhibitor first-line, with gender incongruence affirmed rather than treated; the *Explosive urges* turn on the tension-then-relief arc; and the *Defence of life* turns on the weighed balance, the safety plan and the positively framed means restriction. Redraw the four rooms, name their anchors, and you own the block.

HOLD THIS

Redraw the four-room SEED synthesis map from memory: Somatic (defined by the positive Criterion B, not by being medically unexplained, with factitious and malingering split on the external incentive), Eros (the disrupted phase names the sexual disorder, erectile dysfunction is first-line a PDE5 inhibitor, and gender incongruence is not a mental illness so it is affirmed), Explosive urges (the mounting-tension-then-relief arc of the impulse-control disorders), and the Defence of life (a compassionate structured assessment that weighs the balance rather than trusting a denial, driving a collaborative safety plan and positively framed means restriction, with the attempt decriminalised by Section 115 of the Mental Healthcare Act 2017).

Previously asked

This is a broad territory that is examined at two levels, the syndrome (its clinical features, its differential diagnosis and its course) and the management, with one band, suicide and self-harm, carrying much of the essay weight. The reliable pattern is that the somatic-symptom and conversion disorders recur as full essays, that suicide is the dominant management essay and is repeatedly asked with an Indian and a medico-legal slant, and that the sexual dysfunctions, Dhat, the paraphilias, and the consultation-liaison and psychosomatic topics come as standalone notes. The impulse-control disorders are drawn together in an enumerate-and-describe essay. Every long essay ends in a management plan, so the first-line and the reason for it must be exam-ready, and the suicide answers must be written with the safe, structured, compassionate stance the block rewards. The genuine questions on record are grouped by band below.

? HOW THIS TERRITORY IS ACTUALLY TESTED

Q **The somatic-symptom and conversion disorders, as essays.** "Describe the clinical features, differential diagnosis and management of Somatoform Disorder" has come as a 25-mark essay across more than one sitting, alongside "Discuss the etiology, clinical features and management of Conversion Disorder", "Clinical features and differential diagnosis of Conversion Disorder" and "Differential diagnosis of somatoform pain disorder and its prognosis"; "Pseudoseizures" and "Malingering" recur as 10-mark notes. Prepare the somatoform-to-somatic-symptom-disorder nosology shift and the positive psychological criterion, the somatic-versus-factitious-versus-malingering discrimination, and the physician-centred management of medically unexplained symptoms. essay and short note, recurring

Q **The suicide and self-harm band, the dominant essay theme.** "Enumerate various risk factors for suicide and describe the outline of management of attempted suicide", "Describe the management of the suicidal patient", "Discuss suicide and mental disorders" and "Discuss suicide with special reference to the Indian setting in detail" have all come as 25-mark essays, and "Differential diagnosis and synonym for deliberate self-harm" and the medico-legal "critical appraisal regarding attempted suicide as a crime" as 10-mark notes. Prepare the structured risk assessment and the limits of individual-risk prediction, safety planning and means restriction, the Mental Healthcare Act 2017 decriminalisation of attempted suicide under Section 115, and the anti-suicidal evidence for lithium and clozapine, all written with strict safe-messaging. essay and short note, recurring

Q **The sexual dysfunctions and paraphilias, as notes.** "Premature ejaculation" recurs as a 10-mark note across several sittings, and "Erectile dysfunction" and "Paraphilias" as 10-mark notes. Prepare the normal sexual response cycle, the phosphodiesterase-5-inhibitor-first management of erectile dysfunction, the

on-demand dapoxetine for premature ejaculation, and the consent, distress and harm framing of the paraphilic disorders. short note, recurring

Q **Dhat and the culture-bound presentations, as notes.** "Enumerate the culture-bound syndromes and describe Dhat syndrome in detail" and "Dhat syndrome" recur as 10-mark notes. Prepare Dhat as an Indian culture-bound sexual presentation, the semen-loss attribution, the cultural formulation, and the non-confrontational psychoeducational management. short note, recurring

Q **Consultation-liaison and psychosomatic medicine, as notes.** "Consultation liaison psychiatry" and "The role of the psychiatrist in psychosomatic medicine" have come as 10-mark notes. Prepare the psychosomatic concept and the biopsychosocial model here; the consultation-liaison service model and the disease-specific aspects are developed in the Consultation-liaison, geriatric and transcultural psychiatry notes. short note, recurring

Q **The impulse-control disorders, as an enumerate-and-describe essay.** "Enumerate the various impulse-control disorders and describe the etiology, clinical features and management of trichotillomania" gathers the group into one answer. Prepare intermittent explosive disorder, kleptomania, pyromania and the ICD-11 compulsive sexual behaviour disorder as a compact group, each a recurrent failure to resist an urge.
essay, enumerate

Prepare this material to be assessed and managed, not just recited: the somatic-symptom nosology and the factitious-versus-malingering discrimination, the erectile-dysfunction algorithm and the verified doses, the gender-incongruence affirming frame with its Indian legal basis, and the structured, safe suicide risk assessment and safety planning in these notes are built to the way the block is examined. The positive functional-neurological signs and the full management of conversion or functional neurological symptom disorder are developed in the Dissociative, conversion and anxiolytic/hypnotic pharmacology notes; the deep antidepressant and antipsychotic sexual-dysfunction pharmacology and the lithium and clozapine pharmacology in the Mood disorders: pharmacotherapy notes and the Schizophrenia: management, antipsychotics and adverse effects notes; the consultation-liaison service model and the disease-specific aspects in the Consultation-liaison, geriatric and transcultural psychiatry notes; and the population and public-health suicide prevention in the Community psychiatry and public health notes.

Quick review

SOMATIC SYMPTOM AND RELATED DISORDERS: THE NOSOLOGY, THE DISCRIMINATION, THE MANAGEMENT	
THE NOSOLOGY SHIFT	ICD-10 somatoform disorders collapse into DSM-5 **somatic symptom disorder**, which turns on the **positive psychological Criterion B** (excessive thoughts, feelings and behaviours about the symptoms), NOT on the symptom being "medically unexplained"; a medically explained symptom can qualify. Hypochondriasis becomes **illness anxiety disorder**. ICD-11 uses one graded **bodily distress disorder**.
THE DISCRIMINATION	Somatic symptom disorder and illness anxiety are **genuine, no external incentive**. Conversion or FND is not consciously feigned and is recognised by **positive signs** (taught in the Dissociative notes). **Factitious** = feigned, **no** external incentive (internal sick role; Munchausen, and by proxy). **Malingering** = feigned, **external** incentive; not a disorder. Secondary gain alone is not malingering.
THE SCALES	**PHQ-15**: 15 items 0 to 2, total out of a possible 30; bands 0-4, 5-9, 10-14, 15-30. **SSD-12**: 12 items 0 to 4, total out of a possible 48; cut-off **23 and above**.
MANAGEMENT (IPS 2020, WHO MHGAP)	**Physician-centred care**: one coordinating clinician, validate distress, restrict unnecessary testing, treat comorbid depression or anxiety, shift focus to functioning; reattribution; **CBT** first-line. Do NOT prescribe an antidepressant or anxiolytic for medically unexplained symptoms without specialist advice (mhGAP).
SEXUAL DYSFUNCTIONS, PARAPHILIAS AND GENDER	
RESPONSE CYCLE	Masters and Johnson four phases (excitement, plateau, orgasm, resolution); Kaplan adds **desire** (triphasic); Basson's circular model for responsive female desire.
ERECTILE DYSFUNCTION (ISSM, BSSM)	Screen cardiometabolic risk (an early vascular marker); confirm with the IIEF-5. **PDE5 inhibitor first-line**: sildenafil 25/50/100, tadalafil on-demand 10 or 20 and once-daily 2.5 or 5, vardenafil, avanafil. **Absolute contraindication with nitrates.** Test testosterone, replace only confirmed hypogonadism; no empirical testosterone in a eugonadal man. Second-line alprostadil or vacuum device; third-line prosthesis. IIEF-5 out of a possible 25 (22-25 none to 5-7 severe).
PREMATURE EJACULATION, HSDD	**Dapoxetine** on-demand 30 to 60 mg, 1 to 3 hours before activity, for premature ejaculation. **Flibanserin** 100 mg nightly for premenopausal HSDD (alcohol and hypotension cautions). Female dysfunctions: biopsychosocial and sex therapy first; local oestrogen for GSM dyspareunia; pelvic-floor physiotherapy and graded dilators for GPPPD.

SEXUAL DYSFUNCTIONS, PARAPHILIAS AND GENDER	
GENDER INCONGRUENCE	ICD-11 **depathologises** it: gender incongruence is a sexual-health condition, NOT a mental disorder (as homosexuality was earlier removed). Affirm; WPATH SOC-8 individualised informed-consent pathway. India: **NALSA 2014** and the **Transgender Persons Act 2019**. Trap: pathologising the identity.
DHAT; MEDICATION-INDUCED	**Dhat**: an Indian culture-bound presentation, symptoms attributed to semen loss; cultural formulation and psychoeducation, treat comorbid depression or anxiety. Medication-induced dysfunction: watchful waiting, dose reduction, switch (bupropion, mirtazapine, vortioxetine), or an adjunct; antipsychotic **hyperprolactinaemia** (worst with risperidone, least with aripiprazole).
PARAPHILIC DISORDERS	A paraphilia is a **disorder** only with distress or impairment, or harm or a non-consenting person. Types from exhibitionistic and voyeuristic to paedophilic disorder; psychological relapse-prevention, SSRI, and antiandrogen or GnRH-analogue in high-risk cases.
PSYCHOSOMATIC MEDICINE, CONSULTATION-LIAISON AND THE IMPULSE-CONTROL DISORDERS	
PSYCHOSOMATIC CONCEPT	Psychological factors affecting other medical conditions; the biopsychosocial model; stress-illness pathways (HPA, autonomic, immune). Taught compactly here.
CONSULTATION-LIAISON (CROSS-REF)	The C-L service model and the disease-specific aspects (psycho-oncology, HIV, endocrine, cardiac, transplant, surgical and ICU) are taught in the Consultation-liaison, geriatric and transcultural psychiatry notes.
IMPULSE-CONTROL DISORDERS	**Intermittent explosive disorder** (impulsive aggression out of proportion), **kleptomania** (stealing objects not needed), **pyromania** (fire-setting with fascination), and the ICD-11 **compulsive sexual behaviour disorder** (at the boundary with paraphilia and addiction). Each a recurrent failure to resist an urge.
SUICIDE AND SELF-HARM (THE HIGH-STAKES CORE)	
RISK ASSESSMENT	Weigh **static** factors (a previous attempt the strongest; mental illness; chronic illness; family history) against **dynamic** ones (hopelessness the leading one; ideation with plan and intent; a recent crisis; agitation; access to means at the category level) and the **protective** factors. Separate **chronic** from **acute** risk. The C-SSRS structures an ideation ladder plus a behaviour subscale.
LIMITS OF PREDICTION	The governing principle: **no tool predicts an individual suicide**. Risk-stratification scores must NOT decide who gets care; use a prevention-oriented formulation (risk status, risk state, resources, foreseeable changes). Assessment guides care, it does not forecast.

SUICIDE AND SELF-HARM (THE HIGH-STAKES CORE)	
MANAGEMENT AND SAFETY PLANNING	A compassionate, non-judgemental assessment (NICE); a **collaborative safety plan** (warning signs, coping, contacts, crisis lines, means-restriction counselling framed positively); the level of care (LOCUS); treat the disorder; active follow-up in the high-risk post-discharge window. A denied ideation is not a cleared risk.
DELIBERATE SELF-HARM (NICE NG225)	Self-harm is self-poisoning or self-injury **irrespective of intent**; NSSI is the intent-free subset. Every episode earns a full needs-based psychosocial assessment; **no risk-stratification tool** to predict or to ration care; apparent medical triviality is no reassurance; any self-harm raises future suicide risk.
PREVENTION AND ANTI-SUICIDAL DRUGS	**WHO LIVE LIFE**: limit access to means (highest-yield), responsible media, adolescent life skills, early identification. **Lithium** reduces suicide in mood disorders (Cipriani 2013, 48 RCTs); **clozapine** reduces suicidal behaviour in schizophrenia (InterSePT, Meltzer 2003). India: **Section 115 of the Mental Healthcare Act 2017** presumes severe stress and decriminalises an attempt.
THE GUIDELINE SPINE, THE INDIA CONTEXT AND THE TRAPS	
THE GUIDELINE ORDER	Guidelines-first on the where-to-treat, target-by-phase, modes-of-treatment spine: **NICE** leads the self-harm and suicide pathway, with **WHO LIVE LIFE** for prevention; **ISSM and BSSM** for the sexual dysfunctions; **WPATH SOC-8** for gender; the IPS somatoform guideline and WHO mhGAP for the somatic band.
THE INDIA CONTEXT	The Mental Healthcare Act 2017 **Section 115** (attempted suicide presumed under severe stress, not punished); the National Suicide Prevention Strategy 2022; **Dhat** as a culture-bound presentation; gender-affirmative care via **NALSA 2014** and the **Transgender Persons Act 2019**.
THE TRAPS	Calling somatic symptom disorder "medically unexplained"; confusing factitious (no incentive) with malingering (external incentive); empirical testosterone for a eugonadal man with ED; pathologising gender incongruence; reading a Dhat presentation without the cultural formulation; and the cardinal one, treating a denied ideation as a cleared risk, or a stratification score as a licence to discharge.

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The somatic-symptom, sexual, impulse-control and suicide content is grounded in the standard psychiatry and psychopharmacology sources (the source hierarchy below), with Kaplan and Sadock and the Maudsley Prescribing Guidelines as the depth bar for the phenomenology, the neurobiology, the scale cut-offs and the doses, the New Oxford Textbook and the Companion for

the nosology, and Clinical Methods in Psychiatry for the Indian context. The management is guideline-first: NICE leads for the self-harm and suicide pathway, with WHO LIVE LIFE for prevention, ISSM and BSSM for the sexual dysfunctions, WPATH Standards of Care version 8 for gender-affirmative care, and the Indian Psychiatric Society somatoform guideline and WHO mhGAP for the somatic band. The Indian legal provisions (the Mental Healthcare Act 2017 Section 115, the NALSA judgment 2014 and the Transgender Persons (Protection of Rights) Act 2019) were checked against their primary texts. Every scale cut-off, dose, criterion and legal provision was checked against these sources; anything that could not be confirmed was omitted and flagged rather than guessed. Each journal identifier below was verified against PubMed this build and matched on title, first author and year; books, guidelines and statutes are cited by author or body, title and year.

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PART XII

XII

Psychotherapies, Clinical Assessment, MSE and Nosology

How psychiatry treats and how it assesses: the psychotherapies, the clinical interview, the mental state and nosology.

01 Psychotherapies: general and specific

02 Psychiatric assessment and rating scales

03 Nosology and cross-cutting clinical issues

04 Apply and consolidate

PAPER II

Psychotherapies, clinical assessment, MSE and nosology

Three sections . one complete notes document

This material gathers the psychotherapies, the clinical assessment and the nosology into one document, taught as skills rather than syndromes. The first band is **the psychotherapies**: the classification of the therapies and the common factors that carry much of the outcome, then each modality with its model, its core techniques, its evidence and its lead indication, from supportive psychotherapy, cognitive behaviour therapy and behaviour therapy through psychoanalysis and the ego defences, interpersonal, group and family therapy, the third-wave therapies and motivational interviewing, to the Indian and culturally-adapted context and the selection of the right therapy for the presentation. The second band is **clinical assessment and rating scales**: the psychiatric interview and the mental state examination in full, the cognitive examination with the MMSE and the MoCA, the biopsychosocial formulation, the rating scales as a catalogue, and reliability and validity. The third band is **nosology and cross-cutting clinical issues**: the principles of classification, the ICD-11 and DSM-5 and the changes between them, the categorical-versus-dimensional debate, comorbidity, the cultural concepts of distress, the forensic essentials, the Mental Healthcare Act 2017 and capacity, consent and confidentiality. The examinable skill is to choose the right therapy, examine and formulate a patient, pick the right scale, and place a presentation in the current classification. The disorder-specific therapy protocols and the disorder-specific scales are taught in their disorder chapters and cross-referenced here; a consolidated appendix reproduces or typesets the rating scales of the whole series.

HOW TO USE THESE NOTES

Read the three bands as one continuous account of how a psychiatrist treats with words, examines a mind, and names what is wrong. The **psychotherapies** band is organised by the psychotherapy-family tree: the schools branching to the modalities. It opens with the classification of the therapies and the common, non-specific factors and the therapeutic alliance, then teaches each modality with its model, its core techniques, its evidence and its one lead indication, and closes by choosing the right therapy for the presentation. The widely-practised therapies are taught in full; the niche modalities are kept compact. The **clinical assessment and rating scales** band is organised by the assessment framework: the psychiatric interview and history, then the **mental state examination** in full, domain by domain, as the key examinable skill, then the cognitive examination with the MMSE and the MoCA, the biopsychosocial and 4-Ps formulation, the rating scales as a catalogue, and reliability and validity. The **nosology and cross-cutting** band teaches the principles of classification and the diagnostic process, the ICD-11 taught forward with the DSM-5-TR cross-mapped and the changes between the editions flagged, the categorical-versus-dimensional debate, comorbidity, the cultural concepts of distress, the forensic essentials, the Mental Healthcare Act 2017 and capacity, consent and confidentiality. Figures declare one axis and code it in colour: **petrol** marks structure and the neutral case, **coral** marks the trap, and **marigold** highlights the number to hold. The rating scales are reproduced as the actual instruments where the licence permits and typeset from their structure where it does not, gathered in a consolidated appendix at the back, with every cut-off verified; the cognitive instruments are typeset because they are permission-required. Several boundaries are stated up front: the deep psychometric theory and descriptive psychopathology are taught in the Psychometry, Assessment and Descriptive Psychopathology notes and cross-referenced here; the disorder-specific therapy protocols and the disorder-specific rating scales live in their disorder chapters; and the fuller mental-health legislation and forensic procedure live in the legislation and forensic notes. The modality models, the clinical MSE and assessment skill, the general cognitive instruments and the nosology are owned and fully taught here. This is doctor-facing revision, so the full technical vocabulary is used, the India context is genuine and verified (the Indian Psychiatric Society guidelines, culturally-adapted therapy, yoga and meditation-based interventions, the Mental Healthcare Act 2017), and every MSE component, therapy indication, scale cut-off, eponym count and nosology fact is verified against a source or omitted and flagged.

Psychotherapies: general and specific

1 · Classification of the psychotherapies and the common factors

This is the orienting topic for the whole psychotherapies band, and it earns its place because the examiner rarely asks "describe cognitive behaviour therapy" cold; the marks are in the *map*, being able to place any named therapy on its axes, and in the counter-intuitive fact that most of what heals a patient is not the branded technique at all. Two ideas do the heavy lifting. The first is the **classification of psychotherapies**, the small set of axes (depth, school, duration and format) onto which the twenty-odd named modalities of this chapter are sorted. The second is the **common factors** literature, the finding that the ingredients shared by *all* bona fide therapies,

above all the relationship, carry a larger share of the outcome than the specific procedures that distinguish one school from another.

How to use this page. Fix the definition first, then build the four-axis frame and the **schools of psychotherapy**, learning the master mnemonic seeded here because it is paid off at consolidation and anchors the psychotherapy-family tree for the entire chapter. Then internalise the **non-specific factors** and the **therapeutic alliance**, the **transtheoretical model** with its **stages of change**, and finally the **evidence hierarchy** that ranks how confident a guideline may be. The specific modalities that follow (psychodynamic, behavioural, cognitive, humanistic, systemic and the third-wave therapies) each get their own model, technique, evidence and lead indication; here we teach only the scaffold that holds them.

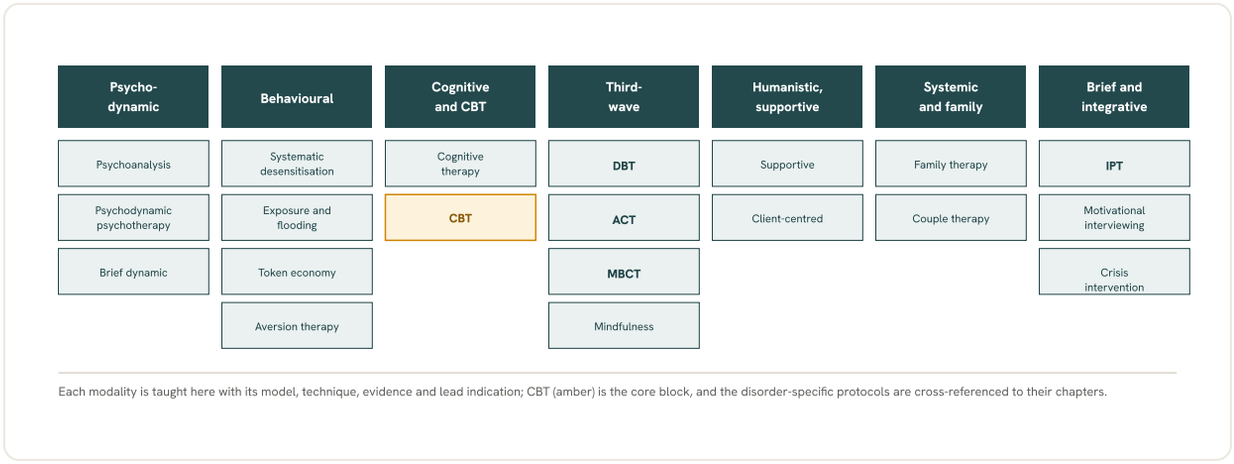


Fig 19.1 The schools of psychotherapy and their modalities. The therapies group into families by their theory of change: the psychodynamic therapies working with the unconscious and the transference; the behavioural therapies applying learning theory through exposure and reinforcement; the cognitive and cognitive-behavioural therapies working with thought and behaviour together, with CBT the most-evidenced modality of all; the third-wave acceptance-and-mindfulness therapies; the humanistic and supportive therapies working through the relationship itself; the systemic and family therapies treating the system rather than the individual; and the brief, interpersonal and integrative therapies. Each is taught here with its model, its core technique, its evidence and its one lead indication.

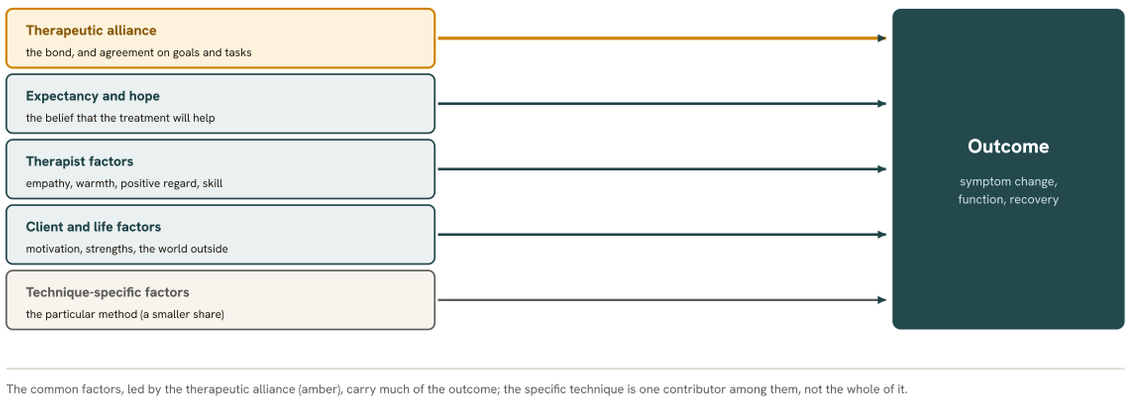


Fig 19.2 The common factors and the therapeutic alliance. Across the psychotherapies, a large share of the outcome is carried not by the specific technique but by factors common to all of them: above all the therapeutic alliance, the bond between patient and therapist together with their agreement on the goals and the tasks of the work, and alongside it the patient's expectancy and hope, the therapist's empathy and warmth, and the patient's own motivation and life circumstances. The particular method contributes too, but it is one factor among several. This is why the quality of the relationship is attended to first in every modality, and why a shared, credible rationale matters as much as the technique itself.

1.1 What psychotherapy is, and is not

A treatment by psychological means, not merely a kind conversation. The durable definition is Wolberg's: psychotherapy is the treatment, by psychological means, of problems of an emotional nature, in which a trained person deliberately establishes a professional relationship with the patient with the object of removing, modifying or retarding existing symptoms, of mediating disturbed patterns of behaviour, and of promoting positive personality growth and development (Wolberg, Technique of Psychotherapy). Three clauses in that sentence are examinable in their own right. **By psychological means** separates psychotherapy from pharmacological and physical treatments: the agent of change is a psychological process (learning, insight, emotional processing, a corrective relationship), not a molecule. **A trained person and a professional relationship** separate it from the genuine but unstructured support of friends, clergy or family: it is deliberate, contracted and bounded. **The stated objects**, from symptom removal at the modest end to personality growth at the ambitious end, foreshadow the depth axis of the classification below.

> **RULE** **The medium is psychological, the relationship is professional and deliberate.** If the agent of change is a drug or a device, or the helper is untrained and the relationship social rather than contracted, it is not psychotherapy, however therapeutic it feels.

1.2 The classification of psychotherapies: four axes, not one

Any therapy is located, not labelled. There is no single correct taxonomy; a given therapy is placed simultaneously on four independent axes, and a clean exam answer names the axis before the category (Kaplan and Sadock CTP 2024; Wolberg). The **depth (or goal) axis** is Wolberg's classical tripartition and the one most often examined: supportive therapy bolsters existing defences and coping without probing, re-educative therapy targets conscious attitudes and

behaviour to build new adaptive patterns, and reconstructive therapy works with unconscious conflict to remodel the personality structure itself. The **school (or theory) axis** sorts by the model of the mind that drives the technique, and is developed as the psychotherapy-family tree below. The **duration axis** runs from brief, time-limited work (often fewer than about twenty-five sessions, with a focal contract) to long-term or open-ended therapy. The **format axis** is defined by who is in the room: individual, group, couple or family. A single named therapy carries a coordinate on each: dialectical behaviour therapy, for instance, is re-educative in depth, cognitive-behavioural and third-wave in school, long-term in duration, and combines individual with group formats.

AXIS	CATEGORIES	THE EXAM HANDLE
Depth / goal (Wolberg)	Supportive; re-educative; reconstructive	**Supportive props up defences; reconstructive remodels the personality via the unconscious**
School / theory	Psychodynamic; behavioural; cognitive and cognitive-behavioural; humanistic and experiential; systemic and family; third-wave	**The model of the mind dictates the technique (the family tree)**
Duration	Brief and time-limited; long-term and open-ended	**Brief work carries a focal contract; most guideline therapies are time-limited**
Format	Individual; group; couple; family	**Defined by who is in the room, not by the theory used**

The four independent axes onto which every named psychotherapy is located; a therapy carries one coordinate on each (Kaplan and Sadock CTP 2024; Wolberg). The psychotherapy-family tree in the accompanying figure expands the school axis.

TRAP **Treating "supportive" as a school.** Supportive is a position on the depth axis, not a theoretical school; a supportive stance can be delivered from a psychodynamic, cognitive or humanistic base. Naming the axis first stops this error.

1.3 The schools of psychotherapy and the "three forces"

Six families, and the master mnemonic for the chapter. The school axis is the psychotherapy-family tree, and the six families it branches into organise the specific-modality topics that follow (Kaplan and Sadock CTP 2024; New Oxford Textbook). A useful historical overlay is the "three forces" of psychology: the **first force** is the psychoanalytic and psychodynamic tradition (Freud and successors, working with the unconscious); the **second force** is behaviourism (learning theory, exposure and contingency); and the **third force** is the humanistic and experiential movement (Rogers and the existentialists, working with the here-and-now, meaning and self-actualisation). The cognitive and cognitive-behavioural school then bridges the second force into the modern mainstream, the systemic and family school shifts the unit of treatment from the person to the relationship, and the third-wave therapies (dialectical behaviour therapy, acceptance and commitment therapy, mindfulness-based cognitive therapy) add acceptance,

mindfulness and dialectics to the cognitive-behavioural core. The accompanying figure draws the tree from these six trunks to their named modalities.

MNEMONIC

PLEASE BRING CARE, HOPE, SUPPORT, TRUST

The chapter's master mnemonic for the six **schools of psychotherapy**, read in order of the family tree: **P**sychodynamic, **B**ehavioural, **C**ognitive (and cognitive-behavioural), **H**umanistic (and experiential), **S**ystemic (and family), **T**hird-wave. The phrase is chosen so its meaning, care, hope, support and trust, is itself the payload of the common-factors half of this topic; the modality-specific mnemonics later in the chapter hang off these six trunks.

1.4 The common (non-specific) factors and their share of the outcome

What the therapies share matters more than what divides them. The **common factors** are the ingredients present in every bona fide therapy regardless of school, and the central empirical claim of the field is that these **non-specific factors** account for a larger portion of the improvement than the specific techniques do (Wampold, 2001; Tasman). Jerome Frank's classic analysis distilled the shared features to four: an emotionally charged, confiding relationship with a helping person; a healing setting; a credible rationale or conceptual scheme that explains the distress; and a ritual or procedure, believed by both parties, that requires the patient's active participation (Frank and Frank, Persuasion and Healing). Meta-analytic estimates converge on the same message: the therapeutic relationship and the other common factors carry roughly one-third to one-half of the therapeutic gain, far exceeding the modest and often statistically fragile increment attributable to any one school's signature technique (Tasman; Wampold). This is not an argument that technique is worthless; it is an argument that a credible technique delivered inside a strong relationship, by a therapist the patient trusts, is doing most of its work through channels every therapy shares. The accompanying figure sets the alliance at the centre of these shared ingredients.

RULE **Common factors outweigh specific factors.** Across bona fide therapies, the alliance and the other non-specific factors account for a larger share of outcome than the branded technique; the technique still matters, but chiefly as a credible vehicle for the shared ingredients.

FRANK'S FOUR COMMON INGREDIENTS OF EVERY PSYCHOTHERAPY

An emotionally charged, **confiding relationship** with a helper; a **healing setting**; a plausible **rationale or myth** that names the problem; and a **ritual or procedure** both believe in and that demands the patient's active participation. Any effective therapy, from psychoanalysis to a village healer's rite, can be read off these four (Frank and Frank).

1.5 The therapeutic alliance: the bond, the goals and the tasks

The single best-evidenced common factor. Of all the non-specific factors, the **therapeutic alliance** is the most robust and most replicated predictor of outcome, and it is the one to be able to define precisely (Horvath and Luborsky; Tasman). Bordin's tripartite model is the standard

answer: the alliance is the sum of three components, the **bond** (the affective attachment of trust, respect and warmth between patient and therapist), agreement on the **goals** of therapy (a shared view of what the work is for), and agreement on the **tasks** (a shared view of how the work will be done and each party's role in it). The clinically useful part of Bordin's model is that it is pan-theoretical and it is negotiated: a rupture in any of the three, a break in the bond, a drift in goals, or disagreement about a task such as a homework assignment or an exposure exercise, damages outcome and must be repaired explicitly rather than pushed through. The alliance is measurable (for example on the Working Alliance Inventory) and, importantly, an early alliance predicts later improvement more than early improvement predicts the alliance, which is part of why it is read as an active ingredient rather than a by-product of getting better.

BORDIN'S THREE COMPONENTS OF THE ALLIANCE

Bond, the affective tie of trust and mutual respect; **goals**, agreement on the aims of the work; **tasks**, agreement on the methods and each person's role. Hold "bond, goals, tasks" as a single unit; a viva favourite is to ask for the components by name and for what happens when one ruptures (repair, do not override).

1.6 Expectancy, therapist and client factors

The rest of the shared machinery. Beyond the alliance sit three further common factors, and a complete answer names all four groups. **Expectancy and hope** (the remoralisation Frank called the antidote to demoralisation) is the patient's belief that the treatment can help, the psychotherapy cousin of the placebo response and a genuine active ingredient rather than an artefact to be subtracted away. **Therapist factors** are the reliable finding that some therapists get consistently better results than others across techniques, mediated by empathy, warmth, positive regard and the capacity to form and repair alliances; the person of the therapist is itself a variable. **Client and extratherapeutic factors**, the patient's motivation, ego strength, social support and the ordinary life events that unfold outside the room, carry a large part of the change and are the reason the same therapy helps one patient far more than another. In Lambert's widely-cited apportionment of the outcome, client and extratherapeutic factors take the largest slice, the therapeutic relationship the next, with expectancy and specific technique smaller and roughly comparable; the exact percentages are contested, but the rank order (client, then relationship, then expectancy and technique) is the durable teaching point.

TRAP **Equating "non-specific" with "inert".** Non-specific factors are shared, not weak; expectancy, alliance and therapist effects are active ingredients with large effects. Calling them "just placebo" and discounting them is the error the common-factors literature exists to correct.

1.7 The transtheoretical model and the five stages of change

A stage map of readiness that cuts across every school. The **transtheoretical model** of Prochaska and DiClemente describes behaviour change as a movement through a sequence of **stages of change**, and its clinical value is that it tells the therapist to match the intervention to the patient's readiness rather than pushing action on someone not yet ready to act (Prochaska and DiClemente; Kaplan and Sadock CTP 2024). The five core stages are **precontemplation** (no

intention to change, often unaware of the problem or attending under pressure), **contemplation** (aware a problem exists and weighing change but not yet committed), **preparation** (intending to act soon, often taking small first steps), **action** (overt behaviour change is underway), and **maintenance** (consolidating gains and preventing relapse). Change is a spiral, not a straight line: **relapse** returns the person to an earlier stage, from which they recycle through the sequence rather than starting from zero, and most people cycle several times before durable change. Some versions add a final **termination** stage where the change is complete and relapse no longer threatens. The model underpins motivational interviewing, whose stage-matched, ambivalence-resolving style is developed for substance use in the Substance use disorders notes.

STAGE	THE PATIENT'S POSITION
Precontemplation	**No intention to change; often unaware, or attending under external pressure**
Contemplation	**Aware of the problem, ambivalent, not yet committed to act**
Preparation	**Intends to act soon; taking small preparatory steps**
Action	**Overt behaviour change actively underway**
Maintenance	**Consolidating gains and guarding against relapse**

The five stages of the transtheoretical model; relapse returns the patient to an earlier stage and they recycle through the sequence (Prochaska and DiClemente).

TRAP **Prescribing action to a precontemplator.** Handing an action-stage plan to a patient who does not yet accept there is a problem breeds resistance; the model's whole point is to meet the patient at the stage they are in and move them one step, not to leap to action.

1.8 The evidence hierarchy, empirically-supported treatments and the dodo-bird debate

How confident may a guideline be. The **evidence hierarchy** ranks the strength of the evidence behind a recommendation, from the weakest (case reports, uncontrolled series and expert opinion) up through non-randomised and randomised controlled trials to the strongest (systematic reviews and meta-analyses of trials), with clinical practice guidelines such as those of NICE and the Indian Psychiatric Society sitting on top as the applied synthesis (Kaplan and Sadock CTP 2024). Out of this tradition grew the idea of empirically-supported treatments, therapies that have demonstrated efficacy for a specific disorder in properly controlled trials, typically manualised and replicated (the American Psychological Association Division 12 criteria); this is the logic behind every "first-line psychotherapy for X" claim in the modality topics that follow, and it is why cognitive behaviour therapy, the most-trialled therapy, is recommended across the widest range of disorders. Against this specificity sits the dodo-bird verdict, named by Rosenzweig in 1936 from the dodo's ruling in Alice in Wonderland that "everybody has won and all must have prizes": the claim, supported by the common-factors reading of the outcome data, that all bona fide psychotherapies produce broadly equivalent results. The verdict is genuinely contested rather than settled: some meta-analyses find a specific

therapy superior for a specific condition (Kaplan and Sadock note a meta-analysis in which cognitive behaviour therapy outperformed other bona fide treatments), so state it as a live debate, not a fact, and let the disorder-specific evidence in each modality topic adjudicate.

RULE **State the dodo-bird verdict as a debate.** "All therapies are equivalent" is a contested hypothesis, not an established finding; the guideline evidence still names specific first-line therapies for specific disorders, and the safe exam line acknowledges both the strong common factors and the residual specific effects.

3	6	5	11
WOLBERG DEPTH LEVELS (SUPPORTIVE, RE-EDUCATIVE, RECONSTRUCTIVE)	SCHOOLS IN THE PSYCHOTHERAPY-FAMILY TREE	STAGES OF CHANGE (TRANSTHEORETICAL MODEL)	YALOM'S THERAPEUTIC FACTORS (DEVELOPED UNDER GROUP THERAPY)

INDIA

The classification and the common factors are examined from the Indian syllabus directly. The Indian Psychiatric Society has published a dedicated clinical practice guideline on the psychotherapies (Agarwal, Nischal, Praharaj, Menon and Kar; Indian Journal of Psychiatry 2020), and it embeds psychotherapy recommendations across its disorder-specific guidelines, so "which psychotherapy, and on what evidence" is a live examinable question here, not a Western import. The common-factors frame also carries a genuine Indian point: because the alliance, a credible rationale and the mobilisation of hope are what travel across cultures, the guideline emphasis on culturally-congruent, often family-inclusive delivery, and the developing evidence base for culturally-adapted cognitive behaviour therapy, is not a dilution of technique but an attempt to strengthen exactly these shared ingredients. Yoga and meditation-based interventions sit at the adjunct level of the evidence, not as stand-alone first-line treatments.

GOOD TO REMEMBER

- **The classification of psychotherapies (the principle):** four independent axes, depth (Wolberg's supportive, re-educative and reconstructive), school (the six families of the psychotherapy-family tree), duration (brief and time-limited versus long-term) and format (individual, group, couple, family). Locate a therapy on each axis; the one discriminator to hold is that supportive is a depth level, not a school.
- **The common factors (the principle):** the non-specific ingredients shared by all bona fide therapies, chiefly the therapeutic alliance (Bordin's bond, goals and tasks), expectancy and hope, therapist factors and client and extratherapeutic factors, account for a larger share of outcome than the specific technique (Wampold; roughly one-third to one-half for the relationship and common factors). The one exam fact is that non-specific does not mean inert.

HOLD THIS

Every psychotherapy is located on four axes (depth, school, duration, format), the six schools branch from the psychotherapy-family tree (PLEASE BRING CARE, HOPE, SUPPORT, TRUST), and the common (non-specific) factors, above all the therapeutic alliance of bond, goals and tasks (Bordin), carry more of the outcome than any branded technique (Wampold), which is why the dodo-bird verdict of broad equivalence is debated rather than dismissed.

2 · Supportive psychotherapy

This opens the psychotherapies chapter with the therapy you will actually practise most, on the ward round, in the emergency room, in the follow-up clinic and beside the medically ill: **supportive psychotherapy**. It is the commonest psychological treatment in real-world psychiatry and the default relational stance of all good general care, yet it is the one candidates most often under-prepare, because it looks like "just talking". It is not. It is a definable modality with an explicit stance, a named set of techniques and a defined aim, and the examiner tests exactly those three: the **ego-supportive** rather than ego-exploratory stance, the technique list, and the fact that its goal is to *maintain or restore* functioning, never to remodel the personality.

How to use this page. Fix the one defining contrast first, that supportive work bolsters defences and coping while expressive, insight-oriented work uncovers and interprets them; then learn the aim, then the technique list (the marks live here), then the two poles of indication (very low ego strength at one end, an acutely overwhelmed but ordinarily healthy person at the other). Ground every evidence claim carefully: supportive psychotherapy is broadly useful and performs surprisingly well as a comparator, but it is a guideline first-line stand-alone treatment in only a few specific, manualised roles, so do not overstate it.

2.1 The ego-supportive stance: bolstering defences, not uncovering them

Support the ego rather than explore it. The defining feature of supportive psychotherapy is that it is **ego-supportive**, not ego-exploratory (Kaplan and Sadock CTP 2024; Tasman). Expressive or insight-oriented therapies deliberately loosen defences and interpret unconscious conflict and transference to produce insight and structural change; supportive therapy does the opposite, working to *shore up* the patient's existing defences, self-esteem, reality testing and coping so they can withstand illness, deficit and life stress without decompensating. The two sit on a single expressive-supportive continuum: every real therapy blends the two, and the clinician slides toward the supportive pole exactly as the patient's ego strength falls. It is deliberately non-interpretive and stays in the here and now, addressing present interpersonal and environmental challenges rather than reconstructing the past. Its lineage is old, traceable to the eighteenth-century moral treatment of Pinel, which first held that a consistent, humane, containing relationship is itself therapeutic.

RULE **Ego-supportive, not ego-exploratory.** Supportive psychotherapy strengthens defences, coping and reality testing; expressive, insight-oriented therapy uncovers and interprets them. When ego strength is low, you move toward the supportive pole.

2.2 The aim: maintain or restore functioning, not structural change

Best possible functioning given the illness and the circumstances. The goal is explicit and examinable: to restore or maintain the patient's best possible level of functioning, given the constraints of the illness and the situation, and to prevent decompensation and regression (Tasman). It is a modest, honest aim. The therapist works to maintain the current level of psychological functioning, restore premorbid adaptation where that is possible, enhance coping mechanisms, strengthen adaptive defence mechanisms (leaving alone only those that are frankly

maladaptive) and support reality testing. What it does *not* set out to do is produce structural personality change or deep insight; symptom relief and better adaptation, not remodelling of the personality, are the currency of success. This distinction was tested directly by the Menninger Psychotherapy Research Project, a longitudinal study spanning twenty-three years (Kaplan and Sadock CTP 2024; Gabbard puts Wallerstein's follow-up of the 42 patients at thirty years) that compared classical psychoanalysis, psychoanalytic psychotherapy and a supportive arm; it found no significant differences among them, that supportive elements accounted for much of the change seen in all three, and that improvement did not occur in proportion to insight. The verdict quietly rehabilitated supportive work as a bona fide therapy rather than a second-best.

2.3 The core techniques

A named toolkit, all delivered inside a warm alliance. The techniques of supportive psychotherapy are concrete and must be reproducible on demand; they are limited only by the clinician's creativity, but the classic core is the following (Kaplan and Sadock CTP 2024; Wolberg). Note that each is a deliberate move, not an accident of kindness, and all are most effective when carried inside a positive therapeutic alliance.

Reassurance

Correcting distorted, catastrophic fears with realistic, credible information; genuine only when grounded in the facts of the case, never empty comfort.

Ventilation and catharsis

Allowing the patient to pour out pent-up feelings in a safe, accepting space, which relieves tension and, of itself, is often experienced as help.

Explanation and guidance

Explaining symptoms and situations so they feel comprehensible and less alien, then offering direct guidance and advice on concrete real-life problems.

Encouragement and praise

Instilling hope and recognising effort and small gains, which lifts self-esteem; over time the patient may introject the therapist's acceptance ("lending ego").

Advice and environmental manipulation

Actively changing external stressors, through significant others, employers or helping agencies, so the load on a fragile ego is reduced.

Ego-strengthening

Reinforcing adaptive defences and building coping and self-soothing skills, so the patient can regulate distress without acting out.

The therapeutic relationship

The consistent, predictable, caring relationship is itself the treatment, the vessel that carries every other technique.

MNEMONIC

GRACE

Hold the technique set as **GRACE**, carried by the relationship. **G**uidance and explanation; **R**eassurance; **A**dvice and environmental manipulation; **C**atharsis, that is ventilation of feelings; **E**ncouragement, praise and ego-strengthening. All five are delivered *through* the therapeutic relationship, which is why the alliance is listed as a technique in its own right, not just a backdrop.

GOOD TO REMEMBER

- **The technique set (GRACE):** guidance and explanation, reassurance, advice and environmental manipulation, catharsis (ventilation), and encouragement, praise and ego-strengthening, all delivered inside the therapeutic relationship. The single point to hold is that reassurance is credible only when grounded in the facts, and that the relationship is itself a technique, not merely the setting.

2.4 The relationship and the corrective emotional experience

A positive transference, deliberately maintained, is the cornerstone. Where expressive therapy analyses the transference, supportive therapy manages it: the therapist works to maintain a *positive* transference and, when the alliance is strained, repairs the rupture by actively providing comfort and reassurance rather than by interpreting it (Kaplan and Sadock CTP 2024). The healing mechanism was named by Franz Alexander as the corrective emotional experience: the patient re-lives difficult feelings within an accepting, nurturant relationship and emerges changed by that experience of being contained, without needing insight to have caused it. The therapist's style is therefore conversational and warm, not a blank screen; the long anxiety-provoking silences of analytic work are avoided. Confrontation, in the technical sense of gently holding a mirror to a self-defeating pattern, is available but only where the alliance is strong enough to carry it, and it is delivered in an accepting, never a stern, manner.

PEARL

The alliance is not just a nicety here, it is the active ingredient. The therapeutic alliance is the factor most consistently correlated with good outcome across every therapy, patient type and country, and in supportive work it is deliberately cultivated and protected. This is why supportive psychotherapy delivered by non-specialists, including nurses and family physicians, still works: the powerful common factor, a trusted relationship, is precisely what it maximises.

2.5 Supportive versus expressive, insight-oriented therapy

The same continuum, opposite ends. The cleanest way to hold supportive therapy is against its expressive, insight-oriented counterpart, remembering that real treatments mix the two and shift with the patient's capacity. The contrast is drawn below.

DIMENSION	SUPPORTIVE (EGO-SUPPORTIVE)	EXPRESSIVE, INSIGHT-ORIENTED (EGO-EXPLORATORY)
Aim	Maintain or restore best possible functioning	**Insight and structural personality change**
Stance to defences	Strengthen and support adaptive defences	**Loosen and interpret defences**
Transference	Kept positive, managed, repaired	**Analysed and interpreted, allowed to regress**
Interpretation	Minimal, non-interpretive	**Central, the main lever of change**
Time frame	Here and now, present problems	**Past and unconscious roots of the present**
Suited to	Lower ego strength; acute crisis	**Higher ego strength, psychological mindedness**

The supportive versus expressive contrast along one expressive-supportive continuum; the clinician slides toward the supportive pole as ego strength falls (Tasman; Kaplan and Sadock CTP 2024).

TRAP **Treating "supportive" as doing nothing, or as inferior therapy.** Supportive psychotherapy is a defined modality with explicit techniques and aims, not the absence of technique; the old jibe that "if it is supportive it cannot be psychotherapy" was overturned by the Menninger findings.

2.6 Indications for supportive psychotherapy

Two poles, both defined by a temporarily or chronically overwhelmed ego. The **indications for supportive** psychotherapy fall at two ends of a range (Tasman). At one pole sit patients with *low ego strength*, whose difficulties are better understood as chronic deficits than as neurotic conflict to be interpreted: severe and chronic mental illness such as schizophrenia and bipolar disorder, marked personality pathology with poor impulse control, cognitive deficit, poor psychological mindedness, low frustration tolerance and thin social support; interpreting such a patient would overwhelm rather than help. At the other pole sit ordinarily well-functioning people who have been acutely swamped by an external blow, that is an acute crisis, grief or bereavement, natural disaster, physical illness, or physical or sexual assault, where the ego is temporarily overloaded and needs holding until it recovers. Physical illness is a distinct and important indication, both because the medically ill are frequently distressed and because the psychiatrist meets them in consultation-liaison and general-hospital work. Underlying all of it is the broadest indication of all: supportive technique is the default relational stance of every good general psychiatric contact.

INDICATION	WHY SUPPORTIVE FITS	THE DISCRIMINATOR
Acute crisis and grief	Ego temporarily overwhelmed; needs holding to recovery	**Previously healthy person, external precipitant**
Chronic, severe mental illness	Bolsters coping and reality testing, prevents relapse	**Deficit-based, not conflict-based; interpretation would destabilise**
Low ego strength or personality pathology	Strengthens defences the patient cannot yet do without	**Poor impulse control, low frustration tolerance, thin support**
Physical illness	Sustains the person through the burden of the illness	**Distress and coping, not a primary psychiatric disorder**
General psychiatric care	The universal relational stance of good practice	**Applies to almost every patient as a baseline**

The two-pole indication map: chronically low ego strength at one end, acute overwhelming of a healthy ego at the other (Tasman; Kaplan and Sadock CTP 2024).

WORKED EXAMPLE

A previously well woman is referred a fortnight after her husband's sudden death: tearful, sleepless, unable to face the house, but with intact reality testing and no psychiatric history. The move here is not to interpret or to reach for a drug, but supportive: build the alliance, allow ventilation of grief, offer reassurance that her reactions are a normal response to loss (explanation), mobilise family and practical help (environmental manipulation) and encourage a graded return to routine. Held over a handful of sessions across the coming weeks, most such patients recover without ever needing an exploratory therapy.

2.7 The evidence base and the few guideline-anchored roles

Broadly useful, but a guideline first-line only in specific, manualised roles. The evidence picture is honest and examinable: supportive psychotherapy has a thin specific-efficacy trial base and has most often been studied as the comparator or "treatment as usual" arm, yet it repeatedly performs as well as the specialised therapy it was meant to lose to, precisely because it delivers the powerful common factors (alliance, empathy, positive regard). Its confirmed guideline roles are mostly adjunctive or context-dependent, with one manualised exception. Specialist supportive clinical management (SSCM), a manualised supportive approach, is one of three first-line options for adults with anorexia nervosa (NICE 2017, grade A). Supportive psychotherapy is an add-on once acute symptoms settle in schizophrenia (IPS_CPG 2017, grade B), and a substitute where CBT is not feasible in inhalant use disorder (IPS_CPG 2018). Non-directive supportive therapy is an option for mild-to-moderate depression in patients who decline pharmacotherapy and cannot access first-line psychotherapies (VA_DOD 2022). The one caution to memorise runs the other way: NICE explicitly advises *against* routinely offering supportive therapy for social anxiety disorder (NICE 2013), where structured CBT is the gold standard. The interpersonal and cognitive therapies that outrank it in mood and anxiety disorders are covered in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes; the structured therapies that take precedence in personality disorder are covered in the Personality disorders notes.

23	1984	3
YEARS SPANNED BY THE MENNINGER PSYCHOTHERAPY STUDY (CTP 2024)	WERMAN PUBLISHES THE FIRST SUPPORTIVE-THERAPY TEXTBOOK	FIRST-LINE OPTIONS FOR ADULT ANOREXIA; SSCM IS ONE (NICE 2017)

INDIA

Supportive and brief, motivation-based approaches are the mainstay the Indian Psychiatric Society endorses for older adults with alcohol use, delivered in a deliberately non-judgmental and non-confrontational style (IPS_CPG 2018), a good fit for the family-embedded, help-seeking-averse presentations common in Indian practice. The IPS has also published a dedicated Clinical Practice Guideline on psychotherapies (Agarwal, Nischal, Praharaj, Menon, Kar; Indian J Psychiatry 2020), within which supportive and brief techniques are treated as the accessible, generalist-deliverable backbone of psychosocial care rather than as a specialist product. The motivational-interviewing style that carries this work in the addictions is developed in the Substance use disorders notes.

GOOD TO REMEMBER

- **Supportive psychotherapy (the modality):** an ego-supportive, non-interpretive therapy that maintains or restores the best possible functioning by strengthening defences and coping, never aiming at structural personality change. Its lead guideline first-line role is specialist supportive clinical management (SSCM), one of three first-line treatments for adults with anorexia nervosa (NICE 2017, grade A); elsewhere it is adjunctive or the accessible default. The one technique to name is reassurance, delivered credibly inside a deliberately maintained positive therapeutic alliance.

HOLD THIS

Supportive psychotherapy is EGO-SUPPORTIVE, not ego-exploratory: it bolsters defences, coping and reality testing to maintain or restore the best possible functioning, and it never sets out to produce structural personality change; its techniques are guidance, reassurance, ventilation, advice and environmental manipulation, encouragement and ego-strengthening, all carried by a deliberately positive alliance (Alexander's corrective emotional experience), and its indications run from chronically low ego strength (severe chronic illness, marked personality pathology) to an acutely overwhelmed but ordinarily healthy ego (crisis, grief, physical illness), with SSCM for adult anorexia nervosa (NICE 2017, grade A) as its clearest guideline first-line role.

3 · Cognitive behaviour therapy

Cognitive behaviour therapy (CBT) is the single most examined psychotherapy in this paper, and for good reason: it is the reference-standard, best-evidenced psychological treatment, recommended first-line across the widest range of disorders, and its machinery, a small set of ideas about how thought, emotion and behaviour interlock, is elegant enough to test in a one-line viva and deep enough to fill a long essay. Derived by Aaron Beck from his work on depression in the nineteen-sixties, and drawing the behavioural half of its name from the learning-theory tradition, CBT is *structured, time-limited, present-focused, problem-oriented and collaborative*. Fix those five adjectives first; every technique below is a way of enacting them.

How to use this page. Learn the **cognitive model** as a causal chain, then the three levels of cognition that sit along it, then Beck's cognitive triad and the catalogue of cognitive distortions

that populate depressive thinking. Only then move to the doing of therapy, the cognitive and behavioural techniques, the shape of a single session and the arc of the whole course. Close on the evidence, because the examinable payoff of CBT is not a clever technique but the sentence "first-line, strongest evidence, widest range". The cardinal error the page is built to prevent is treating CBT as vague, insight-seeking talk; it is the opposite, a manualised, agenda-driven, homework-carrying method.

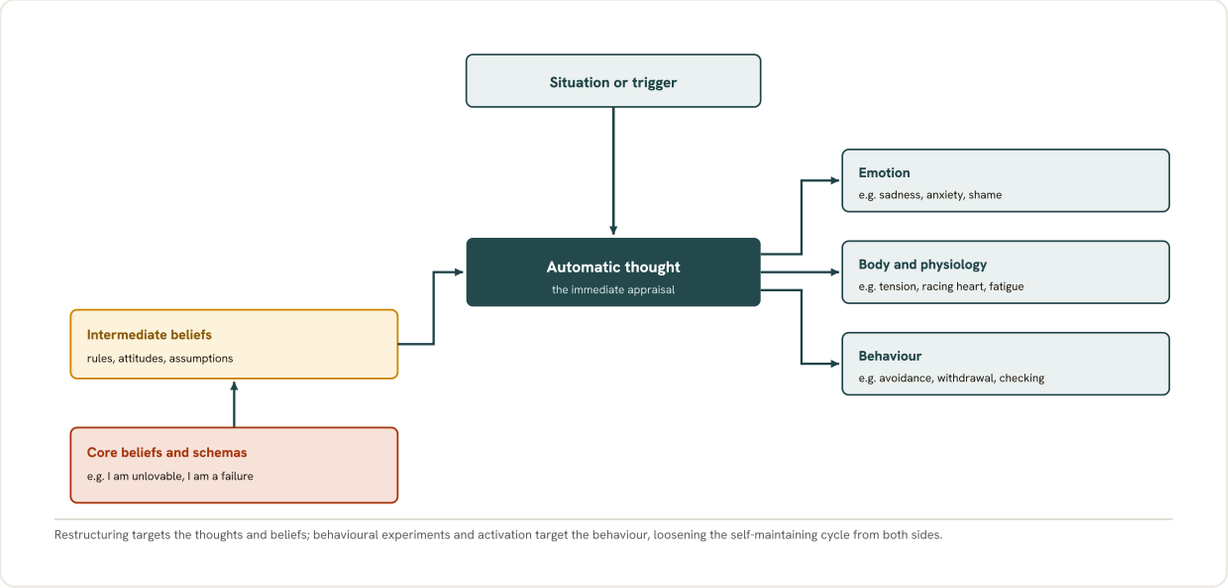


Fig 19.3 The cognitive model of CBT. A situation does not cause the feeling directly; it is the automatic thought, the immediate and often unnoticed appraisal, that drives the emotional, bodily and behavioural response. Those automatic thoughts are shaped by deeper layers: the intermediate beliefs (the rules, attitudes and assumptions a person lives by) and, beneath them, the core beliefs or schemas about the self, others and the world. The response in turn tends to confirm the belief, closing a self-maintaining cycle. Therapy enters at two points: cognitive restructuring tests and revises the thoughts and beliefs, while behavioural experiments and activation change the behaviour, each loosening the cycle from its own side.

3.1 The cognitive model: the situation is not the feeling

A situation triggers a thought, and the thought, not the situation, drives the response. The cognitive model is the foundational proposition of CBT: it is not events themselves but our *interpretation* of events that determines how we feel and act (Beck; Kaplan and Sadock CTP 2024). A situation activates an immediate, involuntary appraisal, the automatic thought, and that appraisal then drives three responses that run in parallel, an *emotional* response (the felt mood), a *physiological* response (bodily arousal) and a *behavioural* response (what the person does or avoids). Because two people meeting the same event can feel and behave utterly differently, the difference must lie in the interpretation, and that is precisely the lever CBT reaches for. The chain is also a vicious cycle: the behavioural response, characteristically avoidance or withdrawal, feeds back to confirm the original thought, so the loop tightens unless it is interrupted. The accompanying figure lays out this chain, situation to automatic thought to the emotional, physiological and behavioural response, with the maintaining feedback arrow closing the loop.

RULE **Interpretation, not the event, is the target.** CBT works because the automatic thought sits causally between the situation and the response; change the appraisal and you change the emotion, physiology and behaviour that follow it.

3.2 The three levels of cognition

Surface thoughts, the rules beneath them, and the bedrock beliefs at the base. Cognition in CBT is stratified into three depths, and knowing which level a therapist is working at is a favourite discrimination question (Beck, CBT Basics and Beyond). At the surface are automatic thoughts, the fleeting, involuntary, situation-specific appraisals that stream through the mind and are the most accessible layer, the one the patient learns to catch first. Beneath them lie **intermediate beliefs**, the relatively enduring rules, attitudes and conditional assumptions ("If I am not perfect, I have failed") through which experience is filtered. At the base sit the core beliefs, the deepest, most global and absolute ideas a person holds about the self, others and the world; when these organise experience as stable cognitive structures they are called schema. Beck grouped depressive core beliefs about the self into three families, the helpless, the unlovable and the worthless. Therapy usually begins at the accessible surface, with automatic thoughts, and works downward only as trust and skill accumulate, because the deeper the belief, the more central and the more defended it is.

TRAP **Confusing an automatic thought with a core belief.** An automatic thought is surface, fleeting and tied to one situation ("I got that wrong"); a core belief is deep, global and absolute ("I am worthless"). Early CBT targets the former; schema-level work targets the latter.

3.3 Beck's cognitive triad

Three negative views that together generate depression. The cognitive triad is Beck's account of the content of depressive cognition, and it has exactly three components (Beck 1967; Kaplan and Sadock CTP 2024): a negative view of the *self* (defective, inadequate, unworthy), a negative view of the *world* and current experience (demanding, defeating, unfair), and a negative view of the *future* (hopeless, certain to continue). Each corner feeds the others, and together they bias information processing so that neutral or positive events are discounted while negative ones are magnified. The triad is the reason depression feels globally, not locally, bleak, and it is why the therapeutic task is to reverse all three negative views rather than argue a single point. Attribute the count precisely: **3** views, self, world and future, no more and no fewer.

PEARL

Hold the triad as **Me, My world, My future**, all seen through a dark lens. Self, world, future, three corners; the hopeless view of the future is the corner most tightly linked to suicidal thinking and so the one to probe hardest in a depressed patient.

3.4 The catalogue of cognitive distortions

Systematic errors of logic that keep the negative beliefs in business. Cognitive distortions are the habitual, biased styles of reasoning through which automatic thoughts are generated and the cognitive triad is maintained (Beck; Burns). They are the workhorse of the thought record, because naming the distortion in a thought is the first step to loosening it. Ten recur often enough to be worth holding verbatim.

All-or-nothing thinking

Also called black-and-white or dichotomous thinking; a situation is seen in only two categories rather than on a continuum ("If I am not a total success, I am a failure").

Catastrophising

Also called fortune-telling; predicting the future negatively without considering more likely outcomes ("I will be so upset I will not be able to function").

Overgeneralisation

Drawing a sweeping negative conclusion that goes far beyond the current situation ("Because I felt awkward once, I cannot make friends").

Mind-reading

Believing you know what others are thinking, failing to consider more plausible possibilities ("He thinks I am incompetent").

Personalisation

Believing others behave negatively because of you, without weighing more likely explanations for their behaviour.

Emotional reasoning

Taking a feeling as proof of fact, discounting evidence to the contrary ("I feel like a failure, therefore I am one").

Should-statements

Also called imperatives; a fixed idea of how you or others ought to behave, with overestimation of how bad it is when the expectation is not met.

Magnification / minimisation

Unreasonably magnifying the negative and minimising the positive when evaluating yourself, another or a situation.

Mental filter

Also called selective abstraction; dwelling on a single negative detail so that the whole picture is darkened by it.

Labelling

Attaching a fixed, global label to yourself or others ("I am a loser") rather than describing the specific behaviour.

MNEMONIC

CBT is deceptively simple

Group the ten as the errors of the pessimist: he sees in two colours (all-or-nothing), foretells disaster (catastrophising), stretches one bad moment to all of life (overgeneralisation), presumes what others think (mind-reading), takes the blame (personalisation), trusts the feeling over the facts (emotional reasoning), tyrannises himself with shoulds (imperatives), inflates the bad and shrinks the good (magnification and minimisation), reads only the dark detail (mental filter) and names himself by his worst act (labelling).

3.5 Cognitive restructuring and the thought record

The core cognitive technique, worked on paper. Cognitive restructuring is the process of identifying, evaluating and modifying maladaptive automatic thoughts, and its principal instrument is the thought record (also called the dysfunctional thought record or automatic thought record). A patient learns to log, across columns, the *situation*, the *emotion* and its intensity, the *automatic thoughts* that arose, the *evidence for and against* each thought, the specific *distortion* at work, a more balanced *adaptive response*, and finally a *re-rating* of the emotion. The point is not positive thinking but *accurate* thinking: the patient becomes a scientist gathering evidence about a hypothesis rather than a defendant asked to think happy thoughts. Restructuring is what most people picture when they picture CBT, and it is examinable both as a named technique and as a worked sequence.

WORKED EXAMPLE

A woman whose email to a colleague goes unanswered feels a sharp drop in mood. Her automatic thought is "She is ignoring me because I annoyed her" (mind-reading and personalisation). On the thought record she lists the evidence: the colleague is on leave, has replied late before, and said nothing critical at their last meeting. Her adaptive response, "She is probably away or busy, and I have no evidence she is angry", drops the intensity of her distress from high to mild. Nothing about the situation changed; only the appraisal did.

3.6 Socratic questioning, guided discovery and collaborative empiricism

The therapist asks rather than tells, and patient and therapist test beliefs together. CBT is not delivered by lecturing the patient out of their beliefs; it is delivered by Socratic questioning, a series of graded, curious questions ("What is the evidence? What is an alternative view? What would you tell a friend who thought this?") that lead the patient to examine a thought for themselves. The wider stance this serves is *guided discovery*: the therapist guides, but the patient discovers, so that conclusions are owned rather than imposed. Both sit inside the defining relational posture of the whole therapy, collaborative empiricism, in which therapist and patient work as a team of co-investigators, treating each belief as a hypothesis to be tested against evidence rather than a truth to be accepted or a falsehood to be corrected (J. S. Beck; Tasman). This collaborative, empirical stance is what distinguishes a CBT exchange from supportive reassurance on one side and from confrontation on the other.

3.7 The behavioural techniques

Change behaviour to change belief, and to change mood directly. The behavioural half of the therapy supplies several techniques, and their examinable distinctions matter. Behavioural experiments are planned, real-world tests of a specific belief: the patient makes a prediction ("If I speak up, I will be humiliated"), designs an experiment to test it, runs it, and compares the outcome with the prediction, so belief change is driven by lived evidence rather than by discussion alone. This is distinct from exposure, whose aim is the extinction of anxiety rather than the disproof of a cognition. Behavioural activation re-engages a withdrawn, depressed patient with rewarding and mastery-giving activity, breaking the withdrawal-low mood-further withdrawal loop, and it has strong stand-alone evidence in depression. *Activity scheduling*, the

planning of the week hour by hour with activities rated for pleasure and mastery, is the practical tool that delivers behavioural activation. *Graded exposure*, the stepwise confrontation of feared situations along a hierarchy, is the behavioural engine for the anxiety disorders. The graded-exposure and response-prevention protocols, and the trauma-focused work, are developed where they belong, in the Anxiety, OCD and trauma-related disorders notes.

DO NOT CONFUSE THESE

A **behavioural experiment** tests a *belief* and its yardstick is whether the prediction came true; **graded exposure** reduces *anxiety* and its yardstick is habituation along a hierarchy. Both involve approaching what is avoided, but one is a cognitive test and the other is an anxiety-extinction procedure. **Behavioural activation** is different again: it targets the *withdrawal* of depression, not anxiety, and is delivered through activity scheduling.

3.8 The structure of a session, and of the course

Every session follows the same shape, and the whole therapy is time-limited. The **session structure** is not incidental; adhering to a standard format is a defining feature that makes the therapy efficient and teachable (Beck, CBT Basics and Beyond). A typical session opens with a brief *mood check*, moves to collaboratively *setting the agenda*, *bridges from the previous session by reviewing the homework*, then does *the work* on the agenda items, sets *new homework* (the action plan) that flows from that work, and closes by eliciting *feedback* and a summary. Homework is not an optional extra: it is where the therapy is generalised into life, and completion of it predicts outcome. The course as a whole is short and structured; a standard acute course for depression runs to about **12** to 20 sessions over a four to five month period (Kaplan and Sadock CTP 2024), most sessions lasting roughly **45** to 50 minutes, with the first evaluation session usually longer. The aim throughout is to make the patient their own therapist, so that gains outlast the therapy.

MNEMONIC

M-A-B-W-H-F

The order of a CBT session: **M**ood check, **A**genda set, **B**ridge from the last session (review homework), **W**ork the agenda, new **H**omework assigned, **F**eedback elicited. Same shape every time, which is exactly why the therapy is called structured.

3	12-20	45-50
VIEWS IN BECK'S COGNITIVE TRIAD (SELF, WORLD, FUTURE)	SESSIONS IN A STANDARD ACUTE COURSE FOR DEPRESSION	MINUTES, STANDARD SESSION LENGTH

3.9 The evidence base and the lead indications

The most-evidenced psychotherapy, and first-line across the widest range. If one sentence about CBT must be exam-ready, it is this: CBT is the reference-standard evidence-based psychotherapy, with strong meta-analytic support and the broadest first-line reach of any psychological treatment (Beck; the guideline evidence). It is a first-line psychological treatment for major depressive disorder (IPS_CPG 2017 grade A; CANMAT 2016; NICE 2022; WHO mhGAP 2023) and for the anxiety disorders across the board, generalised anxiety disorder

(IPS_CPG 2020; NICE 2011), panic disorder (NICE 2011 grade A; CANMAT 2014) and social anxiety disorder, where it is the gold standard (NICE 2013; CANMAT 2014). It is the psychological treatment of choice for obsessive-compulsive disorder when delivered with exposure and response prevention (IPS_CPG 2025 Level 1; NICE 2005), for post-traumatic stress disorder as trauma-focused CBT (NICE 2018 grade A), and for chronic insomnia as CBT for insomnia, CBT-I (BAP 2019 grade A; NICE 2023). Beyond these it is a recommended *adjunct*, not a monotherapy, for psychosis (NICE 2014; IPS_CPG 2017 B) and bipolar disorder (IPS_CPG 2017 A), and it supports relapse prevention in alcohol use disorder (IPS_CPG 2014 A). The interpersonal-therapy and CBT evidence in depression, together with the depression rating scales, is carried in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes.

3.10 The disorder-specific CBT protocols

One method, many manualised protocols; name them, do not re-teach them. The strength of CBT is that its core method is tailored into disorder-specific packages, each with its own evidence and its own home chapter. *Exposure and response prevention* (ERP) is the specific behavioural CBT protocol for obsessive-compulsive disorder, in which the patient is exposed to the obsessional trigger while the compulsive response is prevented; it, and *trauma-focused CBT* for post-traumatic stress disorder, are developed in the Anxiety, OCD and trauma-related disorders notes. *CBT-I*, cognitive behaviour therapy for insomnia, combines stimulus control, sleep restriction, sleep hygiene and cognitive work on sleep-related beliefs, and is the first-line treatment for chronic insomnia ahead of hypnotics. CBT for psychosis targets distressing delusional and hallucinatory beliefs without disputing them head-on. The examinable move is to recognise each as a branded CBT protocol resting on the one cognitive model above, and to place it in its disorder rather than to describe it as a separate therapy.

GOOD TO REMEMBER

- **ERP, trauma-focused CBT and CBT-I (the branded protocols):** ERP is CBT for OCD (exposure plus prevention of the compulsion); trauma-focused CBT is CBT for PTSD; CBT-I is CBT for chronic insomnia (stimulus control, sleep restriction, cognitive work). All three are the one cognitive model tailored to a disorder, not new therapies; learn them in their own chapters.

3.11 CBT in the Indian setting

Guideline-endorsed and culturally adaptable, with realistic caveats. The Indian Psychiatric Society places CBT first-line across depression, generalised anxiety disorder, obsessive-compulsive disorder, somatic symptom disorder and, for relapse prevention, alcohol use disorder, both in its disorder-specific clinical practice guidelines and in its dedicated psychotherapies guideline (IPS_CPG 2020). Culturally adapted CBT, associated with Naeem and colleagues, modifies the content, language, idioms of distress, degree of family involvement and explanatory models for South Asian settings, and has feasibility and randomised-trial-level evidence for depression and psychosis; it is best framed as a promising adaptation with a developing evidence base rather than as a distinct guideline-endorsed therapy. The practical constraint in India is supply, not demand: trained CBT therapists are scarce relative to need, which is why guideline

attention has turned to brief, low-intensity and task-shifted delivery by non-specialist health workers.

INDIA

The IPS psychotherapies guideline (IPS_CPG 2020) and the disorder-specific CPGs make CBT the default first-line psychotherapy for the common disorders, but the workforce to deliver it is thin. Culturally adapted CBT (Naeem and colleagues) and community-delivered, non-specialist-led brief CBT are the realistic Indian answers; state both the guideline endorsement and the delivery gap, because an examiner who asks about CBT in India is usually testing whether you know the second half.

GOOD TO REMEMBER

- **Cognitive behaviour therapy (the therapy):** the model is that interpretation, not the event, drives emotion, physiology and behaviour, so identifying and modifying maladaptive automatic thoughts, intermediate beliefs and core beliefs changes the response; the lead indication is major depression and the anxiety disorders, where CBT is first-line and the best-evidenced psychotherapy of all; the one signature technique is cognitive restructuring via the thought record, delivered through collaborative empiricism.

HOLD THIS

CBT is structured, time-limited, present-focused and collaborative; its cognitive model holds that the automatic thought, not the situation, drives the emotional, physiological and behavioural response; Beck's cognitive triad has exactly three components (self, world, future); the therapy is delivered through cognitive restructuring, Socratic questioning and behavioural experiments within collaborative empiricism, on a fixed session structure of mood check, agenda, homework review, the work, new homework and feedback; and it is the most-evidenced psychotherapy, first-line across the widest range of disorders.

4 · Behaviour therapy

Behaviour therapy is the oldest of the empirically grounded psychotherapies and the one whose logic an examiner can test in a single line: it takes the laws of learning theory out of the animal laboratory and applies them, directly and without recourse to the unconscious, to observable maladaptive behaviour. Where psychoanalysis seeks buried meaning and cognitive therapy targets appraisal, behaviour therapy targets the behaviour itself, the antecedents that cue it and the consequences that maintain it, on the premise that what was learned can be unlearned. Two engines drive everything below, classical conditioning (Pavlov, applied to therapy by Wolpe) and operant conditioning (Skinner); fix which engine powers which technique and the whole topic becomes orderly.

How to use this page. Learn the two conditioning paradigms first, then the classical-conditioning techniques built on extinction of a conditioned fear, the exposure family and aversion, then the operant techniques built on reinforcement and its withdrawal, then the assessment method that precedes all of them, functional analysis. The single error this page is built to prevent is the cardinal viva trap of confusing **flooding** (maximal exposure, no hierarchy)

with **systematic desensitisation** (graded hierarchy, paired with relaxation). Get that discrimination clean and most of the marks are secured.

4.1 Learning theory: the two engines of behaviour therapy

Classical conditioning acquires the fear; operant conditioning maintains the avoidance. Classical conditioning, described by Pavlov, is learning by association: a neutral stimulus repeatedly paired with a stimulus that already produces a response comes itself to produce that response. Operant conditioning, formalised by Skinner in the nineteen-fifties and anticipated by Thorndike's law of effect, is learning by consequence: behaviour followed by a favourable consequence is strengthened, behaviour followed by an unfavourable one is weakened. The two combine in Mowrer's two-factor theory of fear, the conceptual backbone of the anxiety treatments: a phobia is first acquired by classical conditioning (a neutral object paired with a frightening event becomes a conditioned trigger) and then maintained by operant conditioning (avoiding the object removes the fear, and that relief negatively reinforces the avoidance, so the fear never extinguishes). Behaviour therapy works by breaking that second, maintaining loop.

Unconditioned stimulus (UCS)

A stimulus that naturally and without learning elicits a response (food evoking salivation).

Unconditioned response (UCR)

The unlearned, reflexive response to the UCS (salivation to food).

Conditioned stimulus (CS)

A previously neutral stimulus that, after repeated pairing with the UCS, comes to elicit the response (the bell).

Conditioned response (CR)

The learned response now produced by the CS alone (salivation to the bell).

Extinction (classical)

Weakening and loss of the CR when the CS is presented repeatedly without the UCS; the mechanism most exposure treatments exploit.

RULE **Behaviour, not insight, is the target.** Behaviour therapy applies learning theory to change observable behaviour and its contingencies directly; it does not require the patient to understand why the behaviour arose.

4.2 Systematic desensitisation: Wolpe's graded hierarchy and relaxation

A ladder of feared situations climbed one rung at a time while the body stays relaxed. Systematic desensitisation is the flagship classical-conditioning technique, devised by Joseph Wolpe, whose *Psychotherapy by Reciprocal Inhibition* (Wolpe, nineteen fifty-eight) grounded it in learning theory. It rests on reciprocal inhibition: if a response incompatible with anxiety is made to occur in the presence of the anxiety-provoking stimulus, the bond between that stimulus and anxiety is weakened, because a person cannot be deeply relaxed and anxious at the same instant (Wolpe; Companion to Psychiatric Studies). The relaxation is the incompatible response. The procedure has three classic steps: first, training in deep muscular relaxation; second, collaborative construction of an *anxiety hierarchy*, a rank-ordered list of feared situations from the least to the

most anxiety-provoking; third, graded pairing, in which the relaxed patient is exposed, in imagination or in vivo, to the lowest item until it evokes no anxiety, then to the next, ascending the hierarchy only as each rung is mastered. The lead indication is **specific phobia**, and exposure-based treatment of this kind is first-line for it (CANMAT 2014).

WORKED EXAMPLE

A student with a spider phobia is first taught progressive muscular relaxation. Together with the therapist she builds a hierarchy of roughly ten steps, from looking at a cartoon spider (mildly anxiety-provoking) to letting a live spider walk across her hand (the peak). Relaxed, she pictures the cartoon spider until it no longer disturbs her, then a photograph, then a spider in a jar across the room, moving up only when each rung has been neutralised. The anxiety attached to each image is inhibited by the relaxation with which it is paired, and the hierarchy is dismantled from the bottom up.

PEARL

Hold reciprocal inhibition as the one-line mechanism of systematic desensitisation: **relaxation and anxiety cannot coexist**, so pairing the feared item with relaxation drains the fear out of it. The hierarchy is graded and the pace is set by mastery, never by the clock.

4.3 Graded exposure, flooding and implosion: the exposure family

All expose the patient to what is feared; they differ in gradient and intensity. Graded exposure, typically delivered in vivo (in real life rather than imagination), is the modern workhorse: the patient confronts feared situations step by step along a hierarchy and remains in each until anxiety subsides, so that *habituation* and extinction of the conditioned response occur. Unlike systematic desensitisation it does not formally pair each step with trained relaxation; the therapeutic ingredient is staying in contact with the feared stimulus long enough for anxiety to fall of its own accord, which is why *response prevention*, blocking the escape or safety behaviour, is essential. At the opposite pole sits flooding: exposure that is immediate and maximal, beginning with the most feared item and holding the patient there, with no hierarchy and no gradual ascent, until the anxiety peaks and then habituates. Its imaginal cousin is implosion (implosive therapy, Stampfl), maximal exposure conducted entirely in imagination. The detailed exposure and response-prevention protocols for obsessive-compulsive disorder and the trauma-focused exposure work are developed in the Anxiety, OCD and trauma-related disorders notes.

TECHNIQUE	HIERARCHY	RELAXATION PAIRED	INTENSITY AND MODE	PROTOTYPE USE
Systematic desensitisation	Graded, least to most	Yes (reciprocal inhibition)	Gradual; imaginal or in vivo	Specific phobia
Graded exposure	Graded, least to most	No (habituation-based)	Gradual; in vivo	Agoraphobia, phobic and obsessional disorders
Flooding	**None; most-feared first**	No	Maximal; in vivo	Phobias, rapid treatment
Implosion (implosive therapy)	**None; most-feared first**	No	Maximal; imaginal	Phobic and anxiety disorders

The exposure family: systematic desensitisation is graded and relaxation-paired; flooding and implosion are maximal with no hierarchy.

TRAP **Flooding is not systematic desensitisation.** Flooding uses maximal exposure to the most-feared item with no hierarchy and no relaxation; systematic desensitisation is graded up a hierarchy and paired with relaxation. Swapping these two definitions is the single commonest behaviour-therapy error in the viva.

4.4 Aversion therapy and covert sensitisation

Pair the unwanted behaviour with something unpleasant so its pull declines. Aversion therapy is the classical-conditioning technique that runs in the opposite direction to exposure: instead of extinguishing an unwanted fear, it deliberately conditions an unwanted *attraction* to an aversive state by pairing the target behaviour with a noxious stimulus, classically a subthreshold electric shock or an emetic such as apomorphine. Its imaginal form is *covert sensitisation*, in which the patient repeatedly imagines the unwanted behaviour immediately followed by a vividly unpleasant consequence (nausea, disgust), so the pairing is rehearsed in the mind rather than in the body. Historically applied to alcohol dependence (disulfiram exploits the same aversive logic pharmacologically), to the paraphilias and to other appetitive problems, aversion therapy has fallen sharply out of routine use on both effectiveness and ethical grounds and now occupies a small, tightly consented niche. It is examinable chiefly as the counter-example that shows conditioning can build an aversion as readily as it can dissolve a fear.

4.5 The operant techniques: reinforcement, shaping, chaining, extinction, time-out

Change the consequences and you change the frequency of the behaviour. The operant half of behaviour therapy manipulates what follows a behaviour. Reinforcement always *increases* a behaviour and punishment always *decreases* it, and each comes in a positive form (a stimulus is added) and a negative form (a stimulus is removed). The two-by-two of consequences below is worth holding as a grid, because the label that trips candidates, negative reinforcement, is not punishment at all.

OPERANT CONSEQUENCE	INCREASES BEHAVIOUR	DECREASES BEHAVIOUR
Stimulus added	Positive reinforcement (praise, reward)	Positive punishment (aversive stimulus)
Stimulus removed	**Negative reinforcement (relief of an aversive state)**	Negative punishment (response cost, time-out)

The four operant consequences: reinforcement raises a behaviour, punishment lowers it; positive means add, negative means remove.

On this base sit the operant procedures used to build up or strip away behaviour.

Shaping

Building a new behaviour by reinforcing successive approximations to the target, rewarding ever-closer attempts until the full behaviour appears.

Chaining

Linking discrete learned behaviours into an ordered sequence, taught either forwards from the first step or backwards from the last.

Extinction (operant)

Withholding the reinforcer that has been maintaining a behaviour so that the behaviour gradually declines; expect a transient extinction burst first.

Time-out

Brief, contingent removal of the person from all sources of positive reinforcement following an unwanted behaviour; a form of negative punishment, widely used in child behaviour work.

Prompting and fading

Supplying a cue that triggers the desired behaviour, then gradually withdrawing the cue as the behaviour becomes independent.

> **COMMON TRAP**
>
> **Negative reinforcement is not punishment.** Negative reinforcement *removes* an aversive state and therefore *increases* the behaviour that ended it (taking a painkiller relieves pain, so pill-taking is reinforced). Punishment decreases behaviour. If the behaviour goes up, it was reinforcement, whatever was added or taken away.

4.6 The token economy and contingency management

Structured, ward-wide operant systems that reward adaptive behaviour on a schedule. The **token economy** is the most developed operant application, a structured contingency-management system devised by Ayllon and Azrin for chronic inpatient and rehabilitation settings. Tokens, functioning as secondary (conditioned) reinforcers exactly as money does, are earned immediately for specified target behaviours (self-care, attendance, participation) and later exchanged for backup reinforcers such as privileges or goods; the immediacy of the token bridges the delay to the real reward. Its classic home is the long-stay ward, chronic institutionalised schizophrenia with negative symptoms and self-care deficits, and intellectual disability and children's units. Its close relative, contingency management, delivers tangible incentives (typically vouchers) contingent on an objectively verified target such as a drug-negative urine screen, and is

a well-evidenced operant treatment in the addictions, developed in the Substance use disorders notes.

GOOD TO REMEMBER

- **Token economy (the technique):** the model is operant, a structured contingency-management system in which tokens act as secondary reinforcers earned for target behaviours and exchanged for backup reinforcers; the lead indication is chronic inpatient and rehabilitation settings (chronic institutionalised schizophrenia, intellectual disability); the one technique is immediate tokens redeemed later, attributed to Ayllon and Azrin.

4.7 Behavioural assessment and functional analysis

No technique is chosen until the behaviour has been analysed in context. Behaviour therapy begins not with a diagnosis but with a functional analysis, a systematic description of the problem behaviour together with the conditions that trigger and maintain it. The organising frame is the *ABC* sequence: the *Antecedents* that cue the behaviour, the *Behaviour* itself defined in observable, measurable terms (frequency, duration, intensity rather than inference), and the *Consequences* that follow and thereby reinforce or punish it. The clinician gathers this from interview, direct observation, self-monitoring diaries and rating scales, establishes a baseline, and only then designs an intervention aimed at the maintaining contingency, most often a consequence that is inadvertently reinforcing an unwanted behaviour. This functional, here-and-now analysis is what makes behaviour therapy a targeted procedure rather than a generic conversation, and the same measured behaviours provide the outcome data.

MNEMONIC

A-B-C

Functional analysis reads the behaviour in its context: **A**ntecedents (what cues it), **B**ehaviour (defined observably), **C**onsequences (what maintains it). Change the C, and the behaviour changes.

4.8 Social-skills and assertiveness training

Deficient interpersonal behaviours are taught the way any skill is taught. Where the problem is not an excess of anxiety or an unwanted habit but a *deficit* in interpersonal repertoire, behaviour therapy supplies *social-skills training* and its focused subset *assertiveness training*. Both use a standard behavioural teaching package, instruction and modelling of the target skill, rehearsal through role-play, corrective feedback and reinforcement of successful attempts, and homework to generalise the skill into real settings. Assertiveness training specifically builds the capacity to express needs, refuse unreasonable demands and stand up for oneself without aggression or passivity, and Wolpe regarded assertive responses as themselves reciprocally inhibiting of interpersonal anxiety. These methods are staples of the rehabilitation of chronic schizophrenia (remediating negative-symptom social withdrawal), of social anxiety, and of skills-building work across many conditions.

4.9 Indications, the evidence base and behaviour therapy in India

Robustly evidenced, above all as exposure for the phobic and obsessional disorders. The examinable summary is that behaviour therapy is strongly evidenced where a behaviour or a conditioned fear is the target, and that its techniques are also the active behavioural ingredients inside cognitive behaviour therapy. Exposure-based treatment is the first-line treatment of choice for *specific phobia* (CANMAT 2014), with applied muscle tension added for the blood-injection-injury type; graded exposure is recommended for *agoraphobia* (CANMAT 2014). Exposure and response prevention is a first-line acute psychological treatment for *obsessive-compulsive disorder* (BAP 2014 grade A; CANMAT 2014), and prolonged exposure is a recommended trauma-focused psychotherapy for *post-traumatic stress disorder* (NICE 2018; VA_DOD 2023), both carried in full in the Anxiety, OCD and trauma-related disorders notes. Behavioural activation, the operant-flavoured re-engagement technique, is a first-line psychological treatment for *major depressive disorder* (CANMAT 2016; IPS_CPG 2017 grade A) and is developed with the depression therapies. The token economy and contingency management hold their niche in chronic rehabilitation and the addictions respectively.

1958 WOLPE'S PSYCHOTHERAPY BY RECIPROCAL INHIBITION	**2** FACTORS IN MOWRER'S TWO-FACTOR THEORY OF FEAR	**3** STEPS OF SYSTEMATIC DESENSITISATION (RELAX, HIERARCHY, GRADED PAIRING)

INDIA

The Indian Psychiatric Society names behavioural activation among the strongest-evidence psychotherapies for depression in its depression guideline (IPS_CPG 2017), and its obsessive-compulsive disorder guidance places exposure and response prevention first-line. India also has a long institutional behaviour-therapy tradition, with behavioural and behavioural-medicine work established at NIMHANS; state the guideline endorsement confidently and frame the wider tradition as an established service history rather than citing a specific trial.

GOOD TO REMEMBER

- **Systematic desensitisation (the technique):** the model is classical conditioning via reciprocal inhibition (Wolpe), pairing a graded anxiety hierarchy with relaxation so fear cannot coexist with the relaxed state; the lead indication is specific phobia; the one technique is graded, relaxation-paired ascent of the hierarchy, contrasted sharply with flooding.
- **Behaviour therapy (the modality):** the model applies learning theory, classical and operant conditioning, to modify observable maladaptive behaviour and its contingencies directly; the lead indication is the phobic and obsessional disorders treated by exposure, with the token economy for chronic institutional behaviour; the one signature technique is graded exposure, the disciplined confrontation of the feared stimulus until anxiety extinguishes.

HOLD THIS

Behaviour therapy applies learning theory to observable behaviour: classical conditioning yields systematic desensitisation (Wolpe, a graded hierarchy paired with relaxation via reciprocal inhibition) and flooding (maximal exposure, most-feared first, no hierarchy), while operant conditioning yields reinforcement, shaping, extinction and the token economy (Ayllon and Azrin); exposure is first-line for specific phobia and, as response prevention, for obsessive-compulsive disorder.

5 · Psychoanalysis and psychodynamic psychotherapy

This is the oldest of the talking treatments and the one that gave the field its whole vocabulary: **unconscious conflict**, **transference**, defence, insight. Freud's psychoanalysis is rarely practised in its pure, five-times-a-week form in Indian psychiatry, yet the examiner returns to it every year, because its concepts underpin the mental status interview, the formulation, and every dynamic therapy that followed. What is tested is not the philosophy but the scaffold: the two models of the mind, the three clinical phenomena (transference, **counter-transference**, resistance), the named techniques, and the spectrum that runs from classical analysis down to brief dynamic work.

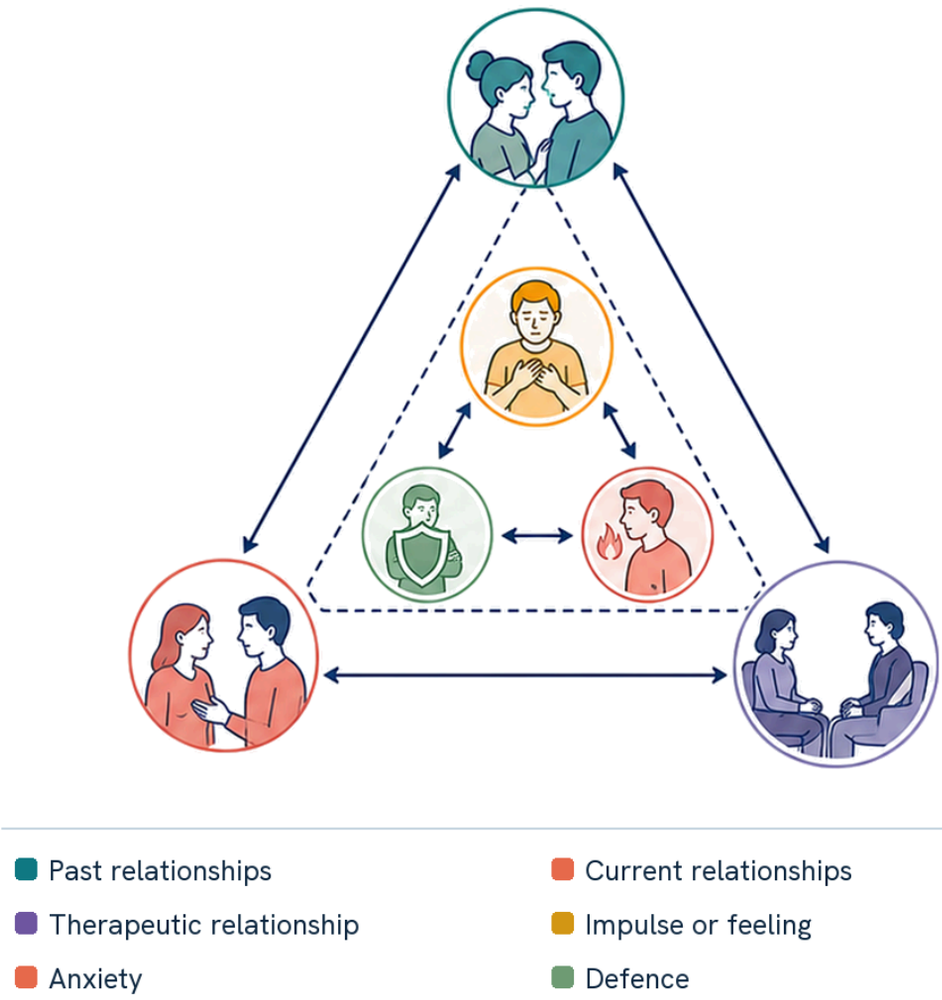


Fig 19.4 Psychodynamic formulation often uses two linked triangles: recurring patterns across past relationships, current relationships and the therapeutic relationship; and the sequence from impulse or feeling through anxiety to defence.

How to use this page. Learn the two maps first, the **topographic model** and the **structural model**, because everything else hangs on them. Then fix the three clinical concepts and the technique list, where the marks live. Then place the modality honestly on the evidence: classical **psychoanalysis** is a guideline first-line treatment for no disorder, whereas short-term **psychodynamic psychotherapy** is a reasonable second-line or alternative option, so do not overstate it. The deeper Freudian and post-Freudian metapsychology, and the descriptive vocabulary of slips and parapraxes, are developed in the Psychometry, Assessment and Descriptive Psychopathology notes.

5.1 The topographic model: three systems of the mind

Conscious, preconscious, unconscious, ranked by their relation to awareness. Freud's first map of the mind, the topographic model, classified mental events by their degree of awareness rather than by any anatomical seat (Kaplan and Sadock CTP 2024). It has three systems. The *system conscious* is what is in awareness now. The *system preconscious* is the antechamber, material

not conscious at this moment but retrievable at will, and it acts as a censor, admitting a forbidden wish to consciousness only if it is disguised past recognition. The *system unconscious*, the deepest layer, holds the wishes and drive-representations that are unacceptable to the person; it is governed by the **pleasure principle** and primary-process thinking, which ignores logic and time, tolerates contradiction, and knows no negatives. This is the model behind the popular iceberg image; the accompanying figure sets the three systems out in that form. Its clinical value is the claim that symptoms, dreams and slips are disguised derivatives of unconscious wishes, not random noise.

5.2 The structural model: id, ego and superego

Three agencies, introduced in *The Ego and the Id* (1923). Freud found the topographic model could not explain why the very defences that produced repression were themselves unconscious, so he rebuilt the map as the tripartite structural model (Kaplan and Sadock CTP 2024). Its three agencies do not map cleanly onto the three systems: the ego and superego each straddle conscious and unconscious. Hold them by their governing principle and their job.

AGENCY	NATURE AND PRINCIPLE	ITS ROLE IN THE CONFLICT
Id	Wholly unconscious reservoir of sexual and aggressive drive; pleasure principle, primary process	**The impulse that presses for discharge**
Ego	Largely unconscious, part conscious; reality principle, secondary process	**The mediator; deploys the defences against the impulse**
Superego	Largely unconscious; internalised parental and moral standards; source of conscience and guilt	**The prohibition; the moral objection to the impulse**

The structural model: a symptom is a compromise between the id impulse, the superego's prohibition and the ego's defence (Kaplan and Sadock CTP 2024).

The clinical pay-off is the idea of **unconscious conflict**: a symptom is a *compromise formation*, the best bargain the ego can strike between a forbidden id impulse, the superego's prohibition and external reality. Neurotic anxiety is the signal that this bargain is failing. Every dynamic formulation you will ever write is, at root, a statement of that three-way conflict.

5.3 Transference and counter-transference

The patient's feelings toward the therapist are a re-run of formative relationships. Transference is the displacement onto the therapist of feelings, wishes and expectations first formed in the patient's early, formative relationships, usually with parents (Kaplan and Sadock CTP 2024). The patient does not experience it as a repetition; a positive transference feels like real gratitude and trust, a negative transference like real suspicion and grievance. Its systematic analysis is what Freud held to be the single feature separating **psychoanalysis** from every other psychotherapy. Counter-transference is the mirror phenomenon: the therapist's own emotional response to the patient. Freud first saw it as an obstacle, a contamination to be analysed away in

the therapist's own analysis; the modern view, informed by object-relations and intersubjective theory, treats the clinician's disciplined counter-transference as a source of data about what the patient evokes in others. Both are worked with, not acted on.

WORKED EXAMPLE

A patient becomes coldly contemptuous whenever the therapist ends a session on time, complaining of being "processed like a case". The therapist notices an urge to over-explain and apologise. The dynamic reading is a negative **transference**: the punctual ending revives an early experience of a preoccupied, withholding parent, and the pull to placate is the therapist's **counter-transference**. The move is not to defend the clock but to interpret the pattern, linking the feeling in the room to its formative template.

RULE **Transference analysis is the heart of the method.** The systematic interpretation of the transference is the one feature that distinguishes psychoanalysis from every other form of psychotherapy.

TRAP **Reversing the direction.** Transference runs patient to therapist; counter-transference runs therapist back to patient. Swapping the two is the classic examination error.

5.4 Resistance, the alliance and the unconscious conflict

Everything in the patient that opposes the surfacing of unconscious material. Resistance is the name for all the ways, mostly out of awareness, in which the patient avoids a topic, blocks an affect, comes late, falls silent or otherwise opposes the treatment (Kaplan and Sadock CTP 2024). It is not obstinacy to be overcome by force but the defences seen in action, and analysts of every school agree that a large part of the work is helping the patient recognise resistance as an obstacle to be understood. Set against it is the therapeutic alliance, the real, reality-based, collaborative bond between the patient's observing ego and the therapist; it is distinct from the transference and is the most consistent predictor of good outcome across every therapy. The three concepts interlock: resistance defends the **unconscious conflict**, the transference displays it, and the alliance is what makes examining it bearable.

Transference

Displacement onto the therapist of feelings from formative early relationships.

Counter-transference

The therapist's own emotional response to the patient; an obstacle in the classical view, a source of data in the modern one.

Resistance

The patient's largely unconscious opposition to the surfacing of unconscious material; the defences in action.

Therapeutic alliance

The real, collaborative working bond, distinct from transference; the strongest common predictor of outcome.

Unconscious conflict

The clash of id impulse, superego prohibition and ego defence that generates anxiety and symptom.

5.5 The techniques: free association to working through

The patient's one task, and the analyst's graded toolkit. The patient is bound by a single instruction, the *fundamental rule*: to say whatever comes to mind, however trivial, repellent or illogical, without censoring. This is free association, the method that, as Freud abandoned hypnosis, became the true creation of **psychoanalysis** (Kaplan and Sadock CTP 2024; Wolberg). Alongside it the analyst reads the *royal road* of dreams and the tell-tale slips and parapraxes of everyday speech, treating each as a disguised derivative of the unconscious. The analyst's own interventions form a graded ladder from surface to depth, and the terms are examinable in their own right.

INTERVENTION	WHAT IT DOES	DEPTH
Clarification	Pulls together and sharpens what the patient has already said, bringing vague material into focus; adds no new inference	**Surface**
Confrontation	Directs the patient's attention to something being avoided or not attended to, typically a defence or a pattern	**Surface to middle**
Interpretation	Offers a hypothesis making the unconscious conscious, linking a current feeling or act to an unconscious wish, defence, the past or the transference; the chief agent of change	**Deep**
Working through	The repeated, effortful re-application of an insight across many situations and over time until change becomes durable; not a single act	**Consolidation**

The interpretive ladder: clarification and confrontation address the surface and the defences, interpretation reaches the unconscious, and working through embeds the gain (Kaplan and Sadock CTP 2024; Gabbard).

Working through is where insight becomes change. A single well-timed **interpretation** rarely cures anything; **working through** is the slow, repetitive labour of meeting the same conflict again and again, in the transference and in outside life, until the patient can respond differently by habit rather than by effort. It is the reason analytic work is long, and the reason a good interpretation delivered too early, before the alliance and the working-through capacity are in place, tends to feed resistance rather than insight.

PEARL

Read the ladder as ascending in depth, not in worth. Clarification and confrontation are not lesser tools; they prepare the ground. An **interpretation** is only as good as its timing, and premature depth is a technical error, not a virtue. The rule of thumb is to interpret the resistance and the defence before the hidden impulse, and to work from the surface down.

5.6 The analytic frame and neutrality

The fixed conditions that make the transference legible. The *frame* is the set of contractual conditions of treatment: the fixed time, place and fee, and the use of the couch (Kaplan and Sadock CTP 2024). Classical analytic sessions run 45 to 50 minutes, three to five times a week, with the patient reclining on the couch and the analyst out of sight, a deliberate arrangement that loosens censorship and encourages the regression and *transference neurosis* the work depends on. The analyst holds a stance of *neutrality* (taking no side among the patient's id, ego, superego and reality), *anonymity* (revealing little of the self, so the transference is the patient's own creation), and *abstinence* (declining to gratify the transference wishes directly). Any deliberate departure from the standard technique, such as sitting the patient up or meeting less often, is called a *parameter*, and is itself explored for its meaning rather than slipped in silently.

5.7 The spectrum: classical analysis to brief dynamic therapy

One family, graded by intensity, regression and focus. The dynamic therapies sit on a single continuum. At the intensive pole is classical **psychoanalysis**: frequent, couch-based, open-ended, aiming at broad structural change through regression and the analysis of a full transference neurosis. In the middle is **psychodynamic psychotherapy**, its briefer and less regressive derivative: once or twice weekly, face to face, with the same core concepts but a lighter touch on regression and more attention to the here and now (Tasman; Gabbard). At the focused pole are the brief dynamic therapies, time-limited and organised around a single dynamic focus agreed at the outset.

FEATURE	CLASSICAL PSYCHOANALYSIS	PSYCHODYNAMIC PSYCHOTHERAPY	BRIEF DYNAMIC THERAPY
Frequency	Three to five times a week	Once or twice a week	**Once a week, time-limited**
Position	Couch, analyst unseen	Face to face, upright	**Face to face, upright**
Regression	Encouraged; full transference neurosis	Limited	**Actively discouraged**
Focus	Open-ended, whole personality	Broad but bounded	**A single agreed dynamic focus**
Goal	Structural change through insight	Insight plus adaptation	**Resolution of the focal conflict**

The dynamic spectrum from classical analysis to brief dynamic therapy; the accompanying figure renders it as a single graded bar (Tasman; Gabbard).

The brief dynamic therapies are named after their pioneers. The classic short-term dynamic psychotherapies share time limits and a focus but differ in tactics. Sifneos developed short-term anxiety-provoking psychotherapy, an Oedipally-focused treatment of **10** to **20** sessions using high activity and a positive transference. Malan, from Balint's Tavistock group, organised the work around two triangles, the triangle of conflict (impulse, anxiety, defence) and the triangle of the person (therapist, current figures, past figures), holding to a 40-session upper limit; his enduring research finding is that the more interpretations linking the transference to the past and present, the better the outcome. Davanloo's intensive short-term dynamic psychotherapy drives at resistance through a central dynamic sequence of technical steps, including his "head-on collision" with the patient's defences. Mann's time-limited psychotherapy fixes treatment at exactly **12** sessions, using the deadline itself as a lever on the conflict around separation and loss.

MNEMONIC

SMDM: Sifneos, Malan, Davanloo, Mann

The four classic brief dynamic pioneers, easiest held by their signatures: **S**ifneos, anxiety-provoking and Oedipal; **M**alan, the two triangles; **D**avanloo, the head-on collision with resistance; **M**ann, the fixed twelve-session frame built on time and loss.

5.8 Evidence and indications: keep the modality honest

No first-line role for classical analysis; a second-line role for its brief derivative. The evidence base is thinner than for CBT, and it must be stated carefully. Classical, long-term **psychoanalysis** is a guideline first-line treatment for no disorder. Short-term psychodynamic psychotherapy (STPP) has a moderate base and appears in guidelines as an option or a second-line choice, never as the reference-standard therapy. STPP is one of several psychotherapy options for major depression (VA_DOD 2022; brief psychodynamic therapy, WHO_mhGAP 2023), taking its place beside the interpersonal and cognitive therapies covered in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes. Focal psychodynamic therapy is a later-line option for adults with anorexia nervosa when first-line treatments fail (NICE 2017). STPP is an alternative for social anxiety in patients who decline CBT (NICE 2013), and a second-line psychotherapy for somatisation (IPS_CPG 2020), whose place is set out in the Somatic-symptom, sexual, impulse-control disorders and suicide notes; psychodynamic interpersonal therapy is offered to reduce repetition of self-harm (RANZCP 2016). The best-evidenced psychoanalytically derived therapy is mentalisation-based treatment (MBT) of Bateman and Fonagy for borderline personality disorder, taken up with transference-focused psychotherapy in the Personality disorders notes.

COMMON TRAP

Presenting **psychoanalysis** as an evidence-based first-line treatment. Only short-term **psychodynamic psychotherapy** reaches the guidelines, and always as an option or second-line choice. Classical, long-term analysis carries no guideline first-line indication for any disorder; claiming one is a marked error.

3-5	1923	12
WEEKLY SESSIONS IN CLASSICAL PSYCHOANALYSIS	THE EGO AND THE ID: FREUD'S STRUCTURAL MODEL	SESSIONS IN MANN'S TIME-LIMITED THERAPY

INDIA

Formal, high-frequency **psychoanalysis** is scarce in Indian practice; what the guidelines actually endorse is its brief, focused derivative. The Indian Psychiatric Society lists short-term **psychodynamic psychotherapy** as a second-line psychotherapy for somatisation and undifferentiated somatoform disorder (IPS_CPG 2020), and has published a dedicated Clinical Practice Guideline on psychotherapies (Agarwal, Nischal, Praharaj, Menon, Kar; Indian J Psychiatry 2020). Frame dynamic work in the Indian setting as a bounded, focal treatment delivered by trained clinicians, not as open-ended analysis.

5.9 The ego defence mechanisms, named here

The ego's unconscious strategies against the forbidden impulse. The defences are the ego's automatic, unconscious manoeuvres for keeping an unacceptable impulse or affect out of awareness; they are the very machinery that **resistance** puts on display in the room. They are named here for completeness and developed in full, with Vaillant's mature-to-primitive hierarchy, in the topic that follows on the ego defence mechanisms.

Repression

The cornerstone; the active keeping of an unacceptable impulse or memory out of awareness.

Denial

Refusal to register an external reality that is too painful to face.

Projection

Attributing one's own disowned impulse or feeling to another person.

Reaction formation

Converting an unacceptable impulse into its conscious opposite.

Displacement

Shifting a feeling from its true object onto a safer substitute.

Sublimation

Channelling an impulse into a socially valued activity; a mature defence.

Splitting and projective identification

The primitive defences central to borderline personality organisation.

GOOD TO REMEMBER

- **Psychoanalysis and psychodynamic psychotherapy (the modality):** a treatment that makes **unconscious conflict** conscious by analysing the **transference**, **resistance** and defence to produce insight and change, mapped by the topographic model (conscious, preconscious, unconscious) and the structural model (id, ego, superego); classical **psychoanalysis** is intensive and couch-based, while **psychodynamic psychotherapy** is its briefer, face-to-face derivative. Its lead role is as a second-line or alternative option: short-term psychodynamic psychotherapy for major depression, somatisation (IPS_CPG 2020) and social anxiety in those declining CBT (NICE 2013), with MBT for borderline personality disorder as its best-evidenced offshoot; classical analysis is guideline first-line for no disorder. The one technique to name is **interpretation** of the transference, built on the patient's **free association**.

HOLD THIS

Psychoanalysis works by making the unconscious conscious through the analysis of TRANSFERENCE, RESISTANCE and defence; its two maps are the TOPOGRAPHIC model (conscious, preconscious, unconscious) and the STRUCTURAL model (id, ego, superego); classical analysis is intensive (couch, three to five weekly sessions, regression) while psychodynamic psychotherapy is its briefer face-to-face derivative, and INTERPRETATION of the transference, built on free association and consolidated by working through, is the one technique that defines the method.

6 · The ego defence mechanisms

This is one of the highest-yield grids in the whole psychodynamic syllabus, and it earns its place because the examiner almost never wants a loose description; the marks are in the *hierarchy*, being able to name a defence, place it on its maturity level, define it in a line and give a clean clinical example. The **ego defence mechanisms** are the unconscious mental operations the ego deploys to keep unacceptable impulses, and the anxiety they generate, out of awareness. Every person uses them; what distinguishes health from disorder is not their presence but their *maturity* and *rigidity*. The single organising idea is the maturity hierarchy, which sorts the two-dozen named **defence mechanisms** into four ranked levels and, crucially, maps them onto personality organisation.

How to use this page. Fix the definition and the short history first, then learn the four-level frame, then drill the four defs lists (**mature defences**, **neurotic defences**, **immature defences** and **psychotic defences**) with one crisp example each. The consolidated grid near the end is your single-glance revision table; the final subtopic is where the marks hide, because it links the grid to Kernberg's levels of personality organisation and to the clinical stance the examiner expects.

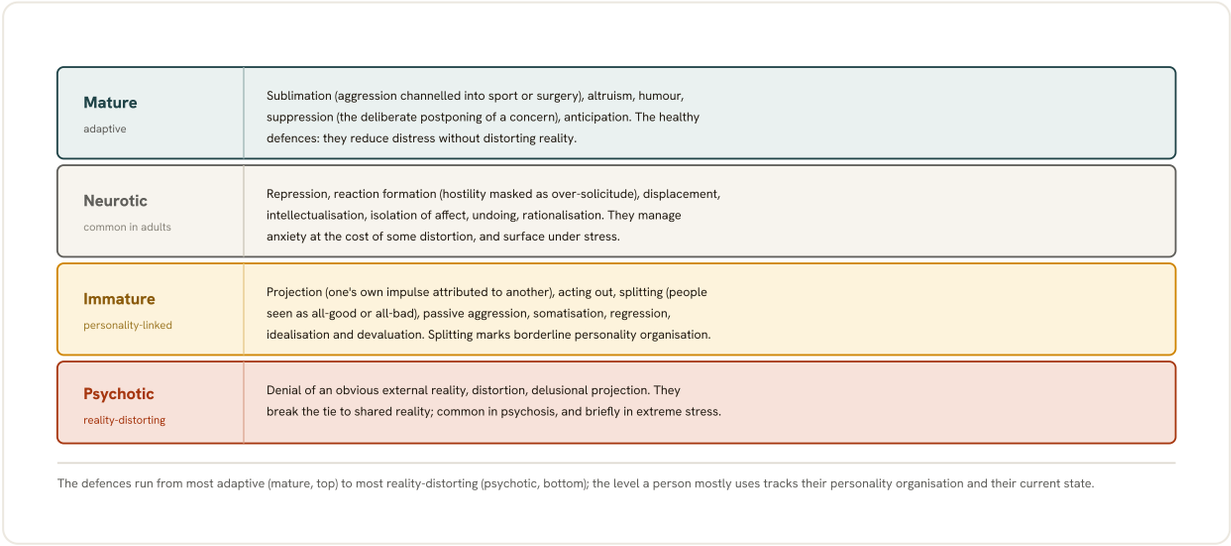


Fig 19.5 The ego defence mechanisms by level of maturity. Defences are unconscious mental operations that protect against anxiety and unacceptable impulses, and they are ranked by how adaptive they are. The mature defences reduce distress without distorting reality and are the mark of health. The neurotic defences, common in everyone and more prominent under stress, manage anxiety at the cost of some distortion. The immature defences, prominent in the personality disorders, distort relationships and reality more heavily, with splitting the hallmark of borderline organisation. The psychotic defences break the tie to shared reality altogether. Which level a person mostly relies on is one of the most useful things the examination and the formulation can establish.

6.1 What a defence mechanism is

An unconscious, involuntary operation against anxiety, not a conscious coping strategy. A defence mechanism is an automatic psychological process that protects the ego against anxiety and against the awareness of internal or external dangers or stressors (Kaplan and Sadock CTP 2024; DSM-5-TR glossary). Three features define it and each is examinable. It is **unconscious**: the person does not know they are doing it, which separates a defence from a deliberate coping tactic. It is **involuntary**: it is triggered automatically by conflict, not chosen. And it is **anxiety-reducing**: its function is to manage the affect thrown up when an unacceptable wish, feeling or piece of reality presses toward consciousness. Defences are universal and, in themselves, adaptive; a life without them is not possible. Pathology enters only when a defence is too primitive for the situation, too rigid to yield, or so costly that it distorts reality or relationships.

RULE **The defence is unconscious; its maturity, not its presence, is what is pathological.** Everyone uses defences all the time; the clinical question is never "is there a defence" but "at what level, and how rigidly".

6.2 A short history: Freud, Anna Freud and the maturity hierarchy

From a single mechanism to a ranked catalogue. Sigmund Freud first used the term "defence" in *The Neuro-Psychoses of Defence* in 1894, then for years let it be eclipsed by **repression**, before reinstating "defence" as the general class in *Inhibitions, Symptoms and Anxiety* in 1926, with repression demoted to one member of it. His daughter Anna Freud, in *The Ego and the Mechanisms of Defence* in 1936, gave the founding systematic catalogue and moved the ego, rather than the drives, to the centre of clinical attention. The developmental and empirical ranking that examiners want is Vaillant's: from his longitudinal study of adult development he arranged the defences into **four** levels of adaptiveness, **mature**, **neurotic**, **immature** and **psychotic**

(pathological), a hierarchy later echoed by the DSM-IV Defensive Functioning Scale, which ranked defences by their adaptive value. The accompanying figure draws these four levels as an ascending ladder from psychotic denial at the base to sublimation at the top.

6.3 Mature defences

The adaptive summit: they gratify the impulse in a way that also serves the self and others. The **mature defences** are the hallmark of healthy adult functioning and of the well-integrated personality; they let the person handle conflict without distorting reality, damaging relationships or paying a symptomatic price (Vaillant; Kaplan and Sadock CTP 2024). They can, of course, be recruited pathologically in excess, but as a group they are what good adaptation looks like.

Sublimation

Channelling an unacceptable impulse into a socially valued or creative activity; the impulse is expressed, not blocked. A person with strong aggressive urges becomes a surgeon or a competitive boxer.

Altruism

Meeting one's own needs vicariously through constructive service to others. Someone deprived in childhood devotes themselves to feeding and schooling street children.

Humour

Overt expression of feeling that names a painful truth without discomfort to self or others. A patient given a grave diagnosis makes a wry joke that acknowledges the fear rather than denying it.

Suppression

The conscious or semi-conscious decision to postpone attention to a distressing impulse or feeling, intending to return to it. A candidate deliberately sets worry about a sick relative aside until the examination is over.

Anticipation

Realistic planning and emotional rehearsal for future inner discomfort. Before surgery a patient reads about the procedure and mentally rehearses the recovery, blunting later distress.

MNEMONIC

SOME ADULTS HAVE SUPER APTITUDE

The five **mature defences** in order: **S**ublimation, **A**ltruism, **H**umour, **S**uppression, **A**nticipation. The trap the phrase guards against is suppression, the only one on this list that is partly conscious; hold it against repression below.

6.4 Neurotic defences

The middle band: common in everyone under stress, and the signature of the neurotic (repression-based) personality. The **neurotic defences** keep conflict out of awareness at a cost that is usually private rather than reality-distorting, and they cluster around a firm repression barrier (Vaillant; Gabbard, *Long-Term Psychodynamic Psychotherapy*). Several map directly onto symptom pictures, most famously undoing onto obsessional rituals and isolation of affect onto the obsessional's flat recounting of distressing material.

Repression

Unconscious exclusion of an unacceptable idea, feeling or memory from consciousness; the foundational defence. A woman abused as a child has no accessible memory of the events yet reacts with unexplained anxiety to reminders.

Reaction formation

Transforming an unacceptable impulse into its conscious opposite. A person with unacceptable hostility toward a sibling becomes conspicuously doting and over-solicitous.

Displacement

Redirecting a feeling from its true object onto a safer substitute. A man humiliated by his employer goes home and shouts at his children.

Intellectualisation

Using abstract reasoning and detail to keep the affect of a conflict out of awareness. A newly diagnosed patient discusses survival statistics and cell biology fluently but shows no feeling.

Isolation of affect

Separating a feeling from the idea or event it belongs to, so the event is recalled without its emotion. A patient describes a horrifying accident in flat, factual detail.

Undoing

A symbolic act meant to cancel or atone for an unacceptable thought or deed; the mechanism behind obsessional rituals. A person with intrusive aggressive thoughts performs repeated counting or checking to "cancel" them.

Rationalisation

Offering plausible but false reasons to justify a feeling or act whose real motive is unacceptable. A rejected applicant decides the job was beneath them anyway.

> **COMMON TRAP**
>
> **Suppression is not repression.** Suppression is a mature defence and is *conscious* or semi-conscious: the person knows the worry exists and deliberately shelves it. Repression is a neurotic defence and is *unconscious*: the material is barred from awareness altogether and cannot be retrieved at will. The conscious-versus-unconscious contrast is the single most-asked discriminator in this topic.

6.5 Immature defences

The primitive band: seen in children, in adolescence, and prominently in the personality disorders. The **immature defences** distort reality and relationships more openly and provoke the reactions in others that keep the pattern going (Vaillant; Kaplan and Sadock CTP 2024). Their persistence into adult life, and above all their dominance, is what marks the more disturbed personality organisations.

Projection

Attributing one's own unacceptable impulses, feelings or thoughts to another person; the precursor of paranoia. A man with unacknowledged jealousy accuses his partner of being unfaithful.

Acting out

Expressing an unconscious wish or impulse directly through action, to avoid being aware of the feeling behind it. An adolescent who cannot bear feelings of abandonment absconds or self-harms rather than voicing the distress.

Splitting

Experiencing self and others as all-good or all-bad, unable to hold contradictory qualities together; the pattern oscillates. A patient adores one nurse as perfect and condemns another as cruel, then reverses the two the following week.

Passive aggression

Expressing aggression toward others indirectly, through non-compliance, procrastination, inefficiency or covert obstruction. A resentful employee repeatedly "forgets" tasks and hands work in late.

Somatisation

Converting intrapsychic distress into bodily symptoms and seeking medical rather than psychological help. A man unable to grieve develops disabling headaches and chest pain with no organic cause.

Regression

Retreating to an earlier developmental level of functioning to escape present demands. A hospitalised adult becomes clingy, demanding and childlike.

Idealisation / devaluation

Attributing exaggeratedly positive, or abruptly negative, qualities to another; the two poles of splitting in action. A patient insists a new therapist is the only one who ever understood them, then dismisses them as useless.

6.6 Psychotic defences

The most primitive band: they abolish reality itself, and they are normal only in early childhood and in dreams. The **psychotic defences** alter the person's perception of external reality rather than merely their inner experience of it, and their presence in an adult signals psychotic-level functioning (Vaillant; Kaplan and Sadock CTP 2024).

Denial

Refusal to accept an aspect of external reality that is obvious to others because it is too threatening; at this level the reality is abolished, not merely minimised. A woman with an advanced, visible tumour insists nothing is wrong and declines all investigation.

Distortion

Grossly reshaping external reality to fit inner need, including sustained wish-fulfilling or grandiose misperception. A man is convinced, against all evidence, that he has a special mission and cannot fail.

Delusional projection

Frank delusional, usually persecutory, beliefs about external reality, in which projected content is experienced as a real external threat. A patient is certain that neighbours are pumping poison gas into the flat to kill him.

PEARL

Denial is the classic "trick" answer: it exists at more than one level. Mild denial (minimising a piece of bad news for a while) is seen across the milder levels, but the full-blown abolition of an obvious external reality, as in the woman denying a visible tumour, is the *psychotic*-level defence. When the examiner asks "what level is denial", the safe answer names the psychotic level while noting that milder denial is not by itself psychotic.

6.7 The consolidated maturity grid

One table, the whole answer. This is the grid to reproduce under exam pressure: the level, the defence, its one-line definition and a clean example (Vaillant; Tasman; Gabbard). Learn it column by column, because a viva will pick a random cell (name the level of undoing; define isolation of affect; give an example of sublimation).

LEVEL	DEFENCE	ONE-LINE DEFINITION	EXAMPLE
Mature	Sublimation	**Impulse channelled into valued activity**	Aggressive urges expressed as a surgical career
	Altruism	Own needs met through service to others	A deprived person devotes life to feeding children
	Humour	Painful feeling named without discomfort	A wry joke about one's own grave diagnosis
	Suppression	**Conscious postponing of a distressing feeling**	Shelving family worry until the exam is done
	Anticipation	Realistic emotional rehearsal of future distress	Reading up and rehearsing recovery before surgery

LEVEL	DEFENCE	ONE-LINE DEFINITION	EXAMPLE
Neurotic	Repression	**Unconscious barring of ideas from awareness**	No memory of childhood abuse, only unexplained anxiety
	Reaction formation	Impulse turned into its conscious opposite	Hostility to a sibling shown as doting concern
	Displacement	Feeling redirected onto a safer object	Shamed by the boss, shouts at the children
	Intellectualisation	Abstract reasoning used to avoid affect	Discussing cancer statistics, showing no feeling
	Isolation of affect	Feeling divorced from its idea	Recounting a horror in flat, factual detail
	Undoing	Symbolic act to cancel an unacceptable thought	Counting rituals to "cancel" aggressive thoughts
	Rationalisation	Plausible false reasons for the real motive	The rejected applicant decides the job was beneath them
Immature	Projection	**Own impulses attributed to another**	Jealous man accuses the partner of infidelity
	Acting out	Impulse discharged in action, not felt	Absconding or self-harm instead of voicing distress
	Splitting	**Self and others seen as all-good or all-bad**	One nurse idealised, another condemned, then reversed
	Passive aggression	Aggression shown as covert non-compliance	"Forgetting" tasks and handing work in late
	Somatisation	Distress converted into bodily symptoms	Ungrieved loss becomes headaches and chest pain
	Regression	Retreat to an earlier level of functioning	A hospitalised adult turns clingy and childlike
	Idealisation / devaluation	Exaggerated all-positive then all-negative views	The therapist is the only one who understands, then useless

LEVEL	DEFENCE	ONE-LINE DEFINITION	EXAMPLE
Psychotic	Denial	**Obvious external reality abolished**	A visible tumour insisted to be nothing
	Distortion	External reality grossly reshaped to inner need	Grandiose certainty of a special, unfailing mission
	Delusional projection	Projected content lived as real external threat	Certainty that neighbours are gassing the flat

The four-level maturity hierarchy of the ego defence mechanisms, with a one-line definition and a clinical example for each (Vaillant; Tasman; Gabbard). The accompanying figure renders these levels as an ascending ladder.

6.8 Clinical relevance: defences map to personality organisation

The grid is a diagnostic instrument, not a curiosity. The examinable payoff is that a person's *habitual, predominant* defences locate them on a spectrum of personality organisation (Kernberg; Gabbard). A personality run mainly on repression-based **neurotic defences** sits in the **neurotic** organisation, with intact reality-testing and an integrated sense of self and others. A personality run mainly on primitive, immature defences, above all **splitting** with its satellites of projective identification, idealisation and devaluation, primitive denial and acting out, sits in the **borderline** organisation, where identity is diffuse and others cannot be held as whole, contradictory people. Splitting originates developmentally in Melanie Klein's paranoid-schizoid position, and its dominance is the single best pointer to borderline organisation. The therapeutic corollary is equally examinable: supportive therapy deliberately *bolsters* a patient's existing adaptive defences and does not probe them, whereas expressive and psychodynamic work *interprets* them, and you never strip away a defence the patient still needs to stay integrated. The fuller treatment of splitting, and of the dialectical behaviour and schema therapies built to work with it, belongs to the Personality disorders notes.

WORKED EXAMPLE

A young woman on the ward telephones her registrar late at night to say he is the only doctor who has ever truly cared for her, and in the same week complains to the nursing station that a different registrar is heartless and negligent. On the round she recalls a serious overdose in a flat, unemotional voice. Two defences are on display: **splitting** with idealisation and devaluation across the two doctors, and isolation of affect in the account of the overdose. The predominance of splitting, not the single episode, points toward a borderline personality organisation and reframes the "difficult" ward behaviour as a defensive style to be understood rather than a provocation to be punished.

TRAP **Do not diagnose from one defence.** Everyone splits or denies occasionally under stress; personality organisation is read from the *habitual, predominant* defensive level, not from a single act. Calling a patient "borderline" on one instance of splitting is the classic overcall.

4	1894	1936
LEVELS OF THE MATURITY HIERARCHY (VAILLANT)	FREUD FIRST NAMES "DEFENCE"	ANNA FREUD'S FOUNDING CATALOGUE

INDIA

The ego-defence grid is a perennial theory-paper and viva question in the Indian MD and DNB psychiatry examinations, taught straight from Kaplan and Sadock, so the level-by-level list is examined here, not treated as a Western aside. In Indian clinical practice the defensive organisation is most often inferred through the projective testing tradition, the Rorschach and the Thematic Apperception Test, which is a core competency in the NIMHANS clinical-psychology curriculum; the technical detail of those instruments sits in the Psychometry, Assessment and Descriptive Psychopathology notes. A second genuinely Indian anchor is **denial** in alcohol use, where the patient's minimisation of a visible problem is the defence the interview must work around; the motivational approach to exactly that is developed in the Substance use disorders notes.

GOOD TO REMEMBER

- **The principle:** defence mechanisms are unconscious, involuntary ego operations that reduce the anxiety of intrapsychic conflict; they are universal, and only their maturity and rigidity, not their presence, is pathological.
- **The discriminator:** suppression is conscious and mature; repression is unconscious and neurotic. If the person can retrieve the feeling at will, it is suppression, not repression.
- **The one exam fact:** Vaillant ranks defences into four levels, mature, neurotic, immature and psychotic, and a predominance of splitting is the signature primitive defence of borderline personality organisation.

HOLD THIS

Ego defence mechanisms are unconscious, involuntary operations against anxiety; Vaillant ranks them in four levels, mature (sublimation), neurotic (repression), immature (projection, splitting) and psychotic (denial), and it is the predominant level, with splitting marking borderline organisation, that carries the clinical meaning.

7 · Interpersonal psychotherapy

Interpersonal psychotherapy (IPT) is one of only two psychotherapies that sit alongside cognitive behaviour therapy as a *first-line* psychological treatment for depression, and that single fact is the examinable core of the topic. Developed by Gerald Klerman and Myrna Weissman in the nineteen-seventies, originally as the psychotherapy arm of an antidepressant medication trial, IPT is a *brief, time-limited, present-focused, diagnosis-focused* treatment built on one deceptively simple premise: whatever its ultimate cause, a depressive episode arises and is maintained within a **current interpersonal context**, so working on that context relieves the symptoms. Learn IPT as the counterpart to CBT: where CBT reaches for the maladaptive *thought*, IPT reaches for the troubled *relationship*.

How to use this page. Fix the model first, then the machinery. The machinery has two moving parts that examiners love to test: the **three phases** (assessment with its interpersonal inventory,

the middle work, and termination) and the **four problem areas** (grief, role disputes, role transitions and interpersonal deficits), exactly one of which is chosen as the focus of treatment. Close on the evidence, because the payoff sentence is short and hard: first-line for depression, especially perinatal, well evidenced, present-focused, does not target personality. The cardinal error the page guards against is mistaking IPT for open-ended dynamic insight therapy; it is manualised, focal and brief.

7.1 The interpersonal model

Symptoms live in relationships, so relationships are the lever. The interpersonal psychotherapy model holds that psychiatric symptoms, depression above all, arise and are maintained in the patient's *current* interpersonal relationships, and that improving the handling of those relationships lifts the symptoms (Klerman and Weissman; Kaplan and Sadock CTP 2024). IPT makes no claim that interpersonal problems *cause* depression in some ultimate sense; it takes a pragmatic, atheoretical stance, accepting that the illness is multiply determined and simply choosing the interpersonal context as the workable point of entry. Three commitments follow and must be memorised together: the therapy is *time-limited* (a standard acute course runs to about **12** to 16 sessions delivered weekly), it is resolutely *present-focused* (the here-and-now of relationships, not the reconstruction of childhood), and it explicitly *does not target personality*, restructuring neither character nor unconscious conflict. Depression is framed openly as a *medical illness*, and the patient is given the sick role, which names the condition as a treatable illness that is not the patient's fault while obliging them to work actively at recovery.

RULE **Present, relational and brief.** IPT targets the current interpersonal context of a depressive episode across roughly twelve to sixteen weekly sessions; it does not excavate the past and does not attempt to change personality.

7.2 The three phases

Assess and formulate, then work, then say goodbye. IPT runs across **3** defined phases (Kaplan and Sadock CTP 2024). The *initial phase* (roughly the first several sessions) makes the diagnosis, gives psychoeducation and the sick role, takes the interpersonal inventory described below, and ends by naming *one* of the four problem areas as the focus and agreeing an explicit treatment contract. The *intermediate* or *work phase*, the bulk of the therapy, applies the strategies specific to the chosen problem area, keeping every session anchored to the link between the patient's mood and their recent interpersonal events. The *termination phase* (usually four to five sessions in length) reviews and consolidates gains, plans for maintaining them, identifies early warning signs of relapse, and treats the ending itself as a small, real experience of loss, an analogue of grief that is named explicitly rather than glossed over.

7.3 The interpersonal inventory

A structured review of every important relationship, done up front. The interpersonal inventory is the signature assessment procedure of the initial phase: a systematic, relationship-by-relationship review of the significant people in the patient's current life, examining for each the nature of the tie, its frequency and expectations, the satisfying and unsatisfying aspects, and

the changes the patient would want (Weissman; Kaplan and Sadock CTP 2024). Its purpose is not history for its own sake but *formulation*: from the inventory the therapist locates the depressive episode within a relational pattern and derives the interpersonal formulation that pins the illness to one of the four problem areas. The inventory is where the whole subsequent therapy is decided, which is why it belongs to the opening sessions and is done before any change work begins.

7.4 The four problem areas

Every case is worked through exactly one of four templates. IPT organises all its middle-phase work under **4** interpersonal **problem areas**, first specified by Weissman and colleagues, and a defining feature of the method is that the therapist selects a *single* area (occasionally a primary plus a secondary) as the treatment focus. Knowing the four, and being able to tell a role dispute from a role transition, is the most examinable discrimination in the whole topic.

PROBLEM AREA	WHAT IT IS	FOCUS OF THE WORK
Grief (complicated bereavement)	Abnormal, delayed or distorted mourning following the death of a significant person	**Facilitate the delayed mourning, then help rebuild interests and relationships to replace what was lost**
Interpersonal role disputes	A live, non-reciprocal clash of expectations with a significant other who is present (spouse, parent, employer)	Identify the stage of the dispute and the divergent expectations, then renegotiate them or, if truly irresolvable, dissolve the relationship
Role transitions	Difficulty adjusting to a changed life role (marriage, parenthood, a new job, retirement, migration, physical illness)	Mourn the loss of the old role and its attachments, then build mastery of and a positive view of the new one
Interpersonal deficits (sensitivity)	A long history of impoverished, unfulfilling relationships and social isolation	**The residual category, chosen only when the other three do not fit; reduce isolation, using the therapeutic relationship as a model to build new ties**

The four IPT problem areas; exactly one is chosen as the focus, and interpersonal deficits is the default when none of the first three applies and carries the least favourable prognosis.

TRAP **Role dispute is not a role transition.** A *role dispute* is an ongoing conflict of expectations with a person who is still present; a *role transition* is the solo task of adjusting to a role that has itself changed. Divorce conflict is a dispute; becoming a mother is a transition.

7.5 The techniques of the work phase

Focused, affect-oriented, communication-centred. The middle phase uses a small set of named techniques, all bent to the interpersonal focus (Kaplan and Sadock CTP 2024). *Exploratory questions*, mostly open and general, open up the relational material. *Encouragement of affect* helps the patient acknowledge painful feelings, use them to guide interpersonal change, and access emotions they have suppressed. *Communication analysis*, a hallmark technique, walks slowly

through a specific recent interaction or argument to expose the ineffective communication patterns inside it and rehearse better ones. *Decision analysis* weighs the options open to the patient in a stuck situation. And the *therapeutic relationship* itself is used sparingly, chiefly for patients whose focus is **interpersonal deficits** (the therapist's bond becomes a template for relationships outside) or a role dispute (the patient learns how they come across). Throughout, the therapist keeps redirecting unfocused talk back to the tie between recent interpersonal events and the depressive symptoms.

WORKED EXAMPLE

A woman becomes depressed in the months after moving cities for her husband's job, cut off from the friendships that had always sustained her. The interpersonal inventory shows no bereavement and no live conflict, but a clear break between the onset of low mood and the relocation. Her therapist formulates the focus as a *role transition*: together they mourn the support network she left behind and, over the work phase, build concrete steps to form new local relationships. As her isolation eases, her mood lifts, without a single session spent on childhood or on restructuring cognitions.

7.6 The evidence base and the lead indication

First-line for depression, with a special strength in the perinatal period. If one sentence must be exam-ready it is this: IPT is a well-evidenced, first-line psychological treatment for major depression, established through numerous randomised controlled trials including the landmark National Institute of Mental Health collaborative study (Tasman; the guideline evidence). It is named a first-line psychotherapy for major depressive disorder by the Indian Psychiatric Society (IPS_CPG 2017, grade A), CANMAT (2016), VA/DoD (2022) and SIGN (2023). Its most distinctive niche is *perinatal depression*, both antenatal and postpartum, where it is a preferred or first-line option (CANMAT 2016; RANZCP 2020; NICE 2014; VA/DoD 2023), a strength that flows naturally from a therapy built around role transitions and role disputes, the very stuff of new parenthood. IPT is also offered in the continuation phase to reduce depressive relapse (VA/DoD 2022). The comparison of IPT with CBT in depression, and the depression rating scales used to track response, are developed in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes.

PEARL

Two sister therapies, two levers. In a depressed patient, reach for **CBT** if the maladaptive *cognitions* are foreground and **IPT** if the trigger and maintainer is a *relationship* problem, a loss, a dispute or a life transition. Both are first-line and roughly equal in efficacy for depression; the choice is often about fit and availability rather than a difference in evidence grade.

7.7 The adaptations

One method, several named offshoots. IPT's tight structure has made it easy to adapt, and three offshoots are worth naming. IPT-A, interpersonal psychotherapy for adolescents (Mufson), tailors the model to depressed teenagers, adding attention to the transition to adolescence and to relationships with parents, and is an established treatment for adolescent depression.

Interpersonal and social rhythm therapy (IPSRT), developed by Ellen Frank, marries IPT's interpersonal work to the stabilisation of daily *social rhythms* (sleep, meals and activity), on the premise that circadian and social-routine disruption precipitates mood episodes; it is a recommended adjunct to pharmacotherapy in bipolar disorder (IPS_CPG 2017, grade A; VA/DoD 2023) and adds a fifth focus, grief for the lost healthy self, to the original four. IPT has also been delivered successfully in a *group* format and in the perinatal setting. The use of IPSRT in bipolar disorder, and of IPT in unipolar depression, is cross-referenced to the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes.

INDIA

The Indian Psychiatric Society names interpersonal psychotherapy among the three strongest-evidence psychotherapies for depression in its depression clinical practice guideline (IPS_CPG 2017), placing it first-line alongside CBT and behavioural activation, and it endorses IPSRT as an adjunctive treatment in its bipolar guideline (IPS_CPG 2017). The realistic Indian caveat is the same as for CBT: guideline endorsement is firm, but trained IPT therapists are scarce, so access, not evidence, is the limiting factor.

4	3	12-16	4-5
INTERPERSONAL PROBLEM AREAS, ONE CHOSEN AS FOCUS	PHASES (ASSESSMENT, WORK, TERMINATION)	WEEKLY SESSIONS IN A STANDARD ACUTE COURSE	SESSIONS IN THE TERMINATION PHASE

MNEMONIC

GRID

The four problem areas: **G**rief, **R**ole disputes, **I**nterpersonal deficits, **D**evelopmental and life-role transitions. Hold that grief is about the *dead*, a role dispute is a conflict with the *living*, a transition is a change in the *self's role*, and deficits is the isolated *residual* category.

GOOD TO REMEMBER

- **Interpersonal psychotherapy (the therapy):** the model is that a depressive episode arises and is maintained in the patient's current interpersonal context, so a brief, present-focused, personality-sparing course of about twelve to sixteen sessions worked through one of the four problem areas (grief, role disputes, role transitions, interpersonal deficits) relieves the symptoms; the lead indication is major depression, first-line and best-evidenced in the perinatal period; the one signature technique is communication analysis anchored to the chosen problem area.

HOLD THIS

IPT (Klerman and Weissman) is a time-limited, present-focused therapy that links depression to the current interpersonal context and works through exactly one of four problem areas, grief, interpersonal role disputes, role transitions and interpersonal deficits, across three phases (assessment with the interpersonal inventory, the middle work, and a termination of four to five sessions); it is first-line for depression, strongest in the perinatal period, and its bipolar offshoot is IPSRT.

8 · Group psychotherapy

Group psychotherapy is the treatment of several patients together by one or two trained therapists who use the group itself, rather than the therapist alone, as the instrument of change. Its examinable core is not a set of techniques but a mechanism: assembled strangers who share a difficulty become, over time, a small society in which each member's characteristic ways of relating are re-enacted, seen and reworked. The single most tested content on this modality is Yalom's catalogue of therapeutic factors, the ingredients through which a group heals, and the examiner almost always wants the exact count, so anchor it now: there are exactly **11**.

How to use this page. Learn the eleven therapeutic factors as a list you can reel off, with **cohesiveness** understood as the central one; then the main types of group and how they differ in aim, structure and which factors they lean on; then the practical frame, composition, size and the five stages a group passes through; and finally who should and should not be put into a group. The cardinal error the page is built to prevent is treating a leaderless peer self-help meeting as though it were formal group psychotherapy, and the second is forgetting that the acutely psychotic or actively suicidal patient does not belong in an insight-oriented group.

8.1 The group as a social microcosm

The group, not the therapist, is the treatment. The founding idea, developed by Yalom from the interpersonal tradition, is that a therapy group becomes a *social microcosm*: given enough time and freedom, members recreate inside the room the very relational patterns that trouble them outside it (Yalom and Leszcz; Tasman ch. 95). The therapist's task is therefore to work in the here and now, drawing attention to what is happening between members as it happens, so that a maladaptive pattern can first be lived, then noticed through *process illumination*, and finally revised. This is why feedback from a peer often lands harder than the same observation from the therapist, and why a group can expose ego-syntonic blind spots that individual therapy leaves untouched. The group is a delivery format for many therapies, but as a modality in its own right its active agent is member-to-member interaction.

RULE **The therapeutic agent is the interaction between members.** In group psychotherapy the group functions as a social microcosm; change comes from here-and-now interpersonal learning, not from the therapist treating each patient in turn with an audience present.

8.2 Yalom's eleven therapeutic factors

The eleven ingredients through which a group heals. Yalom and Leszcz described the therapeutic factors as the mechanisms of change common to therapy groups; the canonical examinable set numbers eleven, and you should be able to name them and give a one-line gloss for each (Yalom and Leszcz; Kaplan and Sadock CTP 2024). Later formulations subdivide interpersonal learning into an input and an output component and add self-understanding, which is why some texts quote a higher figure, but the count to give unless asked otherwise is **11**.

THERAPEUTIC FACTOR	WHAT IT DOES IN THE GROUP
Universality	The member discovers that others share the same feelings, thoughts and problems, dissolving the sense of being uniquely afflicted or alone.
Instillation of hope	Seeing other members improve, especially those once as unwell as oneself, breeds optimism that recovery is possible.
Imparting information	Didactic instruction and advice from the therapist or fellow members, that is, psychoeducation about illness and coping.
Altruism	Members raise their own self-worth by giving to and helping others, countering the feeling of being useless or a burden.
Corrective recapitulation of the primary family group	The group re-evokes the dynamics of the early family, now available to be re-experienced and worked through in a corrective way.
Development of socialising techniques	The group is a training ground for adaptive social skills, giving feedback that refines how a member communicates and relates.
Imitative behaviour	Members learn by observing and modelling the therapist and one another, a vicarious or observational learning.
Interpersonal learning	Through honest here-and-now feedback the member gains insight into their interpersonal impact and then practises new, more adaptive ways of relating.
Group cohesiveness	**The sense of belonging, trust and togetherness; the group-level analogue of the therapeutic alliance and the precondition on which the other factors depend.**
Catharsis	The open release and expression of strong affect, about past or present experience, within a containing group.
Existential factors	Coming to accept responsibility for one's own life, and to face its ultimate contingencies, mortality, aloneness and the limits of what others can give.

Yalom's eleven therapeutic factors, with group cohesiveness marked as the central mechanism through which the rest operate.

MNEMONIC

Support, Learn, Disclose, Exist

Recall the eleven in four clusters rather than as a flat list. **Support** factors: universality, altruism, instillation of hope, cohesiveness. **Learning** factors: imparting information, imitative behaviour, development of socialising techniques, interpersonal learning. **Disclosure** factors: catharsis and corrective recapitulation of the primary family group. **Existential**: the eleventh, existential factors. Four plus four plus two plus one makes exactly eleven, and a wrong count is the commonest error on this question.

TRAP **A self-help group is not group psychotherapy.** A twelve-step or peer-support group is leaderless, run by fellow sufferers, and is not, strictly, a psychotherapy; formal group psychotherapy has a trained leader, screened members and defined therapeutic factors. They share factors such as universality and cohesiveness but are not the same thing.

8.3 Cohesiveness, the central factor

Cohesiveness is to the group what the alliance is to individual therapy. Of the eleven, cohesiveness is singled out as the central mechanism of action, therapeutic in its own right and the platform on which every other factor rests (Yalom and Leszcz). It is the sense of belonging, trust and togetherness that members feel towards the group and its leader, and it is the group's analogue of the therapeutic relationship; the more cohesive the group, the more members will self-disclose, take interpersonal risks and tolerate feedback. A common misconception is that a cohesive group is a conflict-free one. The opposite is nearer the truth: a securely cohesive group is precisely the one that can voice disagreement and hostility openly, because unexpressed conflict festers into covert hostility that erodes cohesion. Cohesiveness is best thought of as the container that makes the frightening work of the other factors safe enough to attempt.

PEARL

If asked for the single most important therapeutic factor, answer **cohesiveness**, and justify it as the group's version of the therapeutic alliance: it is both curative itself and the precondition for universality, catharsis and interpersonal learning to do their work. A cohesive group is not a quiet one; it is one safe enough to argue in.

8.4 The types of group

One format, several distinct modalities. The main types of group used in practice differ in what they aim for, how they are structured and which therapeutic factors they lean on (Kaplan and Sadock; Tasman Table 95-2). Learn them as a spectrum from the most supportive and symptom-focused to the most exploratory, plus the leaderless peer meeting and the whole-environment community at the two ends.

TYPE OF GROUP	CHIEF AIM	STRUCTURE (SIZE, TEMPO)	LEADING FACTORS	PROTOTYPE
Supportive	Improve adaptation, reduce isolation, shore up coping in the seriously ill	5-15 members, open; once to several times weekly	Cohesion, universality, reality-testing, hope	Inpatient ward group
Interpersonal / process (psychodynamic)	Personality and relational change through insight into maladaptive patterns	5-10, closed; once to twice weekly; long-term	**Interpersonal learning, self-understanding, cohesion**	Outpatient Yalom-style interactional group
Cognitive-behavioural	Symptom relief via skills learned and rehearsed for use outside the group	5-15, closed; once to twice weekly; time-limited, up to six months	Imparting information, behavioural rehearsal, hope	Group CBT for depression or anxiety
Psychoeducational	Impart knowledge and illness-management skills to patients and families	Leader-led, structured; time-limited	Imparting information, universality	Illness-education group for families in psychosis
Self-help	Mutual support, reduced shame, acceptance of a shared condition	Leaderless peers, unlimited, open; variable to daily	Universality, altruism, hope, cohesion	Alcoholics Anonymous and the twelve-step groups
Therapeutic community	The whole living and working milieu as treatment; social learning through communal life	Residential or ward as the unit; flattened hierarchy	Social learning, reality confrontation	Maxwell Jones's therapeutic community; rehabilitation settings

The main types of group, arranged from supportive through exploratory to the leaderless peer group and the whole-environment community.

The therapeutic community, also called milieu therapy, is worth holding as a distinct entity: pioneered by Maxwell Jones, it treats the entire residential environment as therapeutic, flattening the staff-patient hierarchy so that communal meetings and shared decision-making become the vehicle for social learning. The interpersonal or process group, the one most people picture as classical group therapy, is the exploratory modality that pursues genuine relational change, while group CBT, supportive and psychoeducational groups use the group chiefly as an efficient setting for a defined task.

8.5 Composition, size and the stages of group development

How a group is built, and the arc it travels. An interactional outpatient group runs to about seven or eight members, with a workable range of roughly five to ten (Yalom and Leszcz; Tasman Table 95-2); too few and interaction thins, too many and members cannot all be held in mind. It usually meets once a week for sixty to ninety minutes. Composition follows a useful rule of

thumb: groups do best when *homogeneous* for ego strength and level of functioning, so that no one is far out of their depth, but *heterogeneous* for the presenting conflicts and personality styles, so that there is friction to learn from. Groups may be *closed*, admitting no new members once begun, or *open*, replacing members as they leave; and the dropout rate is high, commonly around thirty to forty per cent in the early weeks, which is why careful selection and a pregroup preparation session matter so much.

Well-run groups pass through a recognised developmental sequence. The American Group Psychotherapy Association consolidated the historical models into a five-stage paradigm (Kaplan and Sadock CTP 2024), which maps onto Tuckman's familiar labels: *forming* (preaffiliation, the anxious search for acceptance and similarity), *storming* (power and control, testing the leader and negotiating conflict), *norming* (intimacy, deeper disclosure against a secure base of cohesion), *performing* (differentiation, mature interpersonal work with responsibility shared across members) and *adjourning* (separation, consolidating gains and mourning the ending). Attribute the count precisely: there are **5** stages, and the leader's job is to intervene in a way appropriate to the stage the group is in, since a well-meant confrontation delivered before cohesion has formed can damage a fragile member.

MNEMONIC

Forming, Storming, Norming, Performing, Adjourning

Tuckman's five, in order: the group **forms** (comes together, anxious), **storms** (conflict and control), **norms** (intimacy and trust), **performs** (mature working) and **adjourns** (separation). Same five stages the AGPA paradigm names as preaffiliation, power and control, intimacy, differentiation and separation.

8.6 Indications for group psychotherapy, and the contraindications

Who belongs in a group, and who does not. The indications for group psychotherapy follow from its mechanism. A group is well suited to problems that are fundamentally interpersonal, social withdrawal, loneliness, relationship difficulties and the character pathology that plays out with others, because these are exactly what the social microcosm brings into the room. It is powerful where universality and peer support carry weight, in the addictions, bereavement, chronic medical illness, trauma and other stigmatised or isolating conditions, and where modelling and skills practice help, as in rehabilitation of chronic mental illness. It is also economical, reaching more patients per therapist hour than individual work. A patient does well in an exploratory interactional group if they are reasonably motivated, self-reflective, psychologically minded and able to give and receive feedback; those low on these qualities are better placed in a supportive or skills-based group than excluded outright.

The contraindications are, above all, states that cannot tolerate or would disrupt the group's shared task. The acutely psychotic patient who is not yet stabilised, the actively suicidal patient for whom high group affect could destabilise, and the person preoccupied by an acute crisis are all unsuitable for an insight-oriented interactional group. So too is the patient whose first language is not the group's, and, for the exploratory group, the severely cognitively impaired. Marked

antisocial traits are a classic exclusion from a mixed group, though such patients may be treated in specialised homogeneous groups where the leader and setting are equipped for them.

COMMON TRAP

Do not place an acutely psychotic, actively suicidal or crisis-preoccupied patient into an interpretive, insight-oriented group. The intensity of affect and confrontation can worsen an unstable state; these patients need stabilisation first, and if a group at all, a structured supportive or psychoeducational one, not an exploratory interactional group.

11	5	7-8
YALOM'S THERAPEUTIC FACTORS	STAGES OF GROUP DEVELOPMENT (FORMING TO ADJOURNING)	IDEAL MEMBERS IN AN INTERACTIONAL GROUP

8.7 The evidence base, the lead indications and the Indian setting

Strong as a format, especially group CBT, more modest as a distinct modality. The examinable nuance is that group is chiefly a delivery format: the group version of an evidence-based therapy carries that disorder's evidence, so group CBT inherits CBT's standing, while the evidence for group-specific factors as a stand-alone treatment is more modest (the guideline evidence). On that basis, group CBT is first-line for gambling disorder (NICE 2025) and an option for binge-eating disorder (NICE 2017); group-based cognitive and behavioural therapy is recommended for antisocial personality disorder (NICE 2015); group cognitive stimulation therapy is recommended for mild-to-moderate dementia (NICE 2018 grade A); and group IPT or CBT is an option for perinatal depression (CANMAT 2016). The wider CBT and interpersonal-therapy evidence in depression sits in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes, and the group-based work for personality disorder connects to the Personality disorders notes.

INDIA

The Indian Psychiatric Society guidance names individual or group CBT for inhalant use disorder and group-format psychoeducation for somatic symptom disorder (IPS_CPG 2018; 2020). The therapeutic community and milieu approach is standard in Indian de-addiction and rehabilitation settings, and Alcoholics Anonymous, a self-help group, is among the most widely used community supports for alcohol dependence in India. The motivational and brief work that sits alongside these in the addictions is developed in the Substance use disorders notes.

GOOD TO REMEMBER

- **Group psychotherapy (the modality):** the model is the group as a social microcosm working through Yalom's eleven therapeutic factors, with cohesiveness the central one; the lead indication is interpersonal and relational problems, and, as an efficient format, the group version of an evidence-based therapy (group CBT is first-line for gambling disorder and an option for binge-eating disorder); the one signature technique is here-and-now process illumination and interpersonal feedback within a cohesive group.

HOLD THIS

Group psychotherapy works through Yalom's eleven therapeutic factors, cohesiveness foremost as the group's version of the therapeutic alliance, with the here-and-now group functioning as a social microcosm; interactional groups run about seven or eight members through five developmental stages (forming, storming, norming, performing, adjourning); the interpersonal or process group targets relational change while supportive, cognitive-behavioural, psychoeducational, self-help and therapeutic-community groups each lead on different factors; and the acutely psychotic, actively suicidal or crisis-bound patient is excluded from the insight-oriented group.

9 · Family therapy and couple therapy

Family therapy and **couple therapy** are the psychotherapies that change the unit of treatment: the patient is no longer the person in the chair but the web of relationships around them. Kaplan and Sadock define family therapy as a mosaic of techniques sharing one goal, the direct alteration of maladaptive family processes (Kaplan and Sadock CTP 2024). The examinable core is a single premise, that a symptom is best understood inside the system that carries it, and a small set of named schools that operationalise that premise differently. This is a favourite viva topic because it forces two clean discriminations: structural family therapy against strategic and Milan work, and a family-blaming aetiology (long discredited) against the modern, evidence-anchored idea of expressed emotion.



- Circular causality
- Feedback loop
- Boundaries
- Subsystems
- Alliance
- Reorganisation

Fig 19.6 Family-systems thinking replaces one-way blame with circular causality: symptoms participate in reciprocal feedback shaped by boundaries, subsystems and alliances, which therapy helps the family reorganise.

How to use this page. Fix the systemic premise first, then the structural vocabulary of boundaries and subsystems, then the two great systemic schools (structural and strategic and Milan), then the psychoeducational intervention and expressed emotion, which is where the strongest evidence sits. Learn the genogram and the family life cycle as the assessment tools of the field, and close on **couple therapy** and the guideline-anchored **indications**. The one sentence to carry out is that family and couple therapy is first-line for adolescent anorexia nervosa and a core relapse-reducing treatment in schizophrenia; everything else is model and technique built around those two indications.

9.1 The systemic premise: the family, not the individual, is the unit

The symptom belongs to the system, not only to the symptom-bearer. Systemic therapy rests on general systems theory (von Bertalanffy) and the cybernetics of Bateson: a family is a self-regulating system whose members are so interlocked that one cannot move without moving the others, like the interlocking gears of a clock (Kaplan and Sadock CTP 2024). Three ideas carry the premise. The identified patient is the member the family nominates as "the problem", but the

systemic clinician reads that symptom as a signal of, and a thing maintained by, the whole configuration, the classic instance being a couple's marital conflict detoured through a symptomatic child. **Homeostasis** is the system's tendency to return to its prior state through feedback loops, so that a symptom can paradoxically be doing a job, holding the family in a familiar equilibrium, which is why removing it is resisted. And causality is read as circular, not linear: A does not simply cause B; A and B cause each other in a repeating loop, so the question shifts from "who started it" to "what pattern keeps it going". Treat the pattern of relationships and the communication that sustains it, and the symptom loses its function.

Identified patient

The family member designated as "the problem"; systemically, the symptom-bearer who expresses or absorbs a dysfunction that belongs to the whole system.

Homeostasis

The family's self-correcting tendency, through feedback, to preserve a stable state; a symptom may serve to maintain this equilibrium.

Circular causality

Behaviour understood as mutually reinforcing loops rather than a one-way cause and effect; the focus is the repeating interactional pattern.

Boundaries

The implicit rules governing who takes part, and how, in a subsystem; they range from rigid (disengagement) through clear to diffuse (enmeshment).

RULE **The unit of treatment is the system.** In family and couple therapy the identified patient's symptom is read as a product of, and maintained by, the family system; you intervene in the relationships and the communication, not only in the person who carries the symptom.

The field divides into a handful of named schools, each a different pane on the same family (Kaplan and Sadock CTP 2024). The map below anchors the rest of the page.

SCHOOL	KEY FIGURES	FOCUS AND SIGNATURE TECHNIQUE
Structural	Salvador Minuchin	**Boundaries, subsystems and hierarchy; enactment and restructuring in the room**
Strategic	Jay Haley, Cloe Madanes	**The symptom's function; directives and paradoxical prescription**
Milan systemic	Mara Selvini Palazzoli	**Beliefs that hold the system; circular questioning and the therapist team**
Psychoeducational	Carol Anderson, Ian Falloon	**Illness education and lowering expressed emotion; the multifamily group**
Experiential and emotion-focused	Carl Whitaker, Virginia Satir, Susan Johnson	**Present-moment affect and attachment; sculpting and enactment of emotion**
Transgenerational	Murray Bowen	**Differentiation of self across generations; the genogram**

The main schools of family and couple therapy; the structural and strategic systemic schools carry most of the examinable weight (Kaplan and Sadock CTP 2024; Tasman).

9.2 Structural family therapy (Minuchin): boundaries, hierarchy, enactment

Redraw the family's structure in the room. Structural family therapy, developed by Salvador Minuchin and colleagues at the Philadelphia Child Guidance Center, holds that a family's problems live in its structure: the invisible organisation of subsystems, boundaries and hierarchy through which it operates (Kaplan and Sadock CTP 2024; Rutter). The family is organised into subsystems, the spousal, parental and sibling subsystems chief among them, and each is bounded. Boundaries that are too rigid produce disengagement (members are emotionally cut off); boundaries that are too diffuse produce enmeshment (members are over-involved, and autonomy is lost). Healthy families keep a clear, generation-respecting hierarchy in which the parental subsystem holds authority. The structural therapist is deliberately leader-centred and active, and works less by talking about the family than by watching and changing it live through enactment, having the family perform its typical interaction in the session so the pattern can be seen and then altered on the spot. The overall aim is restructuring: resetting the boundaries and the hierarchy so the system can function.

Enmeshment

Boundaries too diffuse; over-involvement, poor differentiation, little privacy; the classic structure described in families of adolescents with anorexia nervosa (Minuchin).

Disengagement

Boundaries too rigid; emotional distance and under-involvement, so members function as isolated units.

Enactment

The family is directed to perform its habitual interaction in the room, letting the therapist observe the live pattern and intervene to change it.

Restructuring

The active resetting of subsystem boundaries and hierarchy, through boundary-making, unbalancing and challenging the family's assumptions.

MNEMONIC

JEM-HBUC

Minuchin's structural method proceeds in **seven** steps (Nichols): **J**oining and accommodating (reduce the family's anxiety), **E**nactment (let the pattern play out), structural **M**apping (widen the lens from the identified patient to the whole family), **H**ighlighting and modifying interactions (turn the intensity up or down), **B**oundary-making (realign the subsystems), **U**nbalancing (shift a stuck dyad or triad), and **C**hallenging unproductive assumptions.

WORKED EXAMPLE

An adolescent girl is presented as the problem: she and her mother argue constantly and she is losing weight. In the room the therapist notices the mother answers every question put to the daughter, and the father sits silent and outside. The structure is enmeshed mother-daughter, disengaged father, with the marital conflict routed through the girl. The therapist uses enactment (asks the parents to discuss a decision while the daughter stays out of it), makes a boundary around the spousal subsystem, and unbalances by aligning with the father to bring him in. The symptom is left alone; the structure is changed.

GOOD TO REMEMBER

- **Structural family therapy (the therapy):** Minuchin's model reads the family's problem in its structure, the subsystems, the boundaries (rigid or disengaged versus diffuse or enmeshed) and the hierarchy; its lead indication is the child or adolescent presented as the identified patient, classically the family of an adolescent with anorexia nervosa; the one signature technique is enactment, staging the interaction in the room and restructuring the boundaries live.

9.3 Strategic and Milan systemic therapy: the symptom's function and paradox

Design a specific intervention to interrupt the symptom's role. The strategic school grew from Bateson's Palo Alto group and the Mental Research Institute, with Don Jackson, Jay Haley, Cloe Madanes, John Weakland and Paul Watzlawick, and it is rooted in communication theory (Kaplan and Sadock CTP 2024). Where the structural therapist maps the structure, the strategic therapist asks what the symptom does, treating it as a communication that serves a function in the system, then designs a specific strategy (a directive) to disrupt that function. Madanes set out several parameters to weigh before intervening, among them whether the symptom is voluntary or involuntary, who in the family holds the real power, and whether maintaining the symptom serves a purpose. The signature moves are directives and, most famously, paradoxical interventions: prescribing the symptom (asking the family to perform the very behaviour they came to lose), so that the behaviour either comes under voluntary control or reveals its function; assigning rituals or ordeals that disturb the homeostasis; and reframing a behaviour from

pathological to protective. The Milan systemic group, led by Mara Selvini Palazzoli, added a team of therapists observing behind a screen, circular questioning (asking one member to comment on the relationship between two others, so differences and patterns surface), and hypothesising, neutrality and paradox and counterparadox as its working stance.

PEARL

Hold the two systemic schools by their verbs. The **structural** therapist *restructures*, working in the here and now on boundaries and hierarchy through enactment. The **strategic** therapist *strategises*, working on the symptom's function through directives and paradox. Both are brief, active and directive; the Milan variant adds the team behind the screen and circular questioning.

GOOD TO REMEMBER

- **Strategic and Milan systemic therapy (the therapy):** the model treats the symptom as a communication with a function in the family and designs a targeted strategy to interrupt it (Haley, Madanes; the Milan group under Selvini Palazzoli); its lead use is the rigid, stuck or treatment-refractory family, including families around a life-threatening symptom; the one signature technique is the paradoxical intervention, prescribing the symptom, plus circular questioning in the Milan form.

9.4 Psychoeducational family intervention and expressed emotion

Educate the family and lower the emotional temperature to cut relapse. The psychoeducational family intervention is the best-evidenced family treatment and the mainstay for severe and disabling mental illness (Kaplan and Sadock CTP 2024). Developed by Carol Anderson and Ian Falloon and delivered by McFarlane in a multifamily format of between two and ten families, it teaches the family to see the illness as a biological condition (so as to reduce blame), to recognise early signs of relapse, to support medication and appointments, and, above all, to lower the emotional intensity in the home. Its scientific engine is **expressed emotion**, a construct measuring the amount of criticism, hostility and emotional over-involvement a relative directs at the identified patient (Kaplan and Sadock CTP 2024). Expressed emotion is assessed in research by the Camberwell Family Interview, a semistructured interview conducted with the relative alone that rates **five** dimensions, criticism, hostility, emotional over-involvement, warmth and positive remarks, of which the first three define a high-expressed-emotion household; a briefer proxy is the Five Minute Speech Sample. The examinable payoff is that high expressed emotion robustly predicts relapse, and that psychoeducational work which lowers expressed emotion reduces relapse and rehospitalisation in schizophrenia. The deep clinical use of expressed emotion in psychosis is developed in the Schizophrenia: clinical features and phenomenology notes, and its role in mood relapse in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes.

TRAP **Reading expressed emotion as blaming the family.** The double-bind and the "schizophrenogenic mother" were family-blaming aetiological theories, now discredited; expressed emotion is not an aetiology but a measure of how the family *responds* to an established illness and can buffer or worsen its course (Kaplan and Sadock CTP 2024). Do not present the family as the cause.

3	5	7
COMPONENTS OF HIGH EXPRESSED EMOTION (CRITICISM, HOSTILITY, OVER-INVOLVEMENT)	DIMENSIONS RATED BY THE CAMBERWELL FAMILY INTERVIEW	STEPS OF STRUCTURAL FAMILY THERAPY (NICHOLS)

GOOD TO REMEMBER

- **Psychoeducational family intervention (the therapy):** the model treats the illness as a biological condition and equips the family with information, relapse-recognition and lower expressed emotion (Anderson, Falloon; the multifamily group of McFarlane); its lead indication is schizophrenia and first-episode psychosis, where it is a core relapse-reducing treatment; the one signature target is high expressed emotion, whose reduction cuts relapse and rehospitalisation.

9.5 Assessing the family: the genogram, the life cycle and the McMaster model

Map three generations, place the family in its life stage, and rate its functioning. The genogram is the field's core assessment tool: a graphical map of a family's structure and relationships across three or more generations, resembling a family tree but annotated with relationship quality, illness, deaths and cut-offs (Kaplan and Sadock CTP 2024; Rutter). The technique originates in the transgenerational work of Murray Bowen and its symbols were standardised by McGoldrick and Gerson; drawn in the room, it depathologises the family's struggle by placing it in a longer story. The *family life cycle* (Carter and McGoldrick) frames normal family development as a sequence of stages, leaving home, forming a couple, raising young children, living with adolescents, launching them, and later life, each with a transition that can become a sticking point; symptoms often erupt at these junctions, and reading a presentation against the life cycle is itself an intervention. For structured measurement, the McMaster Model of Family Functioning (Epstein, Bishop and Baldwin) rates the family on six dimensions, problem-solving, communication, roles, affective responsiveness, affective involvement and behaviour control, operationalised in the self-report Family Assessment Device. Together these are the assessment layer that any structural, strategic or psychoeducational treatment is built upon.

GOOD TO REMEMBER

- **The genogram and family assessment (the principle):** the genogram is an assessment and mapping tool, not a therapy, a diagram of three or more generations that surfaces patterns, illness and cut-offs (Bowen; McGoldrick and Gerson); the one discriminator is that the family life cycle reads symptoms against normal developmental transitions, and the one exam fact is the McMaster model's six dimensions of family functioning measured by the Family Assessment Device.

9.6 Couple therapy: behavioural and emotion-focused

Two well-evidenced routes to the same distressed dyad. **Couple therapy** targets the interactional patterns that block intimacy and generate conflict, and two models dominate the examinable ground (Kaplan and Sadock CTP 2024; Tasman). Behavioural couple therapy, developed by Jacobson, treats distress as learned, poorly-rewarding interaction and rebuilds it through behaviour exchange (deliberately increasing pleasing exchanges) and through communication and problem-solving skills training; its later refinement, integrative behavioural couple therapy (Christensen and Jacobson), adds emotional acceptance where change is not possible and matches the outcomes of the purely behavioural form. Emotion-focused couple therapy, developed by Susan Johnson, is an experiential and attachment-based model: it reads the couple's fights as protests against a threatened attachment bond, de-escalates the negative cycle, and restructures the interaction so partners can voice underlying attachment needs and respond to them, forging a more secure bond. Behavioural couple therapy is the option to name for alcohol use disorder (the sober partner supports abstinence and the dyad rebuilds trust), where it is a guideline-endorsed treatment, and couple therapy is offered for depression when relationship distress is driving or maintaining the disorder; the motivational-interviewing style that accompanies couple work in the addictions is developed in the Substance use disorders notes.

FEATURE	BEHAVIOURAL COUPLE THERAPY	EMOTION-FOCUSED COUPLE THERAPY
Originator	Jacobson (integrative form, Christensen and Jacobson)	**Susan Johnson**
Model of distress	Learned, poorly-rewarding interaction	**A threatened attachment bond**
Core technique	Behaviour exchange; communication and problem-solving training	**De-escalate the negative cycle; restructure to voice attachment needs**
Named indication	Alcohol use disorder; depression with relationship distress	**Relationship distress and insecure attachment**

The two dominant couple therapies; behavioural (skills-based) and emotion-focused (attachment-based) (Kaplan and Sadock CTP 2024; Tasman; the guideline evidence).

GOOD TO REMEMBER

- **Couple therapy (the therapy):** two evidence-based models, behavioural couple therapy (Jacobson: behaviour exchange plus communication and problem-solving training) and emotion-focused couple therapy (Johnson: attachment-based de-escalation of the negative cycle); the lead named indication is behavioural couple therapy for alcohol use disorder, with couple therapy also offered for depression complicated by relationship distress; the one technique to name is communication and problem-solving skills training.

9.7 Indications and the evidence base

Two strong indications, several good adjunctive ones. The confirmed **indications** for family and couple therapy cluster around two well-evidenced roles and a set of adjunctive ones (the

guideline evidence). Anorexia-nervosa-focused family therapy (family-based treatment) is first-line for children and young people with anorexia nervosa (NICE 2017, grade A; RANZCP 2014). Family intervention is a core, relapse-reducing treatment in schizophrenia and first-episode psychosis (NICE 2009 and 2014; IPS_CPG 2017; MOH_SG 2011; RANZCP 2016). Family-focused therapy is a recommended adjunct in bipolar disorder (IPS_CPG 2017 grade A; VA_DOD 2023), and family-based therapy for bulimia is offered to young people (NICE 2017). On the couple side, behavioural couples therapy is an option for alcohol use disorder (VA_DOD 2021; WHO mhGAP 2012) and couples-focused therapy is offered for depression with relationship distress (VA_DOD 2022). Generic systemic indications, from the schools above, include the child or adolescent presented as the identified patient, families in crisis at a life-cycle transition, and problems that span the generations.

PRESENTATION	MODALITY	EVIDENCE AND STATUS
Adolescent anorexia nervosa	Family-based treatment (FT-AN)	**First-line for children and young people (NICE 2017, grade A)**
Schizophrenia, first-episode psychosis	Family intervention, psychoeducational	**Core relapse-reducing treatment (NICE 2009 and 2014; IPS_CPG 2017)**
Bipolar disorder	Family-focused therapy	**Recommended adjunct (IPS_CPG 2017 grade A; VA_DOD 2023)**
Bulimia nervosa (young people)	Family-based therapy (FT-BN)	**Offered to young people (NICE 2017)**
Alcohol use disorder	Behavioural couples therapy	**An option (VA_DOD 2021; WHO mhGAP 2012)**
Depression with relationship distress	Couple therapy	**Offered where the relationship drives the disorder (VA_DOD 2022)**

The guideline-anchored indications for family and couple therapy; adolescent anorexia and schizophrenia relapse prevention are the two strongest (the guideline evidence).

INDIA

The collectivist, co-resident Indian family makes family involvement the natural default rather than an add-on. The Indian Psychiatric Society operationalises this: its alcohol-use guideline endorses family-based treatment that uses a co-resident relative as recovery monitor and supervisor of disulfiram (IPS_CPG 2014, grade B), a culturally specific adaptation to Indian family structures, and the IPS psychotherapy guideline (Agarwal, Nischal, Praharaj, Menon, Kar; Indian J Psychiatry 2020) treats family and psychoeducational work as core psychosocial care. The NIMHANS tradition of family-focused management of severe mental illness sits in the same space. State both the guideline endorsement and the cultural fit; an examiner asking about family therapy in India is usually testing the disulfiram-supervision adaptation.

GOOD TO REMEMBER

- **Family and couple therapy (the indications):** the two strongest confirmed roles are family-based treatment for adolescent anorexia nervosa (first-line, NICE 2017 grade A) and family intervention for schizophrenia and first-episode psychosis (core, relapse-reducing); family-focused therapy is an adjunct in bipolar disorder, and behavioural couples therapy an option for alcohol use disorder; the systemic indication is any case where the identified patient's symptom is embedded in the family or couple system.

HOLD THIS

Family and couple therapy treats the SYSTEM, not the individual: the identified patient's symptom is read within the family's homeostasis and circular causality. Minuchin's structural family therapy restructures boundaries, subsystems and hierarchy through enactment; strategic and Milan work (Haley, Madanes, Selvini Palazzoli) targets the symptom's function through directives, paradox and circular questioning; the psychoeducational intervention lowers expressed emotion (criticism, hostility and emotional over-involvement, rated by the Camberwell Family Interview) to cut relapse in schizophrenia; the genogram maps three or more generations; and couple therapy is behavioural (Jacobson) or emotion-focused (Johnson). The two strongest indications are family-based treatment for adolescent anorexia nervosa (first-line, NICE 2017 grade A) and family intervention for schizophrenia relapse prevention.

10 · Brief and crisis-focused psychotherapies

Grouped here are the deliberately short, sharply focused interventions: the **brief and time-limited psychotherapies**, the **crisis intervention** that Gerald Caplan built on Erich Lindemann's grief work, and problem-solving therapy. They matter for the examination out of proportion to their length, because they carry a handful of hard, quotable facts, an eponym or two, and one principle that examiners return to again and again: a *crisis-focused* therapy aims to restore the person to the level they were functioning at before the crisis, not to remake the personality. Learn the family by its shared skeleton first, then hang the named models on it.

How to use this page. The three moving parts are, in order, the shared architecture that makes any therapy *brief* (a single agreed focus, a fixed session limit, an active therapist, careful selection); the named brief dynamic and brief cognitive forms; and crisis intervention with its underlying crisis theory. Keep the discriminator sharp throughout: brief dynamic therapy still reaches, cautiously, for insight, whereas crisis intervention stays resolutely on the surface and on the present emergency.

10.1 The shared architecture of brief therapy

Short is not simply "less of" long. Every brief psychotherapy is defined by four shared commitments rather than by session count alone (Wolberg; Companion to Psychiatric Studies). There is a single *circumscribed focus* agreed by patient and therapist, with deliberate **selective inattention** to peripheral material however tempting; a *time limit*, usually set in advance, with most models running between about twelve and twenty-six sessions; an *active, engaged therapist* who keeps the work on the focus rather than waiting on free association; and *careful patient selection*, since these methods suit the psychologically minded, motivated patient with good ego strength and a focal, not diffuse, problem. Wolberg groups the short therapies into 3 kinds, worth

holding as a spine: *crisis intervention*, *supportive-educational* short-term therapy, and *dynamic* short-term therapy, ascending roughly from surface stabilisation toward the beginnings of personality change. The governing maxim of the supportive-educational band is Wolberg's own: get in fast and get out fast.

RULE **Focus, limit, activity, selection.** A therapy is *brief* because it has one agreed focus, a session limit fixed in advance, an active therapist, and a well-chosen patient, not merely because it has few sessions.

10.2 Brief dynamic and brief cognitive forms

A small pantheon of named focal therapies, plus a cognitive wing. The *dynamic* short-term therapies keep the concepts of psychoanalysis (unconscious conflict, transference, defence, interpretation) but cap the breadth and depth of the work around one focus, with no expectation of a regressive transference neurosis (Companion). The focal therapy tradition begins with Michael Balint's focal psychotherapy and matures in four classic models that are the examinable core of this section. In parallel, the *cognitive* wing simply delivers the standard method in a shortened, present-focused frame: brief CBT and structured counselling over roughly six to eight sessions are established short-term options for mild-to-moderate depression (Companion). The comparison of full-length CBT with interpersonal therapy in depression is developed in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes.

MODEL (ORIGINATOR)	DEFINING FEATURE	SIGNATURE TECHNIQUE OR FRAME
Focal psychotherapy (Balint)	The founding brief-dynamic idea: keep aims limited and work to a single agreed focus	Selective attention to one focal conflict; applied psychoanalysis, made brief by design
Brief / focal therapy (Malan, Tavistock)	Interprets a focal conflict through two triangles	**The 2 triangles: the triangle of conflict (impulse, anxiety, defence) and the triangle of person (transference, current other, past parent)**
Time-limited psychotherapy (Mann)	A fixed, non-negotiable ceiling of **12** sessions with the final date set at the outset	A single "central issue" tied to separation; mastering the ending models mastery of other anxieties
Short-term anxiety-provoking psychotherapy (Sifneos)	Actively raises anxiety to press an oedipal-level focus in high-functioning patients	Anxiety-provoking confrontation and clarification; tight selection criteria
Intensive short-term dynamic psychotherapy (Davanloo)	Relentless, early challenge to defences and resistance	The "trial therapy" as both assessment and treatment; rapid unlocking of the unconscious

The brief dynamic models; Malan's two triangles and Mann's fixed twelve-session frame are the most quotable single facts, and the accompanying figure lays out Malan's two triangles.

Mann's model adds a second quotable list: **4** basic universal conflicts that surface around separation and loss, namely independence versus dependence, activity versus passivity, adequate

versus lost self-esteem, and unresolved grief. Selection is the practical gatekeeper across all of these: a circumscribed focal complaint, psychological mindedness, motivation to change rather than merely to relieve symptoms, and the capacity to form a rapid working alliance.

GOOD TO REMEMBER

- **Brief and time-limited psychotherapy (the therapy):** the model is a psychoanalytically informed but strictly bounded treatment worked to a single focus with a session limit set in advance; the lead indication is a well-selected, psychologically minded patient with a circumscribed focal or neurotic conflict (short-term psychodynamic psychotherapy is also a reasonable option for depression); the one frame to quote is Mann's fixed twelve-session ceiling, or Malan's interpretation through the two triangles.

10.3 Crisis intervention and crisis theory

Restore the pre-crisis equilibrium, nothing grander. A **crisis** is a self-limiting period of psychological disequilibrium set off when a hazardous event, a loss or a threat, overwhelms the person's habitual coping and problem-solving (Caplan; Lindemann's study of acute grief after the Coconut Grove fire). Crises are *time-limited* by nature, usually running their course within about six weeks, and Caplan described them unfolding across **4** phases: an initial rise in tension as usual coping is challenged; mounting tension and disorganisation as those methods fail; mobilisation of internal and external resources with novel, emergency problem-solving; and, if still unresolved, a breaking point with major disorganisation. Caplan also split crises into *developmental* (maturational, such as adolescence or retirement) and *situational* (accidental, such as bereavement or disaster). The goal of crisis intervention follows directly and is the single most examinable line here: to restore the person to the pre-crisis level of functioning, at minimum, occasionally leaving them stronger, but never aiming at personality reconstruction (Wolberg). The stance is active, present-focused and time-limited, typically one to six sessions over the first several weeks, with the therapist mobilising social support, involving family, tackling the concrete precipitant, and, where suicidality is present, building a collaborative safety plan. Because the goals are limited, the method drifts deliberately away from insight work toward practical, behavioural and problem-solving techniques.

TRAP **Crisis intervention is not brief dynamic therapy.** Chasing insight or the unconscious in an acute crisis is the classic error; the goal is restoration of the pre-crisis equilibrium through active problem-solving and support, not interpretation.

WORKED EXAMPLE

A young woman presents in acute distress the week after a sudden broken engagement, tearful, not eating, not sleeping, with fleeting thoughts that life is not worth living but no plan. The crisis-focused response is not to explore her childhood attachments. Over a handful of sessions the therapist names the precipitant, restores sleep and appetite with practical measures, mobilises a sister and two friends as an active support network, agrees a simple safety plan, and helps her rehearse the next concrete steps. Within a few weeks she is back to her baseline; the deeper work, if she wants it, is a separate referral. The suicide risk assessment and the safety-planning tools used here are developed in the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

INDIA

The Indian Psychiatric Society anchors the screening-and-brief-intervention (SBIRT) framework at every psychiatric and primary-care contact and endorses brief, motivation-based psychosocial interventions for alcohol use (IPS_CPG 2014; 2018), a natural fit for busy, under-resourced services; the motivational-interviewing side of this is developed in the Substance use disorders notes. The IPS also recommends brief crisis intervention with a collaboratively agreed crisis plan in borderline personality disorder to reduce hospitalisation (IPS_CPG 2023; NICE 2009), covered further in the Personality disorders notes.

GOOD TO REMEMBER

- **Crisis intervention (the therapy):** the model is Caplan's, a self-limiting crisis (about six weeks, four phases) in which coping is overwhelmed; the lead indication is any acute psychosocial or suicidal crisis, disaster or bereavement; the one technique is active, time-limited problem-solving plus mobilising support, with the fixed goal of restoring the pre-crisis level of functioning.

10.4 Problem-solving therapy

Teach the process, not the answer. Problem-solving therapy (PST), developed by D'Zurilla and Nezu, rests on the idea that stress plus poor coping breaks down a person's problem-solving ability and so feeds depression; the remedy is to train a structured, transferable problem-solving process (Geriatric Psychiatry Study Guide). Its staged sequence runs from a constructive *problem orientation* through *defining and formulating* the problem, *generating alternatives* (brainstorming without early judgement), *decision-making* that weighs the options, and finally *implementing and verifying* the chosen solution in real life. It is brief, structured and highly teachable, which is exactly why guidelines reach for it in hard-pressed settings: structured problem-solving therapy is offered for self-harm (NICE 2022; WHO_mhGAP 2015) and is one recognised psychotherapy option for major depression, with its best evidence in older adults and primary care (VA/DoD 2022).

MNEMONIC

ORIENT, DEFINE, GENERATE, DECIDE, DO

The problem-solving sequence: a constructive **orient**ation to problems, **defin**ing the problem, **generat**ing options, **decid**ing between them, then **do**ing and verifying. The first step, orientation, is the one novices skip and the one that most separates PST from mere advice-giving.

GOOD TO REMEMBER

- **Problem-solving therapy (the therapy):** the model is that depression follows a breakdown in coping with life problems; the lead indication is self-harm and depression, especially in older adults and primary care; the one technique is training the staged problem-solving sequence, orientation, definition, generating options, deciding, and implementing.

12	4	6
SESSIONS, THE FIXED CEILING OF MANN'S TIME-LIMITED PSYCHOTHERAPY	PHASES OF A CRISIS IN CAPLAN'S MODEL	WEEKS, THE USUAL SELF-LIMITING COURSE OF A CRISIS

PEARL

Three overlapping "briefs", one discriminator. All three families are short and focal, but the *aim* separates them: brief dynamic therapy still reaches for a measure of insight into a focal conflict; crisis intervention reaches only for restored pre-crisis functioning; problem-solving therapy reaches for a durable coping skill. When a stem describes an acute emergency and asks for the goal, the answer is restoration of the pre-crisis level, not insight.

HOLD THIS

Crisis intervention (Caplan, building on Lindemann) treats a self-limiting crisis, about six weeks across four phases, with an active, time-limited, problem-solving stance whose single goal is to restore the pre-crisis level of functioning while mobilising the patient's support, and it never aims at personality change.

11 · Relaxation training and biofeedback

Relaxation training and **biofeedback** are the physiological end of the psychotherapies: rather than working on thoughts, relationships or the unconscious, they teach the patient to turn down the body itself, on the premise that a relaxed body cannot easily sustain an anxious mind. They are niche in the examiner's mind but not obscure, because two of them carry firm guideline indications, applied relaxation is a first-choice treatment for generalised anxiety disorder, and relaxation and biofeedback are named first-line for somatoform pain, so a single mis-stated indication is the easiest way to lose a mark here.

How to use this page. Learn the family as one shared principle expressed four ways (Jacobson's muscular route, autogenic self-suggestion, breathing, and applied relaxation as the portable coping form), then learn **biofeedback** as the instrumented cousin that adds one thing the others

lack, a real-time signal of a normally-unconscious body function. Fix which channel treats which disorder, and close on the two indications examiners actually test.

11.1 The relaxation-response model

A relaxed body is incompatible with anxiety, so lower the body to quiet the mind. Every technique on this page rests on one idea: the peripheral physiology of anxiety, raised muscle tension, rapid shallow breathing and sympathetic arousal, can be deliberately down-regulated, and a state of low physiological arousal is reciprocally incompatible with the state of anxiety (the same reciprocal-inhibition rationale that lets relaxation serve as the counter-conditioning partner to graded exposure in systematic desensitisation). Relaxation training is therefore both a stand-alone anxiety-management skill and a building block inside behaviour therapy. The techniques differ only in the door they use into the same relaxed state: skeletal muscle (Jacobson), autonomic self-suggestion (autogenic training), the respiratory cycle (diaphragmatic breathing), or an external instrument (biofeedback).

RULE **Down-regulate the body first.** Relaxation-based methods treat anxiety by damping muscular and autonomic arousal, a physiological state incompatible with anxiety; the portable, real-situation form is applied relaxation, and it is the one with a first-line indication.

11.2 The relaxation family: JPMR, applied relaxation, autogenic training and breathing

One relaxed state, four routes in. The reference technique is Jacobson progressive muscular relaxation, JPMR, described by the American physiologist Edmund Jacobson. Its signature move is the systematic *tense-and-release* of successive muscle groups: the patient deliberately tenses a group (hands, forearms, face, neck, shoulders, chest, abdomen, then the legs), holds the tension, then releases it, learning to discriminate the felt difference between a tense and a relaxed muscle and to reproduce the released state at will. It is often abbreviated progressive muscle relaxation and taught as a daily home practice. Applied relaxation, developed by the Swedish psychologist Lars-Goran Ost, takes that trained skill and makes it usable in the moment: the patient is progressively shaped from full progressive relaxation, through release-only and cue-controlled relaxation, to a rapid, portable version that can be deployed within seconds inside a real anxiety-provoking situation, which is why it, and not lying-down JPMR, is the form with the strongest anxiety-disorder evidence. Autogenic training (the German psychiatrist Johannes Schultz) reaches the same state by silent autonomic self-suggestion, the patient repeating standard formulae to induce sensations of *heaviness* (muscular relaxation) and *warmth* (peripheral vasodilation) in the limbs, plus a calm heartbeat, easy breathing, abdominal warmth and a cool forehead. Diaphragmatic breathing corrects the rapid shallow thoracic overbreathing of anxiety with slow abdominal breaths, reversing the hypocapnia that drives the somatic symptoms of the hyperventilation syndrome.

TECHNIQUE	ROUTE IN / SIGNATURE MOVE	LEAD USE
JPMR (Jacobson)	Sequential tense-then-release of muscle groups, learning to feel tension leave	General anxiety and tension; the relaxation partner in systematic desensitisation
Applied relaxation (Ost)	Shaping to a rapid, cue-controlled skill deployed in the real situation	**Generalised anxiety disorder, a first-choice high-intensity psychological intervention**
Autogenic training (Schultz)	Silent self-suggestion of heaviness and warmth across the six standard exercises	Stress-related and psychophysiological disorders
Diaphragmatic breathing	Slow abdominal breathing that reverses the hypocapnia of overbreathing	**Hyperventilation and panic; somatoform presentations**

The relaxation family; applied relaxation is the portable, in-situation form and the only member with a first-line anxiety-disorder indication.

PEARL

The examiner's discriminator inside the family is **applied relaxation versus JPMR**. JPMR is the foundational drill, tense-and-release done in a quiet room; *applied relaxation* is what you build on top of it, a rapid coping skill the patient uses *while* anxious in real life. When a stem says "first-line psychological treatment for generalised anxiety disorder that is not CBT", the answer is applied relaxation, not plain progressive muscle relaxation.

11.3 Biofeedback: the principle and the channels

Show the patient a hidden body signal, and they learn to control it. Biofeedback attaches an electronic instrument to a physiological parameter the person is normally unaware of, then feeds that parameter back in real time as a sound or a moving display; watching the signal, the patient gradually learns to shift it in the wanted direction, and with practice can reproduce the control without the machine. It is, in effect, operant learning of an autonomic or muscular function, and the feedback signal is its active, defining ingredient. The channels are worth knowing by which body function they read and which disorder they treat.

CHANNEL	SIGNAL FED BACK	TYPICAL INDICATION
EMG (electromyographic)	Muscle tension (microvolts from a muscle group)	**Tension-type headache, muscle-contraction pain, rehabilitation**
Thermal	Peripheral skin temperature (a proxy for blood flow)	**Migraine and Raynaud's phenomenon (learning to warm the hands)**
EEG (neurofeedback)	Cortical rhythms	Epilepsy (sensorimotor rhythm) and attention-deficit disorder
Electrodermal / HRV	Skin conductance, or heart-rate variability	Anxiety, hypertension and general stress arousal

The four common biofeedback channels; the two highest-yield pairings are EMG with tension headache and thermal with migraine.

WORKED EXAMPLE

A patient with frequent tension-type headache is set up with an **EMG** sensor over the frontalis and neck muscles; the instrument turns the muscle tension into a tone that rises with tightening. Over successive weekly sessions she learns to drop the tone by consciously loosening those muscles, first with the machine and then without it, and her headache frequency falls. The instrument taught nothing the muscle could not do on its own; it simply made an invisible signal visible long enough to be brought under voluntary control.

TRAP **Biofeedback is not just relaxation with wires.** Its defining, active element is the instrument feeding a normally-unconscious signal back in real time so the patient learns voluntary control of *that specific parameter*; ordinary relaxation training reaches a low-arousal state with no instrument at all. And JPMR is tense-*then*-release, not relax-only.

11.4 Evidence base and lead indications

Modest and mostly adjunctive, with two firm first-line roles. Across disorders the relaxation methods are best read as effective components or adjuncts rather than powerful stand-alone cures, and controlled evidence for biofeedback being superior to simple relaxation is thin. But two indications are exam-solid. First, applied relaxation is one of two equivalent first-choice high-intensity psychological interventions for generalised anxiety disorder (alongside CBT) in the NICE guidance, delivered over roughly twelve to fifteen weekly sessions. Second, relaxation therapy and biofeedback are named first-line for somatoform (medically unexplained) pain in somatic symptom disorder, with progressive muscular relaxation and diaphragmatic breathing first-line for somatoform presentations generally. Relaxation is also offered for anxiety in intellectual disability, and biofeedback has established uses in tension headache, migraine and Raynaud's; the honest caveat is that guideline bodies have found insufficient evidence to recommend for or against adding biofeedback in major depression. Applied relaxation as an anxiety treatment sits beside the exposure methods developed in the Anxiety, OCD and trauma-related disorders notes, and its somatoform role beside the fuller account in the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

INDIA

The Indian Psychiatric Society somatic-symptom guidance (IPS_CPG 2020) places *progressive muscular relaxation, diaphragmatic breathing and biofeedback* as first-line for somatoform and somatoform-pain presentations, the disorders in which relaxation methods matter most in Indian practice, where somatic idioms of distress are common. This dovetails with the strong indigenous tradition of yoga and breath-regulation practices and the NIMHANS behavioural-medicine tradition, so relaxation-based work is often the culturally most acceptable first psychological step.

2
FIRST-CHOICE HIGH-INTENSITY PSYCHOLOGICAL INTERVENTIONS FOR GAD (APPLIED RELAXATION, WITH CBT)

6
STANDARD AUTOGENIC-TRAINING EXERCISES (HEAVINESS, WARMTH AND THE REST)

MNEMONIC

MET

The three biofeedback pairings to hold: **M**uscle tension → EMG → tension headache; **E**EG → neurofeedback → epilepsy and ADHD; **T**emperature (thermal) → migraine and Raynaud's. If it is a headache, ask muscle (EMG) versus vascular (thermal).

GOOD TO REMEMBER

- **Jacobson progressive muscular relaxation (JPMR):** model is that a relaxed muscle is incompatible with anxiety; lead use is general anxiety and tension and as the relaxation half of systematic desensitisation; the one technique is sequential tense-and-release of muscle groups.
- **Applied relaxation (Ost):** model is a portable coping skill built from progressive muscle relaxation; lead indication is generalised anxiety disorder (a first-choice high-intensity psychological intervention); the one technique is rapid, cue-controlled relaxation deployed in the real anxious moment.
- **Autogenic training (Schultz):** model is autonomic self-regulation by silent self-suggestion; lead indication is stress-related and psychophysiological disorders; the one technique is inducing heaviness and warmth in the limbs.
- **Biofeedback:** model is operant learning of an unconscious body signal made visible by an instrument; lead indications are tension headache (EMG), migraine and Raynaud's (thermal) and somatoform pain; the one technique is real-time feedback of a physiological parameter to gain voluntary control.

HOLD THIS

Relaxation training lowers physiological arousal to a state incompatible with anxiety, and its portable form, applied relaxation (Ost), is a first-choice psychological treatment for generalised anxiety disorder; biofeedback adds a real-time instrument signal so the patient learns voluntary control of a hidden body function, its two signature pairings being EMG for tension headache and thermal for migraine, and relaxation and biofeedback are first-line for somatoform pain in the Indian somatic-symptom guidance.

12 · The third-wave therapies

The **third-wave therapies** are the acceptance-and-mindfulness generation of behaviour therapy: a family of treatments that, instead of arguing a patient out of a distressing thought, teach a new *relationship* to that thought, one of awareness, acceptance and willingness rather than dispute. Where classical cognitive behaviour therapy asks "is this thought true, and can we make it more accurate?", the third wave asks "must this thought be obeyed at all, and can you hold it lightly while you act on what matters?". Three members carry the examinable weight and are widely practised in real clinics, dialectical behaviour therapy (DBT), acceptance and commitment therapy (ACT) and mindfulness-based cognitive therapy (MBCT); each is built on mindfulness, and each has a distinct lead indication that the examiner will expect you to name without hesitation.

How to use this page. Learn DBT in depth first, because it is the most examined and the most clinically important of the three, its biosocial theory, its four modes and its four skills modules,

then its lead indication in borderline personality disorder. Then take ACT through its one idea (psychological flexibility) and its six processes, and MBCT through its one job (preventing depressive relapse). Close on the evidence, kept honest against the guideline evidence, because the trap the whole page is built to prevent is over-claiming: DBT is not ordinary CBT, and ACT and MBCT are not first-line for everything just because they are fashionable.

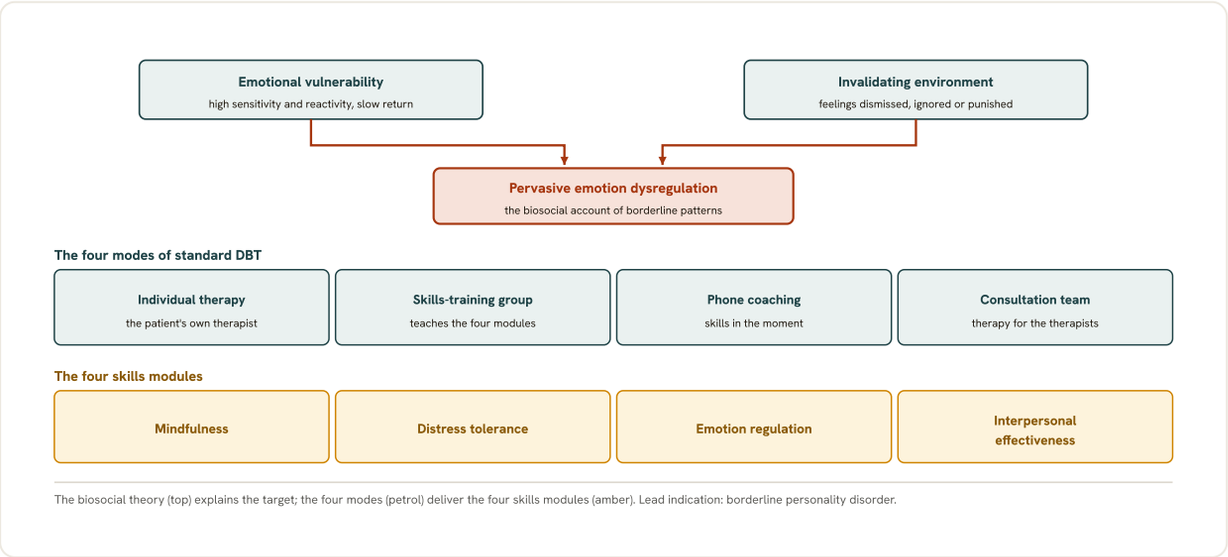


Fig 19.7 Dialectical behaviour therapy: the biosocial theory, the four modes and the four skills modules. Linehan's biosocial theory holds that a constitutional emotional vulnerability meeting a persistently invalidating environment produces the pervasive emotion dysregulation that underlies borderline patterns. Standard DBT treats this through four coordinated modes: individual therapy, a skills-training group, between-session telephone coaching to apply skills in the moment, and a therapist consultation team that keeps the therapists effective. The skills group teaches four modules: mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. Its strongest evidence and lead indication is borderline personality disorder, taught in full in the Personality disorders notes.

12.1 Three waves of behaviour therapy

First change the behaviour, then the thought, then your relationship to the thought.

Behaviour therapy has moved through three eras, and naming them is the cleanest way to place the third wave (Kaplan and Sadock CTP 2024). The *first wave*, from the mid-nineteen-fifties, was pure learning theory: classical and operant conditioning, the work of Skinner, Wolpe and Eysenck, targeting observable behaviour alone. The *second wave*, from the nineteen-seventies, added cognition, giving Beck's cognitive therapy and Ellis's rational emotive therapy and, in time, the integrated cognitive behaviour therapy that is still the dominant system worldwide; its lever is the *content* of thought. The **third-wave therapies** emerged partly from Jacobson's finding that behavioural activation alone matched full CBT in depression, and they are marked by themes new to behaviour therapy, metacognition, acceptance, mindfulness, dialectics and values. Their shared move is contextual, not content-focused: they change how a person relates to inner experience rather than trying to rewrite the experience itself.

RULE **Acceptance, not disputation, is the defining move.** The third wave changes the patient's *relationship* to thoughts and feelings (awareness, acceptance, willingness), whereas second-wave CBT changes their *content* and accuracy. That single distinction separates DBT, ACT and MBCT from classical CBT.

12.2 Dialectical behaviour therapy: Linehan and the biosocial theory

An emotionally vulnerable temperament meeting a chronically invalidating environment. **Dialectical behaviour therapy** was developed by Marsha Linehan for chronically suicidal and self-harming women, most of whom met criteria for borderline personality disorder, and it synthesises change-oriented behaviourism with acceptance drawn from Zen (Oxford Handbook of DBT). Its aetiological engine is the biosocial theory: a biological *emotional vulnerability*, meaning heightened sensitivity to emotional stimuli, greater reactivity and a slow return to baseline, transacts over years with a pervasively invalidating environment, one that dismisses, punishes or erratically reinforces the child's private emotional experience. The two sides feed each other, the environment amplifying the biology and the intense emotion provoking further invalidation, until the result is pervasive *emotion dysregulation*, which DBT treats as the core problem from which the self-harm, impulsivity and interpersonal chaos of borderline personality disorder all follow. The word "dialectical" names the central tension the therapy holds, radical acceptance of the patient exactly as they are, balanced against a relentless push for change. The accompanying figure sets out this biosocial transaction, vulnerability and invalidation looping into emotion dysregulation.

TRAP **Calling DBT "just CBT for borderline".** DBT adds three things CBT lacks: an explicit dialectic of acceptance and change, mindfulness and acceptance as core skills, and a multi-modal team-delivered structure. Its target is pervasive emotion dysregulation, not a single disorder-specific cognition.

12.3 The four modes of standard DBT

Four modes, each doing a different job. Standard, comprehensive DBT is not one appointment but a programme of exactly **4** modes, and this count is a favourite viva discrimination (Oxford Handbook of DBT). Linehan built each mode to deliver a distinct *function*, so that a patient's motivation, skill, real-world carry-over and the therapist's own resilience are all covered at once. The modes are best learned against those functions, as the accompanying figure lays them out.

MODE OF STANDARD DBT	WHAT HAPPENS IN IT	FUNCTION IT DELIVERS
Individual therapy (weekly)	Targets the treatment-hierarchy behaviours (life-threatening first, then therapy-interfering, then quality-of-life-interfering) using behavioural and solution analysis	**Enhances motivation to change**
Skills-training group (weekly)	Teaches the skills curriculum in a class-like format, run twice across roughly six months	**Enhances capabilities**
Telephone and between-session coaching	Brief out-of-hours contact to coach skills in the moment of crisis, under a twenty-four-hour rule	**Generalises skills to daily life**
Therapist consultation team	"Therapy for the therapists"; the team supports fidelity and manages the emotional demands of the work	**Enhances therapist capability and motivation**

The four modes of standard DBT and the function each is designed to deliver.

PEARL

Hold the modes by their jobs: the patient gets **motivated** in individual therapy, gets **skilled** in the group, gets those skills to **generalise** through phone coaching, and the therapist gets **supported** by the consultation team. Miss any one mode and it is no longer standard DBT, only a fragment of it.

12.4 The four skills modules

Two acceptance skills, two change skills. The skills-training group teaches **4** modules, and their pairing mirrors the dialectic of the whole therapy, two rooted in acceptance and two in change (Oxford Handbook of DBT).

Mindfulness (core mindfulness)

The foundational module, taught first and revisited between the others; non-judgemental, present-moment awareness, observing and describing experience without acting on it. An acceptance skill, and DBT was the first psychotherapy to use **mindfulness** as an explicit skill set.

Distress tolerance

Getting through a crisis without making it worse, through skills for surviving unbearable moments and for radical acceptance of what cannot presently be changed. An acceptance skill.

Emotion regulation

Identifying, understanding and reducing the intensity of unwanted emotions, and building positive experiences so vulnerability to negative mood falls. A change skill.

Interpersonal effectiveness

Asking for what one needs and saying no while keeping the relationship and one's self-respect intact. A change skill.

MNEMONIC

Mindful Dragons Eat Idlis

Mindfulness, **D**istress tolerance, **E**motion regulation, **I**nterpersonal effectiveness. The first two are the acceptance pair (be with the feeling), the last two are the change pair (do something about it), which is the acceptance-and-change dialectic in miniature.

12.5 DBT: the evidence base and the lead indication

The first-choice structured therapy for borderline personality disorder. DBT has the strongest **evidence base** of any psychotherapy for borderline personality disorder, and its signal effect is the reduction of self-harm and suicidal behaviour and of emotion dysregulation (the guideline evidence). It is the recommended psychotherapy in the early stages of borderline personality disorder (IPS_CPG 2023) and the comprehensive programme of choice where reducing recurrent self-harm is the priority (NICE 2009); RANZCP lists it among the therapies that reduce self-harm repetition (RANZCP 2016). The adolescent adaptation, DBT-A, which keeps the same modes and adds family involvement, is offered to young people with significant emotion dysregulation and frequent self-harm (NICE 2022; RANZCP 2016). The fuller treatment of borderline personality disorder, and the place of schema therapy alongside DBT, belongs in the Personality disorders notes; here, learn DBT as the exemplar third-wave therapy and BPD as its lead indication.

GOOD TO REMEMBER

- **Dialectical behaviour therapy (the therapy):** the model is Linehan's biosocial theory, an emotionally vulnerable temperament transacting with a pervasively invalidating environment to produce emotion dysregulation, treated by synthesising acceptance and change; the lead indication is borderline personality disorder, especially where self-harm must be reduced (IPS_CPG 2023; NICE 2009); the signature structure is the four modes (individual therapy, skills group, phone coaching, consultation team) delivering the four skills modules.

12.6 Acceptance and commitment therapy: psychological flexibility and the hexaflex

Stop fighting inner experience; act on your values instead. Acceptance and commitment therapy was developed by Steven Hayes in the nineteen-nineties (originally called comprehensive distancing), and its whole aim is psychological flexibility, the capacity to stay in contact with the present moment and, guided by chosen values, to change or persist in behaviour (Kaplan and Sadock CTP 2024). Its core premise is that suffering is driven by *experiential avoidance*, the unwillingness to feel unwanted thoughts, feelings and sensations, so ACT works not by removing those experiences but by loosening their grip. The model is drawn as a six-pointed hexaflex, and the six interlocking processes are worth holding verbatim; there are exactly **6**.

Acceptance

Actively making room for unwanted private experiences rather than struggling against them, as the alternative to experiential avoidance.

Cognitive defusion

Stepping back to see thoughts *as* thoughts, passing mental events, rather than fusing with them as literal truths or commands.

Contact with the present moment

Flexible, non-judgemental attention to the here-and-now, the mindfulness element of ACT.

Self-as-context

The "observing self", a stable vantage point from which experience is witnessed, distinct from the changing content of experience.

Values

Clarifying the chosen life directions that make behaviour meaningful and give change its purpose.

Committed action

Building patterns of effective, values-guided behaviour, the behavioural-change engine that keeps ACT a behaviour therapy.

COMMON TRAP

Do not promote ACT to a broad first-line therapy. On the guideline evidence it is *one option* among several for major depression (VA_DOD 2022) and a weak-for adjunct in early psychosis and schizophrenia (VA_DOD 2025); its one confirmed first-line role is as an option (with MBCT) for illness-anxiety presentations in the IPS somatic-symptom guideline (IPS_CPG 2020). Say "evidence-supported option", not "guideline first-line".

GOOD TO REMEMBER

- **Acceptance and commitment therapy (the therapy):** the model is that experiential avoidance drives suffering, so the goal is psychological flexibility built through the six hexaflex processes; the lead indication is not a broad first-line status but a values-and-acceptance option across depression and, confirmed as first-line, illness-anxiety presentations (IPS_CPG 2020); the one signature technique is cognitive defusion, holding a thought as a thought rather than a fact.

12.7 Mindfulness-based cognitive therapy: the eight-session programme

Built for one job, preventing the next depression. **Mindfulness-based cognitive therapy** was developed by Segal, Williams and Teasdale in the mid-nineteen-nineties, marrying the mindfulness training of Kabat-Zinn's stress-reduction programme with elements of cognitive therapy (Kaplan and Sadock CTP 2024). It is a group programme delivered over **8** weekly sessions with home practice and a day of practice. Crucially, unlike CBT, MBCT does not try to change the content of thoughts; it teaches *decentring*, the stance that "thoughts are not facts" and "I am not my thoughts", so that low mood no longer recruits the old ruminative machinery that reinstates a full depressive episode. That mechanism is exactly why its indication is narrow and specific: the *prevention of depressive relapse* in people with recurrent depression who are currently well, not the treatment of an acute episode. Its strongest confirmed role is first-line relapse prevention in the maintenance phase of major depression (CANMAT 2016) and an option in the continuation phase for patients at high relapse or recurrence risk (VA_DOD 2022); the acute treatment of depression, with CBT and interpersonal therapy, sits in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes.

GOOD TO REMEMBER

- **Mindfulness-based cognitive therapy (the therapy):** the model is decentring from depressive thought patterns rather than disputing them, mindfulness plus cognitive therapy over eight weekly group sessions; the lead indication is the *prevention of depressive relapse* in recurrent depression in the well phase (CANMAT 2016; VA_DOD 2022), not acute depression and, per NICE 2013, not social anxiety; the one signature technique is mindful decentring, "thoughts are not facts".

12.8 The evidence base across the third wave, and the Indian setting

One strong indication each; do not blur them. The examinable shape of the third wave is that each therapy owns one lead indication and should not be over-generalised beyond it, a point on which the guidelines are strict. DBT is the first-choice structured therapy for borderline personality disorder; ACT is an evidence-supported option rather than a broad first-line therapy; and MBCT is first-line specifically for preventing depressive relapse.

THERAPY	ORIGINATOR	CORE TARGET	LEAD INDICATION (GUIDELINE)
DBT	Linehan	Emotion dysregulation	**Borderline personality disorder, reducing self-harm (IPS_CPG 2023; NICE 2009)**
ACT	Hayes	Experiential avoidance / psychological inflexibility	Option for depression; first-line option for illness anxiety (IPS_CPG 2020; VA_DOD 2022)
MBCT	Segal, Williams and Teasdale	Ruminative relapse to depression	**Preventing depressive relapse in recurrent depression (CANMAT 2016; VA_DOD 2022)**

The three widely-practised third-wave therapies, with the single lead indication each is best evidenced for.

4 MODES OF STANDARD DBT (INDIVIDUAL, SKILLS GROUP, PHONE COACHING, CONSULTATION TEAM)	**4** DBT SKILLS MODULES (MINDFULNESS, DISTRESS TOLERANCE, EMOTION REGULATION, INTERPERSONAL EFFECTIVENESS)	**6** HEXAFLEX PROCESSES IN ACT	**8** WEEKLY SESSIONS IN THE MBCT PROGRAMME

INDIA

The Indian Psychiatric Society embeds the third wave in its guidelines: DBT is the recommended psychotherapy for borderline personality disorder (IPS_CPG 2023), and both ACT and MBCT are named as first-line options for illness-anxiety presentations in the somatic-symptom guideline (IPS_CPG 2020). Mindfulness and meditation-based interventions have deep cultural roots here, and the NIMHANS yoga-therapy research stream has studied adjunctive yoga in depression and schizophrenia, but keep this at the honest level, yoga and meditation are adjuncts, not stand-alone or first-line psychiatric treatments, and that research stream is literature-level rather than guideline-confirmed.

HOLD THIS

The third-wave therapies change your relationship to inner experience, not its content; DBT rests on Linehan's biosocial theory (emotional vulnerability meeting an invalidating environment) and is delivered through four modes, individual therapy, skills group, phone coaching and consultation team, teaching four skills modules, mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness, with borderline personality disorder as its lead indication; ACT builds psychological flexibility through six hexaflex processes; and MBCT is an eight-session programme whose one job is preventing depressive relapse.

13 · Motivational interviewing

Motivational interviewing (MI) is the psychiatry answer to a problem every clinician meets and few are trained for: the patient who knows the drinking is killing them and drinks anyway, who half wants to stop and half does not, and who, the moment you argue for change, argues back for the status quo. Devised by William Miller and Stephen Rollnick from Miller's work with problem drinkers in the nineteen-eighties, MI is defined as a collaborative, person-centred, goal-directed style of communication designed to strengthen a person's own motivation and commitment to change by exploring and resolving **ambivalence**. It is examinable in two registers, as a named psychotherapy with a lead indication in the addictions, and as a general counselling style that underlies every stage of substance-use work, so learn both the machinery and the one-sentence indication.

How to use this page. Fix first that the target of MI is ambivalence, not the substance and not the diagnosis. Then learn the underlying stance (the spirit of motivational interviewing), the four guiding principles that operationalise it, the distinction between change talk and sustain talk that the whole method is built to shift, and the core micro-skills, OARS, that do the shifting. Close on the transtheoretical stages of change that MI is so often paired with, and on the evidence, whose examinable payoff is the phrase "first-line in the addictions". The cardinal error the page is built to prevent is picturing MI as gentle, aimless listening; it is directional and deliberate, it simply reaches its direction by evoking the patient's own arguments rather than supplying the clinician's.

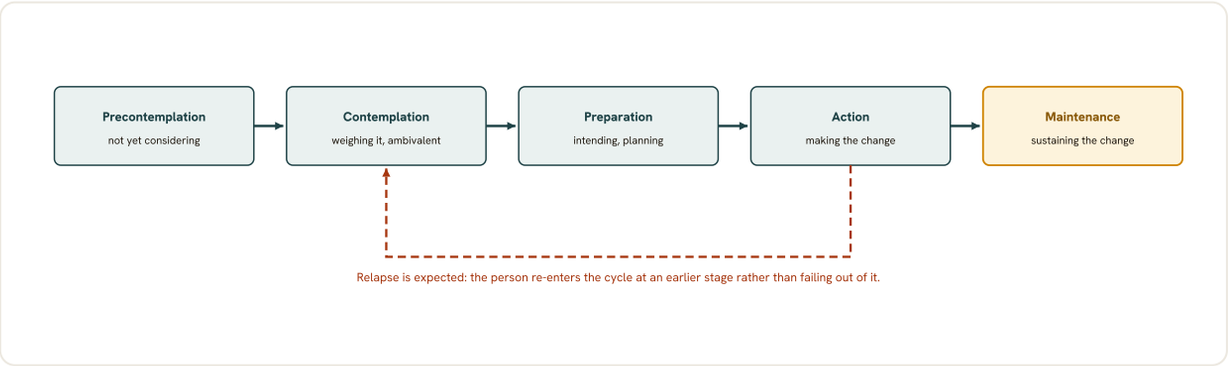


Fig 19.8 The transtheoretical stages of change. Prochaska and DiClemente's model describes readiness for change as a sequence: precontemplation (not yet considering it), contemplation (weighing it, ambivalent), preparation (intending and planning), action (making the change) and maintenance (sustaining it). The clinical value is that the intervention is matched to the stage: raising awareness in precontemplation, exploring ambivalence in contemplation, and supporting action later. Relapse is treated not as failure but as a return to an earlier stage, from which the person moves forward again. This is the map that motivational interviewing works within, meeting the patient at their stage and eliciting their own reasons for change rather than pushing against ambivalence.

13.1 What MI targets: ambivalence, not the substance

The patient already holds both sides of the argument; MI tips the balance from within. The central insight is that a person contemplating change is not unmotivated but *ambivalent*, holding simultaneous and genuine reasons both to change and to stay the same, and that this ambivalence is the normal psychology of change rather than a sign of denial or pathology (Miller and Rollnick; Tasman). Because the arguments for change are already present in the patient, the clinician's task is not to install motivation from outside but to selectively evoke, elaborate and reinforce the patient's own change-favouring statements until they outweigh the arguments for the status quo. This reframes the whole encounter: the person, not the clinician, voices the case for change, which matters because people are more persuaded by what they hear themselves say than by what they are told.

RULE **Evoke, do not install.** MI resolves ambivalence by drawing out and strengthening the patient's own change talk, never by supplying the clinician's reasons; motivation is called forth from the person, not imposed on them.

13.2 The spirit of motivational interviewing

The underlying attitude matters more than any technique. Miller and Rollnick insist that MI is carried less by its methods than by its animating stance, the spirit of motivational interviewing, and in the third edition this spirit has exactly **4** interlocking elements. *Partnership* makes the encounter a collaboration between two experts, the clinician on change and the patient on their own life, rather than an expert acting on a passive recipient. *Acceptance* combines Rogerian accurate empathy, unconditional positive regard, honouring the patient's autonomy to choose, and affirmation of their strengths. *Compassion* commits the clinician to actively promote the patient's welfare and give priority to their needs. *Evocation* assumes the resources and motivation for change already reside within the patient and are to be called out, the opposite of a deficit model in which the clinician fills an empty vessel. Without this spirit the techniques become manipulation; with it they become MI.

MNEMONIC

PACE

The spirit of MI keeps **P** artnership, **A**cceptance, **C**ompassion and **E**vocation. Set the PACE of the conversation with the patient, walking alongside them rather than pulling them.

13.3 The four guiding principles

Express empathy, develop discrepancy, roll with resistance, support self-efficacy. The spirit is enacted through four classic principles that are among the most reliably examined content in this topic (Miller and Rollnick). *Express empathy* through skilled reflective listening, communicating acceptance so the patient feels understood rather than judged. *Develop discrepancy* by helping the patient perceive the gap between their present behaviour and their broader goals and values, because it is this felt mismatch, and not the clinician's disapproval, that powers change. Rolling with resistance means not opposing or arguing against reluctance but reflecting and reframing it, turning what looks like opposition into further exploration. *Support self-efficacy* by building the patient's belief that change is possible and is theirs to achieve, since hope of success is itself a strong predictor of it. Two of these, developing discrepancy and rolling with resistance, are the ones a viva examiner reaches for first.

TRAP **The righting reflex backfires.** The clinician's instinct to correct, warn and argue the patient into change, the righting reflex, predictably provokes the patient to voice the opposite (sustain talk and discord); in MI you suppress that reflex and roll with resistance instead of confronting it.

13.4 Change talk versus sustain talk

Every technique in MI is aimed at increasing one kind of speech and softening the other. Change talk is any patient statement that favours movement toward change; *sustain talk* is any statement that favours the status quo. Because ambivalent people produce both, the clinician listens for change talk, then uses open questions, reflection and affirmation to elaborate and amplify it while gently letting sustain talk pass without reinforcement. Preparatory change talk is captured by the mnemonic DARN, the patient's *Desire* ("I want to cut down"), *Ability* ("I could stop if I tried"), *Reasons* ("my liver is suffering") and *Need* ("I have to do something"); mobilising change talk, which predicts action more strongly, is captured by CAT, *Commitment* ("I will"), *Activation* ("I am ready") and *Taking steps* ("I threw the bottles out"). The clinician's job is to shift the ratio of change talk to sustain talk across the conversation, since that shift, and not any lecture, is what predicts a subsequent change in behaviour.

WORKED EXAMPLE

A man with harmful alcohol use says, "I am not an alcoholic, my father was, but I suppose the mornings have got worse." Instead of correcting the first clause (the righting reflex), the clinician reflects the last, "The mornings are worse than they were," and asks, "What have you noticed?" The patient elaborates on the tremor and the missed work, voicing his own Reasons and Need. Nothing was argued; the clinician simply steered toward the change talk the patient had already offered and let it grow.

13.5 The core skills: OARS

Four micro-skills carry the whole method. The moment-to-moment technique of MI reduces to OARS, a set of **4** communication skills borrowed from client-centred counselling and put to a directional purpose (Miller and Rollnick; Tasman). *Open questions* invite the patient to do most of the talking and to explore rather than answer yes or no. *Affirmations* recognise and reinforce the patient's strengths, efforts and worth, building self-efficacy. *Reflective listening*, the signature skill, feeds back the clinician's best guess at the patient's meaning as a statement, which deepens exploration, conveys empathy and, crucially, lets the clinician selectively reflect change talk. *Summaries* gather the threads of the conversation, and a well-built summary can deliberately collect the patient's change talk into one place so they hear their own case for change spoken back to them. OARS is the examinable acronym; know that reflection, not questioning, is its centre of gravity.

MNEMONIC

OARS

Row the conversation forward with **O**pen questions, **A**ffirmations, **R**eflective listening and **S**ummaries. Reflective listening is the longest of the four oars; lean on it hardest.

13.6 The stages of change: the transtheoretical model

MI meets the patient wherever they sit on the road to change. MI is almost always taught alongside the transtheoretical model of Prochaska and DiClemente, whose stages of change describe how readiness evolves over time. The **5** core stages are *precontemplation* (no intention to change, often unaware of the problem or attending under pressure from others), *contemplation* (aware of the problem and weighing change but not yet committed), *preparation* (intending to act soon, taking small first steps), *action* (making overt behaviour change) and *maintenance* (consolidating gains and preventing relapse). Some formulations add a sixth stage, either *termination* (Prochaska, DiClemente and Norcross) or, in several Indian texts, *relapse*; attribute the core count as five and name the sixth as a variant. The clinical payoff is stage matching: pushing action tasks on a precontemplative patient produces drop-out, so the model tells you when to evoke and when to plan, while MI supplies the how. Change is a spiral, not a ladder, and relapse is treated as an expected loop back rather than a failure. The accompanying figure sets the stages out as a cycle with the spiral of relapse and re-entry marked.

COMMON TRAP

Do not equate MI with the stages-of-change model. They are separate: the transtheoretical model is a *theory of how readiness changes*, MI is a *clinical method for moving it*. MI can be delivered without ever naming a stage, and the stages can be assessed without doing MI; the exam rewards knowing they are complementary, not identical.

13.7 Evidence, MET and the lead indication

First-line in the addictions, as a brief structured therapy and as the foundational counselling style. The examinable sentence is that MI is a well-evidenced, first-line psychological

intervention across the substance-use disorders and, more broadly, in behaviour change (the guideline evidence). Its brief, manualised form, motivational enhancement therapy (MET), delivers the method in about four structured sessions built around personalised assessment feedback, and MET is a first-line psychological treatment for alcohol use disorder (IPS_CPG 2014 grade A; VA_DOD 2021) and first-line psychosocial management for cannabis use disorder (IPS_CPG 2014; VA_DOD 2021). Beyond these, MI is the foundational counselling style used across all stages of substance-use disorder generally (IPS_CPG 2014; WHO mhGAP 2016), is offered for gambling disorder following CBT (RANZCP 2024; NICE 2025), and is a main behavioural treatment for adolescent tobacco use (IPS_CPG 2018). Keep the claim disciplined: strong and first-line in the addictions and for behaviour change, an evidence-based adjunct or preparatory intervention elsewhere, not a first-line stand-alone treatment for the mood or anxiety disorders. The substance-specific detail, the SBIRT framework and the pharmacological pairings live in the Substance use disorders notes.

INDIA

The Indian Psychiatric Society makes MI and MET first-line across the addictions, most firmly for alcohol (IPS_CPG 2014, grade A). The dedicated IPS guideline on psychosocial interventions in addictive disorders in India (Murthy and colleagues, 2018) names motivation-enhancement and relapse-prevention approaches as core and signals a shift toward community-based and home-based delivery, an adaptation to the Indian reality of scarce specialist therapists and family-embedded care. State both the guideline endorsement and the delivery shift; an examiner asking about MI in India is usually testing the second half.

5	4	4
CORE STAGES OF CHANGE (PROCHASKA AND DICLEMENTE)	ELEMENTS OF THE MI SPIRIT (PARTNERSHIP, ACCEPTANCE, COMPASSION, EVOCATION)	STRUCTURED SESSIONS IN MOTIVATIONAL ENHANCEMENT THERAPY

GOOD TO REMEMBER

- **Motivational interviewing (the therapy):** the model is that ambivalence is the normal psychology of change, so the clinician evokes and strengthens the patient's own change talk within a collaborative, autonomy-honouring spirit rather than confronting them; the lead indication is the substance-use disorders and behaviour change, where MI and its four-session form MET are first-line (IPS_CPG 2014 grade A for alcohol); the one signature technique is reflective listening within OARS, used to selectively amplify change talk.

HOLD THIS

MI (Miller and Rollnick) works with ambivalence by evoking the patient's own change talk instead of confronting them; its spirit is partnership, acceptance, compassion and evocation, its principles are express empathy, develop discrepancy, roll with resistance and support self-efficacy, its skills are OARS, and its lead indication is the addictions, delivered first-line as the four-session MET (IPS_CPG 2014 grade A for alcohol).

14 · The Indian and culturally-adapted context

Every therapy on this note was developed and trialled largely in high-income, well-resourced settings, and the examiner will expect you to know what changes when the same therapies meet an Indian clinic: a wide **treatment gap**, a thin specialist workforce, strong family systems, and a living tradition of yoga, meditation and indigenous healing. The examinable shape of the Indian context is that it adds four things to the evidence-based therapies rather than replacing them, its own body of Indian Psychiatric Society guidance, the cultural adaptation of the manualised therapies, an indigenous yoga and meditation-based evidence stream, and a set of brief, task-shared, lay-counsellor delivery models built for scale. Hold each at its honest evidence level; the trap that runs through the whole topic is over-claiming a culturally resonant intervention as a first-line stand-alone treatment.

How to use this page. Learn the IPS psychotherapy guidance first, because it is the most directly examinable Indian fact and it tells you that the evidence-based therapies (CBT, IPT, MI and the rest) remain first-line here too. Then take culturally-adapted CBT as an *adaptation with a developing evidence base*, yoga and meditation as *adjuncts*, and the task-sharing and lay-counsellor stream as the Indian answer to the treatment gap. Close on guru-chela and indigenous healing at the cultural level, and on an honest ledger of what is guideline-confirmed against what is literature-level. The wider transcultural frame of the cultural concepts of distress belongs in the Consultation-liaison, geriatric and transcultural psychiatry notes; here, learn how the therapies themselves are adapted and delivered in India.

14.1 The IPS psychotherapy guidelines and their place

India has its own psychotherapy guidance, and it keeps the evidence-based therapies first-line. The Indian Psychiatric Society has published a dedicated Clinical Practice Guideline on the psychotherapies (Agarwal and colleagues, *Indian Journal of Psychiatry* 2020) and a companion guideline on psychosocial interventions in addictive disorders in India (Murthy and colleagues 2018); in addition, the disorder-specific IPS CPGs embed psychotherapy recommendations for depression (2017), obsessive-compulsive disorder, generalised anxiety disorder (2020), somatic symptom disorder (2020) and borderline personality disorder (2023) (the guideline evidence). What the **IPS psychotherapy** guidance does is important and bounded: it endorses and localises the internationally evidenced therapies rather than inventing new ones, so CBT stays first-line across depression, GAD, OCD and somatic symptom disorder, behavioural activation is named among the strongest options in depression, IPT sits alongside CBT for depression, and motivational interviewing and motivation enhancement therapy are first-line across the addictions (IPS_CPG 2014; 2017; 2020). Do not inflate this into a claim that a single unified all-modality Indian psychotherapy manual exists; the defensible statement is that the IPS has published these specific guidelines and that they cover these areas.

RULE **Adapt the delivery and the idiom, not the evidence base.** In the Indian setting the guideline-anchored therapies (CBT, IPT, MI, behavioural activation) remain first-line; the Indian contribution is to localise, culturally adapt and task-share them, plus add yoga and meditation as adjuncts, not to displace them.

INDIA

A signature Indian adaptation lives in the IPS alcohol-use guidance: family-based treatment that enlists a co-resident relative as recovery monitor and supervisor of supervised disulfiram (IPS_CPG 2014, grade B). This works precisely because the Indian family is typically co-resident and involved, turning a structural feature of Indian households into a therapeutic lever, the kind of cultural tailoring that defines this whole topic. Motivational interviewing in substance use itself sits in the Substance use disorders notes.

14.2 Culturally-adapted CBT in the Indian setting

The same therapy, retuned to language, idiom, family and explanatory model. Culturally-adapted CBT is not a new therapy but a systematic re-tuning of standard CBT for a cultural setting, and the work most associated with South Asian and Indian adaptation is that of Naeem and colleagues (the guideline evidence). The adaptation touches content, not mechanism: the therapist works in the local language, uses local idioms of distress rather than imported metaphors, engages the family instead of assuming an autonomous individual client, respects religious and spiritual explanatory models, and adjusts the balance of guided-discovery versus a more directive, expert stance that many Indian patients expect. The evidence for **culturally-adapted** CBT in South Asian and Indian settings runs from feasibility work up to randomised-trial level for depression and psychosis, which is genuinely promising but is not drawn from a guideline row. Frame it, therefore, as an adaptation with a developing evidence base, not as a guideline-endorsed first-line therapy distinct from CBT.

PEARL

The clean viva line: culturally-adapted CBT changes the *packaging* (language, idioms, family involvement, explanatory model, therapist stance), while keeping the *active ingredients* of CBT intact. That is why it inherits CBT's evidence base in principle but must still be tested locally, and why it is described as promising and developing rather than separately guideline-confirmed.

14.3 Yoga and meditation-based interventions: the Indian evidence stream

Deep cultural roots, real research, but adjunctive evidence. India contributes a distinctive research stream on **yoga** and **meditation-based** interventions, much of it from the NIMHANS yoga-therapy programme, studying adjunctive yoga in depression and in schizophrenia (Tasman and Kaplan and Sadock place yoga, paced breathing and meditation among the mind-body integrative practices). The honest evidence level is *adjunct*, and here the guideline evidence is strict. As an add-on, yoga has guideline-level support: it is offered as an adjunct for the positive and negative symptoms of schizophrenia (VA_DOD 2025, weak-for), exercise including yoga is suggested as an adjunct in major depression (VA_DOD 2022), and yoga and mindfulness are offered for depressive symptoms in the perinatal period (VA_DOD 2023). Equally examinable are the cautions: VA_DOD found insufficient evidence to recommend for or against yoga or meditation for chronic insomnia (VA_DOD 2025) and insufficient evidence for meditation as a major-depression adjunct (VA_DOD 2022). The NIMHANS Indian yoga stream itself sits at the

adjunct level and is literature-based rather than guideline-confirmed. Keep yoga and meditation firmly at "adjunct, not first-line, not stand-alone".

TRAP **Calling yoga, meditation or culturally-adapted CBT a first-line stand-alone treatment.** No source supports yoga or meditation as a stand-alone or first-line psychiatric treatment; their confirmed roles are adjunctive, and culturally-adapted CBT is developing evidence, not a guideline first-line. Say "adjunct" and "promising", never "first-line monotherapy".

14.4 The treatment gap and the case for brief, task-shared, lay-counsellor care

Too few specialists for too many patients forces a different delivery model. The structural fact behind the Indian context is scarcity: the National Mental Health Survey put the current prevalence of any mental disorder near one in ten adults, yet reported an 85% treatment gap for common mental disorders and 73.6% for severe mental illness, against a workforce of only about **0.3** psychiatrists per 100,000 population, most of them urban (National Mental Health Survey 2016; Indian sources). When specialists cannot possibly see everyone, the answer is task sharing: shifting delivery of simple, manualised psychological treatments to trained non-specialists under specialist supervision. The WHO frames this through the Mental Health Gap Action Programme (mhGAP) and its Intervention Guide (mhGAP-IG), used to train primary-care staff to detect and manage priority conditions in low-resource settings. India has generated some of the strongest evidence for this model: brief psychological treatments delivered by trained lay counsellors, developed and trialled by groups such as Sangath in Goa, have shown that lay-delivered, task-shared care can effectively treat depression and reduce harmful drinking in primary care. The accompanying figure sets out this stepped, task-shared pyramid from self-care and community workers up to scarce specialists.

Treatment gap
The proportion of people with a disorder who receive no treatment for it; in India, an 85% gap for common mental disorders and 73.6% for severe mental illness (NMHS 2016).

Task shifting / task sharing
Redistributing tasks from scarce specialists to trained non-specialist or lay providers under supervision; "sharing" keeps the specialist in a supervisory role rather than fully handing over.

mhGAP Intervention Guide
The WHO's simplified, evidence-based protocol for non-specialist detection and management of priority mental, neurological and substance-use conditions in low-resource settings.

Lay-counsellor-delivered treatment
A brief, manualised psychological treatment given by a trained lay person (not a mental-health professional); the Indian trials targeted depression and hazardous drinking in primary care.

WORKED EXAMPLE

A woman with moderate depression presents to a rural primary health centre where the nearest psychiatrist is a day's travel away. Rather than the referral failing into the treatment gap, a supervised lay counsellor delivers a brief, structured psychological treatment (behavioural activation and problem-solving) across several weekly sessions, escalating to the visiting specialist only if she does not improve or risk rises. This is task-shared, mhGAP-style, evidence-based care fitted to the Indian workforce reality, delivering a first-line therapy through a non-specialist rather than diluting it.

85%	73.6%	0.3
TREATMENT GAP FOR COMMON MENTAL DISORDERS, INDIA (NMHS 2016)	TREATMENT GAP FOR SEVERE MENTAL ILLNESS, INDIA (NMHS 2016)	PSYCHIATRISTS PER 100,000 POPULATION, INDIA

14.5 Guru-chela, indigenous healing, and the honest ledger

Name the indigenous frame at the cultural level, and keep the evidence honest. Long before manualised therapy reached India, help for psychological suffering came through indigenous routes, and these still shape where patients seek care first. The guru-chela (teacher-disciple) relationship has been proposed, classically by Neki, as a culturally native paradigm for the therapeutic relationship, an idealised, hierarchical, nurturing bond that maps onto how many Indian patients expect a healer to relate to them; treat it as a conceptual and cultural model of the therapeutic alliance, not as an evidence-based therapy. Alongside it sit the traditional and faith healers, herbalists and religious and spiritual practitioners whom many patients consult in parallel with, or before, biomedical care. Knowing this matters clinically because it shapes explanatory models, help-seeking pathways and adherence, but the research base for indigenous healing is preliminary and largely naturalistic, so it is named and respected at the cultural level rather than recommended as treatment. The honest ledger below is exactly what the examiner is testing: which parts of this stream are guideline-confirmed and which are literature-level.

ELEMENT OF THE INDIAN / CULTURALLY-ADAPTED STREAM	HONEST STATUS	SOURCE LEVEL
IPS psychotherapy CPG (2020) and addiction guideline (2018)	**Indian guideline that endorses and localises the evidence-based therapies**	Guideline-confirmed (IPS_CPG)
Culturally-adapted CBT (Naeem and colleagues)	Adaptation with a developing evidence base, feasibility to RCT-level in depression and psychosis	**Literature-level, not guideline first-line**
Yoga (adjunct)	**Adjunct for schizophrenia (weak-for) and depression; suggested, not first-line**	Guideline-confirmed as adjunct (VA_DOD)
Meditation-based interventions	Adjunct; insufficient evidence as a depression adjunct and for chronic insomnia	VA_DOD cautions
Task-shared, lay-counsellor delivery	**Effective delivery model for depression and harmful drinking; the answer to the treatment gap**	mhGAP; Indian lay-counsellor trials
Guru-chela and indigenous / faith healing	Cultural and conceptual model of the therapeutic bond; shapes help-seeking	Cultural / textbook (Neki), not evidence-based therapy

The honest evidence ledger for the Indian and culturally-adapted stream: what is guideline-confirmed against what is literature-level or cultural.

GOOD TO REMEMBER

- **The defining principle:** the Indian context *adapts and delivers* the evidence-based therapies rather than replacing them; the discriminator to hold is adjunct or developing-evidence against guideline first-line.
- **IPS psychotherapy guidance:** a dedicated IPS psychotherapy CPG (2020) plus an addiction-psychosocial guideline (2018) and disorder-specific CPGs localise CBT, IPT, behavioural activation and MI as first-line; there is no single unified all-modality Indian manual.
- **Culturally-adapted CBT:** retunes language, idioms, family involvement, explanatory model and therapist stance while keeping CBT's active ingredients; promising, developing evidence (Naeem), not separately guideline first-line.
- **Yoga and meditation-based interventions:** adjuncts only (yoga weak-for in schizophrenia and depression, VA_DOD); the NIMHANS stream is literature-level; never stand-alone or first-line.
- **Treatment gap and task sharing:** an 85% gap for common mental disorders and roughly 0.3 psychiatrists per 100,000 drive brief, task-shared, mhGAP-style, lay-counsellor-delivered care (Sangath trials).
- **Guru-chela and indigenous healing:** named at the cultural level as a native model of the therapeutic bond (Neki) and of help-seeking, not as an evidence-based treatment.

HOLD THIS

The Indian and culturally-adapted context keeps the evidence-based therapies first-line and adds four things around them: IPS guidelines that localise them, culturally-adapted CBT (promising, developing evidence), yoga and meditation as adjuncts only, and task-shared lay-counsellor delivery (mhGAP, the Sangath trials) to close an 85% treatment gap, with guru-chela and indigenous healing named at the cultural level rather than as treatments.

15 · Choosing the right therapy

This is the discrimination topic for the whole psychotherapies band, and it is where the marks actually sit. The examiner rarely rewards a rote description of a single modality; the higher-order question is **therapy selection**, given this patient with this presentation, **which therapy** do you offer first and why. **Choosing the right therapy** is therefore a skill of **matching**: you place the presentation against the modality that carries the strongest **indication** for it, then you individualise. The safe answer names the guideline-endorsed first-line therapy before it reaches for the therapist's favourite school, and it grounds the choice in evidence rather than preference.

How to use this page. Fix the four factors that govern the choice first, because every viva answer on selection is really a request to weigh them. Then read the indication grid, the single highest-yield object in the topic, which matches the seven common presentations to their first-line modality, its evidence anchor and its practical fit. Finally hold the principle that this page selects a therapy but does not teach it: the disorder-specific protocol (exposure and response prevention, trauma-focused cognitive behaviour therapy, dialectical behaviour therapy for borderline personality disorder, interpersonal psychotherapy for depression) always lives in the disorder's own chapter, and this topic only points you to the right door.

Presentation	First-line psychotherapy	The evidence and where it is taught
Depression	CBT or IPT	first-line psychological therapies (IPS 2017, CANMAT 2016); behavioural activation an option
Anxiety and OCD	CBT with exposure; ERP for OCD	exposure is the active ingredient; the ERP protocol is taught in the Anxiety, OCD notes
Borderline personality	DBT (also MBT, schema therapy)	DBT has the strongest evidence; taught in full in the Personality disorders notes
Relational or family problem	Family or couple therapy	the system, not the individual, is the unit of treatment
Adjustment or crisis	Supportive; crisis intervention	restore the pre-crisis level of functioning; brief, active and problem-focused
Substance use	Motivational interviewing and CBT	MET and CBT for relapse prevention (IPS 2014); taught in the Substance use disorders notes
Psychosis	Family psycho-education, CBT for psychosis	alongside antipsychotic medication, not instead of it

Match the therapy to the presentation, the evidence and the formulation. The first-line psychotherapy is highlighted; the disorder-specific protocols are taught in their disorder chapters.

Fig 19.9 Choosing the right therapy. The selection of a psychotherapy follows the presentation, the evidence base and the individual formulation. Depression is answered first-line by CBT or interpersonal therapy; the anxiety disorders and OCD by exposure-based CBT, with exposure and response prevention the active ingredient in OCD; borderline personality disorder most strongly by dialectical behaviour therapy; a relational or family problem by family or couple therapy, which treats the system rather than the individual; an adjustment reaction or crisis by supportive therapy and crisis intervention; a substance-use problem by motivational interviewing and CBT for relapse prevention; and a psychotic illness by family psychoeducation and CBT for psychosis, always alongside medication rather than in place of it. The disorder-specific protocols are taught in their own chapters.

15.1 The four factors that decide therapy selection

Weigh four things, in this order. A clean selection answer names four factors and puts the evidence base first (Kaplan and Sadock CTP 2024; New Oxford Textbook). The **disorder and its evidence base** is the first and strongest filter: for most presentations a guideline already names a first-line psychological treatment, and that is the default from which you reason. The **formulation** refines the default: the same diagnosis can point to different therapies depending on the maintaining mechanism, so a depression driven by a bereavement or a role change tilts toward interpersonal work, while one driven by inactivity and hopeless cognition tilts toward behavioural activation or cognitive work. **Patient preference and capacity for the work** matter because they predict engagement and completion: a patient's stated preference improves adherence, and the capacity for insight-oriented work is gated by motivation, cognitive ability and psychological mindedness, the ability to reflect on one's own feelings, motives and relationships and to consider their meaning (Companion to Psychiatric Studies; Tasman). The **availability and setting** factor is the honest constraint: the best-evidenced therapy is worth little if no trained therapist can deliver it, which is why a stepped care logic offers the least intensive effective option first and steps up only if the patient does not improve.

THE FOUR FILTERS OF THERAPY SELECTION

Disorder and evidence base (the guideline first-line is the default); **formulation** (the maintaining mechanism refines the default); **patient preference and capacity** (preference predicts engagement, and psychological mindedness gates insight work); **availability and setting** (what a trained therapist can actually deliver, under a stepped-care logic). Name all four and lead with the evidence base.

RULE **Match the disorder to its evidence base first, then individualise.** The disorder's guideline-endorsed first-line therapy is the default; the formulation, the patient's preference and capacity, and availability refine the choice, but they override a strong first-line only for a stated reason.

PEARL

Capacity is a real gate, not a courtesy. Insight-oriented and reconstructive therapies presuppose motivation, adequate cognitive ability and psychological mindedness; where these are thin, a supportive or structured behavioural approach matches the patient better than an interpretive one, however fashionable the latter. Suitability for the work is part of the indication, not an afterthought.

15.2 The indication grid: matching the presentation to the first-line modality

Seven presentations, seven first-line answers. The core examinable object is the grid below, which pairs each common presentation with the psychotherapy that carries the strongest guideline indication, the evidence anchor for that claim, and the practical reason it fits (the IPS and NICE guidelines). Learn it as a lookup table: the presentation is the stem, the first-line modality is the answer you must name, and the practical-fit column is the sentence that earns the second mark. The accompanying figure lays the same match out as a decision grid.

PRESENTATION	FIRST-LINE MODALITY (THE ANSWER)	EVIDENCE ANCHOR	PRACTICAL FIT
Depression (major depressive disorder)	**Cognitive behaviour therapy, interpersonal psychotherapy or behavioural activation**	IPS 2017 grade A; CANMAT 2016; NICE 2022	Broadest choice; pick IPT for a clear interpersonal trigger (grief, role transition), behavioural activation where withdrawal and inactivity dominate or access is limited
An anxiety or OCD disorder	**CBT; obsessive-compulsive disorder as CBT with exposure and response prevention**	GAD IPS 2020, NICE 2011; OCD IPS 2025 Level 1, BAP 2014 grade A	Graded exposure is the active ingredient; ERP is the OCD-specific package (expose to the trigger, prevent the compulsion)

PRESENTATION	FIRST-LINE MODALITY (THE ANSWER)	EVIDENCE ANCHOR	PRACTICAL FIT
Borderline personality disorder	**Dialectical behaviour therapy**	IPS 2023; NICE 2009	First choice where recurrent self-harm and emotion dysregulation dominate; skills training plus individual therapy; mentalisation-based treatment is the alternative
A relational or family problem	**Family or couple therapy**	Family therapy for adolescent anorexia NICE 2017 grade A; family intervention in psychosis NICE 2014, IPS 2017; couple therapy VA/DoD 2022	The system, not the individual, is the unit of treatment; targets communication, roles and expressed emotion
An adjustment or crisis	**Brief and crisis therapy (problem-solving, crisis intervention, supportive)**	Problem-solving for self-harm NICE 2022; collaborative crisis plan in BPD IPS 2023, NICE 2009	Time-limited and focal; collaborative safety planning; a supportive stance where structured therapy is unavailable
A substance-use problem	**Motivational interviewing and motivational enhancement therapy (four structured sessions)**	IPS 2014 grade A; VA/DoD 2021	Stage-matched to readiness; brief intervention and SBIRT for hazardous use at every contact
A psychotic illness	**Psychosocial adjuncts: family intervention and CBT for psychosis**	Family intervention NICE 2014, IPS 2017; CBT for psychosis IPS 2017 grade B	An adjunct to antipsychotic medication, never a substitute; family intervention reduces relapse

Matching the seven common presentations to the first-line psychotherapy, its guideline anchor and the practical fit; the disorder-specific protocol is taught in the disorder's own chapter. The accompanying figure renders the same match as a decision grid.

TRAP **Offering psychotherapy as a substitute for medication in a severe illness.** In a psychotic illness the family intervention and CBT for psychosis are adjuncts to an antipsychotic, not replacements; naming a therapy as monotherapy for psychosis (or for severe, high-risk depression) is a selection error.

15.3 Reasoning to the match: when the formulation and the patient refine the default

The grid is the default, not a straitjacket. Selection is a two-step move, read the first-line therapy off the evidence, then check whether the formulation, the patient's preference or the setting shifts it. Two worked lines make the reasoning concrete. A patient with a moderate depressive episode that began after a divorce, who talks fluently about the relationship and wants to work on it, is a clean match for interpersonal psychotherapy over cognitive behaviour therapy, not because the evidence separates them (both are first-line, IPS 2017 grade A) but because the

formulation names an interpersonal trigger and the preference predicts engagement. A patient with borderline personality disorder presenting after repeated self-harm is matched to dialectical behaviour therapy, because reducing self-harm and emotion dysregulation is exactly its lead indication (IPS 2023; NICE 2009), and a purely interpretive therapy would be the weaker fit. The discipline of choosing the right therapy is to let the disorder's evidence base set the default and to move off it only with a reason you can state.

WORKED EXAMPLE

A man in his forties presents with hazardous drinking and clear ambivalence, half-wanting to cut down, half-minimising. The matching move is not to prescribe abstinence-focused work to a contemplator but to meet his readiness: motivational enhancement therapy, its brief four-session form, is first-line for alcohol use disorder (IPS 2014 grade A; VA/DoD 2021), and motivational interviewing is the stage-matched style that resolves the ambivalence before any action-stage plan. Reading the stage of change first, and the diagnosis-default second, is the whole of the selection reasoning here.

COMMON TRAP

Procrustean matching, fitting every patient to the one therapy the clinician happens to practise. Selection is driven by the disorder's evidence base and the individual formulation, not by the therapist's training or preferred school; a service that offers only its favourite modality is choosing the therapist's convenience over the patient's indication. The corrective is to name the guideline first-line for the presentation before naming what you would personally deliver.

15.4 The protocol lives in the disorder chapter, not here

Selection points to a door; the room is furnished elsewhere. Once the presentation is matched to a modality, the manualised protocol that delivers it is taught in the disorder's own chapter, and the examinable move is to name the protocol and place it, not to re-teach it here. Exposure and response prevention for obsessive-compulsive disorder, and trauma-focused cognitive behaviour therapy for post-traumatic stress disorder, are developed in the Anxiety, OCD and trauma-related disorders notes. Dialectical behaviour therapy for borderline personality disorder, together with schema therapy, is developed in the Personality disorders notes. Interpersonal psychotherapy and cognitive behaviour therapy as used in depression, with the depression rating scales, sit in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes. Motivational interviewing and motivational enhancement therapy in addiction belong to the Substance use disorders notes. Keeping the selection question and the protocol question separate is what stops a "which therapy" answer from collapsing into an unfocused description of one technique.

15.5 Therapy selection in the Indian setting

Guideline-anchored choice, delivery-constrained supply. The Indian syllabus examines selection directly. The Indian Psychiatric Society has published a dedicated clinical practice guideline on the psychotherapies (Agarwal, Nischal, Praharaj, Menon and Kar; Indian Journal of Psychiatry 2020), and it embeds first-line psychotherapy recommendations across its disorder-

specific guidelines, cognitive behaviour therapy for depression, generalised anxiety disorder and obsessive-compulsive disorder, motivational enhancement therapy for the addictions (IPS 2014 grade A), and dialectical behaviour therapy for borderline personality disorder (IPS 2023), so the matching question is a live one here, not a Western import. The genuine Indian point is that the binding constraint is availability rather than evidence: trained therapists are scarce relative to need, which is why guideline attention turns to brief, low-intensity and task-shifted delivery by non-specialist workers under a stepped-care model, and to culturally adapted cognitive behaviour therapy (associated with Naeem and colleagues), best framed as a promising adaptation with a developing evidence base. Yoga and meditation-based interventions sit at the adjunct level of the evidence, not as stand-alone first-line treatments.

INDIA

An examiner asking about therapy selection in India is usually testing the second half of the answer. State the guideline first-line for the presentation (the IPS psychotherapies guideline, IPS 2020, plus the disorder-specific CPGs), then name the delivery reality: the availability filter dominates, so stepped and task-shifted care, culturally adapted brief cognitive behaviour therapy, and family-inclusive delivery (for example a co-resident relative as recovery monitor in alcohol use disorder, IPS 2014) are the realistic Indian answers. Keep yoga and meditation as adjuncts.

4
FACTORS WEIGHED IN THERAPY SELECTION (EVIDENCE BASE, FORMULATION, PREFERENCE AND CAPACITY, AVAILABILITY)

3
PATIENT-SIDE MARKERS OF SUITABILITY FOR INSIGHT WORK (MOTIVATION, COGNITIVE ABILITY, PSYCHOLOGICAL MINDEDNESS)

7
COMMON PRESENTATIONS IN THE MATCHING GRID

GOOD TO REMEMBER

- **Choosing the right therapy (the principle):** match the disorder to its guideline first-line modality first, then individualise by the formulation, the patient's preference and capacity for the work, and what is actually available; the strong first-lines to name on sight are cognitive behaviour therapy, interpersonal psychotherapy or behavioural activation for depression, CBT with exposure and response prevention for obsessive-compulsive disorder, dialectical behaviour therapy for borderline personality disorder, family therapy for adolescent anorexia and for psychosis relapse, motivational enhancement therapy and motivational interviewing for substance use, and CBT for psychosis only as an adjunct to medication.
- **The one discriminator:** the disorder's evidence base sets the default; patient factors refine it, but a strong first-line is overridden only for a stated reason (declined, unavailable, or a formulation that points elsewhere).
- **The one exam fact:** in a psychotic or severe illness, psychotherapy is an adjunct to pharmacotherapy, never a substitute.

HOLD THIS

Therapy selection is a two-step move: first read off the disorder's first-line psychotherapy from the evidence (cognitive behaviour therapy or interpersonal psychotherapy or behavioural activation for depression, CBT with exposure and response prevention for obsessive-compulsive disorder, dialectical behaviour therapy for borderline personality disorder, family therapy for adolescent anorexia and for psychosis relapse, motivational enhancement therapy and motivational interviewing for substance use, and CBT for psychosis as an adjunct only), then refine by the formulation, the patient's preference and psychological mindedness for the work, and what is available; the protocol itself is always taught in the disorder's own chapter, not here.

Psychiatric assessment and rating scales

16 · The psychiatric history and the mental state examination

The psychiatric clinical assessment has two limbs, and keeping them apart is the single most examinable habit in this paper. The first limb is the **history**, a longitudinal narrative of the person and the illness assembled from what the patient and the informants report; the second is the mental state examination (MSE), a cross-sectional description of the patient's mental functioning here and now, as observed and elicited during the interview. The history tells you what has happened over time; the MSE tells you what is present in the room. Neither, on its own, is a diagnosis. A viva will test the MSE hardest, because it is the psychiatrist's equivalent of the physical examination, a disciplined, ordered survey of observable phenomena, and the one skill that most reliably separates a trained candidate from an untrained one.

How to use this page. Learn the shape of the history first, quickly, then spend the bulk of your attention on the MSE, because that is where the marks and the errors both sit. Fix the domains in their examined order, **appearance and behaviour**, then **speech**, then **mood and affect**, then thought (**thought form** and **thought content**), then **perception**, then **cognition**, and finally **insight** and **judgement**. For each domain, hold two things: what it captures, and the classic error. The vocabulary of descriptive psychopathology that populates these domains, the fine phenomenology of the individual symptoms, and the psychometric theory behind the instruments are developed in the Psychometry, Assessment and Descriptive Psychopathology notes; this page owns the clinical skill of taking a history and conducting the examination.

	The domain, in order	What it captures	A classic finding or term
1	**Appearance and behaviour**	grooming and self-care, psychomotor activity, rapport, eye contact, abnormal movements	psychomotor retardation; stereotypy; poor self-care
2	**Speech**	rate, rhythm, volume, tone, quantity and the form of production (not the content)	pressured speech; poverty of speech; mutism
3	**Mood and affect**	subjective mood versus observed affect; the range, reactivity and congruence of affect	blunted, labile or incongruent affect
4	**Thought** form and content	FORM, the flow and structure of thinking; and CONTENT, what is thought (including risk)	loosening of associations (form); a delusion (content)
5	**Perception**	hallucinations by modality, illusions, depersonalisation and derealisation	third-person auditory hallucinations
6	**Cognition**	the bedside screen: attention, orientation and memory (the full examination in the next topic)	disorientation; poor short-term recall
7	**Insight and judgement**	awareness of the illness and the need for care; the appraisal of decisions and their consequences	absent insight; impaired judgement

The one principle to hold
The mental state examination is a cross-sectional, here-and-now examination of the present state. It is not the history, and it is not a diagnosis.

Fig 19.10 The mental state examination: the domains in order. The MSE is examined and recorded in a fixed sequence: appearance and behaviour, speech, mood and affect, thought (both its form and its content), perception, cognition, and finally insight and judgement. Each domain has its own vocabulary and its own classic findings, and the discipline of moving through them in order is what stops a domain being missed. The single principle to hold is that the MSE is a cross-sectional snapshot of the patient's present state, gathered at the interview: it is distinct from the history, which is longitudinal, and it is not itself a diagnosis, but the observations from which a diagnosis and a formulation are built.

16.1 The psychiatric interview and the structure of the history

A single, ordered narrative built from the patient and from those who know them.

Psychiatric history-taking follows a fixed skeleton, and the value of the skeleton is that it forces completeness under time pressure. Open with *identifying data* and the *presenting complaints* in the patient's own words and their duration, then the *history of the present illness*, a chronological account from the first change from the person's normal state through the evolution of every symptom, its onset, course, precipitants and effect on functioning. Then work through the *past psychiatric history* (previous episodes, treatments, admissions and response), the *past medical and surgical history* (illnesses and drugs that cause or colour psychiatric symptoms), the *drug and treatment history* including current and past psychotropics, adherence and substance use, the *family history* (psychiatric illness, suicide and the family structure), the *personal and developmental history* (birth and milestones, childhood, education, occupation, relationships and forensic and sexual history), and the *premorbid personality*, the person's habitual character before the illness against which the current change is measured. Finally, and non-negotiably, the *collateral history* from an informant, because so many psychiatric presentations are marked by impaired insight and the patient alone cannot give the whole account. The examinable principle is that history taking in psychiatry elaborates each psychological symptom in depth rather than cataloguing physical complaints, and that it is always corroborated.

RULE **The history is longitudinal and corroborated.** It is the story of the person and the illness over time, and in psychiatry it is incomplete without a collateral account, because impaired insight is a feature of the very disorders being assessed.

INDIA

The AIIMS *Clinical Methods in Psychiatry* resident's handbook (2024) frames the history of the present illness around the mnemonic **A-B-C-D-E** (Affect and mood, Behaviour, Cognition, Dysfunction / Drugs / Disability, Environment), and formalises two properties of the informant that Indian examiners probe: *reliability* (consistency across informants and over time, absent an ulterior motive) and *adequacy* (enough information for a provisional diagnosis and a plan). Collateral history carries extra weight in Indian practice, where stigma, family-mediated help-seeking and frequent lack of insight mean the accompanying relative often supplies the decisive account. Confidentiality is respected throughout, but the risk of suicide or violence overrides it, and consent to interview the family is taken separately from the patient.

16.2 The mental state examination: a cross-sectional snapshot, not the history and not a diagnosis

The here-and-now examination of mental functioning, in a fixed order. The mental state examination is to the psychiatric assessment what the physical examination is to the medical one: a structured, present-tense description of what the clinician observes and elicits *during the interview itself*. It is deliberately cross-sectional. It does not narrate the past (that is the history's job) and it does not attach a label (that is the diagnosis's job); it is the raw observational data from which, together with the history, a diagnosis is later reasoned. The domains are examined in a conventional order that runs from the most observable to the most inferred: appearance and behaviour, speech, mood and affect, thought form and content, perception, cognition, and insight and judgement, 7 domains in all. The accompanying figure sets these out as the structure map of the examination. Learn the order as a fixed sequence; recording an MSE out of order, or omitting a domain, reads as an incomplete examination.

MSE DOMAIN (IN ORDER)	WHAT IT CAPTURES	COMMON ERROR
Appearance and behaviour	Grooming, physique, psychomotor activity, rapport, eye contact, abnormal movements, attitude to examiner	**Reporting an interpretation ("depressed") instead of the observation ("psychomotor slowing, poor eye contact")**
Speech	Rate, rhythm, volume, tone, quantity and the form of production, described as heard	Recording the *content* of what was said instead of the *form* of the speech
Mood and affect	Subjective, sustained mood versus the observed, moment-to-moment affect, its range, reactivity and congruence	**Collapsing mood and affect into one line, or confusing the two**

MSE DOMAIN (IN ORDER)	WHAT IT CAPTURES	COMMON ERROR
Thought form	The structure and flow of thought: circumstantiality, tangentiality, flight of ideas, loosening of associations	Describing content when asked for form
Thought content	Delusions, overvalued ideas, obsessions, preoccupations, and suicidal and homicidal ideation	Failing to ask about, or to record, suicidal and homicidal ideation
Perception	Hallucinations by modality, illusions, and depersonalisation and derealisation	Not specifying the modality, or missing that the phenomenon is an illusion, not a hallucination
Cognition	The bedside screen: consciousness, orientation, attention, memory and higher functions	Omitting it in a cooperative-seeming patient with a possible organic cause
Insight and judgement	The person's awareness of illness, graded, and the soundness of their decision-making	**Recording insight as merely "present" or "absent" rather than grading it**

The seven domains of the mental state examination in their conventional examined order, what each captures, and the classic recording error. The examination is cross-sectional and observational; it is not the history and it is not a diagnosis.

RULE **The MSE is a cross-sectional here-and-now snapshot.** It describes what is observable and elicitable in the interview, in a fixed order; it is the psychiatric physical examination, distinct from the longitudinal history that precedes it.

TRAP **The cardinal error: confusing the MSE with the history, or treating it as a diagnosis.** Past events, previous episodes and reported symptoms belong in the history, not the MSE; and the MSE yields signs, not a label. Writing "MDD" or "schizophrenia" in the MSE, or importing last year's admission into it, is the classic mistake this examination is built to prevent.

MNEMONIC

A Sad ManThinks Poorly, Cognition Intact?

The seven domains in order: **A**ppearance and behaviour, **S**peech, **M**ood and affect, **T**hought (form and content), **P**erception, **C**ognition, **I**nsight and judgement. Run them in this sequence every time so that no domain is dropped.

16.3 Appearance and behaviour

Everything the clinician can see before a word is exchanged. The first domain records *appearance* (build, self-care and grooming, dress, evidence of self-neglect or of specific states such as the flushed overactivity of mania or the stigmata of alcohol use) and *behaviour*, of which the most examinable element is *psychomotor activity*, either slowed (retardation, as in severe depression or catatonia) or increased (agitation, restlessness, overactivity). Note the quality of *rapport* and *eye contact*, the patient's *attitude to the examiner* (cooperative, guarded, suspicious, hostile, seductive, perplexed), and any *abnormal movements*: tremor, tics, mannerisms, stereotypies, dyskinesias, and the catatonic signs (posturing, waxy flexibility, negativism,

echopraxia). The discipline of this domain is to record *observations*, not conclusions. "Unkempt, malodorous, sitting motionless with downcast gaze" is a description; "looks depressed" is an inference that pre-empts the examination.

COMMON TRAP

Do not let an interpretation masquerade as an observation. Psychomotor retardation, poverty of facial expression and poor eye contact are *observed signs*; "depression" is a conclusion you reach later by weighing them against the history and the rest of the MSE. The mark is for the sign, described.

16.4 Speech

The form of the output, described as heard, not what was said. The **speech** domain captures the physical and formal characteristics of talking: *rate* (fast, as in the pressured speech of mania, or slow), *rhythm* and fluency, *volume* (loud or barely audible), *tone* and prosody (monotonous in depression, over-modulated in mania), *quantity* (voluble and hard to interrupt, or spontaneously mute), and the *form of production*. This domain describes the vehicle of thought; the ideas being conveyed are analysed under thought form and content. A single sample of the patient's actual words, quoted, is worth more than an adjective. The examinable discrimination is between disordered speech that reflects a disordered *thought* process (which is scored under thought form) and disordered speech that reflects a *motor or neurological* problem, such as the slurring of dysarthria or the word-finding difficulty of dysphasia, which points towards an organic cause rather than a formal thought disorder.

16.5 Mood and affect

The sustained inner weather versus the moment-to-moment expressed emotion. The **mood and affect** distinction is a perennial examination favourite. *Mood* is the pervasive, sustained emotional state as *subjectively reported* by the patient ("How have your spirits been?"); it is the climate. *Affect* is the emotional state as *objectively observed* by the clinician from face, posture and voice over the course of the interview; it is the weather. Describe mood in the patient's own terms and note whether it is euthymic, depressed, elevated, irritable or anxious. Then describe affect along four axes: its *quality*, its *range* (full, or restricted, blunted, or flat), its *reactivity* (whether it shifts appropriately with the topic, or is fixed and non-reactive), and its *congruence* with the stated mood and with the content of thought. Incongruent affect, for example giggling while describing a bereavement, is itself a sign. Note also whether the subjective mood and the observed affect agree; a patient may deny low mood while displaying a flat, tearful affect.

WORKED EXAMPLE

A man says his mood is "fine" (subjective mood, reported), but throughout the interview his affect is observed to be restricted in range, non-reactive, and incongruently tearful when he mentions his work. The MSE line reads: "Subjectively euthymic; objectively affect restricted, non-reactive, incongruent, with lability on discussing work." Nothing here is a diagnosis; it is a description of the observed emotional state set against the reported one.

TRAP **Mood is not affect.** Mood is subjective and sustained (what the patient reports over recent weeks); affect is objective and cross-sectional (what you observe now). Range, reactivity and congruence are properties of *affect*. Collapsing the two, or applying "reactive" to mood, is the classic slip.

16.6 Thought form

The structure and flow of thinking, inferred from speech. **Thought form** concerns *how* a person thinks, the organisation and connectedness of their ideas, as opposed to what they think about. It is inferred from the form of speech. The formal thought disorders are the named abnormalities of this stream, and the examinable set turns on one axis: does the train of thought reach its goal, and can you follow the links? Jaspers and the descriptive tradition insist that the psychiatrist attend to the form before the content. The table below fixes the four classic disorders the topic names, plus two more you must recognise.

FORMAL THOUGHT DISORDER	WHAT THE THINKING DOES	REACHES THE GOAL?
Circumstantiality	Over-inclusive, tediously detailed and full of digressions, but the point is eventually made	**Yes, eventually**
Tangentiality	Replies veer off at an angle and drift further from the point with each step	**No, never returns**
Flight of ideas	A rapid, pressured stream leaping between topics on chance links, rhyme, clang and distraction; the thread is followable (classically manic)	Loosely; links are discernible
Loosening of associations	Ideas shift with no logical or comprehensible connection (derailment, knight's-move thinking); the thread is lost (classically schizophrenic)	No; the links themselves are broken
Thought block	A sudden, involuntary cessation of the flow of thought, midstream, the mind going blank	Interrupted
Perseveration	Inappropriate persistence or repetition of a word or idea after the context has moved on (often organic)	Stuck

The formal thought disorders, discriminated by whether the train of thought reaches its goal and whether the links between ideas can be followed. Flight of ideas keeps followable links; loosening of associations breaks them.

TRAP **Circumstantiality versus tangentiality, and flight of ideas versus loosening.** Circumstantiality gets there by a long road; tangentiality never arrives. Flight of ideas is fast but its links are traceable (rhyme, pun, distraction); loosening of associations has links you cannot trace at all. The first pair is about arrival; the second pair is about whether the connections make sense.

16.7 Thought content

What preoccupies the mind, from delusions to the ideation that carries risk. **Thought content** records *what* the person is thinking about. Elicit and describe abnormal beliefs and preoccupations, and define them precisely, because the definitions discriminate the diagnoses.

Delusion

A fixed, false belief, out of keeping with the person's social and cultural background, held with unshakeable conviction despite contrary evidence; described by its content (persecutory, grandiose, nihilistic and so on) and whether it is primary or secondary, mood-congruent or incongruent.

Overvalued idea

A comprehensible, strongly held and emotionally invested belief that comes to dominate the person's life; not held with delusional conviction and not resisted as senseless, sitting between a normal belief and a delusion.

Obsession

A recurrent, intrusive, unwanted thought, image or impulse recognised as the person's own and as senseless, resisted (at least initially), and provoking anxiety; distinct from a delusion in that insight into its absurdity is retained.

Preoccupation

A non-delusional, non-obsessional theme that repeatedly draws the mind, such as pervasive worry, rumination or hypochondriacal concern.

The examination of thought content is also where *risk* is formally elicited. Ask directly about *suicidal ideation* (thoughts, intent, plan, preparatory acts and protective factors) and about *homicidal or violent ideation*; both are recorded here, and asking about suicide does not plant the idea. The structured suicide-risk instrument, the Columbia Suicide Severity Rating Scale, and the wider suicide-risk assessment are developed in the Somatic-symptom, sexual, impulse-control disorders and suicide notes; within the MSE, the task is to elicit and document the ideation, its intensity and its associated plan.

> **COMMON TRAP**
>
> An abnormal belief is not a delusion until you have tested three things: its *fixity*, its *falseness*, and its *incongruence with the person's culture*. A belief widely shared within a religious or cultural community is not delusional simply because it is unfamiliar to the examiner. The wider transcultural frame is set out in the Consultation-liaison, geriatric and transcultural psychiatry notes.

16.8 Perception

Disturbances in how the world and the self are apprehended. The **perception** domain covers false or altered percepts, and the definitions again do the discriminating work.

Hallucination

A percept experienced in the absence of any external stimulus, with the full force and quality of a true perception, and located in external space; specify the *modality*, auditory (second-person or third-person voices, running commentary), visual, olfactory, gustatory, tactile or somatic.

Pseudohallucination
A percept experienced in inner subjective space and lacking the substantiality of a true perception, over which the person retains some awareness of its unreality.

Illusion
A *misperception* of a real external stimulus (the dressing gown seen as an intruder), distinguished from a hallucination by the presence of an actual stimulus.

Depersonalisation
A distressing sense of being unreal, detached from or an observer of one's own self, thoughts or body.

Derealisation
The corresponding sense that the external world is unreal, remote or lifeless, as though seen through glass.

The examinable line runs between the *illusion*, which is a distorted reading of a real stimulus, and the *hallucination*, which arises with no stimulus at all; and, within hallucinations, between the true hallucination in external space and the pseudohallucination in inner space. Always record the modality, because the modality carries diagnostic weight (third-person auditory hallucinations point one way, visual and olfactory hallucinations raise the question of an organic cause).

16.9 Cognition

The bedside cognitive screen, and the point at which to reach for a standardised tool. The **cognition** domain is the clinical screen of higher mental function, examined in a rough hierarchy: *level of consciousness*, *orientation* to time, place and person, *attention and concentration* (serial sevens, digit span, months in reverse), *memory* (immediate registration, recent and remote recall), and higher functions (language, praxis, abstraction, executive function). Its purpose in the MSE is to flag the organic, because a cognitive deficit in a patient who otherwise seems to have a primary psychiatric disorder is the finding that redirects the whole assessment. When the bedside screen suggests impairment, quantify it with a standardised instrument. The MMSE (Mini-Mental State Examination; Folstein, 1975) and the MoCA (Montreal Cognitive Assessment; Nasreddine, 2005) are the two brief screens to know, each scored out of a possible 30. A widely cited MMSE threshold for cognitive impairment is a score below 24 out of a possible 30, though the cut-off is education-dependent; the MoCA, which is more sensitive to mild cognitive impairment, uses a threshold below 26 out of a possible 30, with one point added for a person with twelve or fewer years of formal education. The full bedside cognitive examination and the typeset structure of these instruments, with the accompanying scale plate, are developed in the cognitive-examination topic that follows; the deeper psychometric theory of reliability, validity and standardisation sits in the Psychometry, Assessment and Descriptive Psychopathology notes.

7	6	24	26
MSE DOMAINS, EXAMINED IN FIXED ORDER	GRADES OF INSIGHT (COMPLETE DENIAL TO TRUE INSIGHT)	MMSE THRESHOLD: A SCORE BELOW THIS, OUT OF A POSSIBLE 30, SUGGESTS IMPAIRMENT	MOCA THRESHOLD: A SCORE BELOW THIS, OUT OF A POSSIBLE 30, SUGGESTS IMPAIRMENT

16.10 Insight and judgement

Awareness of illness, graded, and the soundness of decision-making. **Insight** is the patient's awareness and understanding of their own condition: that they are unwell, that the illness is psychiatric in nature, and that treatment is needed. It is not usefully recorded as simply "present" or "absent"; it is a graded continuum. The classic scheme runs to **6** grades, from complete denial of illness at one end to true emotional insight at the other.

GRADE	LEVEL OF INSIGHT
Grade I	Complete denial of illness
Grade II	Slight awareness of being sick and needing help, while denying it at the same time
Grade III	Awareness of being sick, but blaming it on others, on external factors or on a physical cause
Grade IV	Awareness that the illness is due to something unknown within the patient
Grade V	**Intellectual insight: admits the illness and that symptoms are due to their own irrational feelings, but cannot apply this to future experience**
Grade VI	**True emotional insight: emotional awareness of the motives and feelings within, which can lead to real change in behaviour**

The six grades of insight, from complete denial (Grade I) to true emotional insight (Grade VI). The examinable discriminator is Grade V versus Grade VI: intellectual insight knows but does not change; true insight is emotionally owned and can change behaviour.

Judgement is the appraisal of the patient's ability to make sound, reasoned decisions in their own and others' interest, assessed from their real-life choices during and around the illness and, where needed, from their reasoning about a hypothetical situation. It bears directly on capacity and on risk, and it can be intact where insight is impaired, or vice versa, so the two are recorded separately.

16.11 Recording and integrating the assessment

The MSE feeds the formulation; it does not replace it. A good MSE is written in observational, present-tense language, domain by domain in order, quoting the patient where a quotation is more precise than an adjective. Its findings are then integrated with the history to build the diagnostic formulation and the differential, but the integration is a separate step: the MSE supplies signs, the history supplies the story, and only their synthesis yields a diagnosis. Two failures recur. The first is importing the history into the MSE, writing past episodes or reported symptoms into a domain that is meant to be here-and-now. The second is closing the MSE with a diagnostic label, as though the description of signs were itself the conclusion. Guard both borders and the examination does its job, which is to be the disciplined observational base on which everything downstream is built.

GOOD TO REMEMBER

- **The principle:** the mental state examination is a cross-sectional, here-and-now, observational survey of mental functioning across seven domains in fixed order (appearance and behaviour, speech, mood and affect, thought form and content, perception, cognition, insight and judgement); it is distinct from the longitudinal history and is not, in itself, a diagnosis.
- **The discriminator:** the history is what the patient and informants *report* over time and must be corroborated by a collateral account; the MSE is what the clinician *observes and elicits* now. Within it, mood is subjective and sustained while affect is objective and cross-sectional.
- **The one exam fact:** the seven domains run appearance and behaviour, speech, mood and affect, thought (form and content), perception, cognition, insight and judgement; insight is graded to six levels; MMSE and MoCA screen cognition out of a possible 30, with thresholds below 24 and below 26 respectively.

HOLD THIS

The MSE is the psychiatric physical examination: a cross-sectional, here-and-now, observational survey of seven domains in fixed order (appearance and behaviour; speech; mood and affect; thought form and content; perception; cognition; insight and judgement), distinct from the longitudinal, corroborated history and never, by itself, a diagnosis.

17 · Higher mental functions and the cognitive examination

This topic teaches the bedside skill that separates a psychiatrist from a symptom-checklist: the structured examination of the **higher mental functions**, the cortical faculties of attention, orientation, memory, language, praxis and executive control. It earns flagship space because it is examined in two registers at once. In the viva the examiner hands you a patient and watches you test, so the marks are in doing the **cognitive examination** in the right order with the right instruction; in the written paper the marks are in the numbers, the domains and the verified cut-offs of the two screening instruments every candidate is expected to reproduce cold. Cognition is also the sixth of the seven mental-state domains (appearance and behaviour; speech; mood and affect; thought; perception; cognition; insight and judgement), so the whole of this page sits inside the mental state examination as a cross-sectional, here-and-now snapshot, never a diagnosis in itself.

How to use this page. Learn the examination as a hierarchy, not a list. Test **attention and concentration** first, because a patient who cannot hold attention cannot be validly tested on anything downstream; then **orientation**, then registration and **memory testing**, then language and praxis, then the **frontal lobe tests** of executive control. Only once the individual faculties are understood do the packaged screens make sense: the MMSE and the MoCA are simply these bedside items bundled and scored. The deeper lobe-by-lobe functional neuroanatomy and the formal test batteries belong to the neuropsychology overview; the reliability and validity of these scales, and the descriptive-psychopathology vocabulary, belong to the Psychometry, Assessment and Descriptive Psychopathology notes. Here we teach the examination itself.

MNEMONIC

ALL SANE MEN THINK PRECISELY CONSIDERING INSIGHT

The seven mental-state domains in their conventional order, so you can locate where the cognitive examination sits: **A**ppearance and behaviour, **S**peech, **M**ood and affect, **T**hought (form and content), **P**erception, **C**ognition, **I**nsight and judgement. Cognition is the **C**, the sixth station; the higher mental functions on this page are what you test when you reach it.

Domain	What is tested	Points
Orientation to time	year, season, month, day, date	5
Orientation to place	country, state, town, building, floor	5
Registration	repeat three named objects	3
Attention and calculation	serial sevens, or spell a word backward	5
Recall	recall the three objects	3
Language	naming, repetition, a three-stage command, reading, writing	8
Visuospatial	copy two intersecting pentagons	1
Total		30

A score below 24 out of a possible 30 suggests cognitive impairment; interpret against age and education. Folstein 1975; permission-required, structure typeset, not reproduced.

Fig 19.11 The Mini-Mental State Examination (MMSE). A brief clinician-administered screen of orientation, registration, attention, recall, language and construction, scored out of a possible 30. A score below 24 suggests cognitive impairment, but the cut-off must be read against the person's age and education: a highly educated person may be impaired while still scoring well, and a person with little formal schooling may score lower without being impaired. It is a screen, not a diagnosis, and it is relatively insensitive to the earliest, mild and predominantly executive deficits. The structure is typeset here from the published instrument; the MMSE is copyright and permission-required, so the form itself is not reproduced.

Domain	What is tested	Points
Visuospatial and executive	trail-making, cube copy, clock drawing	5
Naming	name three animals (lion, rhinoceros, camel)	3
Attention	digit span, target tapping, serial sevens	6
Language	repeat two sentences, verbal fluency	3
Abstraction	similarities between two items	2
Delayed recall	recall five words after a delay	5
Orientation	date, month, year, day, place, city	6
Total		30

26 or above out of a possible 30 is normal; add a point for twelve years or fewer of education. Nasreddine 2005; permission-required, structure typeset.

Fig 19.12 The Montreal Cognitive Assessment (MoCA). A brief screen scored out of a possible 30 that samples visuospatial and executive function, naming, attention, language, abstraction, delayed recall and orientation. A score of 26 or above is taken as normal, with one point added for people with twelve years or fewer of formal education. It is more sensitive than the MMSE to mild cognitive impairment and to the executive and visuospatial deficits of the earliest stages, which is why it is often preferred where an early or subtle decline is the question. The instrument is copyright and, in most current editions, requires training or certification to administer, so the structure is typeset here rather than the form reproduced.

17.1 Attention and concentration: the gateway faculty

Test attention first, because everything else rests on it. Attention is the capacity to focus on a stimulus, and concentration is the capacity to sustain that focus over time; together they are the substrate on which registration, memory and language testing depend, which is why they are examined at the very start of **bedside cognition** (Clinical Methods in Psychiatry, AIIMS 2024; Fish and Sims). Three bedside tasks carry the load. The digit span is the purest measure: random digits are read one per second and repeated back, and a healthy adult manages about seven forwards and five in reverse, so a forward span below five points to an attentional deficit; the reverse span additionally taxes working memory. The **serial sevens** asks the patient to subtract seven serially from one hundred (100, 93, 86, 79, 72, 65), and spelling the word WORLD backwards is the standard less numerate alternative. **Reciting the months of the year backwards** is a quick, education-light screen of sustained attention. Impaired, fluctuating attention is the single signature of delirium, and its presence should stop you reading a poor memory score as amnesia until attention is restored.

RULE **Attention is the gateway; test it first.** A patient who cannot attend cannot be validly tested on memory, language or executive function. Inattention that fluctuates is the hallmark of delirium, not of dementia, and it invalidates every tier below it.

TRAP **Reading a failed serial sevens as pathology.** The serial sevens is heavily confounded by numeracy and education; a poorly schooled patient may fail it while wholly attentive. Corroborate with months backward or digit span before calling attention impaired, and never rest a conclusion on the serial sevens alone.

17.2 Orientation: time, place and person

The most sensitive bedside marker of an acute organic state. Orientation is the patient's awareness of the situation across three axes, and it is tested and recorded in a fixed order: **time** (day, date, month, year, season, approximate time of day), **place** (building, town, floor, kind of place) and **person** (their own identity and that of those around them). The clinically useful fact is the gradient of vulnerability: orientation to time is lost first and recovers last, place follows, and orientation to person is the most robust, surviving into severe global impairment. Disorientation to time out of proportion to any memory deficit is an early and sensitive sign of delirium, which is why it opens the cognitive screen. The reverse pattern is a red flag for a non-organic picture: a patient who does not know who they are while remaining fully oriented to time and place is far more likely to be presenting a dissociative or functional disturbance than an organic amnesia.

> **PEARL**
>
> Follow the gradient, time before place before person. When it is inverted, when a patient is disoriented to their own identity yet knows the day and the ward, suspect a functional or dissociative process rather than delirium or dementia, because organic disorientation almost never takes out person while sparing time.

17.3 Registration and memory: immediate, recent and remote

Separate encoding from storage from retrieval, and separate the time-frames. Memory testing walks three temporal windows. **Immediate memory (registration)** is tested by naming three unrelated words (for example apple, table, penny) and having the patient repeat them at once; this is really a test of attention and encoding, not of memory storage. **Recent memory** is the critical amnestic measure: after a few minutes of distraction the patient is asked to recall those same three words, and impaired delayed recall that does not improve with category cues is the signature of the hippocampal-type amnesia of Alzheimer disease. **Remote memory** is probed through well-anchored autobiographical and general events (schooling, marriage, prime ministers, major public events), and in the typical amnestic gradient recent memory fails while remote memory is relatively preserved. Two further distinctions are examinable: **anterograde** amnesia (a failure to lay down new memories after an insult) versus **retrograde** amnesia (loss of memories from before it); and **verbal** memory (word lists, stories, a left-temporal function) versus **visual** memory (recalling and reproducing a figure, a right-temporal function), the latter tapped at the bedside by asking the patient to copy and later redraw a design.

TRAP **Confusing registration with recall.** Failing the immediate three-word repetition is an attention or encoding failure; failing the delayed recall of words that were registered is the true amnestic sign. Only the second, uncued delayed recall, discriminates early Alzheimer-type memory loss, and only if attention was intact when the words went in.

17.4 Language and praxis

Six language channels and the two apraxias. Language is examined across a fixed set of channels, and testing them in order localises the lesion. **Spontaneous speech and fluency** (is output effortful and non-fluent, as in a Broca-type picture, or fluent but empty and paraphasic, as

in a Wernicke-type picture); **comprehension** (following graded one-, two- and three-step commands); **repetition** (repeating a phrase such as "no ifs, ands or buts", the channel selectively spared in transcortical and lost in conduction aphasia); **naming** (confrontation naming of objects and their parts, the most sensitive and earliest-affected language function, its failure being anomia); **reading**; and **writing**. Praxis, the ability to carry out a learned, purposeful movement when the elementary motor and sensory systems are intact, is tested separately and is the classic parietal-frontal sign.

Ideomotor apraxia

The idea of the movement is intact but cannot be mapped onto the motor engrams: the patient fails to perform a gesture to command ("show me how you would wave goodbye", "how you would use a comb") yet may perform it spontaneously.

Ideational apraxia

The concept of the act itself is lost or degraded, so a sequence of actions (filling and lighting a pipe, preparing a letter for posting) cannot be organised, even though each isolated element may be possible.

WORKED EXAMPLE

A right-handed patient names a watch but calls its strap and winder a "thing", follows a one-step command but not a three-step one, and cannot mime striking a match to instruction though he does it when handed a real matchbox. The early anomia and the gesture-to-command failure with preserved spontaneous use are ideomotor in type and point the examination toward the dominant temporo-parietal cortex, to be pursued with the fuller batteries in the neuropsychology overview.

17.5 The frontal-executive tests

The functions the MMSE forgets. Executive control, the planning, set-shifting, abstraction and inhibition mediated by the prefrontal cortex, is invisible to the older screens and must be sought deliberately with the **frontal lobe tests**. **Verbal fluency** comes in two forms: phonemic (as many words as possible beginning with a given letter, classically F, A and S, in a minute each) and semantic or category fluency (as many animals as possible in a minute); reduced output, especially disproportionately reduced phonemic fluency, signals frontal dysfunction. The Luria three-step, the fist-edge-palm motor sequence, tests motor programming and perseveration. The **go/no-go** paradigm (tap once when I tap once, do not tap when I tap twice) tests inhibitory control, and the related conflicting-instruction task tests sensitivity to interference. **Abstraction** is drawn out by similarities (how are an apple and an orange alike; the impaired answer is concrete, "both are round", rather than the categorical "both are fruit") and by **proverb interpretation**, where a concrete reading of "a rolling stone gathers no moss" betrays loss of abstraction. These are packaged into the Frontal Assessment Battery (FAB) of Dubois and colleagues (2000), six subtests scored from 0 to 3, giving a score out of a possible 18.

FAB SUBTEST	FRONTAL FUNCTION PROBED	BEDSIDE TASK
Similarities	Conceptualisation	**In what way are a banana and an orange alike (category, not appearance)**
Lexical fluency	Mental flexibility	**Words beginning with S in sixty seconds**
Motor series	Programming	**Luria's fist-edge-palm sequence**
Conflicting instructions	Sensitivity to interference	**Tap twice when I tap once**
Go / no-go	Inhibitory control	**Tap once when I tap once; do not tap when I tap twice**
Prehension behaviour	Environmental autonomy	**Does the patient grasp the examiner's proffered hands despite instruction not to**

The six subtests of the Frontal Assessment Battery, each scored from 0 to 3, for a bedside frontal screen out of a possible 18 (Dubois et al 2000; Lishman's Organic Psychiatry).

17.6 The Mini-Mental State Examination (MMSE)

The classic global screen, and what it misses. The **MMSE** of Folstein and colleagues (1975) is the most widely used bedside cognitive screen, taking five to ten minutes and scored out of a possible 30 across five domains: orientation, registration, attention and calculation, recall and language (with a visuoconstructive copy). The domain weighting is worth holding, because the accompanying scale plate typesets the permission-required form in full and the examiner is expected to know how the marks are distributed. The conventional cut-off is **24**: a total below 24, that is at or below 23, suggests cognitive impairment, though this must be read against the patient's age and education. Two caveats are examinable. Highly educated patients may score a perfect 30 out of a possible 30 while already declining, a ceiling effect that masks early disease; poorly educated or elderly patients may fall below the cut-off without pathology, so age- and education-adjusted norms are preferred over the raw threshold. Critically, the MMSE has few memory items and no executive or frontal items at all, which is exactly why it under-detects both mild cognitive impairment and frontal-predominant dementias.

MMSE DOMAIN	POINTS	SAMPLE BEDSIDE ITEM
Orientation	10	**Time (year, season, date, day, month) and place**
Registration	3	**Repeat three named objects immediately**
Attention and calculation	5	**Serial sevens or WORLD spelt backwards**
Recall	3	**Recall the three objects after a delay**
Language and praxis	9	**Naming, repetition, a three-stage command, reading, writing, copying**

The five scored domains of the MMSE, totalling out of a possible 30; the accompanying scale plate carries the typeset form (Folstein et al 1975; Clinical Methods in Psychiatry, AIIMS 2024).

TRAP **Treating a low MMSE as a diagnosis.** The score is a cross-sectional measure of impairment, not a diagnosis of dementia. Delirium, depressive pseudodementia, low education, sensory deficit, language barrier and poor cooperation all pull it down; a single number never diagnoses, and a normal number never excludes early or frontal disease.

17.7 The Montreal Cognitive Assessment (MoCA)

The screen built to catch what the MMSE misses. The **MoCA** of Nasreddine and colleagues was developed in the late 1990s specifically to remedy the MMSE's insensitivity to mild cognitive impairment, and it is scored out of a possible 30 across seven domains, adding the executive, abstraction and richer delayed-recall items the MMSE lacks. Its cut-off is **26**: a total at or above 26 is taken as normal, and below 26 as impaired. A single point is added to the total for anyone with twelve years or fewer of formal education, a built-in correction absent from the MMSE and one that matters greatly in populations of variable schooling. Because it loads on delayed free recall and on frontal-executive tasks (trail-making, clock drawing, phonemic fluency, abstraction), the MoCA is the more sensitive of the two to mild cognitive impairment and early Alzheimer disease, at some cost in specificity. Like the MMSE it is permission-required and now requires certified training to administer; the accompanying scale plate carries the typeset structure.

MOCA DOMAIN	POINTS	WHAT IT ADDS OVER THE MMSE
Visuospatial / executive	5	**Trail-making, cube copy and clock drawing, absent from the MMSE**
Naming	3	**Low-frequency animals (lion, rhinoceros, camel)**
Attention	6	**Digit span, vigilance tap-test and serial sevens**
Language	3	**Sentence repetition and phonemic fluency**
Abstraction	2	**Similarities (train and bicycle; watch and ruler)**
Delayed recall	5	**Five words, uncued, the key memory load**
Orientation	6	**Date, month, year, day, place, city**

The seven scored domains of the MoCA, totalling out of a possible 30, with one point added for twelve years or fewer of schooling; the accompanying scale plate carries the typeset form (Nasreddine et al; Kaplan and Sadock CTP 2024).

RULE **For suspected mild cognitive impairment, reach for the MoCA.** Its executive load and its five-word uncued recall catch the early decline the MMSE ceilings past; the price is lower specificity, so a below-cut-off MoCA screens in, it does not diagnose.

24 MMSE CUT-OFF FOR IMPAIRMENT (OUT OF A POSSIBLE 30)	**26** MOCA CUT-OFF FOR IMPAIRMENT (OUT OF A POSSIBLE 30)	**1** EXTRA MOCA POINT FOR TWELVE YEARS OR FEWER OF SCHOOLING	**18** FAB MAXIMUM, SIX SUBTESTS SCORED 0 TO 3

INDIA

The education and language caveats are not academic in the Indian setting, where literacy varies widely and the raw MMSE and MoCA cut-offs travel poorly. The Hindi Mental State Examination (HMSE) was developed as a culturally and linguistically adapted screen for low-literacy and non-literate Indian populations and is listed alongside the MMSE, MoCA and Addenbrooke's examination in the standard Indian bedside repertoire (Clinical Methods in Psychiatry, AIIMS 2024), and it appears in Indian medicolegal capacity assessments of elderly individuals. Vernacular adaptations of the MoCA and the ACE, and the indigenous neuropsychological batteries developed in the NIMHANS and AIIMS traditions, exist for the same reason: to keep the cognitive examination valid across the country's languages and schooling levels rather than importing a Western cut-off wholesale.

GOOD TO REMEMBER

- **The principle:** the cognitive examination is a hierarchy, attention first, then orientation, memory, language and praxis, then executive function, because a deficit at any tier invalidates the tiers below it, and the whole is a cross-sectional snapshot of the higher mental functions, never a diagnosis on its own.
- **The discriminator:** the MMSE (out of a possible 30, cut-off 24) has no executive items and misses mild cognitive impairment; the MoCA (out of a possible 30, cut-off 26, plus one point for twelve years or fewer of schooling) adds executive and delayed-recall load and is the more sensitive to mild cognitive impairment.
- **The one exam fact:** attention is tested first, and fluctuating inattention, not amnesia, is the signature of delirium.

HOLD THIS

Examine the higher mental functions in hierarchical order (attention, orientation, memory, language and praxis, executive), because inattention, the hallmark of delirium, invalidates everything below it; then bundle them into the two screens whose cut-offs must be reproduced cold, the MMSE at 24 out of a possible 30 (blind to executive function and to mild cognitive impairment) and the MoCA at 26 out of a possible 30 with a one-point allowance for twelve years or fewer of schooling (the more sensitive to mild cognitive impairment), remembering that a score measures impairment, it never makes the diagnosis.

18 · The biopsychosocial and 4-Ps formulation

The single skill that binds the whole of this chapter, the history, the mental state examination and the diagnostic label, into one usable clinical product is the **case formulation**. Where a diagnosis places a patient in a category, a formulation tells the story of why *this* person developed *this* problem at *this* moment, and it is the formulation, not the diagnosis, that a management plan is actually built on. It is also the most reliably examined assessment skill on the paper: the long case and the viva reward the candidate who can move past "the diagnosis is a depressive episode" to "here is a middle-aged man, vulnerable for these reasons, tipped over now by these events, kept unwell by these, and protected by these, so here is what I would do first".

How to use this page. Fix the diagnosis-versus-formulation distinction first, because the commonest exam error is to offer a diagnosis when a formulation is asked for. Then learn the **biopsychosocial model** as the vertical axis (biological, psychological, social) and the **four Ps** as the horizontal axis (predisposing, precipitating, perpetuating, protective); the two axes cross to make the grid that the accompanying figure lays out, and that grid is the answer template for almost any "formulate this case" question. Finally see how the grid generates the plan: the perpetuating column is what treatment attacks, the protective column is what treatment mobilises.

The 4 Ps	Predisposing	Precipitating	Perpetuating	Protective
Biological	genetic loading, family history, birth or developmental insult	a physical illness, substance use, a medication change	chronic pain, ongoing substance use, poor adherence	good physical health, no substance use, a good treatment response
Psychological	early adversity, maladaptive schemas, low self-esteem	a loss, a failure, a threat to self-worth	cognitive distortions, avoidance, hopelessness	insight, coping skills, psychological-mindedness
Social	childhood neglect, poverty, migration	bereavement, job loss, relationship breakdown	isolation, high expressed emotion, financial strain	supportive relationships, employment, a faith community

Fig 19.13 The formulation grid: the biopsychosocial model and the 4 Ps. A formulation is the individual account of why this person has this problem at this time, and it is what turns a diagnosis into a plan. The grid crosses the three biopsychosocial levels, biological, psychological and social, against the four temporal factors: predisposing (the long-standing vulnerabilities), precipitating (what tipped it over now), perpetuating (what keeps it going) and protective (the strengths and supports to build on). Working through the twelve cells forces attention to factors a diagnosis alone would miss, and the perpetuating and protective columns in particular point directly to what the treatment should target and what it can lean on.

18.1 Diagnosis versus formulation: the category and the individual account

A diagnosis is nomothetic, a formulation is idiographic. A **diagnosis** is a shared category: it matches the patient's symptom pattern to the criteria of ICD-11 or DSM-5-TR and answers the question "what is the disorder?". It is deliberately impersonal, because its value is precisely that it is the same for every patient who meets the criteria, which is what lets it carry a prognosis and an evidence-based treatment. A case formulation answers a different and complementary question, "why this person, why this problem, why now?", and its value is precisely that it is unique to the individual in front of you. Formulation is not a competitor to diagnosis but its clinical partner: the diagnosis says what treatments have worked for this *kind* of problem, the formulation says how to deliver them to *this* patient and what else must be addressed. A formulation is, in Jaspers' terms, an exercise in both understanding (an empathic grasp of the patient's experience) and explaining (an evidence-based account of the contributing causes), and following Jaspers the two must be held together rather than collapsed into one. Crucially, a formulation is a hypothesis: it is provisional, iterative and revised as new information arrives, whereas the diagnosis, once criteria are met, is comparatively stable.

FEATURE	DIAGNOSIS	FORMULATION
What it is	The disorder category the illness belongs to (ICD-11, DSM-5-TR)	**The individualised account of why this person has this problem now**
Question answered	"What is the disorder?"	**"Why this person, why this problem, why now?"**
Level	Nomothetic: shared across all who meet criteria	Idiographic: specific to the individual
Content	Symptom pattern matched to operational criteria	Predisposing, precipitating, perpetuating and protective factors across the biological, psychological and social domains
Status	Relatively fixed once criteria are met	A working hypothesis, revised with new information
What it drives	Prognosis and evidence-based treatment selection	The individualised, sequenced management plan

The diagnosis names the category; the formulation explains the individual. They are partners, not rivals: the diagnosis carries the evidence base, the formulation carries the delivery.

RULE **A diagnosis labels, a formulation explains.** When the examiner asks you to "formulate", give the individualised causal account across the biopsychosocial domains and the four Ps, not the ICD or DSM category; naming the disorder is a necessary first line, never the whole answer.

18.2 The biopsychosocial model: the vertical axis (Engel, 1977)

Three domains, and an argument against dualism. The biopsychosocial model, proposed by George Engel (Science, 1977), holds that illness is never purely "physical" or purely "mental": every presentation is shaped simultaneously by **biological**, **psychological** and **social** factors, and a complete account must weigh all three. It was framed explicitly as a corrective to the Cartesian biomedical model, which split mind from body and so mishandled exactly the mixed presentations psychiatry sees. For the formulation this model supplies the vertical axis, the three rows into which any causal factor is sorted. The biological row covers disease and physiology (genetic loading, the brain, physical illness, substances and drugs). The psychological row covers cognition, mood and behaviour (temperament, attachment and early experience, beliefs and schemas, coping style, personality). The social row covers the interpersonal, the social and occupational, and the health-care system (family, relationships, work, housing, culture, access to care).

Biological

Disease and physiology: genes and family history, the brain and its neurochemistry, physical illness, substances and medication.

Psychological

Cognition, mood and behaviour: temperament, attachment and early experience, beliefs and maladaptive schemas, coping and defensive style, personality.

Social

Interpersonal, social and occupational, and the health-care system: family and relationships, work and finances, housing, culture and community, access to care.

INDIA

In Indian practice the social row carries unusual weight, and the family sits at its centre. The co-resident family is routinely a predisposing factor (high expressed emotion, enmeshment), a perpetuating factor (conflict, stigma, treatment interruption) and, most importantly, a protective factor and treatment ally: the Indian Psychiatric Society's alcohol-use guidance formalises this by naming a co-resident relative as the recovery monitor and supervisor of supervised disulfiram (IPS_CPG 2014). A culturally competent formulation also captures the patient's explanatory model and idiom of distress in the social row; the wider transcultural frame of the cultural concepts of distress is developed in the Consultation-liaison, geriatric and transcultural psychiatry notes.

18.3 The 4-Ps grid: the horizontal axis

Four factor-classes, set on a time axis. The **four Ps** are the horizontal axis of the formulation, sorting every factor not by its domain but by the *role* it plays in the illness across time. There are four, and the exam expects all four by name. A predisposing factor is a long-standing background vulnerability that set the stage (the "why this person"). A precipitating factor is the recent trigger that brought the problem on now (the "why now"). A perpetuating factor is what maintains the problem and blocks recovery once it has begun. A protective factor is a strength or resource that buffers the person and improves the prognosis. Setting the vertical biopsychosocial axis against this horizontal four-Ps axis produces the grid the accompanying figure draws: three rows by four columns, twelve cells, each prompting a specific question and together making the standard template for a written or spoken formulation.

Predisposing

Long-standing vulnerabilities that set the stage, from before the illness (genes, early adversity, temperament, chronic disadvantage). The "why this person".

Precipitating

Recent triggers that brought the problem on at this point (an acute stressor, a loss, a physical illness, a substance). The "why now".

Perpetuating

Factors that maintain the problem and impede recovery (ongoing substance use, avoidance, rumination, unemployment, conflict, non-adherence). The treatment target.

Protective

Strengths and resources that mitigate the illness and aid recovery (insight, social support, engagement with care, employment, faith and community). The prognosis and the plan's allies.

DOMAIN	PREDISPOSING	PRECIPITATING	PERPETUATING	PROTECTIVE
Biological	Family history, genetic loading, obstetric or developmental insult, chronic physical illness	Substance intoxication or withdrawal, an acute illness, a medication change	**Continued substance use, poor physical health, medication non-adherence**	Good physical health, no substance dependence, prior treatment response
Psychological	Insecure attachment, early trauma, maladaptive schemas, personality traits, low self-esteem	A recent loss, a perceived failure or narcissistic injury	**Cognitive distortions, avoidance, rumination, hopelessness**	Psychological-mindedness, insight, adaptive coping, motivation to change
Social	Childhood adversity, poverty, disrupted or chaotic family	Bereavement, job loss, relationship breakdown, migration	**Unemployment, marital conflict, high expressed emotion, isolation, stigma**	Supportive family, stable work and housing, a community or faith network

The biopsychosocial 4-Ps grid: the three Engel domains (rows) crossed with the four Ps (columns) give twelve cells, each with a prompting question. The perpetuating column (shaded) is what treatment attacks; the protective column carries the prognosis.

MNEMONIC

PREDISPOSING · PRECIPITATING · PERPETUATING · PROTECTIVE

The four Ps, in time order: what made the person **vulnerable** (predisposing), what **triggered** it now (precipitating), what **keeps** it going (perpetuating), and what **helps** (protective). Some schemes add a fifth P for the presenting **Problem** itself; the core examinable set is four.

TRAP **Confusing predisposing with precipitating, and forgetting protective.** A long-standing trait belongs under predisposing; the recent event that tipped the patient over belongs under precipitating. Filing a recent job loss as "predisposing" is the classic slip. The equally common error is omitting the protective column altogether, which is where prognosis and the patient's own resources live.

3	4	12	1977
BIOPSYCHOSOCIAL DOMAINS (ENGEL: BIO, PSYCHO, SOCIAL)	PS OF THE FORMULATION (PREDISPOSING, PRECIPITATING, PERPETUATING, PROTECTIVE)	CELLS IN THE GRID (THREE DOMAINS BY FOUR PS)	ENGEL'S BIOPSYCHOSOCIAL PAPER (SCIENCE)

18.4 The aetiological and the longitudinal formulations

Two further lenses that overlay the grid. The grid is the workhorse, but two related formats are worth naming. The aetiological formulation is essentially the predisposing, precipitating and perpetuating columns read as a causal chain of vulnerability, trigger and maintenance; the classical teaching (Shorter Oxford; Companion to Psychiatric Studies) is that the perpetuating causes are the usual target for treatment of the established illness, while the predisposing and precipitating causes are the ones relevant to prevention. The longitudinal formulation (also called

the developmental formulation) tells the story chronologically instead of by category: it traces the patient's life epoch by epoch, showing how temperament, attachment, early adversity, later stresses and current supports accumulated into the present presentation. In an Indian long case the developmental history feeding this longitudinal account is a graded skill in its own right; the descriptive-psychopathology vocabulary and the deeper psychometric theory that the interview and mental state examination draw on are developed in the Psychometry, Assessment and Descriptive Psychopathology notes. Both formats are just re-cuts of the same biopsychosocial and four-Ps material, not new content to memorise.

18.5 From formulation to the management plan

The plan mirrors the grid. The formulation is not an academic flourish; it directly generates the management plan, and it does so along the same two axes. Reading down the biopsychosocial rows gives a plan that is itself biological, psychological and social (for example medication, a specific psychotherapy, and a social or family intervention), which is why a good management answer is structured biopsychosocially. Reading across the four Ps tells you what each part of the plan is *for*: treatment concentrates on the **perpetuating** factors, because those are what is keeping the patient unwell and are the most modifiable now; the **protective** factors are deliberately mobilised and strengthened (engaging a supportive spouse, building on the patient's motivation); and the predisposing and precipitating factors, largely historical, inform prevention and relapse-planning rather than the acute plan. Where the presentation carries risk, the same four Ps are applied to the risk itself (predisposing, precipitating, perpetuating and protective factors for suicide), a formulation-driven approach developed with the suicide risk assessment and the C-SSRS as used inside the MSE in the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

WORKED EXAMPLE

A middle-aged man presents with a depressive episode (the diagnosis). The **formulation**: *predisposing*, a family history of depression and perfectionistic, self-critical traits; *precipitating*, a recent enforced redundancy; *perpetuating*, social withdrawal, rising alcohol use and escalating marital conflict; *protective*, a supportive wife, no established alcohol dependence, and that he sought help himself. The plan follows directly: an antidepressant and a review of alcohol use (biological), cognitive behaviour therapy targeting the self-critical cognitions and withdrawal (psychological), and couple work plus support with re-employment (social), aimed squarely at the perpetuating column while mobilising the protective factors already present.

GOOD TO REMEMBER

- **The principle:** a formulation is the individualised, idiographic account of why this person has this problem now, built by crossing Engel's three biopsychosocial domains with the four Ps; it partners the diagnosis rather than replacing it, and it is a revisable hypothesis.
- **The one discriminator:** predisposing = long-standing vulnerability ("why this person"); precipitating = the recent trigger ("why now"); perpetuating = what maintains it (the treatment target); protective = strengths and resources (the prognosis and the plan's allies).
- **The one exam fact:** perpetuating factors are the usual target of treatment while predisposing and precipitating factors inform prevention (Shorter Oxford; Companion), and the model itself is Engel's 1977 biopsychosocial approach.

HOLD THIS

A diagnosis names the category; the formulation crosses Engel's three domains (biological, psychological, social) with the four Ps (predisposing, precipitating, perpetuating, protective) to explain why this person is ill now, and the management plan then attacks the perpetuating column and mobilises the protective column.

19 · The rating scales

A clinical interview *describes* a patient; a **rating scale** *quantifies* what the interview finds, converting a symptom picture into a number that can be tracked, compared against a threshold, and read against an evidence base. The rating scales are therefore not a substitute for the mental state examination but its metric complement: the examination tells you a patient is depressed, the scale tells you how depressed, and whether the treatment has moved the needle. On the paper this is a compact, high-yield topic that rewards precise recall, because almost every question is of one shape, name the scale for a construct, state who rates it, say how it is built, and give its verified cut-off, and a single wrong number loses the mark.

How to use this page. Fix two cross-cutting distinctions first, since they organise the whole field: whether an instrument is **clinician-rated** or **self-report**, and whether its job is screening, diagnosis or severity and outcome measurement. Then work through the catalogue family by family, the mood scales, the psychosis scales, the anxiety and OCD scales, the cognitive instruments, and the global-functioning and outcome instruments, learning for each what it measures, how it is structured, and its verified band or threshold expressed *out of a possible* maximum. Finally learn the selection step, how to **pick the right scale** for the construct and the setting. The instrument forms themselves are not reproduced here; each is gathered in the accompanying catalogue and the scales appendix at the back, and the deeper machinery of reliability, validity, sensitivity and specificity, standardisation and norms that decides whether any of these numbers can be trusted is developed under reliability and validity above and, in full, in the Psychometry, Assessment and Descriptive Psychopathology notes.

19.1 The two distinctions that sort every scale: who rates it, and what it is for

Classify a scale before you use it, along two axes. The first axis is the *rater*. A clinician-rated (observer-rated) instrument is scored by a trained interviewer who applies clinical judgement to anchored descriptions, so it captures signs the patient may not report and resists exaggeration, at

the cost of time and the need for training and inter-rater reliability; the Hamilton scales, the PANSS, the YMRS and the Y-BOCS are of this kind. A self-report (patient-rated) instrument is completed by the patient, is quick and cheap, needs no trained rater and gives the patient's own perspective, but depends on literacy, insight and candour and is vulnerable to over- or under-reporting; the GAD-7, the PHQ-9 and the Beck inventories are of this kind. The second axis is the *purpose*. A **screening** scale is a brief, high-sensitivity net cast over an unselected population to flag possible cases for further assessment; a **diagnostic** instrument (typically a structured interview such as the SCID or MINI) operationalises criteria to confirm or exclude a disorder; and a **severity and outcome** scale, the largest group here, assumes the diagnosis is already made and measures how ill the patient is and how that changes with treatment. The commonest error on the paper is to blur these purposes, so hold them apart from the outset.

AXIS	TYPE	WHAT IT MEANS, AND THE EXEMPLARS
Rater	Clinician-rated	**Scored by a trained interviewer against anchors; captures signs, resists faking; needs training and inter-rater reliability (HAM-D, MADRS, YMRS, PANSS, BPRS, HAM-A, Y-BOCS)**
	Self-report	**Completed by the patient; fast, cheap, gives the patient's view; limited by literacy, insight and candour (GAD-7, PHQ-9, BDI, GDS)**
Purpose	Screening	Brief, high-sensitivity case-finding in an unselected population; a positive screen triggers fuller assessment (GAD-7, AUDIT, EPDS)
	Diagnostic	A structured interview operationalising criteria to confirm or exclude a disorder (SCID, MINI)
	Severity / outcome	**Assumes the diagnosis; grades severity and tracks change with treatment (HAM-D, MADRS, YMRS, PANSS, Y-BOCS)**

Every instrument in the catalogue sits at the crossing of a rater axis (clinician-rated versus self-report) and a purpose axis (screening, diagnostic, or severity and outcome). Naming both for a given scale is half the answer.

RULE **Rater and purpose first, number second.** Before quoting a cut-off, state whether the scale is clinician-rated or self-report and whether it screens, diagnoses or measures severity; a severity scale grades an established diagnosis, it does not make one.

19.2 The mood scales: HAM-D, MADRS and YMRS

Three severity scales carry the mood chapter: two for depression, one for mania, all clinician-rated. The Hamilton Depression Rating Scale (HAM-D, HDRS; Hamilton, 1960) is the oldest and most-used depression scale in trials. The original had 21 items, but Hamilton advised counting only the first 17, so the **17**-item version is standard, each item scored either 0 to 4 or 0 to 2, giving a total out of a possible 52. Scores at or below 7 mark remission; a widely used severity scheme reads 8 to 13 as mild, 14 to 18 as moderate, 19 to 22 as severe and 23 and above as very severe, and a response is conventionally a fall of at least half from baseline. Its known weakness is a heavy loading of somatic and insomnia items, which can flatter sedating drugs. The Montgomery Asberg Depression Rating Scale (MADRS; Montgomery and Asberg, 1979) answers that weakness: a leaner 10-item clinician-rated scale, each item scored 0 to 6, giving a total out of a possible 60, weighted toward psychological rather than somatic symptoms and expressly built to be sensitive to change, which is why it is favoured as a primary antidepressant-trial outcome. Here a score at or below 10 indicates remission and a score above 30 to 35 indicates severe depression. For the manic pole the Young Mania Rating Scale (YMRS; Young and colleagues, 1978) is the gold standard: 11 clinician-rated items, seven scored 0 to 4 and four core items (irritability, speech, thought content, and disruptive or aggressive behaviour) double-weighted 0 to 8, giving a total out of a possible 60, with remission usually set at 12 or below. Because a few items can score modestly in euthymia, a "normal" YMRS is not necessarily zero. All three, together with the HAM-D, MADRS and YMRS as applied at the bedside, belong with the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes.

HAM-D (HDRS)

Clinician-rated depression severity; 17-item standard form, out of a possible 52; remission at or below 7; somatic-item heavy.

MADRS

Clinician-rated, 10 items each 0 to 6, out of a possible 60; psychologically weighted and change-sensitive; remission at or below 10.

YMRS

Clinician-rated mania scale; 11 items, four double-weighted, out of a possible 60; gold standard for manic severity; remission at or below 12.

> **PEARL**
>
> When an examiner asks why the MADRS, not the HAM-D, is the modern antidepressant-trial workhorse, the answer is its psychological weighting and superior sensitivity to change: three of the seventeen HAM-D items are sleep items, so a sedating drug can lower the HAM-D without truly lifting mood, a bias the MADRS largely escapes.

19.3 The psychosis scales: PANSS and BPRS

Two clinician-rated interviews grade psychotic symptom severity, one the modern standard, one its parent. The Positive and Negative Syndrome Scale (PANSS; Kay, Fiszbein and Opler, late 1980s) is the gold-standard outcome measure in schizophrenia trials. It has 30 items across three subscales, seven for positive symptoms (delusions, hallucinations), seven for negative symptoms

(blunted affect, withdrawal, avolition), and 16 for general psychopathology, and each item is rated on a seven-point anchored scale running from 1 (absent) to 7 (extreme). A subtle but examinable point follows: because the floor of every one of the 30 items is 1, not 0, the total runs from a floor at 30 up to a ceiling out of a possible 210, so the lowest possible PANSS is 30 rather than zero, and there is no single official diagnostic cut-off, the scale being read as change and by subscale. It is semi-structured, needs specific rater training, and takes roughly half an hour to forty minutes. The Brief Psychiatric Rating Scale (BPRS; Overall and Gorham, 1962) is the older, shorter parent from which the PANSS grew: 18 items covering both psychotic and non-psychotic symptoms, each rated on a seven-point scale, giving a total out of a possible 126. Its strength is brevity; its weakness is limited coverage of negative symptoms, the very gap the PANSS was designed to close. The PANSS and BPRS in clinical use are developed with the Schizophrenia: clinical features and phenomenology notes.

TRAP **Quoting the PANSS minimum as zero.** Every item is anchored at 1 for "absent", so a fully asymptomatic patient still scores 30. The PANSS runs from 30 to a possible 210, and a "50 percent reduction" in a trial is measured from that floor, not from zero.

19.4 The anxiety and OCD scales: HAM-A, GAD-7 and Y-BOCS

One clinician-rated anxiety scale, one self-report screen, and the OCD gold standard. The Hamilton Anxiety Rating Scale (HAM-A; Hamilton, 1959) is the clinician-rated severity and outcome measure for generalised anxiety: 14 items, each scored 0 to 4, giving a total out of a possible 56, split across psychic and somatic anxiety clusters. A total in the high teens (a threshold near 17 to 18) marks clinically significant anxiety, and a common scheme reads up to 17 as mild, 18 to 24 as mild to moderate and 25 to 30 as moderate to severe. The GAD-7 (Spitzer and colleagues, 2006) is its self-report counterpart, and the standard primary-care screen for anxiety: seven items, each scored 0 to 3, giving a total out of a possible 21, with 5, 10 and 15 marking mild, moderate and severe, and a score at or above 10 the usual threshold to prompt fuller assessment. For obsessive-compulsive disorder the Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman and colleagues, 1989) is the undisputed gold standard: a 10-item semi-structured scale (five items for obsessions, five for compulsions) rating time, interference, distress, resistance and control, each 0 to 4, giving a total out of a possible 40 that is independent of symptom content. Its bands are worth memorising, 0 to 7 subclinical, 8 to 15 mild, 16 to 23 moderate, 24 to 31 severe and 32 to 40 extreme, and a score at or above 16 is the threshold that marks clinically symptomatic OCD in treatment trials. The Y-BOCS as used to track exposure and response prevention belongs with the Anxiety, OCD and trauma-related disorders notes.

HAM-A

Clinician-rated anxiety severity; 14 items each 0 to 4, out of a possible 56; threshold for significance in the high teens.

GAD-7

Self-report anxiety screen; 7 items each 0 to 3, out of a possible 21; screen-positive at or above 10 (bands at 5, 10, 15).

Y-BOCS

Semi-structured OCD gold standard; 10 items each 0 to 4, out of a possible 40; clinically symptomatic at or above 16.

19.5 The cognitive instruments: MMSE and MoCA

Two brief cognitive screens, both scored out of a possible 30, differing in what they catch. The Mini-Mental State Examination (MMSE; Folstein, Folstein and McHugh, 1975) is the classic bedside cognitive screen: an 11-question instrument sampling five domains, orientation, registration, attention and calculation, recall, and language, scored out of a possible 30 and taking five to ten minutes. A score at or below 23 is the conventional threshold indicating cognitive impairment. Its limitations are examinable: it is insensitive to frontal-executive and subcortical deficits, shows a ceiling effect in the well-educated, and is confounded by low literacy and language, so a normal MMSE does not exclude early or executive impairment. The Montreal Cognitive Assessment (MoCA; Nasreddine and colleagues, 2005) was built precisely to catch what the MMSE misses, mild cognitive impairment in people who score in the normal range on the MMSE. It also runs out of a possible 30, adds executive, visuospatial and abstraction tasks, and takes about ten minutes; the authors' recommended clinical cutoff is 26, meaning a score at or above 26 is read as normal and below 26 as impaired, with one point added for twelve or fewer years of education. As these are permission-required instruments, their domains and scoring are set out on the accompanying scale plate rather than reproduced here.

TRAP **Treating a normal MMSE as a normal cognition.** The MMSE ceilings in educated patients and barely samples executive function; a patient with early frontal or subcortical impairment can score above 23 and still be impaired. Reach for the MoCA (cutoff 26) when mild or executive impairment is the question.

30	23	26	16
MMSE AND MOCA MAXIMUM (EACH SCORED OUT OF A POSSIBLE 30)	MMSE AT OR BELOW THIS INDICATES COGNITIVE IMPAIRMENT	MOCA RECOMMENDED CUTOFF (AT OR ABOVE 26 IS NORMAL)	Y-BOCS AT OR ABOVE THIS MARKS CLINICALLY SYMPTOMATIC OCD

INDIA

Imported cognitive screens travel badly across India's languages and literacy levels, so the field re-standardises rather than borrows. The Hindi Mental State Examination (HMSE) is the vernacular adaptation of the MMSE for low-literacy Indian populations, and the NIMHANS Neuropsychology Battery is the indigenous instrument set for deeper testing (verbal fluency, working memory, set-shifting), alongside the PGI and AIIMS batteries. For disability itself India has its own device: the Indian Disability Evaluation and Assessment Scale (IDEAS), developed by the Indian Psychiatric Society's Rehabilitation Committee in 2002, scores four domains (self-care, interpersonal activities, communication and understanding, and work) each 0 to 4 and, with duration of illness, yields the global disability score used for statutory certification of mental illness. The principle that a cut-off is only valid in the population its norms were drawn from is developed in the Psychometry, Assessment and Descriptive Psychopathology notes, and the statutory disability frame in the Mental health legislation and forensic psychiatry notes.

19.6 The global-functioning and outcome instruments, and the substance, somatic and suicide pointer

Beyond symptoms, three instruments grade global functioning and change. The Global Assessment of Functioning (GAF) is a single clinician-rated number from 1 to a possible 100, higher meaning better psychological, social and occupational functioning; it was the old DSM Axis V. DSM-5 retired it as too unreliable and confounded by symptoms, replacing it with the WHODAS 2.0 (the World Health Organization Disability Assessment Schedule, second edition), a 36-item instrument covering six domains, cognition, mobility, self-care, getting along with people, life activities and participation, available in self, proxy and interviewer forms and validated in Hindi. The Clinical Global Impression (CGI; ECDEU, 1976) is the pragmatic trial workhorse: a clinician's global rating with a severity limb (CGI-S) and an improvement limb (CGI-I), each on a simple one-to-seven scale, valued precisely because a single expert judgement often tracks change as well as a long scale. Beyond these, the catalogue extends into families pointed to elsewhere: for substances, the self-report AUDIT (out of a possible 40, screen-positive at or above 8) and CAGE belong with the Substance use disorders notes; the C-SSRS (the Columbia Suicide Severity Rating Scale) for suicide-risk stratification, and the self-report PHQ-9 for depression in primary care, belong with the suicide risk assessment and the C-SSRS as used inside the MSE in the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

19.7 The scale catalogue and how to pick the right scale (Step 5b)

Selection is a construct-to-instrument match, not a reflex. The final assessment step, choosing an instrument, follows a fixed logic that the accompanying catalogue is built to serve. First name the *construct* (which symptom dimension, and which disorder). Second name the *purpose* (to screen, to diagnose, or to grade severity and track outcome). Third fix the *setting and rater* (a busy clinic favours a brief self-report; a trial or a medicolegal assessment demands a trained clinician-rated interview). Fourth match the *population and language* (a validated, locally normed translation, never a raw import). Run those four filters and the instrument is usually determined: to track a depressive episode in a trial, the MADRS; to grade mania, the YMRS; to measure schizophrenia outcome, the PANSS; to follow OCD, the Y-BOCS; to screen anxiety in primary care, the GAD-7; to screen cognition, the MMSE, or the MoCA when mild impairment is the question. This is the discipline of **scale selection**, and being able to **pick the right scale** for the construct and setting is exactly what the arc's Step 5b examines. The consolidated **scale catalogue** below is the reference for that choice; the instrument forms themselves are reproduced in the scales appendix.

SCALE	CONSTRUCT (DISORDER)	RATER	STRUCTURE AND TOTAL (OUT OF A POSSIBLE N)	VERIFIED CUT-OFF OR BAND
HAM-D	Depression severity (mood)	Clinician-rated	17 items; 52	**Remission at or below 7; mild 8–13, moderate 14–18, severe 19–22, very severe 23+**

SCALE	CONSTRUCT (DISORDER)	RATER	STRUCTURE AND TOTAL (OUT OF A POSSIBLE N)	VERIFIED CUT-OFF OR BAND
MADRS	Depression severity, change-sensitive (mood)	Clinician-rated	10 items each 0–6; 60	**Remission at or below 10; severe above 30–35**
YMRS	Mania severity (mood)	Clinician-rated	11 items, 4 double-weighted; 60	**Remission at or below 12; gold standard for mania**
PANSS	Schizophrenia symptom severity	Clinician-rated	30 items each 1–7 (7+7+16); 210	**Floor 30 (not 0); read by change and subscale, no fixed cut**
BPRS	Psychotic and non-psychotic symptoms	Clinician-rated	18 items each rated 1–7; 126	The older, briefer parent of the PANSS
HAM-A	Anxiety severity (GAD)	Clinician-rated	14 items each 0–4; 56	**Significant in the high teens (near 17–18)**
GAD-7	Anxiety screen	Self-report	7 items each 0–3; 21	**Screen-positive at or above 10 (bands 5, 10, 15)**
Y-BOCS	OCD severity	Either (semi-structured)	10 items each 0–4; 40	**Symptomatic at or above 16; 8–15 mild, 16–23 moderate, 24–31 severe, 32–40 extreme**
MMSE	Global cognition screen	Clinician-rated	11 questions, 5 domains; 30	**Impairment at or below 23**
MoCA	Mild cognitive impairment screen	Clinician-rated	Multi-domain; 30	**Normal at or above 26; +1 point if 12 or fewer years' education**
GAF	Global functioning	Clinician-rated	Single rating; 100	Higher is better; the retired DSM Axis V
WHODAS 2.0	Disability and functioning	Self / proxy / interviewer	36 items, 6 domains	DSM-5 replacement for the GAF; Hindi validated
CGI	Global severity and change	Clinician-rated	CGI-S and CGI-I limbs, 1–7 each	Pragmatic trial workhorse
AUDIT	Alcohol-use screen (substance)	Self-report	10 items; 40	**Screen-positive at or above 8**

SCALE	CONSTRUCT (DISORDER)	RATER	STRUCTURE AND TOTAL (OUT OF A POSSIBLE N)	VERIFIED CUT-OFF OR BAND
C-SSRS	Suicide risk (somatic / suicide)	Clinician-rated	Ideation and behaviour subscales	Stratifies severity of ideation and behaviour
PHQ-9	Depression screen (primary care)	Self-report	9 items each 0–3; 27	**Bands at 5, 10, 15, 20; item 9 screens suicidality**

The rating-scale catalogue: for each instrument, its construct, rater, structure, and verified threshold. Every total is stated out of its possible maximum; the mood, psychosis, anxiety and OCD rows cross-reference their disorder chapters.

RULE **Match the construct, the purpose, the setting and the rater.** The right scale is the one whose construct fits the symptom, whose purpose fits the task (screen, diagnose, or track), and whose format fits the clinic and the patient's language; a validated local translation always beats a raw import.

WORKED EXAMPLE

A man with schizophrenia and low mood is entering a clinic trial of an adjunctive antidepressant. Selection runs the four filters. The primary construct is psychotic symptom severity in a trial by a trained rater, so the PANSS. The secondary construct is comorbid depression, needing a scale that does not double-count psychotic items, so a self-report such as the PHQ-9 or BDI rather than the somatic-heavy HAM-D. Global change for the sponsor is captured cheaply by the CGI-I, and cognition, if adjunctive effects are a concern, by the MoCA rather than the MMSE. Four instruments, each chosen because its construct, purpose, rater and format fit, not because it is familiar.

GOOD TO REMEMBER

- **The principle:** a rating scale quantifies a construct an interview has already identified, and every one is defined by four facts, its rater (clinician-rated or self-report), its purpose (screening, diagnostic, or severity and outcome), its structure, and its verified threshold stated out of a possible maximum.
- **The one discriminator:** mood is HAM-D and MADRS for depression (MADRS the change-sensitive, less somatic one) and the YMRS for mania (all out of a possible 60 except the HAM-D's 52); psychosis is the PANSS (floor 30, up to a possible 210) and its parent the BPRS; anxiety and OCD are the HAM-A, the self-report GAD-7 and the Y-BOCS; cognition is the MMSE (impairment at or below 23) and the MoCA (normal at or above 26), both out of a possible 30.
- **The one exam fact:** the two cognitive cut-offs are the crunch, MMSE 23 or below indicates impairment and the MoCA cutoff is 26, both scored out of a possible 30, and the MoCA exists to catch the mild and executive impairment the MMSE ceilings past.

HOLD THIS

Classify every scale by rater (clinician-rated versus self-report) and purpose (screen, diagnose, or track severity) before quoting its number, and memorise the crunch cut-offs out of their possible maxima: HAM-D remission at or below 7 (out of a possible 52), MADRS remission at or below 10 and YMRS at or below 12 (each out of a possible 60), PANSS floored at 30 (up to a possible 210), Y-BOCS symptomatic at or above 16 (out of a possible 40), and the cognitive pair, MMSE impaired at or below 23 and MoCA normal at or above 26 (each out of a possible 30).

20 · Reliability and validity

Every rating scale in this chapter, and every scale reproduced in the consolidated appendix, is only as trustworthy as its **psychometric properties**, and the two that decide whether a score means anything are reliability and validity. The examiner tests this in the plainest possible form: reliability is **consistency**, validity is **accuracy**, and the candidate who can hold those two ideas apart, and state how each is measured, has the marks. This page teaches the properties as they bear on the practical question a clinician actually faces, which is whether to believe a number a scale has produced, and whether to reach for that scale in the first place.

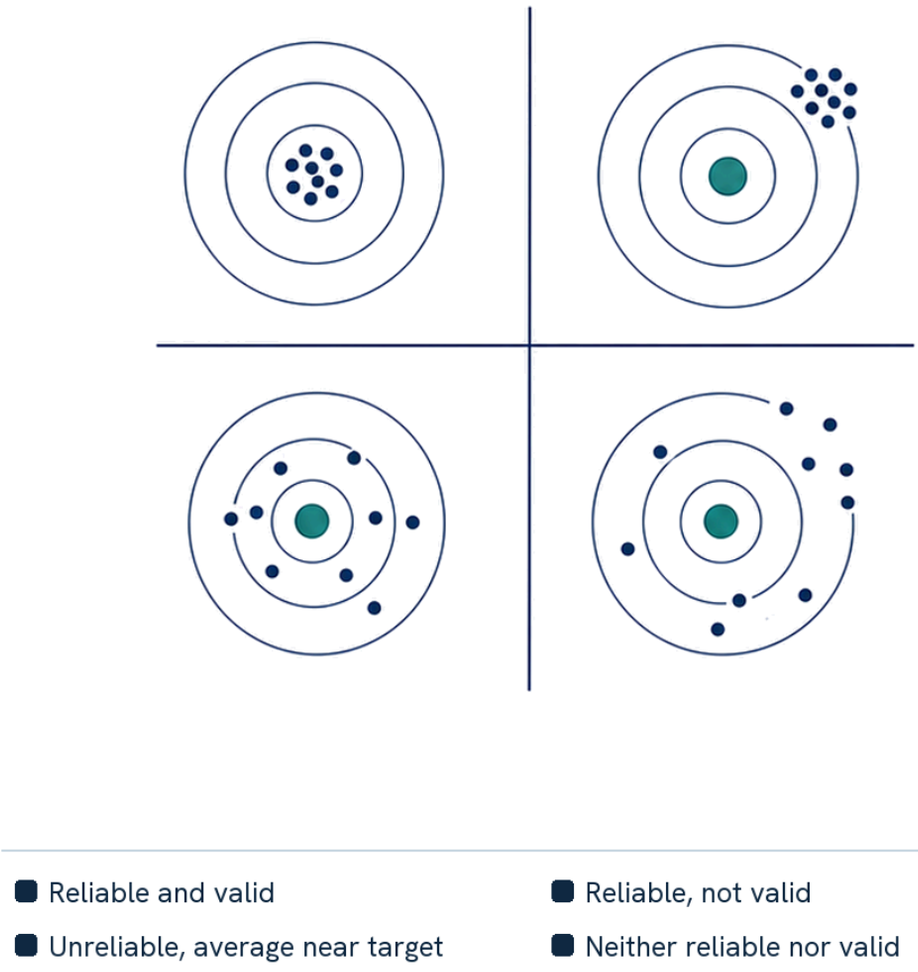


Fig 19.14 Reliability is consistency and validity is accuracy. Measurements may be both reliable and valid, reliably biased, scattered around the target on average, or neither consistent nor accurate.

How to use this page. Fix the headline distinction first, because it is the single commonest confusion on the paper: a scale can be perfectly *reliable* and still be *invalid*, but it can never be valid without first being reliable. Then learn the forms each property takes, since the exam rewards the specific names, the four kinds of consistency and the families of accuracy, not a vague gesture at "the scale is good". Finally see how these ideas become **sensitivity and specificity** and the predictive values when the instrument is a screening test, and how a raw score means nothing until **standardisation** and norms give it a reference point. The deep theory underneath all of this, the mathematics of factor analysis, the mechanics of test construction and item analysis, and standardisation in full, is developed in the Psychometry, Assessment and Descriptive Psychopathology notes; here the treatment is kept to what governs choosing and reading a clinical scale.

20.1 The two questions a scale must answer: consistency and accuracy

Reliability asks "is it consistent?"; validity asks "is it measuring the right thing?". Reliability is the reproducibility of a score: the degree to which the same instrument gives the same answer on

the same unchanged subject, across occasions, across raters, or across the items within it. It is quantified as a correlation coefficient running from 0.00, meaning no reliability at all, to 1.00, meaning perfect reproducibility, and it is a property not of the test in the abstract but of the test scores as produced in a particular sample. Validity is a different and higher demand: the degree to which the score actually corresponds to the construct, the diagnosis or the trait it was built to measure, that is, its accuracy. Reliability is a necessary but not a sufficient quality of a useful scale; a scale must be consistent before it can be believed, but consistency alone never guarantees that what it consistently measures is what you wanted. The classic image, drawn in the accompanying figure, is the marksman: reliability is a tight grouping of shots, validity is a grouping centred on the bullseye, and a tight cluster in the wrong corner is the very picture of a reliable but invalid instrument.

RULE **Reliability is consistency; validity is accuracy.** Reliability asks whether the scale gives the same answer twice; validity asks whether that answer is the truth. Get the two words the right way round and most of this topic is already won.

20.2 The forms of reliability: four ways to test consistency

Consistency is checked across time, across raters, and across items. There are four standard estimates, and the exam expects them by name and by what source of error each one probes. Test-retest reliability administers the same scale to the same people on two separate occasions and correlates the two sets of scores; the resulting coefficient of stability captures consistency across time, and the interval matters, a fortnight being appropriate for a fluctuating state such as depression but a longer gap for a stable trait such as a personality dimension. Inter-rater reliability asks whether two or more clinicians scoring the same patient arrive at the same rating, and is the critical property for any clinician-administered instrument; it is reported as a Kappa coefficient for categorical judgements or an intra-class correlation for continuous scores, with Kappa above **0.70** counted as excellent agreement. Internal consistency asks whether the items of a scale hang together and measure a single underlying dimension, and is expressed as Cronbach's alpha (coefficient alpha), which is mathematically the average of every possible split-half of the test; a clinically usable scale should reach an alpha of **0.80** or higher, nearer 0.90 in practice. The split-half method is the older single-administration version of the same idea: the items are divided, usually odd against even, the two halves correlated, and the value corrected upward for the full test length by the Spearman-Brown formula.

Test-retest reliability

Same scale, same people, two occasions, correlated. The coefficient of stability, capturing consistency over time. Its error source is time sampling.

Inter-rater reliability

Agreement between two or more raters scoring the same subject. Kappa (categorical) or intra-class correlation (continuous). The key property of a clinician-rated scale.

Internal consistency

The degree to which items measure one dimension, indexed by Cronbach's alpha, the mean of all possible split-halves. Its error source is content sampling.

Split-half

A single-administration internal-consistency estimate: correlate one half of the items (odd against even) with the other, then correct with the Spearman-Brown formula.

ESTIMATE	WHAT CONSISTENCY IT CHECKS	STATISTIC AND BENCHMARK
Test-retest	Stability of the score across time (same test, two occasions)	**Correlation (coefficient of stability); interval must suit state versus trait**
Inter-rater	Agreement between different raters scoring one subject	**Kappa or intra-class correlation; Kappa above 0.70 is excellent**
Internal consistency	Whether items cohere as one dimension	**Cronbach's alpha; 0.80 or higher for clinical use**
Split-half	Coherence, from a single sitting (halves compared)	**Half-test correlation, Spearman-Brown corrected**

The four standard reliability estimates: test-retest checks consistency across time, inter-rater across observers, and internal consistency and split-half across the items themselves.

20.3 The forms of validity: from surface appearance to the underlying construct

Validity is a ladder from what a test looks like to what it truly measures. The families run from the weakest to the strongest form of evidence. Face validity is the most superficial: whether the scale simply looks, to the person taking it, as though it measures what it claims. It is not a technical property at all but a matter of acceptability, and its real value is that a test which looks relevant keeps the patient engaged and cooperative. Content validity is the first substantive form: whether the items are a representative sample of the whole behavioural domain being measured, so that an anxiety scale with no item on worry has a content gap; it is judged by expert consensus rather than by statistics. Criterion validity correlates the scale against an external, independent gold-standard measure of the same thing, and comes in two time-framed subtypes. Concurrent validity takes the criterion at the same moment (validating a new brief scale against an established one administered together), while predictive validity takes the criterion in the future (whether today's score forecasts a later outcome, such as response to treatment). Construct validity is the most comprehensive: whether the scale genuinely captures the abstract, unobservable construct, the "depression" or "hopelessness" itself. It is built from two complementary strands, convergent evidence, that the scale correlates with other measures of the same construct, and discriminant validity (divergent validity), that it does *not* correlate with measures of unrelated constructs. Campbell and Fiske's 1959 multitrait-multimethod matrix was designed to demonstrate both at once, and Cronbach and Meehl (1955) argued that construct validity ultimately subsumes the others.

Face validity

Whether the test superficially appears to measure what it claims. A matter of acceptability and rapport, not a technical index.

Content validity

Whether the items representatively sample the full behavioural domain. Judged by expert consensus; non-statistical.

Criterion validity

Correlation of the scale with an external gold-standard criterion of the same variable.

Concurrent validity

Criterion measured at the same time as the test (a new scale validated against an established one).

Predictive validity

Criterion measured later; whether the score forecasts a future outcome.

Construct validity

Whether the scale captures the abstract trait it targets, evidenced by convergent and discriminant findings.

FAMILY	THE QUESTION IT ANSWERS	HOW IT IS ESTABLISHED
Face	Does it look like it measures the right thing?	**Subjective appearance to the test-taker; secures cooperation, not proof**
Content	Do the items cover the whole domain?	**Expert consensus that the items sample the construct fully**
Concurrent	Does it agree with a present gold standard?	**Correlate with an established criterion measured at the same time**
Predictive	Does it forecast a future outcome?	**Correlate today's score with a criterion obtained later**
Convergent	Does it track other measures of the same construct?	**High correlation with scales of the same trait**
Discriminant	Does it stay clear of unrelated constructs?	**Low correlation with scales of different traits (Campbell and Fiske, 1959)**

The families of validity, from the surface (face) inward to the construct. Concurrent and predictive are the two subtypes of criterion validity; convergent and discriminant are the two strands of construct validity.

20.4 The cardinal relationship: reliable without valid, never valid without reliable

Reliability is necessary but not sufficient for validity. This is the single most examined line on the topic, and it works in one direction only. A scale can be entirely reliable and yet invalid: if it consistently measures the wrong thing, it will give reproducible, stable, internally coherent scores that simply do not correspond to the intended construct. The bathroom scale that reads three kilograms heavy on every single weighing is perfectly reliable and perfectly wrong; a "depression" questionnaire whose items in fact tap anxiety will show a handsome alpha and good test-retest stability while failing to measure depression at all. The converse, however, is impossible. A scale whose scores scatter unpredictably from one occasion to the next, or on which raters cannot agree, cannot line up with any true criterion, because its own noise swamps any signal;

unreliability sets a ceiling on validity. So reliability is the gatekeeper: it must be present for validity to be even attainable, but its presence never certifies validity on its own.

WORKED EXAMPLE

A team builds a brief "burnout" scale from items that, on inspection, mostly ask about low mood and poor sleep. On piloting it performs beautifully on every reliability index: Cronbach's alpha is 0.91, and the two-week test-retest correlation is 0.86. Reassured, they deploy it, and it flags half the workforce as burned out. The scores are consistent, but they are consistently measuring depression, not burnout: high reliability, poor construct validity. The consistency was real and told them nothing about whether the right thing was being measured. Only a validity study, correlating the scale against an accepted burnout criterion and showing it diverges from a depression measure, would have caught the error.

TRAP **Reading high reliability as proof the scale works.** A stellar alpha and a strong test-retest coefficient show only that the instrument is consistent, not that it measures the intended construct. A reliable scale can be reliably wrong; never let reproducibility stand in for accuracy.

20.5 Sensitivity and specificity and the predictive values of a screening scale

When the scale is a screen, validity is expressed as diagnostic accuracy. A screening instrument is judged against a diagnostic gold standard, and its accuracy is carried by two numbers. Sensitivity is the proportion of people who truly have the condition that the test correctly flags positive, its true-positive rate; a sensitive test misses few genuine cases, that is, it produces few false negatives. Specificity is the proportion of people who truly do not have the condition that the test correctly clears, its true-negative rate; a specific test raises few false alarms, that is, few false positives. Crucially, sensitivity and specificity are intrinsic properties of the test and do not change with how common the disorder is. The predictive values do change. The positive predictive value is the proportion of those who screen positive who genuinely have the condition, and the negative predictive value the proportion of those who screen negative who genuinely do not; both depend heavily on the base rate, so that even an accurate test, applied where the disorder is rare, throws up many false positives and a disappointing positive predictive value. This is why a screen is deliberately tuned for high sensitivity, to catch every possible case and accept some false positives, leaving a later confirmatory assessment to weed them out.

INDEX	WHAT IT MEASURES	CLINICAL READING
Sensitivity	Of those with the disorder, the share the test flags positive	**High sensitivity means few false negatives; good for ruling out**
Specificity	Of those without the disorder, the share the test clears negative	**High specificity means few false positives; good for ruling in**
Positive predictive value	Of those who screen positive, the share who truly have it	**Falls as the disorder gets rarer (base-rate dependent)**
Negative predictive value	Of those who screen negative, the share who truly lack it	**Rises as the disorder gets rarer (base-rate dependent)**

Sensitivity and specificity are fixed properties of the test; the predictive values shift with prevalence. A screen favours sensitivity so as to miss no case, at the cost of false positives.

MNEMONIC

SnNout · SpPin

SnNout: a highly **Sn**sitive test, when **N**egative, rules the diagnosis **out** (few false negatives, so a negative result is trustworthy). **SpPin**: a highly **Sp**ecific test, when **P**ositive, rules the diagnosis **in** (few false positives, so a positive result is trustworthy). Screening leans on SnNout; confirmation leans on SpPin.

20.6 Standardisation and norms: giving a raw score its meaning

A raw score is meaningless until it is referenced. **Standardisation** has two limbs. The first is procedural: administering and scoring the instrument under fixed, uniform conditions for every test-taker, so that a score reflects the person and not the circumstances of testing. The second is the normative reference: establishing, from a large representative standardisation sample, the distribution of scores in the population, which becomes the yardstick against which any individual raw score is read. Those reference data are the *norms*, the average performance of the standardisation sample, and a raw number is converted into a derived score (a percentile, a z-score, a standard score) to locate the person within them. This is norm-referencing, comparing a person to a group; it is distinct from criterion-referencing, comparing a person to a fixed performance standard irrespective of others. The practical corollary is the one that catches candidates out: a cut-off is only valid in the population from which its norms were drawn, which is exactly why an imported threshold cannot be lifted wholesale into a different population.

INDIA

This is where standardisation stops being academic in Indian practice. A scale developed and normed in a Western sample carries Western norms and cut-offs that travel poorly across India's languages, literacy levels and idioms of distress, so before an imported instrument is used it must be translated and back-translated, its reliability and validity re-established, and fresh norms generated on an Indian standardisation sample. The indigenous test-development tradition at NIMHANS and AIIMS exists for precisely this reason, and the Hindi Mental State Examination, built as a culturally and linguistically adapted screen for low-literacy Indian populations, is the standard worked example of a scale re-standardised rather than borrowed. The general principle holds across the rating-scale catalogue: a cut-off is only as good as the population it was normed on.

PEARL

Sensitivity and specificity describe the test; predictive values describe the test *in a population*. When an examiner says a screen "performs poorly" in primary care despite good published sensitivity, the answer is almost always the low base rate dragging down the positive predictive value, not a flaw in the instrument.

0.80 MINIMUM CRONBACH'S ALPHA (INTERNAL CONSISTENCY) FOR CLINICAL USE, NEARER 0.90 PREFERRED	**0.70** KAPPA ABOVE WHICH INTER-RATER AGREEMENT IS RATED EXCELLENT	**4** VALIDITY FAMILIES: FACE, CONTENT, CRITERION, CONSTRUCT	**1.00** A PERFECT RELIABILITY OR VALIDITY COEFFICIENT (0.00 = NONE AT ALL)

GOOD TO REMEMBER

- **The principle:** a scale's worth rests on its psychometric properties, reliability (consistency, checked by test-retest, inter-rater, internal consistency with Cronbach's alpha, and split-half) and validity (accuracy, running from face and content through criterion, both concurrent and predictive, to construct with its convergent and discriminant strands).
- **The one discriminator:** reliability is consistency, validity is accuracy; a scale can be reliable without being valid, but never valid without being reliable, because reliability is necessary but not sufficient for validity.
- **The one exam fact:** for a screening scale, sensitivity and specificity are fixed properties of the test, while the positive and negative predictive values depend on prevalence, so a screen is tuned for high sensitivity (SnNout) and its false positives are cleared by later confirmation.

HOLD THIS

Reliability is consistency and validity is accuracy: a scale can be reliable without being valid but never valid without being reliable, because reliability is necessary but not sufficient for validity, and when the scale is a screen its sensitivity and specificity are intrinsic to the test while its predictive values swing with the base rate.

21 · Neuropsychological and projective testing

Beyond the bedside cognitive screen sits a second tier of assessment that the psychiatrist rarely administers but must be able to order, read and act on: the formal psychological tests run by the

clinical psychologist. Three families are examined. **Projective testing** probes the latent, unconscious layers of personality through ambiguous stimuli; **neuropsychological testing** maps cognition onto brain structure and quantifies deficit; and **intelligence testing** yields a standardised, norm-referenced index of general ability. The examinable marks here are the named instruments and who devised them, the two or three high-yield numbers, the one indication each family answers, and, for the projective tests, the long-running argument over whether their psychometric properties justify their use at all.

How to use this page. Keep it compact and comparative: this is a map of what each test does and when to reach for it, not a manual for administering it. The deep theory underneath, reliability against validity, standardisation, norming, test construction and factor analysis, together with the descriptive-psychopathology vocabulary these interviews rest on, is developed in the Psychometry, Assessment and Descriptive Psychopathology notes; the bedside cognitive examination of the higher mental functions, with the MMSE, the MoCA and the frontal tests, is the screen these batteries extend, covered in its own topic above. Here we cover the formal, psychologist-administered instruments that sit one step beyond that screen.

21.1 Projective testing: the projective hypothesis and its instruments

An ambiguous stimulus becomes a screen for the self. The **projective hypothesis** holds that when a person is shown an unstructured, ambiguous stimulus that permits an almost unlimited range of responses, what they produce is shaped by their own needs, thoughts and conflicts, so the stimulus acts as a blank screen onto which personality is projected (Kaplan and Sadock CTP 2024). Projective tests are therefore indirect, broad-band measures of personality as a whole, aimed at latent and unconscious material, and because the patient cannot see how a response will be scored they are relatively hard to fake, in deliberate contrast to the structured, self-report objective inventories (the true or false items of the MMPI and its kin). Four instruments carry the tradition. The Rorschach inkblot test, devised by the Swiss psychiatrist Hermann Rorschach around 1921, presents ten symmetrical inkblot cards, some coloured and some achromatic, and asks only "what might this be?"; responses are coded by location, determinant and content, with five competing pre-Exner scoring systems (Beck, Hertz, Klopfer, Piotrowski and Rapaport) and Exner's Comprehensive System, which synthesised them, the most widely used and best researched. The Thematic Apperception Test (the TAT), developed by Morgan and Murray in 1935, shows a set of around twenty ambiguous picture cards and asks the patient to tell a story for each, what is happening, what led up to it, what the figures feel and how it will end, revealing recurrent themes, needs and object relations. The **sentence-completion test** is the most direct, semi-projective member: the patient finishes incomplete stems ("My greatest fear is..."), and Rotter's and Sacks' forms are the standard versions. The **Draw-A-Person** and House-Tree-Person drawing tests round out the set.

PROJECTIVE TEST	STIMULUS AND TASK	WHAT IT IS TAKEN TO TAP
Rorschach inkblot test	Ten symmetrical inkblot cards, coloured and achromatic; "what might this be?"	**Perceptual organisation, reality-testing, thought disorder, affect (Exner scoring)**
Thematic Apperception Test (TAT)	Around twenty ambiguous picture cards; make up a story for each	**Dominant needs, motives, object relations and recurrent conflictual themes**
Sentence-completion test	Incomplete sentence stems finished by the patient (Rotter, Sacks)	**Attitudes, conflicts and concerns, elicited semi-directly**
Draw-A-Person / House-Tree-Person	Free drawing of a human figure (or house, tree, person)	**Self-image and body-image; weakest psychometrically**

The four classic projective instruments, from the most to the least researched; all rest on the single projective hypothesis (Kaplan and Sadock CTP 2024; Clinical Methods in Psychiatry, AIIMS 2024).

RULE **The projective hypothesis is the whole logic.** The stimulus is deliberately ambiguous so that structure comes from the patient, not the card; the response is read as a projection of latent personality. Kill the ambiguity and you kill the test, which is why these are unstructured, broadband and interpreted, never scored like a true-or-false inventory.

21.2 The psychometric debate over projective tests

Rich clinically, contested psychometrically. The recurring examination and viva point is that projective tests trade measurement rigour for clinical depth. Reliability and validity are, for most of the set, modest to poor: several Rorschach interpretive systems have unproven validity, and the sentence-completion tests and figure drawings largely lack the reliability and validity studies to support them and are easy to fabricate or distort (Kaplan and Sadock CTP 2024). Scoring and interpretation are time-consuming and examiner-dependent, so two clinicians may read the same protocol differently. Against that, the Rorschach remains the most-researched projective device, standardised administration under Exner's system improved its reproducibility, and the Society for Personality Assessment issued a formal 2005 statement defending its place in clinical and forensic use; many clinicians still combine it with the TAT in a personality workup. The defensible summary is that a projective finding is a hypothesis-generating clue to be corroborated, valuable alongside interview and objective testing, never a stand-alone diagnostic verdict.

TRAP **Confusing reliability with validity.** Reliability is consistency, the same result on repeat or across raters; validity is accuracy, whether the test measures what it claims. A projective test can be made more reliable by standardising the scoring (as Exner did) and still remain of doubtful validity for the trait inferred. The two are separate hurdles, and a test can clear one while failing the other.

PEARL

Read a projective sign the way you read a raised inflammatory marker: it flags that something may be there and points you where to look, but it does not name the illness. The moment a Rorschach response or a drawing is quoted as if it were the diagnosis, the test has been over-read.

21.3 Neuropsychological testing: the batteries and what they add over the bedside screen

Cognition mapped onto the brain, and quantified. A **neuropsychological** test is a task designed to measure a specific cognitive function known to depend on a particular brain structure or pathway, used to detect, localise and quantify impairment after injury or illness (Clinical Methods in Psychiatry, AIIMS 2024). The field organises around two approaches: the fixed, standardised battery, which runs every patient through the same comprehensive set, and the flexible, hypothesis-testing approach, which selects tests to answer a specific referral question. Two fixed batteries are the classic named pair. The Halstead-Reitan Neuropsychological Battery is the comprehensive empirical battery that yields an impairment index and speaks to the presence, lateralisation and localisation of cortical dysfunction; the Luria-Nebraska Neuropsychological Battery operationalises Luria's qualitative, functional-systems method into standardised clinical scales. Alongside the batteries sit domain-specific tests the examiner should recognise: the Wisconsin Card Sorting Test for set-shifting and executive control, the Trail Making and Stroop tests for attention and interference, verbal fluency (the COWA), the Rey Auditory-Verbal Learning Test and the Wechsler Memory Scale for verbal memory, and the Benton Visual Retention Test and the Bender Gestalt test for visuoconstructive ability. What all of this adds over the bedside cognitive screen is decisive: where the MMSE or MoCA return a single number that ceilings out in mild or focal disease, a battery returns a normed, multi-domain cognitive profile with lateralising and localising value, sensitive to the subtle deficits of early dementia, head injury and ADHD, and usable for rehabilitation planning, disability certification and research.

FIXED BATTERY	TRADITION	CHIEF CLINICAL YIELD
Halstead-Reitan	Comprehensive, empirically derived American battery	**Impairment index; presence, lateralisation and localisation of cortical dysfunction**
Luria-Nebraska	Standardisation of Luria's functional-systems method	**Profile of clinical scales across motor, language, memory and executive systems**

The two classic fixed neuropsychological batteries; both are administered whole and read against norms, in contrast to the flexible hypothesis-testing approach (AIIMS 2024).

INDIA

Western cut-offs and norms travel poorly across Indian languages and schooling, so an indigenous neuropsychological tradition was built to replace them. The NIMHANS Neuropsychological Battery (Rao and colleagues, 2004) comprises nineteen tests standardised for Indian adults with norms for ages sixteen to sixty-five, adapted from the Halstead-Reitan model, and now has parallel batteries for children and for the elderly. The AIIMS Comprehensive Neuropsychological Battery in Hindi (Gupta and colleagues, 2000) is built on Luria-Nebraska principles, runs to one hundred and sixty items across ten basic scales with norms for ages fifteen to eighty, and is used to lateralise and localise lesions. The PGI Battery of Brain Dysfunction and the widely used PGI Memory Scale complete the core Indian repertoire, keeping the assessment valid in the settings where the imported batteries are not.

21.4 Intelligence testing: the Wechsler scales and the concept of IQ

General ability, expressed against same-age peers. An **intelligence** test is a norm-referenced instrument that samples a broad range of verbal and performance tasks and compares the person's score against a same-age reference group. The clinical workhorses are David Wechsler's scales, the WAIS for adults, the WISC for children and the WPPSI for the preschool years, each giving verbal and performance indices and a full-scale intelligence quotient. The Stanford-Binet, Terman's revision of the original Binet-Simon scale, is the other historic lineage, and Raven's Progressive Matrices offers a largely non-verbal, culture-reduced estimate. The **concept of IQ** itself has shifted. The original ratio IQ was the ratio of mental age to chronological age multiplied by a hundred, which broke down in adulthood once mental age plateaus. Modern scales use the **deviation IQ** instead: scores are treated as normally distributed and centred on **100** with a standard deviation near **15**, so the number expresses how far a person stands from the population average rather than any age ratio.

Ratio IQ

The historic formula: mental age divided by chronological age, multiplied by a hundred. Serviceable in childhood, invalid in adults once mental age ceases to rise.

Deviation IQ

The modern standard: a standard score placing the person on a normal distribution centred on 100 with a standard deviation near 15 (Wechsler). It expresses relative standing, not an age quotient.

INDIA

Indian intelligence testing runs on adapted and indigenous scales: the Binet-Kamat Test, Malin's Intelligence Scale for Indian Children (MISIC), Bhatia's Battery of Performance Tests of Intelligence and the Seguin Form Board are in routine use, and the Vineland Social Maturity Scale (VSMS) is the adaptive measure drawn on for disability certification in intellectual disability. As with the neuropsychological batteries, the point is to keep the norm relevant to the population being tested.

10	100	19	5
RORSCHACH INKBLOT CARDS (HERMANN RORSCHACH)	DEVIATION-IQ MEAN, WITH A STANDARD DEVIATION NEAR 15	TESTS IN THE NIMHANS NEUROPSYCHOLOGICAL BATTERY	PRE-EXNER RORSCHACH SCORING SYSTEMS, SYNTHESISED BY EXNER

GOOD TO REMEMBER

- **The principle:** projective tests read latent personality off an ambiguous stimulus (the projective hypothesis) and are psychometrically weak; neuropsychological and intelligence tests are norm-referenced, quantified batteries that add a standardised, multi-domain profile the bedside screen cannot give.
- **The discriminator:** projective = unstructured, unconscious, contested validity (Rorschach's ten inkblots, Exner scoring; the TAT's picture-story cards); neuropsychological = brain-behaviour, fixed against flexible battery (Halstead-Reitan and Luria-Nebraska); intelligence = norm-referenced ability, the Wechsler deviation IQ centred on 100 with a standard deviation near 15.
- **The one exam fact:** the Rorschach has ten symmetrical inkblot cards (Hermann Rorschach, around 1921) and the modern deviation IQ is centred on 100 with a standard deviation near 15, replacing the old mental-age ratio.

HOLD THIS

Three test families, three anchors: projective testing reads latent personality off an ambiguous stimulus by the projective hypothesis and is rich but psychometrically shaky (the Rorschach's ten inkblots under Exner scoring, the TAT's story cards); neuropsychological testing maps and quantifies cognition through a fixed or flexible battery (Halstead-Reitan, Luria-Nebraska, and in India the nineteen-test NIMHANS battery); and intelligence testing places general ability on a normal curve centred on 100 with a standard deviation near 15 via the Wechsler deviation IQ.

Nosology and cross-cutting clinical issues

22 · The principles of psychiatric classification and the diagnostic process

Every diagnosis a psychiatrist makes rests on a **classification**, a shared system that carves the continuous mess of human distress into named categories. This page teaches the **principles of psychiatric classification** and the **diagnostic process** that runs on top of them: why we classify at all, where our systems came from, the concepts that hold a classification together, how a clinician actually reaches a diagnosis, and how we judge whether a diagnostic label is any good. The examiner tests this as pure understanding rather than fact-recall, so the marks go to the candidate who can say what a classification is *for*, hold reliability apart from validity, and place the modern systems in the arc that produced them.

How to use this page. Fix the historical spine first, because almost every examinable idea here is a response to a historical problem: Kraepelin's two-disease dichotomy founded the field, the **reliability of diagnosis** collapsed in mid-century, and the operational turn of the nineteen-seventies and -eighties was the cure. Then learn the **purposes of classification**, the building concepts (category, prototype, the polythetic criteria set, the hierarchy, comorbidity), the categorical-versus-dimensional debate, and finally the diagnostic process and the validators that certify a diagnosis. The deep psychometric theory beneath reliability and validity, factor analysis,

test construction and standardisation, belongs to the Psychometry, Assessment and Descriptive Psychopathology notes; here the treatment stays at the level of the classification and the clinical act of diagnosing.

22.1 The history of classification: from Kraepelin to the operational turn

Modern diagnosis begins with a clinician who watched the course of illness. The **history of classification** is the story of psychiatry trying, and repeatedly failing, to carve nature at its joints. Philippe Pinel enumerated four broad forms of madness in the early nineteenth century, but the pivotal figure is Emil Kraepelin, who placed the diagnostic interest of psychiatry at the bedside, on the *course and outcome* of the illness rather than on theory or anatomy. On that basis, in the sixth edition of his textbook, he drew the great dichotomy that still structures psychiatry: dementia praecox, a deteriorating disorder of thought later renamed schizophrenia by Bleuler, set against manic-depressive insanity, a periodic disorder of mood with a comparatively good prognosis. Kraepelin erected a firewall between the two that survives, as major depression against schizophrenia, in every system since.

The twentieth century then split into two traditions. American psychiatry, under psychoanalytic influence, produced the theory-laden DSM-I and DSM-II, and interest in diagnosis waned. The corrective was the **neo-Kraepelinian** revival at St Louis, which insisted that psychiatry return to describable, verifiable clinical syndromes. Its instrument was the *operational* criteria set: an explicit, rule-bound definition specifying exactly which and how many symptoms are required, so that two clinicians applying it to the same patient reach the same diagnosis. Eli Robins and colleagues published such operational criteria in 1972 (the Feighner criteria), Spitzer's group turned them into the Research Diagnostic Criteria, and in 1980 the revolutionary DSM-III operationalised almost every diagnosis at once, stripping out psychoanalytic theory. That operational turn, not any new discovery about the brain, is the single most important event in the modern history of classification. The accompanying figure sets out this spine from Pinel to the present.

MILESTONE	FIGURE AND DATE	WHAT CHANGED
The great dichotomy	Kraepelin, 1899	**Course and outcome split psychosis into dementia praecox and manic-depressive insanity**
The name "schizophrenia"	Bleuler, 1908	Recast dementia praecox as a less deteriorating, any-age disorder
Psychoanalytic era	DSM-I 1952, DSM-II 1968	Theory-laden, unreliable; diagnosis fell into disrepute
Operational criteria	Feighner et al, 1972	**Explicit rule-bound criteria for research; the neo-Kraepelinian instrument**
The operational turn	DSM-III, 1980	**Operationalised almost every diagnosis; removed psychoanalytic theory**
The current systems	DSM-5 2013; ICD-11 in effect 2022	Harmonised metastructure, hybrid categorical-dimensional

The historical spine of psychiatric classification. The pivot is the operational turn: a fix for unreliability, not a discovery about aetiology.

Why the operational turn was needed: the reliability crisis. Through the nineteen-fifties and -sixties, studies of ordinary clinical practice found the **reliability of diagnosis** to be alarmingly poor. In a much-cited English study, five experienced raters who had agreed their criteria beforehand still reached only about **46%** average agreement on the presence of a symptom, barely better than a coin toss. Two forces drove this: *information variance* (clinicians eliciting different facts) and *criterion variance* (clinicians applying different thresholds to the same facts). The transatlantic mismatch, in which American psychiatrists diagnosed schizophrenia where the British saw mania, and the notoriety of pseudopatients admitted and labelled on a single reported symptom, made the crisis public. The remedy was twofold, and it is the examinable pair: the *structured interview* attacked information variance by fixing what is asked, and the *operational criteria set* attacked criterion variance by fixing the threshold. Together they transformed reliability, so that in skilled hands a psychiatric diagnosis is now as reproducible as clinical judgements elsewhere in medicine.

RULE **Operationalisation was a cure for unreliability, not for uncertain validity.** Fixing the criteria (DSM-III) made clinicians agree; it did not prove the agreed-upon categories were real diseases. Reliability was bought; validity was not.

1899 KRAEPELIN'S DICHOTOMY: DEMENTIA PRAECOX VERSUS MANIC-DEPRESSIVE INSANITY

1980 DSM-III, THE OPERATIONAL TURN THAT FIXED CRITERION VARIANCE

2013 DSM-5 PUBLISHED (APA)

2022 ICD-11 CAME INTO EFFECT FOR MORBIDITY (1 JANUARY)

22.2 Why we classify: the purposes of a classification

A classification earns its keep by what it lets us do. The **purposes of classification** are the standard opening to any essay on this topic, and there are five. **Communication** is first and foremost: a diagnostic term compresses a large body of clinical information into a word two clinicians can exchange without misunderstanding. **Prediction** is the clinical pay-off: a valid category forecasts course, prognosis and outcome. **Treatment selection** follows, because if more than one treatment exists we must distinguish one kind of patient from another to use them rationally rather than allocating therapy by whim. **Research** requires that investigators in different centres study the same defined populations, which is impossible without an agreed, reliable classification. **Administration**, the least glamorous purpose, covers health statistics, service planning, epidemiology, insurance and the medico-legal record; it is the reason the World Health Organization maintains the ICD at all.

PURPOSE	WHAT IT DELIVERS
Communication	**A shared shorthand that transfers clinical information between professionals**
Prediction	Prognosis, course and expected outcome from the category
Treatment selection	Rational choice among available treatments for a defined patient type
Research	Comparable, replicable study populations across centres
Administration	Statistics, service planning, epidemiology and the medico-legal record

The five purposes of a psychiatric classification. Communication and prediction are the two most examined; administration is why the ICD exists as a global instrument.

The same power carries costs that a complete answer names. A diagnosis conveys only limited information and can flatten the individuality of a predicament; it is stereotypical, since real patients rarely match the textbook portrait exactly; it can be pejorative, so that terms like "psychopath" become veiled contempt; and it invites *reification*, the error of treating the concept as a discovered thing and treating the "disease" instead of the patient's actual symptoms and disabilities. The examinable stance is that classification is indispensable despite these hazards, because no workable alternative to grouping patients has ever been found.

22.3 The building concepts: category, prototype, polythetic criteria, hierarchy, comorbidity

Five ideas hold a classification together, and each is a stock exam question. Learn them as crisp definitions, because the discriminations between them do the work.

Category

A discrete diagnostic class with a boundary: a patient either meets it or does not. All diagnoses are *concepts*, not discovered things; they survive only as long as they remain clinically useful.

Prototype

The description of a typical, ideal member of a category. On the prototype model a real patient is diagnosed by *resemblance* to the prototype rather than by satisfying a fixed checklist, and members vary in how typical they are. This is how experienced clinicians actually recognise a case, and it is the model ICD-11 adopts.

Polythetic criteria set

A definition listing several features of which the patient need show only a specified subset (for example, any five of nine), so no single feature is necessary or sufficient. It contrasts with a *monothetic* set, where every listed feature is required. Polythetic criteria make a category heterogeneous: two patients can share a diagnosis with few symptoms in common.

Diagnostic hierarchy

A rank ordering in which a higher-placed disorder pre-empts a lower one, so that a single diagnosis is chosen. The classic order is organic disorders over psychotic (schizophrenic) over affective over neurotic and stress-related; any diagnosis excludes the symptoms of those above it and embraces those below.

Comorbidity

The co-occurrence of two or more diagnoses in one patient. Where a strict hierarchy once forbade it, the modern manuals largely abandoned hierarchical exclusions, so comorbidity is now recorded rather than suppressed, at the cost of much apparent overlap.

The hierarchy and comorbidity are two sides of one historical shift. Under the older Jaspers-derived hierarchy, and Schneider's rule that first-rank symptoms were diagnostic of schizophrenia "except in the presence of coarse brain disease", a patient could hold only the highest applicable diagnosis; a depressed patient with an organic cause was "organic", full stop. DSM-III and its successors relaxed most of these exclusions to let clinicians record the full picture, which is why comorbidity rates then appeared to soar. The diagnostic hierarchy nonetheless survives as a clinical *rule of the diagnostic process*, examined below: rule out the organic before you rest on the functional.

TRAP **Confusing polythetic with monothetic.** A polythetic set needs only a subset of its features, so the diagnosis is inherently heterogeneous; a monothetic set needs them all. Assuming everyone with one diagnosis shares the same symptoms is the polythetic trap.

22.4 The categorical versus dimensional debate

Two ways to describe a patient: a box, or a set of sliders. The **categorical approach**, the one psychiatry actually uses, sorts patients into discrete named classes. The *dimensional* approach instead rates each patient on continuous scales of severity, as intelligence is rated by IQ rather than by "clever, average, dull". Neither is provably "right"; there is no statistical test that settles it, and the choice is pragmatic, decided by which is more useful. The strongest argument for a categorical system would be the demonstration of **zones of rarity**, natural gaps in the distribution between one disorder and the next, as Kendell put it; but attempts to find such gaps between related syndromes have largely failed, and the frequency with which clinicians reach for hybrid terms like "schizoaffective" is itself evidence that the categories shade into one another.

THE CATEGORICAL APPROACH FAVOURS	THE DIMENSIONAL APPROACH FAVOURS
Familiarity and ease of use, memory and communication	**More information: finer distinctions are preserved**
A ready prelude to action (diagnosis X implies treatment D)	**Flexibility, and easy conversion back to categories with a cut-off**
A prototype that captures the essence of a clinical concept	**No false boundaries imposed where none exist in reality**
Fits medical tradition and a conservative profession	**Handles boundary and mixed cases without distortion**

Categories versus dimensions. Categories win on usability and action; dimensions win on information and on not distorting patients who sit between classes.

The field's settled answer is a *hybrid*: retain categorical diagnoses for their usability while adding dimensional measures for severity and for cross-cutting symptoms. This is exactly the direction of both current manuals, and it is why the debate is not "which wins" but "how they combine".

TRAP **Treating the absence of zones of rarity as proof that a disorder is not real.** Continuity of symptoms across a boundary weakens the case for a natural category, but a concept can remain clinically useful (and worth keeping) even without a discoverable joint to carve at.

22.5 The two current systems: ICD-11 and DSM-5

One world classification, one American manual, deliberately harmonised. The ICD-11 chapter on mental, behavioural and neurodevelopmental disorders is the World Health Organization's global system, approved by the World Health Assembly and in effect since January 2022; DSM-5 (2013) is the American Psychiatric Association's manual. Their revisions were coordinated so that the two share a common organisation, the *metastructure*, that opens with neurodevelopmental disorders and orders the rest along developmental and internalising-externalising lines rather than the old organic-first hierarchy. Both abandoned the multiaxial system of DSM-IV (its five axes), folding contextual and disability information into the main diagnosis and a separate functioning measure. DSM-5 keeps three parts: an introductory section, the diagnostic criteria proper, and a Section III of emerging measures, the cross-cutting symptom scales, the cultural formulation interview and the alternative dimensional model of personality disorder.

The examinable difference is one of *style*. DSM-5 is strictly *operational*: it specifies exact symptom counts and durations. ICD-11 deliberately moved the other way, replacing rigid criteria with flexible *essential features*, the symptoms a clinician can reasonably expect in a typical case, applied as a prototype with room for clinical judgement and cultural variation. Field work showed clinicians overwhelmingly preferred this flexibility to a criteria-counting exercise. Both also moved toward dimensions where the evidence demanded it, most visibly in personality disorder, which ICD-11 now rates by severity (and optional trait domains) instead of the discrete personality types.

FEATURE	ICD-11	DSM-5
Owner and scope	WHO, global, all of medicine	**APA, United States, mental disorders**
In effect	Since 2022	**Since 2013**
Definitional style	Flexible "essential features", prototype-based	**Operational: explicit symptom counts and durations**
Guiding intent	Global, cross-cultural, clinical-judgement-friendly	**Reliability and research precision**
Structure	Chapter on mental, behavioural and neurodevelopmental disorders	Three sections; emerging measures in Section III
Multiaxial system	Never adopted a five-axis format	**DSM-IV five axes abandoned in DSM-5**
Personality disorder	Fully dimensional: severity plus trait domains	Categorical types; dimensional hybrid model in Section III
New entities	Gaming disorder, complex PTSD, prolonged grief disorder	Retains categorical syndromes with dimensional specifiers
Metastructure	**Shared, harmonised: developmental order, neurodevelopmental disorders first**	

ICD-11 against DSM-5. Same harmonised metastructure; the sharp discriminator is prototype-based essential features (ICD-11) versus operational criteria counts (DSM-5).

INDIA

India, as a World Health Organization member state, uses the *ICD*, not the DSM, as its official diagnostic and statistical classification; Indian teaching, examinations and clinical records are ICD-anchored, with the DSM used mainly for research. ICD-11's flexible essential-features approach, explicitly built to allow cultural variation and clinical judgement, suits India's multilingual, resource-varied settings and its cultural concepts of distress better than a rigid criteria count would (the wider transcultural frame is set out in the Consultation-liaison, geriatric and transcultural psychiatry notes). The classification also carries statutory weight: the Mental Healthcare Act 2017 directs that the determination of mental illness be made in accordance with nationally or internationally accepted medical standards, including the latest edition of the ICD, tying Indian clinical-legal practice to the WHO system (the full legislation is developed in the Mental health legislation and forensic psychiatry notes).

22.6 The diagnostic process: pattern, differential, hierarchy, formulation

How a clinician actually gets from a patient to a diagnosis. The **diagnostic process** has four moves, and naming them in order is a clean exam answer. First, *pattern recognition*: the clinician matches the history and mental state findings against the stored criteria set or prototype, generating a provisional diagnosis, often within minutes for a classical case. Second, the *differential diagnosis*: the alternatives that could produce the same pattern are listed and then tested, symptom by symptom, against the specific discriminators of each. Third, the *hierarchy rule*, the surviving clinical use of the diagnostic hierarchy: exclude the organic before resting on

the functional, because a physical or drug-induced cause overrides and redirects the whole assessment. Fourth, the diagnosis is set within a *formulation*, which does what a bare label cannot: it explains why this person developed this disorder at this time, integrating predisposing, precipitating and perpetuating factors into an individual account that guides management. The diagnosis says *what*; the formulation says *why*, and the two are complementary, not rivals.

WORKED EXAMPLE

A woman in her forties presents with two weeks of low mood, poor sleep and, for the first time, a conviction that her neighbours are poisoning her water. Pattern recognition offers a depressive episode with psychotic features. The differential then widens: is this a primary psychotic disorder, a bipolar mixed state, or an organic mood syndrome? The hierarchy rule fires first, so a cognitive screen, a physical examination and basic investigations are done to exclude a delirium, a space-occupying lesion or a thyroid or steroid effect before the functional diagnosis is accepted. Only once the organic is cleared, and the mood-congruence of the belief and its two-week arc against a low mood are weighed, is a depressive episode with psychotic symptoms settled on, and a formulation built around her recent bereavement and family history to guide treatment.

RULE **Exclude the organic first.** The one surviving clinical use of the diagnostic hierarchy is that a demonstrable organic or substance-induced cause pre-empts every functional diagnosis. Rule it out before you rest on a psychiatric label.

22.7 The reliability and validity of a diagnosis: the Robins and Guze validators

A diagnosis must be both consistent and true, and these are different demands. *Reliability* is the reproducibility of a diagnosis, whether two clinicians, or the same clinician twice, agree; it is quantified for categorical diagnoses by the kappa coefficient, and it is what operationalisation and structured interviews repaired. *Validity* is the harder and higher question of whether the category corresponds to a real, distinct entity in nature, and reliability does not guarantee it: clinicians can agree perfectly on a category that carves no real joint. The landmark answer to how validity is established is Robins and Guze's 1970 paper, which set out a **five**-phase programme, the diagnostic validators, that a category must pass. These validators were the template for the Feighner criteria, and an expanded set of them was applied in building the metastructure of both current manuals.

VALIDATOR	WHAT IT REQUIRES OF THE CATEGORY
Clinical description	**A distinctive cluster of co-varying symptoms and characteristic features**
Laboratory studies	Reliable biological, physiological or psychological markers
Delimitation from other disorders	**Clear exclusion criteria that mark it off from neighbouring diagnoses**
Follow-up study	A characteristic, predictable course and outcome
Family study	Raised rates of the same disorder among first-degree relatives

The five Robins and Guze diagnostic validators (1970). A category earns its validity by passing them; passing none of them, however reliably it is applied, is the mark of a doubtful entity.

MNEMONIC

Clinicians Look, Delimit, Follow, Family

The five Robins and Guze validators in order: **C**linical description, **L**aboratory studies, **D**elimitation from other disorders, **F**ollow-up study, **F**amily study. Reliability lets clinicians agree; these five decide whether what they agree on is real.

PEARL

Kappa is not a fixed property of a diagnosis. It rises and falls with the base rate and comorbidity of the sample it is measured in, which is why a criteria set can look reliable in a research clinic and shakier in a mixed general population. Reliability is a feature of the diagnosis *in a setting*; validity is the deeper claim about the category itself.

TRAP **Reading a reliable diagnosis as a valid one.** High inter-rater agreement (good kappa) shows only that clinicians apply the label the same way; it says nothing about whether the category is a genuine disease. A reliable diagnosis can still be an invalid one, which is precisely why the Robins and Guze validators exist.

GOOD TO REMEMBER

- **The principle:** psychiatric classification exists to serve communication, prediction, treatment selection, research and administration; modern systems (ICD-11 and DSM-5) are symptom-based, operationalised and largely categorical with dimensional additions, born of the operational turn that answered the mid-century reliability crisis.
- **The one discriminator:** reliability (do clinicians agree, measured by kappa) is not validity (is the category a real entity, established by the five Robins and Guze validators); operationalisation bought reliability but validity must be earned separately.
- **The one exam fact:** Kraepelin's 1899 dichotomy of dementia praecox versus manic-depressive insanity founded modern classification; the diagnostic process runs pattern recognition, differential diagnosis, the hierarchy rule (exclude the organic first) and formulation; and a category's validity rests on Robins and Guze's five validators (clinical description, laboratory studies, delimitation, follow-up study, family study).

HOLD THIS

Modern psychiatric classification is operationalised, symptom-based and largely categorical: Kraepelin's 1899 dichotomy founded it, the reliability crisis drove the operational turn of Feighner and DSM-III, and a diagnosis earns its validity through the five Robins and Guze validators, never through reliability alone.

23 · ICD-11 versus ICD-10

The examiner treats the classification chapters as a gift, because the changes between the two editions are finite, structural and easy to score if learned as a list of deltas rather than a re-reading of the whole nosology. ICD-11 was adopted by the 72nd World Health Assembly in 2019 and came into effect on 1 January 2022, with its clinical manual, the Clinical Descriptions and Diagnostic Requirements (CDDR), published in 2024; it is the classification India works to, so the shift from ICD-10 is not academic for the Indian trainee but the operating change in daily coding and in the exam. This page is built around the single question a paper on **icd-11 versus icd-10** actually asks: not "describe ICD-11" but "state, precisely and without error, what changed".

How to use this page. Fix the two framing moves first, the shift from fixed research rules to flexible **essential features**, and the shift from an almost purely categorical system to one carrying dimensional elements, because every specific change below is an instance of one or the other. Then learn the headline chapter-by-chapter deltas as discrete, examinable facts: the schizophrenia rebuild, the dimensional personality model, the batch of new entities, and the restructured and relocated groupings. A wrong change stated with confidence is worse than a gap, so the discipline here is accuracy over coverage. The deeper categorical-versus-dimensional debate and the descriptive-psychopathology vocabulary that populate these categories are developed in the Psychometry, Assessment and Descriptive Psychopathology notes; this page owns the concrete ICD-11 changes themselves.

23.1 From fixed rules to essential features: the CDDR replaces the ICD-10 dual system

ICD-11 abandons arbitrary symptom counts and precise durations for a flexible, prototype-based description. ICD-10 in fact ran two parallel documents: the clinical version, the *Clinical Descriptions and Diagnostic Guidelines* (CDDG), written as prose guidance for the practitioner, and a separate *Diagnostic Criteria for Research* (DCR) that was fully operationalised, with fixed symptom thresholds, exact counts and rigid duration cut-offs modelled closely on the DSM. ICD-11 collapses this into a single manual, the CDDR, and deliberately discards the operationalised straitjacket. Each disorder is now defined by its **essential (required) features**, the symptoms a clinician using reasonable judgement would expect to be present, stated without an arbitrary "five out of nine for two weeks" arithmetic. The stated rationale is that precise counts and durations produced false negatives that offered the clinician no useful guidance and travelled poorly across the world's cultures, and that a prototype description matched to clinical reality is both more usable and more globally applicable. Alongside the essential features, each category carries a standard set of headings: boundary with normality (the threshold), boundaries with other disorders (the differential), coded qualifiers and subtypes, course features, culture-related features, and developmental and sex- or gender-related presentations.

RULE **ICD-11 defines disorders by flexible essential features, not fixed counts.** The move from ICD-10's operationalised research criteria to the CDDR's prototype-based essential features is the master change; every specific delta is downstream of it, and it is designed for clinical judgement and cross-cultural use rather than symptom arithmetic.

23.2 Categorical to dimensional: the second organising shift

ICD-10 was almost purely categorical; ICD-11 keeps categories but adds dimensions in two ways. Under ICD-10 a diagnosis was, with very few exceptions, simply present or absent; the only concessions to gradation were the severity bands for mental retardation (mild, moderate, severe, profound) and for the depressive episode (mild, moderate, severe). Among the **icd-11 changes**, dimensionality enters through two distinct routes. First, more categories are now graded by *severity*: in addition to intellectual developmental disorder and the depressive episode, the CDDR sub-classifies bodily distress disorder, personality disorder and dementia as mild, moderate or severe. Second, several groupings now attach *cross-cutting symptom specifiers*, dimensional profiles that describe a presentation across a whole grouping rather than pinning it to one sub-diagnosis; the two examinable instances are the six symptom domains of the primary psychotic disorders and the trait domains of personality disorder. The point to hold is that ICD-11 did not become a dimensional system; it remained categorical at its base and grafted dimensional detail onto specific groupings where the evidence supported it.

PEARL

When an examiner asks "is ICD-11 dimensional?", the marks are in the qualification: it is a categorical classification that incorporates dimensional elements in two places, severity gradations for a handful of disorders and cross-cutting symptom or trait specifiers for a few groupings. Calling it "a dimensional system" overstates the change and loses the mark.

23.3 Schizophrenia rebuilt: the removal of subtypes, and catatonia set free

The classic subtypes are gone, replaced by symptom-domain and course specifiers. The single most quoted delta is the **removal of subtypes** of schizophrenia. ICD-10's familiar divisions, paranoid, hebephrenic, catatonic, undifferentiated, residual and simple, are abolished, on the evidence that they were unstable over time, poorly reliable and of little prognostic or treatment value. In their place ICD-11 describes the current presentation with two kinds of specifier. The first is a set of **6** *symptom-domain specifiers* that cut across the whole primary-psychotic grouping (positive symptoms, negative symptoms, depressive mood symptoms, manic mood symptoms, psychomotor symptoms and cognitive symptoms), each rated as not present, mild, moderate or severe for the past week. The second is a *course specifier* recording whether this is a first episode, multiple episodes or a continuous illness, and whether the person is currently symptomatic, in partial remission or in full remission. The diagnosis of schizophrenia itself, its core symptom set and duration, is developed with the PANSS and BPRS in clinical use in the Schizophrenia: clinical features and phenomenology notes; here the examinable fact is the swap of static subtypes for a dynamic symptom-and-course profile.

The old catatonic subtype does not simply disappear. ICD-11 recognises catatonia as a standalone grouping in its own right, an arousal-and-psychomotor syndrome that can arise with a mental disorder (6A40), be induced by substances or medications (6A41) or be secondary to another medical condition (6E69). Treating **catatonia as a syndrome** that spans diagnoses, rather than as a variety of schizophrenia, is the conceptual correction: catatonia occurs across mood disorders, psychotic disorders and general medical conditions, and tying it to schizophrenia obscured that.

TRAP **Saying the subtypes were "replaced by course specifiers alone", or that catatonia is now a schizophrenia specifier.** The subtypes were replaced by six cross-cutting symptom-domain specifiers *and* a course specifier; and catatonia was lifted out of schizophrenia entirely to become its own grouping applicable across disorders, not folded in as a psychotic specifier.

23.4 The dimensional personality model: severity plus trait domains

Every categorical personality type is abolished; one diagnosis, graded and profiled, takes their place. This is the boldest single change in the classification. ICD-10's menu of discrete types, paranoid, schizoid, dissocial, emotionally unstable (with its impulsive and borderline variants), histrionic, anankastic, anxious (avoidant) and dependent, is deleted wholesale. In its place stands a single **dimensional personality** disorder diagnosis, built in two steps. The clinician first establishes that a personality disturbance is present and rates its *severity* as mild, moderate or severe (the severity turning on the degree of dysfunction in the sense of self and in interpersonal functioning, and on the associated risk and harm), because severity, not type, is what predicts outcome and guides management. The clinician may then, optionally, record one or more prominent *trait domain* specifiers that describe the flavour of the difficulty: **5** domains are offered, negative affectivity, detachment, dissociality, disinhibition and anankastia. A single vestigial pattern qualifier, the *borderline pattern*, is retained as a pragmatic concession, so that the large evidence base and treatment pathways attached to borderline personality disorder are not orphaned by the reform. The dialectical behaviour therapy and schema therapy that this borderline pattern indicates are developed in the Personality disorders notes.

RULE **Severity first, traits second.** ICD-11 personality disorder is diagnosed by grading severity (mild, moderate, severe), then optionally attaching trait-domain specifiers; the categorical types are gone, and the only surviving named pattern is the borderline pattern qualifier.

23.5 The new entities: five arrivals and a consolidated somatic category

ICD-11 introduces several disorders that had no home in ICD-10. The high-yield newcomers cluster naturally. Two sit in the stress grouping: **complex PTSD** (6B41), which adds to the three core PTSD clusters (re-experiencing, avoidance and a sense of current threat) a further three "disturbances in self-organisation", namely affect dysregulation, a persistently negative self-concept and difficulties sustaining relationships, and captures the sequelae of prolonged or repeated trauma; and **prolonged grief** disorder (6B42), a grief response persisting for an abnormally long period (at least six months, and clearly exceeding the person's social, cultural or religious norm) with intense longing or preoccupation and marked impairment. Two are

behavioural: gaming disorder (6C51), placed in the new grouping of disorders due to addictive behaviours alongside gambling disorder, marked by impaired control over gaming, escalating priority given to it, and continuation despite harm, normally evident over at least twelve months; and compulsive sexual behaviour disorder (6C72), a persistent failure to control intense, repetitive sexual impulses classified among the impulse-control disorders (notably *not* as an addiction). The fifth is body integrity dysphoria (6C21), a rare and enduring desire for a major physical disability (typically amputation of a healthy limb) arising from a mismatch between the felt and the actual body. Separately, ICD-11 consolidates ICD-10's scattered somatoform disorders and neurasthenia into a single graded bodily distress disorder (6C20), defined by distressing bodily symptoms and excessive attention to them rather than by whether the symptoms are "medically explained".

MNEMONIC

Two traumas, two behaviours, one body

The five new entities in two pairs and a single: **two** in the stress grouping (**complex PTSD**, **prolonged grief** disorder); **two** behavioural (**gaming disorder**, an addiction; **compulsive sexual behaviour disorder**, an impulse-control disorder, deliberately not an addiction); and **one** body-focused (**body integrity dysphoria**). Bodily distress disorder is a consolidation, not a true newcomer.

WORKED EXAMPLE

A woman is referred fourteen months after her husband's death, unable to accept the loss, spending hours with his belongings, socially withdrawn and functionally impaired, with no pervasive anhedonia or worthlessness. Under ICD-10 there was no clean category; she would have been coded as an adjustment disorder or a depressive episode, both ill-fitting. Under ICD-11 this is prolonged grief disorder: the response has persisted well beyond the six-month floor and clearly beyond her cultural norm, it centres on longing and preoccupation with the deceased rather than on a depressive syndrome, and naming it correctly changes the therapeutic target from mood to grief.

23.6 Restructured groupings and the disorders moved out of the chapter

ICD-11 re-draws the map, both by creating new groupings and by exporting conditions to other chapters. Within the mental-disorders chapter, obsessive-compulsive disorder is pulled out of the old neurotic bracket into a dedicated *obsessive-compulsive and related disorders* (OCRD) grouping that now gathers hoarding disorder, body dysmorphic disorder, olfactory reference disorder, hypochondriasis (health anxiety) and the body-focused repetitive behaviours; the exposure and response prevention that treats this grouping is developed in the Anxiety, OCD and trauma-related disorders notes. A parallel *disorders specifically associated with stress* grouping brings PTSD, complex PTSD, prolonged grief disorder, adjustment disorder and reactive attachment disorders together under the shared requirement of an identifiable stressor, and in the same reform acute stress reaction is reclassified out of the mental disorders as a normal reaction (coded among factors influencing health status). Beyond the chapter, four ICD-10

subgroupings are exported entirely: nonorganic sleep disorders go to a new sleep-wake disorders chapter, tic disorders join diseases of the nervous system (as Tourette syndrome), and the "organic"/"nonorganic" split of sexual dysfunctions is dissolved by moving them, together with gender-related conditions, to a new chapter on conditions related to sexual health. It is here that **gender incongruence moved** out of the mental-disorders chapter altogether: reframed as a sexual-health condition on field-study evidence that the distress of transgender people is predicted by stigma and victimisation rather than being intrinsic, this depsychopathologisation is one of the most examined single facts in the whole comparison.

AREA	ICD-10	ICD-11 CHANGE
Manual and format	Two documents: clinical Guidelines (CDDG) plus operationalised Research Criteria (DCR) with fixed counts and durations	**Single CDDR with flexible, prototype-based essential features; no arbitrary counts**
Overall approach	Almost entirely categorical (present or absent)	**Categorical base with dimensional elements: severity gradings and cross-cutting specifiers**
Schizophrenia	Classic subtypes (paranoid, hebephrenic, catatonic, undifferentiated, residual, simple)	**Subtypes removed; six symptom-domain specifiers plus a course specifier**
Catatonia	A subtype of schizophrenia	**Standalone grouping applicable across disorders (catatonia as a syndrome)**
Personality disorder	Discrete categorical types (paranoid, schizoid, dissocial, emotionally unstable and the rest)	**Single diagnosis by severity (mild, moderate, severe) plus five trait domains; borderline pattern qualifier retained**
Stress-related	Reaction to severe stress and adjustment disorders (F43)	**New "disorders specifically associated with stress" grouping; adds complex PTSD and prolonged grief; acute stress reaction reclassified as a normal reaction**
Obsessive-compulsive	OCD within the neurotic and anxiety disorders	**New OCRD grouping (adds hoarding, body dysmorphic, olfactory reference, hypochondriasis, skin-picking, hair-pulling)**
Somatoform	Multiple somatoform disorders and neurasthenia	**Consolidated into a single graded bodily distress disorder**
Behavioural addictions	No grouping; pathological gambling coded among habit and impulse disorders	**New "disorders due to addictive behaviours": gambling disorder and gaming disorder**

AREA	ICD-10	ICD-11 CHANGE
Gender	Gender identity disorders within mental disorders (F64)	**Gender incongruence moved to the conditions related to sexual health chapter (depsychopathologised)**
Sleep and tics	Nonorganic sleep disorders (F51) and tic disorders inside the mental chapter	**Sleep-wake disorders and tic disorders (Tourette) exported to their own chapters**
Intellectual disability	Mental retardation, graded on IQ	**Disorders of intellectual development, on adaptive behaviour and intellectual functioning**

The master comparison of the ICD-11 changes against ICD-10, area by area. The highlighted cell in each row is the delta the examiner wants stated exactly; the recurring theme is a move from fixed categories toward flexible, dimensional and aetiologically cleaner groupings.

INDIA

ICD, not DSM, is the classification of record in India, which makes this comparison a working exam and clinical concern rather than a curiosity. The Mental Healthcare Act 2017 anchors the point in statute: it directs that mental illness be determined "in accordance with such nationally or internationally accepted medical standards (including the latest edition of the International Classification of Diseases of the World Health Organisation) as may be notified by the Central Government", so Indian psychiatric diagnosis is tied by law to the ICD, and the migration to ICD-11 flows through to certification, admission and the courts; the fuller legislative and forensic detail sits in the Mental health legislation and forensic psychiatry notes. Indian centres, including NIMHANS, took part in the WHO international field studies that tested the CDDR format, and the flexible, culturally sensitive essential-features approach, with its explicit culture-related features heading, suits the Indian idioms of distress and locally variable bereavement norms better than a rigid symptom-count system; the wider transcultural frame is in the Consultation-liaison, geriatric and transcultural psychiatry notes.

2022 YEAR ICD-11 CAME INTO EFFECT (ADOPTED 2019, CDDR PUBLISHED 2024)	**6** SYMPTOM-DOMAIN SPECIFIERS REPLACING THE SCHIZOPHRENIA SUBTYPES	**5** PERSONALITY-DISORDER TRAIT DOMAINS UNDER THE DIMENSIONAL MODEL	**3** PERSONALITY-DISORDER SEVERITY LEVELS: MILD, MODERATE, SEVERE

GOOD TO REMEMBER

- **The principle:** the two master shifts from ICD-10 to ICD-11 are format (a single CDDR with flexible, prototype-based essential features replacing ICD-10's operationalised research criteria) and structure (a categorical base that now carries dimensional severity gradings and cross-cutting specifiers).
- **The one discriminator:** schizophrenia loses its subtypes and is described instead by six symptom-domain specifiers and a course specifier, while personality disorder loses its categorical types and is described by severity plus trait domains, so in both flagship areas fixed categories give way to a dimensional profile.
- **The one exam fact:** ICD-11 adds complex PTSD, prolonged grief disorder, gaming disorder, compulsive sexual behaviour disorder and body integrity dysphoria; makes catatonia a standalone syndrome; consolidates somatoform illness into bodily distress disorder; and moves gender incongruence out of the mental-disorders chapter to a sexual-health condition.

HOLD THIS

ICD-11 replaces ICD-10's fixed research criteria with flexible essential features and adds dimensions to a categorical base: schizophrenia subtypes give way to six symptom-domain specifiers plus a course specifier, categorical personality types give way to severity plus five trait domains, catatonia becomes a standalone syndrome, complex PTSD, prolonged grief, gaming disorder, compulsive sexual behaviour disorder and body integrity dysphoria are new, and gender incongruence moves out of the mental-disorders chapter to a sexual-health condition.

24 · ICD-11 versus DSM-5

Two classification systems govern the diagnosis of mental disorders, and the examiner expects the candidate to place them side by side and say precisely how they differ. The comparison of **ICD-11 versus DSM-5** is a favourite because it tests understanding rather than recall: the two books cover much the same disorders and were deliberately harmonised, yet they were built by different bodies, for different purposes, on different philosophies, and it is those **conceptual differences** and **structural differences** that carry the marks. The single line to hold above all others is the format contrast: ICD-11 describes each disorder through prose **essential features** and leaves the diagnostic decision to clinical judgement, whereas DSM-5-TR lays out operationalised criteria with explicit symptom counts and durations.

How to use this page. Fix the ownership and orientation first, because almost every downstream difference follows from who built each system and for whom. The World Health Organization built the ICD for every member state and for all of health; the American Psychiatric Association built the DSM for mental disorders and for a research-and-specialist readership. Then learn the format contrast (the classic discriminator), the architecture of each book, the selected content and placement differences, and the personality-disorder models, which are where the two diverge most sharply. Finally take the practical point that matters in this country: in India, as across most of the world, the ICD is the official system, and the DSM is used chiefly in research. The accompanying figure lays the two systems out as a crossmap so the equivalences and the divergences can be read at a glance.

The axis	ICD-11	DSM-5-TR
Diagnostic format the classic discriminator	clinical descriptions and diagnostic requirements: essential features, NO operationalised symptom counts	polythetic OPERATIONALISED criteria: specified symptom counts and durations
How a diagnosis is reached	clinical judgement matched against the prototype	count the criteria met against a stated threshold
Owner and orientation	WHO; global health, multilingual, primary-care inclusive	APA; research and specialist, of North American origin
Coverage and coding	part of a single classification of all health conditions	mental disorders only
Personality disorders	fully DIMENSIONAL: a severity grade plus trait domains	categorical types, with a dimensional alternative model in Section III
Use in India	the official diagnostic system	common in research and teaching

The classic exam discriminator (highlighted): ICD-11 states essential features and asks for clinical judgement, whereas DSM-5-TR sets operationalised criteria to be counted against a threshold.

Fig 19.15 ICD-11 and DSM-5-TR: the structural crossmap. The two systems classify the same disorders but differ in how they do it. The examinable difference is the diagnostic format: ICD-11 gives clinical descriptions and diagnostic requirements built around essential features and asks the clinician to judge the fit against a prototype, with no fixed symptom counts, whereas DSM-5-TR sets polythetic operationalised criteria with specified symptom counts and durations to be met against a threshold. Beneath that sit differences of ownership and purpose (the WHO's global-health, multilingual, primary-care-inclusive system versus the APA's research-and-specialist manual), of coverage (ICD-11 is part of a classification of all of health; the DSM covers mental disorders), and of the personality-disorder model. In India, ICD is the official diagnostic system.

24.1 Two classifications, two owners, two purposes

The orientation and ownership of each system explains the rest. The ICD-11 (the eleventh International Classification of Diseases) is a product of the World Health Organization, adopted by the World Health Assembly in 2019 and in effect from 2022. It is a global-health instrument: multilingual, free to use, designed for every member state from the primary-care health worker to the specialist, and built to generate the world's official morbidity and mortality statistics. Mental disorders are only one chapter of it. The DSM-5-TR (the Diagnostic and Statistical Manual, fifth edition, text revision, 2022) is a product of the American Psychiatric Association, a single national professional body. It covers mental disorders alone, is written for a research-and-specialist audience, is sold commercially, and is oriented to North American practice. This difference in purpose, a whole-of-health public-health classification against a specialist mental-disorders manual, is the root from which the coverage, the coding and the format differences all grow.

ICD-11

WHO's classification of all diseases and health conditions; mental disorders are Chapter 06 of a whole-health system. Global, multilingual, free, primary-care to specialist. The official statistical and reporting standard.

DSM-5-TR

The American Psychiatric Association's manual of mental disorders only. Specialist and research oriented, commercial, North American in origin and primary use.

Coverage

ICD-11 covers all of health; the DSM covers mental disorders exclusively.

Coding

ICD-11 supplies the official alphanumeric codes (for example 6A20 for schizophrenia); the DSM carries no independent code set and maps its disorders onto ICD codes.

RULE **The ICD is the world's official classification; the DSM is a specialist manual.** WHO's ICD-11 codes all of health for every member state and generates official statistics; the APA's DSM-5-TR covers mental disorders alone for a research-and-specialist readership and borrows ICD codes.

24.2 The format contrast: essential features versus operationalised criteria

This is the classic discriminator, and the one line the examiner is listening for. The ICD-11 clinical guideline for mental disorders, its Clinical Descriptions and Diagnostic Requirements (the CDDR, the successor to the ICD-10 "blue book"), sets out for each disorder a prose account of its **essential features**, meaning those features a clinician would reasonably expect to find in all cases, and then as a rule dispenses with rigid thresholds. It gives **no operationalised counts**: it generally avoids fixed symptom tallies and precise duration cutoffs, and leaves it to the diagnosing clinician to weigh whether each feature is present, considering the whole clinical context, culture and course. The design was deliberate, meant to match how clinicians actually diagnose and to raise clinical utility across the world's very different health systems. The **DSM-5 operationalised criteria** take the opposite approach: each disorder carries a numbered, polythetic criteria set with an explicit count and duration, the familiar "at least five of the following nine symptoms, for at least two weeks" template. The strength of the DSM style is reliability and reproducibility, especially for research; the strength of the ICD style is flexibility and fidelity to real clinical reasoning.

DIMENSION	ICD-11 (CDDR)	DSM-5-TR
Diagnostic format	**Prose essential features; clinical judgement**	Numbered polythetic operationalised criteria
Symptom counts	**As a rule none (no operationalised counts)**	Explicit ("at least five of the following")
Duration thresholds	Guideline durations, flexibly applied	Fixed cutoffs (for example two weeks, six months)
Design priority	**Clinical utility and global flexibility**	Reliability and research reproducibility
Culture and context	Culture-related features built into each entry	Cultural formulation and concepts placed in Section III and an appendix

The format contrast in one grid: ICD-11 describes essential features and trusts clinical judgement; DSM-5-TR operationalises the same territory into counted, time-bound criteria.

WORKED EXAMPLE

Take schizophrenia. The DSM-5 operationalised criteria require at least two of the five characteristic symptoms, present for a one-month active phase (with at least one being a core symptom such as delusions, hallucinations or disorganised speech), *and* continuous signs of the disturbance for at least six months in total. ICD-11 requires at least two of a comparable symptom set, at least one from its core list, persisting for at least one month, and it drops the six-month total-illness requirement altogether, presenting the whole as essential features to be weighed rather than a tally to be counted. Same disorder, two formats: the DSM candidate counts symptoms and clocks six months; the ICD candidate recognises the essential clinical picture at one month. The six-month total-duration requirement is a genuine, high-yield difference, present in the DSM and absent from the ICD.

24.3 The architecture of each book

The structural differences are visible before a single disorder is read. The DSM-5-TR is built in three sections. Section I is the basics and the guidance on use; Section II holds the diagnostic criteria and codes, the working chapters arranged on a developmental-and-lifespan metastructure that places neurodevelopmental disorders first and clusters internalising and externalising groupings together; and Section III, "Emerging Measures and Models", houses the assessment measures, the cultural formulation, the alternative dimensional model of personality disorder and the conditions for further study. ICD-11's mental disorders sit as **Chapter 06**, "mental, behavioural and neurodevelopmental disorders", one chapter within the whole classification of health. It has two paired products: the short brief descriptions in the main statistical volume (the MMS), used for coding and statistics, and the fuller Clinical Descriptions and Diagnostic Requirements for clinical, educational and service use. ICD-11 also adopted a lifespan structure, ending the old separation of childhood-onset disorders into their own block, and the two systems were harmonised through a joint WHO and APA working effort so that their groupings largely correspond even where the format differs.

PEARL

The DSM's dimensional experiment is quarantined in Section III precisely because it is "emerging": the alternative personality model and the cross-cutting symptom measures were judged not yet ready to govern routine diagnosis, so Section II still runs on the familiar categorical criteria. When an examiner asks "where does the DSM put its dimensional model?", the answer is Section III, not the main diagnostic text.

24.4 Selected content differences: new entities and where things sit

Beyond format, the two systems differ in what they include and where they place it. Several entities are the ICD-11's own, or sit differently across the two books, and these are the details the paper likes to probe. Complex post-traumatic stress disorder, a distinct diagnosis added in ICD-11 (PTSD plus disturbances in self-organisation), has no separate place in the DSM. Gaming disorder is a recognised diagnosis in ICD-11, whereas the DSM lists internet gaming disorder only as a condition for further study in its Section III. Catatonia is raised in ICD-11 to an

independent grouping rather than being tethered to schizophrenia and mood disorders. Gender incongruence was moved out of the mental disorders chapter entirely in ICD-11, into a new chapter on conditions related to sexual health, a deliberate de-psychopathologisation with no DSM parallel (the DSM retains gender dysphoria among its disorders). Convergence has also occurred: prolonged grief disorder now appears in both, added to ICD-11 and written into the DSM at its 2022 text revision.

ENTITY	ICD-11	DSM-5-TR
Complex PTSD	**Separate diagnosis**	Not a separate diagnosis
Gaming disorder	**Recognised diagnosis**	Section III, for further study only
Prolonged grief disorder	Included	Added at the 2022 text revision
Catatonia	**Independent grouping**	Specifier or associated with other disorders
Gender incongruence	**Moved out of mental disorders (sexual-health chapter)**	Gender dysphoria retained as a disorder
Bipolar type II	Named category	Named category
Personality disorder	**Single diagnosis, dimensional (severity plus traits)**	Ten categorical types (Section II); dimensional model in Section III

Selected content and placement differences. The shaded cells mark the distinctively ICD-11 positions; prolonged grief disorder is the notable convergence, now in both systems.

24.5 The personality-disorder models: the sharpest divergence

Nowhere do the two systems part company more completely than on personality disorder. ICD-11 abolished the traditional named types outright. There is no longer a paranoid, schizoid or histrionic personality disorder; instead there is a single diagnosis, **personality disorder**, graded by severity into one of three levels (mild, moderate or severe), to which the clinician may then add trait-domain qualifiers. There are five such trait domains in ICD-11 (negative affectivity, detachment, dissociality, disinhibition and anankastia), plus a separate borderline pattern qualifier retained for its treatment relevance. DSM-5-TR, by contrast, kept the older architecture in its main text: ten categorical personality-disorder types arranged in three clusters (A, the odd-eccentric; B, the dramatic-erratic; C, the anxious-fearful), diagnosed by operationalised criteria like any other DSM disorder. The DSM's own dimensional answer, the Alternative Model of Personality Disorders, lives only in Section III and rates a level of personality functioning against five pathological trait domains (negative affectivity, detachment, antagonism, disinhibition and psychoticism). So both offer a five-domain dimensional scheme, but ICD-11 has made it the official diagnosis while the DSM keeps it in reserve behind its categorical types. The deeper clinical use of these models for the personality disorders themselves is developed in the Personality disorders notes.

FEATURE	ICD-11	DSM-5-TR (SECTION II)
Structure	**One diagnosis, dimensional**	Ten categorical types
Severity	**Graded: mild, moderate, severe**	Not graded (present or absent)
Trait domains	Five, plus a borderline pattern qualifier	Five, but only in the Section III alternative model
Named types	**Abolished**	Retained in three clusters (A, B, C)

The personality-disorder models. ICD-11 replaced the categorical types with a severity-plus-traits dimensional diagnosis; DSM-5-TR keeps the ten categorical types up front and files its five-domain dimensional model in Section III.

TRAP **Saying ICD-11 kept the categorical personality types.** It did not: ICD-11 abolished the named types (paranoid, schizoid and the rest) and replaced them with a single personality-disorder diagnosis graded by severity with trait qualifiers. It is the DSM-5-TR main text that still runs the ten categorical types; the DSM's dimensional model is the one sitting in reserve, in Section III.

24.6 The Indian and global implication

For most of the world, including India, the ICD is the official system. India is a WHO member state, so the ICD is the classification used for the country's official health statistics and reporting, and Indian psychiatric training, clinical documentation and postgraduate examinations are ICD-based; the DSM is read and used chiefly in research and in the literature. This is not an incidental point but the reason ICD-11's design choices matter here. Its global-health orientation, its intended use from the primary-care worker upward, its multilingual availability and its built-in attention to cultural presentations all fit a country with a vast primary-care burden, many languages and diverse idioms of distress far better than a single-nation specialist manual would. The candidate should therefore treat ICD-11 as the working home system and the DSM-5-TR as the harmonised research reference to be cross-mapped, which is exactly how this chapter, and the accompanying figure, present them. The wider transcultural frame of the cultural concepts of distress is developed in the Consultation-liaison, geriatric and transcultural psychiatry notes.

INDIA

Because ICD is the notified reporting standard and the training classification in India, a candidate who has drilled only DSM criteria is answering in the wrong dialect. The examinable move is to diagnose forward in ICD-11, using its essential features and clinical judgement, and to bring in the DSM's operationalised criteria only to cross-check or to cite a research finding. ICD-11's inclusion of culture-related features in each disorder entry, and its primary-care and multilingual reach, also sit closer to Indian practice, where presentation, language and explanatory model vary widely and a rigid imported symptom count can mislead.

06
ICD-11 CHAPTER FOR MENTAL, BEHAVIOURAL AND NEURODEVELOPMENTAL DISORDERS

3
SECTIONS OF DSM-5-TR (BASICS; CRITERIA AND CODES; EMERGING MEASURES AND MODELS)

5
ICD-11 PERSONALITY TRAIT DOMAINS, PLUS A BORDERLINE PATTERN QUALIFIER

2022
ICD-11 CAME INTO EFFECT; DSM-5-TR ALSO PUBLISHED

GOOD TO REMEMBER

- **The principle:** ICD-11 (WHO, all of health, global, Chapter 06) and DSM-5-TR (APA, mental disorders only, specialist and research) classify the same disorders but were built by different bodies for different purposes, harmonised in content yet opposed in format.
- **The one discriminator:** ICD-11 gives prose essential features with no operationalised counts and trusts clinical judgement; DSM-5 uses operationalised criteria with explicit symptom counts and durations.
- **The one exam fact:** ICD-11 abolished the categorical personality-disorder types for a single severity-graded, five-trait-domain dimensional diagnosis, while DSM-5-TR keeps the ten categorical types in its main text and confines its dimensional model to Section III; in India the ICD is the official system.

HOLD THIS

The dividing line is format: ICD-11 sets out essential features with no operationalised counts and leaves the call to clinical judgement, whereas DSM-5 uses operationalised criteria with fixed symptom counts and durations; and in India, as across most of the world, the ICD is the official classification.

25 · The categorical-versus-dimensional debate

Every diagnostic manual must answer one prior question before it names a single disorder: does psychopathology come in **kinds** or in **degrees**? This is the categorical versus dimensional debate, and settling it is the **nosology call** that shapes the entire architecture of a classification. A categorical system sorts patients into discrete named boxes, present or absent; a dimensional system rates each patient along continuous scales of severity and trait, as intelligence is rated by an IQ score rather than by "clever, average, dull". The examiner tests this as understanding rather than recall, so the marks go to the candidate who can state what each model buys, why neither is provably correct, and how the modern systems have quietly moved to a hybrid.

Why the debate is live. The categorical model has held the clinic for a century because it is usable, but its cracks (arbitrary thresholds, heterogeneous categories, rampant comorbidity, and the not-otherwise-specified overflow) drove the field toward dimensions. The settled answer in both manuals is a hybrid, most visibly in the personality disorders; beyond the manuals sit two research programmes that abandon categories altogether, HiTOP and RDoC. The accompanying figure sets the box against the sliders. This page takes the core contrast first, then each model and its limits in turn, the hybrid the manuals have settled on, and finally the two fully dimensional research frameworks.

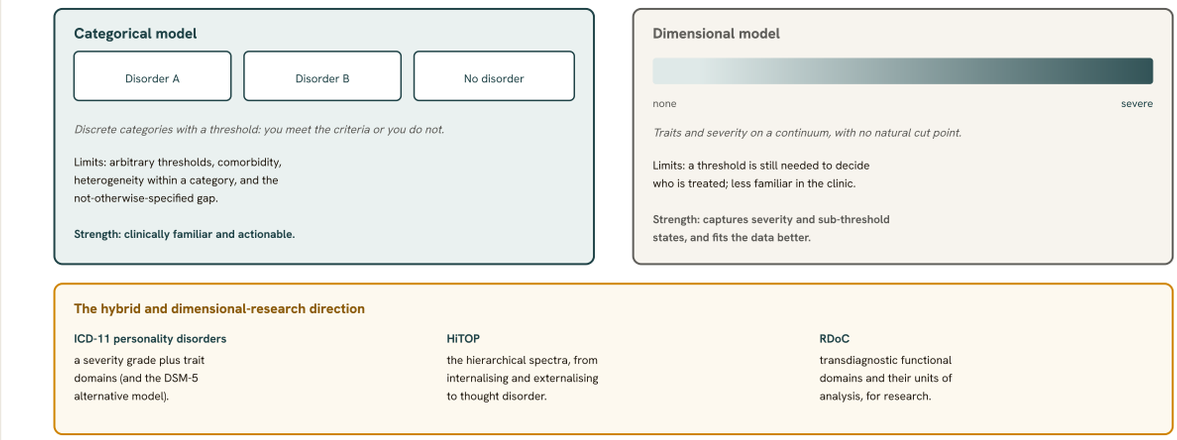


Fig 19.16 Categorical versus dimensional classification. The categorical model, used by the working manuals, sorts presentations into discrete diagnostic categories separated by a threshold: clinically familiar and actionable, but forced to draw arbitrary lines, and answerable for the comorbidity, the heterogeneity within a category and the not-otherwise-specified cases it generates. The dimensional model places traits and severity on a continuum, which fits the data better and captures sub-threshold states, but still needs a cut point to decide who is treated and is less familiar at the bedside. The field is converging on hybrids: ICD-11 already grades personality-disorder severity with trait domains, and the research frameworks HiTOP (hierarchical spectra) and RDoC (transdiagnostic functional domains) push the dimensional programme further.

25.1 The two models: a box, or a set of sliders

Two ways to describe the same patient. The **categorical model**, the one psychiatry actually runs on, places a patient inside a discrete class: the criteria are met or they are not, and the diagnosis is a noun. The dimensional model instead scores the patient on one or more continua, as blood pressure or intelligence is scored, so the description is a set of positions rather than a box. Neither is provably right. There is no statistical test that decides between a kind and a degree; the choice is pragmatic, made on which is more useful for the task at hand. The strongest evidence that would justify a true category is a **zone of rarity**, a natural gap in the distribution between one syndrome and its neighbour, as Kendell and Jablensky framed it. Searches for such gaps between related disorders have largely failed, and the ease with which clinicians reach for hybrid labels such as schizoaffective disorder is itself a sign that the categories shade into one another along a **spectrum**.

RULE **Categories are for use; dimensions are for accuracy.** A category is easy to remember, to communicate and to act on; a dimension preserves information and imposes no false boundary. Because both claims are true, the field's answer is not to pick one but to combine them.

PEARL

The debate is older than psychiatry. The Platonic ideal of classification was an exhaustive set of mutually exclusive categories; the Aristotelian view saw overlapping entities separated from normality only by arbitrary thresholds, which is the dimensional intuition in embryo. Kraepelin's disease categories are the Platonic inheritance; the modern turn to severity and traits is the Aristotelian one returning.

25.2 The categorical model: its clinical utility and its four discontents

Why the clinic keeps the category, and where it breaks. The categorical model earns its place: a single term compresses a mass of clinical information into a word two clinicians can exchange, it fits medical tradition and a conservative profession, and it is a ready prelude to action, since a named diagnosis implies a treatment. But four well-rehearsed problems, each a stock exam point, expose its limits, and each is an argument the dimensional camp turns against it.

DISCONTENT	WHAT GOES WRONG
Arbitrary thresholds	**The symptom count or duration rule (any five features, a two-week or six-month floor) draws a line across a continuum where nature shows no step; a patient one symptom short is called well**
Within-category heterogeneity	Polythetic criteria let two patients share a diagnosis with few or no symptoms in common, so the category is internally mixed rather than a uniform kind
Comorbidity	**Once hierarchical exclusions were relaxed, patients routinely meet several categories at once, suggesting the boxes cut one underlying disturbance into artificial pieces**
The not-otherwise-specified overflow	The more precise and restrictive the criteria, the more real patients fall between them into vague residual codes; "depressive disorder NOS" was once the commonest diagnosis made by North American psychiatrists

The four discontents of the categorical model. Arbitrary thresholds and comorbidity are the two most examined; the NOS overflow is the everyday symptom of categories that do not fit real patients.

TRAP **Forcing a categorical label where a dimensional formulation fits.** A patient who sits between two categories, or one symptom short of a threshold, is not diagnosis-free; the mixed and subthreshold presentations are exactly where a severity-and-trait description carries more truth than a box.

25.3 The dimensional model: its strengths and its clinical-utility limits

More information, at a price the clinic has been slow to pay. The dimensional model's strengths are the mirror of the categorical faults. It preserves fine distinctions rather than discarding them at a threshold; it handles boundary and mixed cases without distortion; it imposes no false discontinuity where the data show none; and it converts back to a category whenever a decision demands one, simply by applying a cut-off. Its costs are equally real, and clinical, which is why the clinic has resisted a wholesale switch.

DIMENSIONAL STRENGTHS	DIMENSIONAL CLINICAL-UTILITY LIMITS
Retains information lost at a categorical threshold	**A profile of scores is harder to remember and communicate than a single name**
Handles boundary, mixed and sub-threshold cases without forcing	**Does not map cleanly onto the yes-or-no decisions medicine makes (admit, treat, certify)**
Imposes no false boundary; convertible to a category by a cut-off	Reimbursement, health statistics and the medico-legal record still demand a categorical code
Tracks change and severity over time on the same scale	Clinicians trained on prototypes find a slider array unfamiliar and slow at the bedside

The dimensional trade-off. Dimensions win on accuracy and on not distorting patients who sit between classes; categories win on usability and on fitting the binary decisions of clinical medicine.

The honest summary is that dimensions win on accuracy and categories win on usability, and a working classification needs both. That is why the debate is no longer "which wins" but "how they combine".

25.4 The hybrid direction in the manuals: personality disorder leads

Both current manuals keep the box and bolt on the sliders, and personality disorder is where they went furthest. The manuals retain categorical diagnoses for usability while adding dimensional measures for severity and cross-cutting symptoms; the sharpest example is the personality disorders, where the categorical types finally collapsed under their own heterogeneity and comorbidity. ICD-11 abolished the named personality types outright and replaced them with a single diagnosis, **personality disorder**, graded into one of three severity levels (mild, moderate or severe, with a sub-threshold "personality difficulty" below them), to which the clinician may add trait qualifiers. There are **five** ICD-11 trait domains, negative affectivity, detachment, dissociality, disinhibition and anankastia, plus a borderline pattern qualifier kept for its treatment value. DSM-5-TR took the cautious route: it kept the ten categorical types in its main text and filed its dimensional answer, the alternative model of personality disorders, in Section III. That model rates a level of personality functioning (Criterion A, covering self and interpersonal functioning) against **five** pathological trait domains (Criterion B: negative affectivity, detachment, antagonism, disinhibition and psychoticism), comprising twenty-five facets. Both, then, describe a five-domain dimensional scheme; ICD-11 has made it the official diagnosis, while the DSM keeps it in reserve behind the categorical types. The deeper clinical use of these models for the personality disorders themselves belongs to the Personality disorders notes.

FEATURE	ICD-11	DSM-5-TR
Categorical types	Abolished; single "personality disorder" diagnosis	**Retained: ten types in three clusters (main text)**
Severity grading	Mild, moderate, severe (plus "personality difficulty")	**Present or absent; level of functioning only in the alternative model**
Trait scheme	Five domains, the official diagnosis, plus borderline pattern	Five domains, in the Section III alternative model only
Status	Dimensional model is the working diagnosis	**Dimensional model held in reserve behind the categories**

The hybrid, seen at personality disorder. ICD-11 made the dimensional model its official diagnosis; DSM-5-TR keeps the ten categorical types up front and files its five-domain alternative model in Section III.

INDIA

India, as a World Health Organization member state, uses the ICD as its official diagnostic and statistical classification, so it is ICD-11's dimensional personality diagnosis, severity plus traits, that now carries clinical and statutory weight in Indian practice rather than the DSM's reserved model. The Mental Healthcare Act 2017 directs that a determination of mental illness be made in accordance with nationally or internationally accepted medical standards, including the latest edition of the ICD, tying the Indian clinical-legal frame to the WHO system (the full statute is developed in the Mental health legislation and forensic psychiatry notes). ICD-11's flexible, severity-based scheme also sits more easily with India's cultural concepts of distress and its multilingual, resource-varied settings than a rigid categorical count would (the wider frame is set out in the Consultation-liaison, geriatric and transcultural psychiatry notes).

25.5 HiTOP: the Hierarchical Taxonomy of Psychopathology

A classification built from the data up, not from the committee down. Where the manuals start with expert-defined categories, the HiTOP model, the Hierarchical Taxonomy of Psychopathology, codified by Kotov and colleagues in 2017, starts from the observed covariation of symptoms and lets the structure emerge. Symptoms that co-occur are grouped into syndromes, and correlated syndromes into **spectra**; comorbidity is not a nuisance here but the very signal used to build the higher levels. The result is a dimensional hierarchy. At the base sit individual signs, symptoms and maladaptive traits; above them components and syndromes (the old disorders); then subfactors; then the broad spectra; and at the apex a general factor of psychopathology, the p factor, capturing a person's overall liability to disorder. The principal spectra run from internalising, through thought disorder and detachment, to the externalising spectra, a continuum that replaces sharp diagnostic borders with graded position. HiTOP reorganises the very clinical material the DSM contains, agnostic to its categories, so a patient placed on these continua can be compared and followed without the arbitrary thresholds and comorbidity artefacts of the categorical system.

HITOP SPECTRUM	WHAT IT GATHERS
Internalising	**The distress and fear conditions: depression, the anxiety disorders, and related eating pathology**
Thought disorder	Psychoticism and reality-testing failure: the schizophrenia-spectrum and psychotic features
Detachment	Social withdrawal, anhedonia and interpersonal disengagement
Disinhibited externalising	**Substance use and impulse-control problems; failures of restraint**
Antagonistic externalising	Aggression, manipulation and antisocial conduct
Somatoform	Bodily-distress and somatic-symptom presentations (a provisional spectrum)

The principal HiTOP spectra, with a general factor of psychopathology (the p factor) above them. Internalising and externalising are the best-validated poles; the continuum, not the boundary, is the unit.

25.6 RDoC: the Research Domain Criteria

Not a diagnostic system at all, but a research framework that ignores diagnoses. The RDoC project, the Research Domain Criteria, launched by the United States National Institute of Mental Health under Cuthbert and Insel in 2009 (its influential seven-pillars statement following in 2013, the year DSM-5 appeared), is dimensional in a deeper sense than HiTOP: it abandons clinical categories entirely and starts from basic neuroscience, asking which brain-and-behaviour systems, studied across the whole range from normal to abnormal, underlie psychopathology across diagnoses. It is arranged as a matrix. The rows are functional *constructs* grouped into a small set of *domains*, originally five (negative valence systems, positive valence systems, cognitive systems, social processes, and arousal and regulatory systems), now six with the addition of sensorimotor systems. The columns are the **units of analysis**, the seven levels at which any construct can be measured, running genes, molecules, cells, circuits, physiology, behaviour and self-report, with a further paradigms column for the tasks used. The intent is transdiagnostic and mechanistic: study fear, or reward, or working memory, as each varies across the population and across these levels, rather than starting from a DSM label. RDoC is explicitly not intended for clinical diagnosis; it is a scaffold for the research that might one day rebuild the nosology on mechanisms rather than on described syndromes.

RDOC DOMAIN	THE SYSTEMS IT COVERS
Negative valence systems	**Responses to aversive situations: acute and potential threat (fear, anxiety), loss, frustrative non-reward**
Positive valence systems	Reward: approach, valuation, effort, learning and habit
Cognitive systems	Attention, perception, working memory, cognitive control and language
Social processes	Affiliation and attachment, social communication, perception of self and others
Arousal and regulatory systems	Arousal, circadian rhythms, sleep and wakefulness, homeostatic regulation
Sensorimotor systems	Control, execution and refinement of motor behaviour (the domain added most recently)

The RDoC domains (originally five; sensorimotor systems added later), each studied across seven units of analysis from genes to self-report. A research matrix, not a clinical classification.

TRAP **Treating HiTOP or RDoC as ready-made diagnostic systems.** Neither is a classification you can diagnose a patient with today. HiTOP is a research taxonomy of dimensions built from symptom covariation; RDoC is a neuroscience research framework that is explicitly not for clinical diagnosis. The clinic still runs on the categorical ICD-11 and DSM-5-TR, hybridised with dimensions.

3
ICD-11 PERSONALITY SEVERITY GRADES (MILD, MODERATE, SEVERE)

5
ICD-11 TRAIT DOMAINS, MATCHED BY FIVE DSM-5 ALTERNATIVE-MODEL DOMAINS

6
RDOC FUNCTIONAL DOMAINS (THE ORIGINAL FIVE PLUS SENSORIMOTOR)

7
RDOC UNITS OF ANALYSIS, GENES TO SELF-REPORT

GOOD TO REMEMBER

- **The principle:** the categorical model classifies by kind and wins on clinical usability; the dimensional model classifies by degree and wins on accuracy; no statistical test settles which is correct, so both current manuals are categorical-dimensional hybrids, most fully at personality disorder.
- **The one discriminator:** HiTOP versus RDoC. HiTOP is a descriptive taxonomy that reorganises symptoms bottom-up into spectra (internalising, thought disorder, externalising) from their covariation; RDoC starts top-down from neuroscience constructs measured across units of analysis and is explicitly not for clinical diagnosis. Both are research frameworks, not clinical systems.
- **The one exam fact:** ICD-11 abolished the categorical personality types for a single diagnosis graded into three severity levels plus five trait domains; DSM-5-TR keeps ten categorical types in its main text and its five-domain alternative model in Section III; HiTOP arranges psychopathology into spectra under a general p factor; RDoC into six domains across seven units of analysis.

HOLD THIS

No test proves psychopathology is kinds rather than degrees, so the categorical versus dimensional call is pragmatic: categories for clinical usability, dimensions for accuracy, hybrids in ICD-11 and DSM-5-TR (severity plus traits at personality disorder), with HiTOP and RDoC the fully dimensional research programmes waiting in the wings.

26 · Comorbidity and the boundary problem

Once psychiatry relaxed its old diagnostic hierarchy and let clinicians record every disorder a patient meets, **comorbidity** stopped being suppressed and started being counted, and the counts turned out to be enormous. This short topic teaches what those high numbers actually mean: how much of the co-occurrence is real and how much is an artefact of the way our manuals carve distress into categories, and how that question opens onto the deeper **boundary problem**, the difficulty of finding a clean edge between one disorder and the next, and between disorder and normality. The examiner uses this material to test whether a candidate can think about classification rather than merely apply it, so the marks go to whoever can separate *true* from *artefactual* co-occurrence and say why the boundaries stay blurred.

How to use this page. Fix three moves. First, the meaning of comorbidity and the true-versus-artefactual split. Second, the boundary problem itself, built from **diagnostic overlap**, the old **splitting versus lumping** tension, and the **heterogeneity** that polythetic criteria leave inside every category. Third, what all this implies for classification: the drift toward a hybrid categorical-dimensional system. This sits alongside the broader account of category, prototype and the reliability-validity distinction in the classification-principles material; here the focus is narrowed to the single fault line of comorbidity and boundaries.

26.1 How common comorbidity is, and what it means: true versus artefactual

Comorbidity is the co-occurrence of two or more diagnoses in one patient, and it is the rule, not the exception. Community surveys such as those of Kessler showed the pattern is pervasive: roughly half of all patients meeting criteria for major depressive disorder also meet criteria for an anxiety disorder, and a person who qualifies for one disorder is far more likely than chance to qualify for another. The important examinable step is not the number but the interpretation, because the term covers two quite different situations. **True comorbidity** is real co-occurrence: either two genuinely separate disorders arising together by chance (the causally unrelated case, such as a presenile dementia beginning in someone with long-standing panic disorder), or two distinct clinical pictures that share one underlying process but are diagnosed separately for want of knowledge or by convention. **Artefactual comorbidity**, by contrast, is not two diseases at all: it is a by-product of how the classification is written, arising either when one broad condition is split across several narrow categories that then appear to "co-occur", or when overlapping criteria let the same symptom count toward two diagnoses at once. It has been argued that a good deal of psychiatric comorbidity is exactly this artefact of diagnostic rules that permit, if not encourage, multiple diagnoses (Maj, 2005), and that a simpler system reducing it would be preferable (Goldberg, 2010).

READING OF A COMORBID PAIR	MECHANISM	WORKED INSTANCE
True (chance)	Two causally unrelated disorders happen to co-occur	**A presenile dementia arising in a person with long-standing panic disorder**
True (shared cause)	One underlying process, two manifestations diagnosed separately for want of knowledge	An anxious and a depressive syndrome expressing one common vulnerability
Artefactual (splitting)	The manual carves one condition into several narrow categories that then "co-occur"	**A broad internalising syndrome recorded as separate depressive and anxiety diagnoses**
Artefactual (overlap)	Shared symptoms are counted toward two criteria sets at once	**A single personality disorder whose features straddle two overlapping criteria sets**

The two readings of any comorbid pair. True comorbidity is real co-occurrence; artefactual comorbidity is a by-product of how the manual splits and overlaps its categories (Maj, 2005).

RULE **Comorbidity means both criteria sets are fully met.** The term applies only when a patient satisfies the criteria for two or more distinct diagnoses; a patient who falls between categories and meets none is not comorbid but sub-threshold, and calling that comorbidity is an error.

TRAP **Reading every comorbid pair as two real diseases.** Much apparent comorbidity is artefactual, the product of splitting one condition across overlapping criteria, so counting diagnoses is not the same as counting diseases; the clinician still asks whether one formulation explains the whole picture.

26.2 The boundary problem: diagnostic overlap, splitting versus lumping, heterogeneity

High comorbidity is a symptom of a deeper condition: the categories do not have clean edges. This is the **boundary problem**, and it operates at two frontiers at once, the boundary between one disorder and its neighbours, and the boundary between disorder and normality. The strongest test of whether a syndrome-defined category is real is whether it is separated from related syndromes, and from health, by a zone of rarity, a genuine gap in the distribution where intermediate cases become uncommon (Kendell and Jablensky, 2003). For most disorders that gap cannot be found: attempts to demonstrate zones of rarity between related syndromes, or between illness and health, have largely failed, and the frequency with which clinicians reach for intermediate labels such as schizoaffective is itself evidence that symptom patterns merge into one another rather than sitting in discrete clusters. The unsettling implication is that the *validity* of many categories remains unproven even where their clinical *utility* is not in doubt. Learn the boundary vocabulary as crisp definitions.

Diagnostic overlap

Two categories share symptoms, so the same clinical feature can satisfy criteria for more than one disorder; overlap manufactures artefactual comorbidity and blurs the line between the categories.

Splitting versus lumping

The perennial tension between the "splitter", who prefers many narrow, homogeneous categories, and the "lumper", who prefers few broad ones. More splitting buys finer distinctions but multiplies

apparent comorbidity; more lumping cuts comorbidity but hides real differences inside each category.

Heterogeneity
The variety of patients who share a single diagnosis. Because criteria sets are polythetic (any specified subset suffices), two people can hold the same label with almost no symptoms in common, so a category name conceals a mixed population.

Boundary with normality
The absence of a natural cut between the disordered and the well; where symptoms shade continuously into ordinary experience, any threshold for "caseness" is a pragmatic convention rather than a discovered line.

Splitting and lumping trade the two problems against each other and neither dissolves the boundary. A splitter reduces heterogeneity inside each category but drives comorbidity up, because a patient's features now spill across several narrow neighbours; a lumper suppresses comorbidity but pays for it with wider heterogeneity inside each broad class. Because there is no zone of rarity to arbitrate, no split is provably the right one, which is why the accompanying figure sets two related syndromes as overlapping distributions with no clean valley between them.

26.3 What it implies for classification

The way out is not a better boundary but a change of instrument. If related disorders shade into one another and into normality, a purely categorical system will always generate the tell-tale strains, and the current manuals name them plainly. The limitations the categorical approach runs into are a stock list: the failure to find zones of rarity, the recurring need for intermediate categories such as schizoaffective disorder, high rates of comorbidity, the frequent resort to "other" and "unspecified" diagnoses, the weak yield of unique validators, and the lack of treatment specificity across categories (DSM-5-TR). The agreed response is not to abandon categories, which remain indispensable for the yes-or-no decisions of clinical work, but to add a dimensional layer on top of them: severity ratings and cross-cutting symptom measures that capture the **heterogeneity** a single label hides, and that describe the patient who sits on a boundary without forcing a false choice. This hybrid, categorical diagnoses with dimensional additions, is the direction of both current systems, and it is the field's practical answer to a boundary problem it cannot solve outright.

PEARL

Comorbidity rates did not rise because patients got sicker; they rose because the classification changed. When DSM-III and its successors relaxed the old hierarchical exclusions that had forced one diagnosis per patient, the co-occurrences that the hierarchy used to suppress became recordable, and the numbers appeared to soar. High comorbidity is partly a measurement effect of a permissive counting rule, which is exactly why the artefactual share is worth naming.

50%	2	6
OF MAJOR DEPRESSIVE DISORDER PATIENTS ALSO MEET CRITERIA FOR AN ANXIETY DISORDER (KESSLER)	READINGS OF ANY COMORBID PAIR: TRUE CO-OCCURRENCE VERSUS ARTEFACTUAL	LIMITATIONS OF THE CATEGORICAL APPROACH LISTED BY DSM-5-TR

INDIA

India, as a World Health Organization member state, classifies with the *ICD*, and the Mental Healthcare Act 2017 ties the determination of mental illness to internationally accepted standards including the latest ICD, so the boundary and comorbidity questions here are asked in ICD terms. The comorbidity most examined in Indian practice is dual diagnosis, the co-occurrence of a substance use disorder with another mental illness, and the standard caution is a true-versus-artefactual one in clinical dress: a substance-induced psychiatric state is *secondary*, not true comorbidity, so it must be distinguished from an independent disorder that merely co-occurs (the fuller treatment sits in the Substance use disorders notes). ICD-11's flexible, prototype-based essential features, built to tolerate cultural variation and clinical judgement, also handle boundary and mixed cases more gracefully than a rigid criteria count.

GOOD TO REMEMBER

- **The principle:** comorbidity, the co-occurrence of two or more diagnoses in one patient, is common (about half of depressed patients also meet criteria for an anxiety disorder) and is partly a real phenomenon and partly an artefact of how the classification is written.
- **The one discriminator:** true comorbidity is real co-occurrence (two independent disorders by chance, or two manifestations of one shared process), whereas artefactual comorbidity is a by-product of splitting one condition across several categories or of overlapping criteria (Maj, 2005).
- **The one exam fact:** the boundary problem is the failure to find zones of rarity between related syndromes and between disorder and normality (Kendell and Jablensky, 2003), which leaves category validity unproven despite clinical utility and drives the field toward a hybrid categorical-dimensional classification.

HOLD THIS

Psychiatric comorbidity is partly true co-occurrence and partly artefactual, the artefact of splitting one condition across overlapping criteria; because no zone of rarity separates related syndromes or marks off normality, the boundary problem cannot be solved by a better line and is instead met with a hybrid categorical-dimensional system.

27 · Cultural concepts of distress and culture-bound syndromes

Distress is never expressed in a cultural vacuum: the words a patient reaches for, the cause they blame, and the very shape of their symptoms are all patterned by the culture they live in. This page teaches the modern framework for that fact, the DSM-5 shift from the old, exoticising language of **culture-bound syndromes** to the broader idea of **cultural concepts of distress**, together with the assessment tool built to elicit it, the **cultural formulation** and its Cultural Formulation Interview. The examiner tests three things: that you can name and separate the three *types* of cultural concept, that you can define the classic examples (with the Indian and Asian ones, **dhat** and **koro**, held tight), and that you can say why getting this right prevents misdiagnosis in either direction.

How to use this page. Fix the reframing first, because the whole topic turns on it: a culture-bound syndrome is a discrete exotic entity, whereas cultural concepts of distress is a wider, non-pejorative construct with three parts. Then learn the three types as crisp definitions, the eight

classic syndromes as a definitions list, and the cultural formulation and its interview as the clinical skill that operationalises all of it. Close on the clinical pay-off, avoiding both the false-positive (pathologising a culturally normative expression) and the false-negative (missing the disorder hidden behind a culturally-framed presentation). The wider transcultural frame of the cultural concepts of distress, its epidemiology, migration and acculturation, belongs to the Consultation-liaison, geriatric and transcultural psychiatry notes; here the treatment stays at the level of the concepts themselves and the formulation that captures them.

27.1 From culture-bound syndromes to cultural concepts of distress

The DSM-5 retired a term it judged both narrow and pejorative. The older phrase culture-bound syndromes, still the term ICD-10 uses, named a set of illnesses thought to be locked to particular cultures and geographical areas and not seen in the developed West: dhat, koro, latah, amok, piblokto, wihtigo and their kin. DSM-5 and DSM-5-TR replaced it with cultural concepts of distress for two reasons. First, the old label *exoticised* non-Western presentations while quietly pretending that Western diagnostic categories are culture-free, when in truth the DSM's own diagnoses are themselves evolving Western cultural syndromes. Second, "syndrome" captured only one of the ways culture shapes distress; culture also patterns how people *talk* about suffering and how they *explain* it. The new construct therefore has three components, and naming all three is the reliable opening to any answer here.

Cultural syndrome

A cluster of co-occurring symptoms recognisable to, and often named by, a particular cultural group (for example, ataque de nervios). It may or may not be treated locally as an illness.

Cultural idiom of distress

A shared way of *talking about* suffering, a linguistic or somatic vocabulary common in a cultural group (for example, "thinking too much," or "butterflies in the stomach").

Cultural explanation or perceived cause

A shared **explanatory model** of what is wrong and why, the culturally patterned attribution of a symptom to a cause (for example, semen loss, soul loss, or a chemical imbalance).

The three are functions, not fixed boxes: the same term routinely serves more than one at once, and a term can migrate between them over time. "Depression" names a syndrome in one mouth and works as a plain **idioms of distress** in another. This is the point the examiner wants: cultural concepts of distress is a broader, more honest and less pejorative construct than culture-bound syndromes, of which the classic syndromes are merely the syndrome-shaped subset.

RULE **Three types, not one.** Cultural concepts of distress subsume cultural *syndromes* (clusters of symptoms), cultural *idioms* of distress (ways of talking about suffering) and cultural *explanations* or perceived causes (explanatory models). The old "culture-bound syndrome" covered only the first.

27.2 The three types, and Kleinman's explanatory model

Separate the cluster, the vocabulary and the cause. The distinction earns its keep clinically because each type is elicited by a different question and each misleads in a different way. A

cultural *syndrome* gives you a recognisable pattern, but that pattern may map onto more than one biomedical diagnosis, or none. A cultural *idiom* gives you the patient's language, which is why a somatic idiom ("my body burns," "gas rises to my head") so often brings anxiety or depression to a physician's door dressed as a bodily complaint. A cultural *explanation* gives you the perceived cause, and this is where the single most examinable name in the topic sits: the explanatory model of illness, pioneered by Arthur Kleinman. Kleinman's insight was that the clinician's biomedical model and the patient's model of the same illness frequently differ, and that eliciting the patient's model, what they call the problem, what they believe causes it, how severe and how long they expect it to run, and what treatment they want, is essential to engagement, adherence and accurate diagnosis.

TYPE	WHAT IT IS	WORKED EXAMPLE
Cultural syndrome	A recognisable cluster of co-occurring symptoms	**Ataque de nervios; dhat syndrome**
Cultural idiom of distress	A shared vocabulary for expressing suffering	**"Thinking too much"; kufungisisa**
Cultural explanation / perceived cause	A shared explanatory model of the cause	**Semen loss (dhat); soul loss (susto)**

The three components of cultural concepts of distress. The same cultural term (for example dhat, or "thinking too much") can act as more than one type at once.

PEARL

The clean viva line: a cultural *syndrome* is a set of symptoms, a cultural *idiom* is a set of words, and a cultural *explanation* is a claimed cause. Kleinman's explanatory model belongs to the third: it is the patient's own theory of their illness, and eliciting it is the engine of the whole cultural assessment.

27.3 The classic examples

Learn each as a one-line definition anchored to its region. DSM-5-TR gives **ten** illustrative examples (ataque de nervios, dhat, hikikomori, khyal cap, kufungisisa, maladi dyab, nervios, shenjing shuairuo, susto and taijin kyofusho), but the classic examinable set blends these with the older culture-bound roster. Hold the two Indian and Asian entries hardest, because they are the ones most likely to walk into an Indian clinic.

Dhat syndrome (dhat)

Indian subcontinent. Anxious preoccupation with the passage of a whitish discharge in the urine, believed to be semen, with fatigue (asthenia) and multiple somatic symptoms, rooted in the traditional belief that semen is a precious vital fluid whose loss weakens the body.

Koro

Asia, including India. A sudden, intense fear that the penis (or, in women, the breasts or vulva) is shrinking or retracting into the body and that death will follow; characteristically occurs in epidemics that spread rapidly through a community.

Amok

South-East Asia, classically Malaysia. A sudden, unprovoked outburst of homicidal rage in which the person "runs amok," attacking or killing indiscriminately, typically followed by exhaustion and amnesia for the episode.

Latah

South-East Asia, classically Malaysia and Indonesia, chiefly in women. An exaggerated startle response to a sudden stimulus, followed by echolalia, echopraxia and automatic obedience; the Japanese analogue is imu.

Ataque de nervios

Latinx contexts. An episode of intense emotional upset with uncontrollable screaming or crying, trembling, heat rising in the chest into the head, aggression and, in some, seizure-like or dissociative features; the hallmark is a sense of being out of control, usually triggered by a family stressor.

Brain fag

West Africa, Nigeria (described by Raymond Prince). Mental fatigue, difficulty concentrating and remembering, and head or neck discomfort, attributed to the strain of study and seen classically in students.

Taijin kyofusho

Japan. An intense fear that one's own body, its parts, odour, gaze or facial expression, will offend, embarrass or displease other people; an other-focused counterpart to social anxiety disorder.

Susto

Latin American contexts. "Fright" or "soul loss," an illness attributed to a frightening event that causes the soul to leave the body, with sadness, disturbed sleep and appetite, low self-worth and somatic symptoms.

INDIA

The two syndromes an Indian examiner will press are dhat and koro. Dhat is the paradigmatic South Asian culture-bound syndrome, classically described in Indian descriptive psychiatry (N.N. Wig), and ICD-10 files it under the "other specified neurotic disorders." Its cultural logic is a genuine explanatory model: the belief that semen is a concentrated, precious essence means its perceived loss is expected to produce weakness, so the patient presents with fatigue, somatic symptoms and sexual worry rather than a complaint of "anxiety." Koro too is seen in India and across Asia and can erupt in local epidemics. Beyond these, the Indian literature also names *suchi-bai* (a purity or washing preoccupation), the ascetic syndrome, nuptial psychosis and jhinjhinia. The clinician's task is not to collect these as curios but to recognise the explanatory model behind them so the underlying, often treatable, anxiety or depression is addressed rather than dismissed.

COMMON TRAP

Do not automatically upgrade a culturally sanctioned concern to a psychotic symptom. A koro conviction held in an epidemic within a community that shares the belief is not, on its own, a delusion in the thought-content sense; a dhat patient's semen-loss attribution is a shared explanatory model, not hypochondriacal delusion. Whether a belief is delusional turns on whether it is idiosyncratic and outside the person's subculture, exactly the distinction developed in the Psychometry, Assessment and Descriptive Psychopathology notes.

27.4 The cultural formulation and the Cultural Formulation Interview

Culture is captured by a structured formulation, not a hunch. The tool is the **cultural formulation**, introduced as the Outline for Cultural Formulation (OCF) in DSM-IV and carried into DSM-5, which places the patient's own experience at the centre of the assessment across five domains. DSM-5 then added its operational companion, the Cultural Formulation Interview (CFI): a semistructured, person-centred set of questions that gathers the information the OCF needs. The core interview runs **16** questions grouped into **four** sections; a CFI-informant version gathers the same from a relative, and a set of **twelve** supplementary modules (explanatory model, level of functioning, social network, psychosocial stressors, spirituality, cultural identity, coping and help-seeking, patient-clinician relationship, children and adolescents, older adults, immigrants and refugees, and caregivers) extend it. The CFI is applicable to every patient, not only to those from a visibly different background.

OCF DOMAIN	WHAT IT ASSESSES
Cultural identity of the individual	**Ethnicity, language, religion, migration and other identities, self-ascribed and ascribed**
Cultural conceptualisations of distress	The syndromes, idioms and explanatory models the patient uses (this is where cultural concepts of distress live)
Psychosocial stressors and cultural features of vulnerability and resilience	**Stressors, supports, the role of family and religion, and culturally-defined functioning**
Cultural features of the clinician-patient relationship	Differences in language, culture and status that shape rapport and trust
Overall cultural assessment	**How the above bears on diagnosis and on a culturally-appropriate management plan**

The five domains of the Outline for Cultural Formulation. The Cultural Formulation Interview is the semistructured instrument that gathers the information each domain requires.

MNEMONIC

PROBLEM · PERCEPTIONS · PAST · PRESENT

The four sections of the core CFI, in order: the cultural **definition of the problem**; cultural **perceptions** of cause, context and support; cultural factors in self-coping and **past** help-seeking; and cultural factors in **present** (current) help-seeking and treatment expectations.

3	4	16	10
TYPES OF CULTURAL CONCEPT: SYNDROMES, IDIOMS, EXPLANATIONS	SECTIONS OF THE CULTURAL FORMULATION INTERVIEW	QUESTIONS IN THE CORE CFI	ILLUSTRATIVE EXAMPLES LISTED IN DSM-5-TR

27.5 Why it matters: avoiding misdiagnosis in both directions

The cultural formulation exists to stop two opposite errors. The *false-positive* error is pathologising a culturally normative expression: an ataque de nervios at a funeral, or grief expressed through vivid somatic and dissociative features, is not automatically a psychiatric disorder, and DSM-5-TR is explicit that some ataques are normative expressions of acute distress

without clinical sequelae. The *false-negative* error is the mirror image and, in practice, the commoner one: mistaking the cultural packaging for the whole story and missing the treatable disorder inside it, reading a dhat presentation as mere "cultural belief" when a major depressive or anxiety disorder sits underneath, or dismissing a somatic idiom of distress as having no psychiatric content at all. The corrective is the same in both cases: elicit the explanatory model, situate the presentation in the patient's subculture, and let the cultural formulation, rather than the surface label, guide the diagnosis and plan.

WORKED EXAMPLE

A young man attends a general clinic complaining that "dhat is leaking" in his urine, that he is weak, cannot concentrate, and fears his marriage will fail. Taken at face value the presentation is a "cultural belief"; taken as an explanatory model it is a doorway. The Cultural Formulation Interview elicits his conviction that lost semen is draining his vitality (his cultural explanation), his family's shared endorsement of that model (context and support), and, behind it, two months of low mood, anhedonia, initial insomnia and hopelessness. The formulation names a depressive episode expressed through a dhat idiom, and management pairs education about semen physiology with treatment of the depression, rather than either scolding the belief or missing the illness.

TRAP **Treating "it's cultural" as a diagnosis or a dismissal.** Labelling a presentation a culture-bound syndrome is not the end of assessment; cultural concepts of distress frequently coexist with, and conceal, standard psychiatric disorders. The error runs both ways: pathologising the normative, or normalising the pathological.

GOOD TO REMEMBER

- **The defining principle:** DSM-5 replaced the narrow, pejorative "culture-bound syndromes" with *cultural concepts of distress*, a broader construct with three parts, cultural syndromes, cultural idioms of distress and cultural explanations or perceived causes (Kleinman's explanatory model).
- **The one discriminator:** a cultural *syndrome* is a cluster of symptoms, a cultural *idiom* is a way of talking about distress, and a cultural *explanation* is a claimed cause; the same term can serve more than one function at once.
- **The one exam fact:** the cultural formulation has five OCF domains and is elicited by the Cultural Formulation Interview (a core interview of sixteen questions in four sections); the classic Indian and Asian examples are dhat (semen-loss concern) and koro (fear of genital retraction), and the whole apparatus exists to prevent misdiagnosis in either direction.

HOLD THIS

Cultural concepts of distress (DSM-5, replacing culture-bound syndromes) come in three types, syndromes, idioms and explanatory models; they are captured by the cultural formulation and its 16-question, four-section Cultural Formulation Interview, and their clinical purpose is to stop the clinician both from pathologising the culturally normal and from missing the treatable disorder behind a dhat, koro or ataque presentation.

28 · The forensic essentials

When a psychiatrist steps into a courtroom the questions change shape: the court does not want a diagnosis, it wants a legal opinion, and the two are not the same thing. These **forensic**

psychiatry essentials gather the small cluster of medico-legal questions that recur in every exam, three of which do almost all the work. Can the accused be tried at all (**fitness to stand trial**)? Was the accused answerable for the act (**criminal responsibility** and the insanity defence)? Can a person make a valid will (**testamentary capacity**)? Each rests on a capacity test with a named authority, and the marks go to the candidate who states the test, the case behind it and the Indian provision without blurring one into another.

How to use this page. Fix the three capacities and the one time-frame rule that separates them, learn the two limbs of the insanity test and their Indian mirror, and hold the four-limb will test with its case name. This is the compact treatment; the fuller forensic material, narcoanalysis and the detailed assessment procedure, the review board and the admission provisions, and the wider statutes, lives in the Mental health legislation and forensic psychiatry notes, and this page cross-refers there rather than repeating it.

Fitness to stand trial

The accused's *present* capacity to understand the charge and the court proceedings and to instruct counsel; a here-and-now assessment, not a comment on the offence.

Criminal responsibility

Whether, *at the time of the act*, the accused was so disordered as to be excused from the guilty mind (mens rea) the offence requires; the insanity defence answers this.

Diminished responsibility

A partial defence: an abnormality of mind that substantially impaired responsibility, reducing murder to manslaughter rather than acquitting.

Testamentary capacity

The capacity to make a valid will, judged task-specifically at the time the will is made, under the Banks v Goodfellow test.

28.1 Fitness to stand trial: understand the charge, follow the proceedings, instruct counsel

Fitness to stand trial is a present-state question about the accused's ability to take part in the trial, not about the offence. The accused must be able to understand the nature of the charge, follow the course of the proceedings, and instruct and assist counsel in the defence; in English practice these are the Pritchard criteria for fitness to plead, and in the United States the parallel is the Dusky standard, a rational and factual understanding of the proceedings together with the ability to consult a lawyer. The decisive feature for the exam is the time-frame: fitness is assessed *here and now*, so a person may be perfectly fit to be tried today yet have been insane at the moment of the crime, or unfit today yet have been fully responsible then. When an accused is found unfit, the trial is postponed and the person is dealt with under the mental-health provisions rather than convicted.

28.2 Criminal responsibility and the insanity defence: the McNaughten rules

The insanity defence asks whether disease of the mind, at the time of the act, deprived the accused of the knowledge that makes an act blameworthy. English law defines this by the McNaughten rules (also spelled McNaughton or M'Naghten), framed by the House of Lords after Daniel McNaughten in **1843** shot and killed Edward Drummond, secretary to the Prime

Minister Sir Robert Peel, under a persecutory delusional system; he was found not guilty by reason of insanity and admitted to Bethlem Hospital, and the public outcry produced the rules. The test requires proof that, at the time of committing the act, the accused was labouring under such a defect of reason, from disease of the mind, as (the first limb) not to know the nature and quality of the act, or (the second limb) if he did know it, not to know that what he was doing was wrong. These are the two limbs of a purely *cognitive* test, the classic right-wrong test: it turns on whether the accused could *know*, never on whether he could *control* his conduct, so an irresistible impulse in someone who knew the act was wrong falls outside it.

WORKED EXAMPLE

A man with schizophrenia, driven by command voices and a fixed belief that his neighbour is an assassin sent to kill him, attacks and kills the neighbour convinced he is defending his own life. At the material time he did not know the act was wrong, so he satisfies the second limb of the insanity test and the Indian provision below. Contrast a man who strangles his wife in a jealous rage, knows perfectly well it is wrong, but says he "could not stop himself": knowledge is intact, so neither the McNaughten rules nor the Indian section excuses him, because there is no volitional (loss-of-control) limb.

RULE **Insanity is a legal verdict, not a diagnosis.** The McNaughten test is cognitive, whether the accused could know the nature of the act or that it was wrong; a psychiatric diagnosis by itself never exculpates, and there is no arm for loss of control.

28.3 The Indian frame: unsoundness of mind under Section 84 of the Indian Penal Code

India codifies the same cognitive test as a general exception to criminal liability. Section **84** of the Indian Penal Code, headed the act of a person of **unsound mind**, states that 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 examinable points sit on top of the McNaughten mirror. First, the section adds the arm "or contrary to law", so incapacity as to *either* moral wrong *or* legal wrong will do. Second, the section covers legal insanity, not medical insanity: a diagnosis, even of florid psychosis, does not by itself attract the benefit; what must be shown is the incapacity to know at the material moment. The crucial time is the instant the act was committed (settled in Rattan Lal versus State of Madhya Pradesh), and the burden of proving unsoundness lies on the accused, on the preponderance of probability, after which the onus shifts to the prosecution.

CAPACITY	THE QUESTION IT ANSWERS	TIME FRAME	GOVERNING STANDARD
Fitness to stand trial	Can the accused understand the charge, follow proceedings and instruct counsel?	**Present (here and now)**	Pritchard criteria (England); Dusky standard (USA); NIMHANS proforma (India)
Criminal responsibility (insanity)	Was the accused so disordered as not to know the act's nature, or that it was wrong?	**At the time of the act**	McNaughten rules; Section 84 of the Indian Penal Code
Diminished responsibility	Did an abnormality of mind substantially impair responsibility for the killing?	At the time of the act	**English partial defence (murder reduced to manslaughter)**
Testamentary capacity	Can the person make a valid will?	When the will is made	**Banks v Goodfellow; Indian Succession Act 1925 (sound disposing mind)**

The forensic capacities separated by their time-frame: fitness is a present-state test, responsibility looks back to the moment of the offence, testamentary capacity to the moment of the will.

TRAP **Collapsing fitness to stand trial into criminal responsibility.** They ask different questions at different times: fitness is the accused's capacity now to be tried; responsibility is his mental state then, at the offence. Currently fit does not mean he was sane at the act, and currently unfit does not mean he was insane.

28.4 Diminished responsibility, in brief

Where insanity fully acquits, diminished responsibility only softens the verdict. It is an English partial defence to murder: where an abnormality of mind (arising from a recognised condition) substantially impaired the accused's mental responsibility for the killing, the charge is reduced from murder to manslaughter, avoiding the mandatory life sentence rather than excusing the act. It is invoked far more often than the insanity defence, which critics find too narrow to fit most mentally ill offenders. India has no equivalent general partial defence; there the routes are the Section 84 exception and the separate law of grave and sudden provocation, so **diminished responsibility** is best learned as the English contrast to the all-or-nothing insanity verdict.

28.5 Testamentary capacity: the Banks v Goodfellow criteria

Capacity to make a will is task-specific: a person with serious mental illness may still make a valid will if the illness does not touch the disposition. The governing test comes from Banks v Goodfellow in **1870**, where John Banks, a testator with chronic delusional illness, was nonetheless held capable because his delusions did not affect how he left his estate, establishing that testamentary capacity is judged against the specific task, not the global mental state. The testator must satisfy four limbs: he must understand the nature of the act of making a will and its effects; know the nature and extent of the property he is disposing of; appreciate the persons who have a reasonable claim as beneficiaries; and be free of any disorder of mind or insane delusion that perverts the disposition. Indian law aligns through the Indian Succession Act 1925,

which requires a sound disposing mind, and treats capacity as both task-specific and time-specific, tied to the moment the will is made and instructed.

BANKS V GOODFELLOW LIMB	WHAT THE TESTATOR MUST SHOW
Nature of the act	Understands that he is making a will and what a will does (disposing of his estate after death)
Extent of the estate	Knows the nature and approximate extent of the property being disposed of
Claims of beneficiaries	Appreciates the persons who have a reasonable claim, the natural heirs he is including or excluding
Undeluded judgment	**Is free from any disorder of mind or insane delusion that perverts the disposition of the estate**

The four limbs of the Banks v Goodfellow test. The last limb is the discriminating one: the delusion must not be shaping who inherits.

MNEMONIC

WILL · WEALTH · WHO · (no) WARP

The four Banks v Goodfellow limbs: understands the **WILL** and its effect; knows the extent of his **WEALTH**; appreciates **WHO** has a claim; and no delusional **WARP** of the disposition.

PEARL

The word "wrong" is where India and the classic English rule diverge. The McNaughten second limb asks only whether the accused knew the act was wrong; Section 84 of the Indian Penal Code spells out "wrong *or* contrary to law", so incapacity as to moral wrong or legal wrong will each suffice. Either way, the test is knowledge at the material time, and a diagnosis without that incapacity does not exculpate: legal insanity is not medical insanity.

1843
THE MCNAUGHTEN CASE, FROM WHICH THE INSANITY RULES WERE FRAMED

84
THE INDIAN PENAL CODE SECTION FOR UNSOUNDNESS OF MIND

1870
BANKS V GOODFELLOW, THE TESTAMENTARY-CAPACITY TEST

4
LIMBS OF THE BANKS V GOODFELLOW TEST

INDIA

The NIMHANS fitness-to-stand-trial proforma structures the assessment into five sections: cognitive functions, understanding of the charges, knowledge of the court proceedings, understanding of one's own lawyer, and expected behaviour during the trial. Criminal responsibility runs through Section 84 of the Indian Penal Code, testamentary capacity through the Indian Succession Act 1925's "sound disposing mind", and the whole field now sits under the Mental Healthcare Act 2017. Note the recodification for current exams: the Indian Penal Code has been replaced by the Bharatiya Nyaya Sanhita 2023, whose unsoundness-of-mind provision (its Section 22) carries essentially the same wording as the old Section 84, so the capacity test is unchanged even as the numbering moves.

GOOD TO REMEMBER

- **The principle:** forensic assessment answers a legal question, not a clinical one; the psychiatrist informs the court, but the verdict, of responsibility, fitness or capacity, is the court's, and a diagnosis alone never decides it.
- **The one discriminator:** time-frame separates the capacities, criminal responsibility looks back to the moment of the act (McNaughten rules; Section 84 of the Indian Penal Code, incapacity to know the nature of the act or that it was wrong), whereas fitness to stand trial is a present-state test (understand the charge and proceedings, instruct counsel).
- **The one exam fact:** testamentary capacity is task-specific under Banks v Goodfellow (1870): understand the nature of the will, the extent of the estate and the claims of beneficiaries, free from any delusion that perverts the disposition.

HOLD THIS

Two questions, two time-frames: criminal responsibility asks whether, at the time of the act, disease or unsoundness of mind left the accused unable to know the nature of the act or that it was wrong (McNaughten; Section 84 of the Indian Penal Code), while fitness to stand trial asks whether, here and now, he can understand the charge and proceedings and instruct counsel.

29 · The Mental Healthcare Act 2017

Indian psychiatry now runs on a single statute, and the examiner treats it as compulsory: the **mental healthcare act 2017** is the law under which every admission, every certificate and every act of compulsory treatment in the country is made lawful. It replaced the custodial Mental Health Act 1987 and rebuilt the field on a **rights-based** foundation, enacted to bring Indian law into line with the United Nations Convention on the Rights of Persons with Disabilities, which India had ratified. Where the old law asked "how do we detain the insane", the new one asks "how do we protect the rights of a person with mental illness while they are treated". That inversion is the single idea from which every provision below descends, and it is what the marks reward.

How to hold the Act. It runs to **16** chapters and **126** sections, but only a spine is examinable: the definition of mental illness and the capacity test that gates it; the two instruments of self-determination, the **advance directive** and the **nominated representative**; the **admission categories**, independent and supported; the oversight bodies, the review board and the two authorities; the decriminalisation of attempted suicide; and the treatments the Act forbids or fences. This page teaches that spine as an exam skill; the full admission procedure, the forensic detail and the wider statutory landscape are developed in the Mental health legislation and forensic psychiatry notes.

29.1 The rights-based turn: from custody to capacity

A law built on capacity, not on custody. The Act received presidential assent in 2017 and came into force on the twenty-ninth of May 2018, repealing the Mental Health Act 1987, whose reception-order machinery had treated the patient as an object of custody rather than a holder of rights. Two definitions carry the whole rights architecture. First, **mental illness** is defined as a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, the capacity to recognise reality or the ability to meet the ordinary

demands of life; the definition expressly takes in conditions arising from the abuse of alcohol and drugs, and expressly excludes **mental retardation** (intellectual disability), a condition of arrested or incomplete development of mind. The determination of mental illness must be made in accordance with nationally or internationally accepted medical standards, such as the latest edition of the ICD, and never on the basis of political, economic or social status, caste, religion, or mere non-conformity with a community's moral, social or cultural norms.

Capacity is the concept the whole Act turns on. Every adult is presumed to have the **capacity** to make their own mental-healthcare decisions unless the contrary is shown, and capacity is decision-specific: the ability to understand the information relevant to the decision, to appreciate the reasonably foreseeable consequences of taking it or not taking it, and to communicate that decision by any means. This is the gate that sorts the patient. A person who retains capacity is admitted and treated only on their own informed consent; a person who has lost it is *supported* to decide rather than simply overruled. On that footing the Act guarantees a suite of rights: access to affordable, good-quality, geographically reachable, community-based care from government services; the right to live with dignity and to be free from cruelty, neglect and degrading treatment; equality and non-discrimination in care; the right to information about one's illness and treatment; confidentiality of records; free legal aid; and the right to complain to the establishment, the review board or the state authority.

RULE **Capacity is the gateway, and it is presumed.** Retained capacity routes a patient to independent admission on their own consent; lost capacity routes them to supported admission, where the nominated representative and the advance directive step in. Establish capacity first; everything else follows from it.

INDIA

The Act is India's instrument for honouring the Convention on the Rights of Persons with Disabilities, and it borrows that Convention's language of supported, not substituted, decision-making. It ties Indian clinical practice to the WHO classification by naming the ICD as the standard for determining mental illness, so the diagnostic frame that carries statutory weight here is the ICD rather than the DSM (the wider transcultural frame is set out in the Consultation-liaison, geriatric and transcultural psychiatry notes). Two Indian realities temper the text on paper: the Act routes the patient's right to free legal aid through the Legal Services Authorities (the NALSA framework), giving a person facing supported admission a route to counsel; and implementation lags the statute, since many states were slow to constitute their review boards and authorities, so the safeguards are only as real as the bodies that deliver them.

29.2 The advance directive: the right to state how one wishes to be treated

The Act's flagship innovation lets a patient bind their future care. An advance directive is a written document in which a person states the way they wish to be cared for and treated for a mental illness, the way they wish *not* to be treated, and the individuals they appoint as nominated representative in order of precedence. Any adult with capacity may make one; a legal guardian may make it for a minor. Its defining feature, and the classic exam point, is that it lies dormant

while the person has capacity and comes into force only when they cease to have the capacity to make mental-healthcare decisions, remaining in effect until capacity returns. It may be revised or revoked any number of times while the person is capacitous, and it is void from the outset if it is made contrary to any law. The directive is registered on an online register maintained by the review board, and it is the duty of the treating psychiatrist and the establishment to give treatment in accordance with a valid advance directive.

The directive is not absolute. A mental health professional, relative or carer who does not wish to follow an advance directive may apply to the **review board**, which then tests whether it was made of the person's own free will and free of coercion, whether it was intended to cover the present circumstances, whether the person was sufficiently informed and had capacity when they made it, and whether its content offends any other law. The board may then uphold, modify or cancel it. A clinician is protected from liability for following a valid advance directive, and equally is not penalised for failing to follow one they were never given a copy of.

> **PEARL**
>
> An advance directive that refuses all treatment is not automatically binding: it is precisely the case a treating team can escalate to the review board, which weighs the refusal against the four validity tests. The Act gives the patient a powerful voice in advance; it does not hand them an unreviewable veto over life-saving care.

29.3 The nominated representative: the patient's chosen decision-partner

A named person who supports, rather than supplants, the patient's choices. The nominated representative is the individual a person appoints, in writing on plain paper with their signature or thumb impression, to support them in mental-healthcare decisions. The role reflects the Act's shift from the old proxy or substituted consent of guardianship to *supported* decision-making: the representative helps the patient reach and voice a decision rather than deciding over their head. Any adult may be appointed, provided they consent in writing and are competent to discharge the duties; a person may revoke or change the appointment at any time. Where a patient has made no nomination, the Act sets an order of precedence (a relative, then a carer, and so on), and where none is available the review board itself appoints a representative. For a minor, the legal guardian is the nominated representative unless the board orders otherwise.

The representative's duties track the whole care pathway: to consider the person's wishes and least-restrictive care, to apply for admission and for discharge, to have access to the person's advance directive and clinical information, to be informed of any use of restraint, and to give or withhold consent to research on the person's behalf. In a supported admission, it is the representative, not the clinician alone, who applies for and consents to admission, which is the structural safeguard against unilateral detention.

29.4 The admission categories: independent and supported admission

Two doors, sorted by capacity. Chapter twelve rebuilt admission around consent. Independent admission is the default and the aspiration: a capacitous adult who understands the nature and purpose of admission, is likely to benefit, and makes the request of their own free will is admitted

on their own application under Section 86, and may not be treated without their informed consent. Such a patient may discharge themselves on request under Section 88, though the establishment may hold them for a maximum of twenty-four hours to assess whether the criteria for supported admission have arisen. Supported admission (the Act's deliberate replacement for the old term "involuntary") is the exception, used only where capacity is lost and a defined risk is present, and it is hedged with time limits, two-professional certification and mandatory reporting to the review board.

CATEGORY	SECTION	WHO AND WHEN	SAFEGUARD AND EXIT
Independent admission (adult with capacity)	Section 86	**Capacity intact; understands nature and purpose; likely to benefit; requests admission of their own free will. No treatment without informed consent**	Self-discharge on request (Section 88); may be held up to twenty-four hours to assess for supported admission; converts to Section 89 if capacity is lost and risk arises
Admission of a minor	Section 87	**On the nominated representative's application; opinion of two independent professionals; least-restrictive option; separate child ward; a female attendant for a minor girl**	Discharged when the representative withdraws support; converts to Section 86 on attaining majority; ECT only with prior board approval
Supported admission, up to thirty days	Section 89	**Representative's application; person lacks capacity *and* meets a harm-to-self, harm-to-others or inability-to-self-care limb; certified by one psychiatrist and one mental health professional or medical practitioner**	Capacity reviewed weekly; reported to the board within seven days, and within three days for a woman or minor; on regaining capacity, moved to Section 86 or discharged
Supported admission, beyond thirty days	Section 90	Continued incapacity with continuing risk; independent evaluation by two psychiatrists	Capacity reviewed every fourteen days; extended in defined steps (up to ninety, then to one hundred and eighty days) under board oversight

The admission categories of the Act. The examinable discriminator is Section 89 against Section 90: the professional and the clock both change at the thirty-day line.

MNEMONIC

Eighty-six ask for yourself; eighty-nine supported to thirty; ninety beyond

Section 86 is the capacitous patient asking for their own admission; Section 89 is the supported admission capped at thirty days on one psychiatrist plus one other professional; Section 90 carries a supported admission beyond thirty days and demands two psychiatrists. Section 87 sits between them for the minor.

WORKED EXAMPLE

A man in his thirties with schizophrenia is brought in acutely psychotic, threatening his family and unable to grasp why admission is proposed. He plainly lacks capacity and meets a risk limb, so he cannot be an independent patient. His nominated representative applies, one psychiatrist and one medical practitioner independently certify the criteria, and he is admitted under Section 89 with the board informed within seven days. His capacity is checked weekly; a fortnight in he improves, understands his situation and consents to stay, so his admission is transferred to Section 86 as an independent patient. Had he still lacked capacity beyond thirty days, two psychiatrists would have had to evaluate him afresh to continue under Section 90.

TRAP **Confusing Section 89 with Section 90.** Section 89 is supported admission up to thirty days, certified by one psychiatrist plus one mental health professional or medical practitioner, with weekly capacity review; Section 90 is the extension beyond thirty days, demanding two psychiatrists and a fortnightly review. Naming the wrong professional or the wrong clock is a stock way to lose the mark.

29.5 The oversight architecture: the review board and the two authorities

A quasi-judicial guardian at the bedside, and two administrative regulators above it. The Act separates the body that protects the individual patient from the bodies that regulate the system. The definitions worth memorising are these four institutions.

Mental Health Review Board

The Mental Health Review Board is the quasi-judicial body, constituted by the state authority, that protects the individual patient. It registers, reviews and can cancel advance directives; appoints nominated representatives; and receives and decides applications against admission decisions under Sections 87, 89 and 90. It is chaired by a district judge and includes a district-administration representative, one psychiatrist and one medical practitioner, and members drawn from persons with mental illness, carers or non-governmental organisations.

Central Mental Health Authority

The Central Mental Health Authority registers and supervises central-government establishments, develops service norms, maintains the national register of clinical psychologists, mental health nurses and psychiatric social workers, and advises the central government.

State Mental Health Authority

The State Mental Health Authority mirrors that role within the state: it registers and supervises establishments in the state, keeps the state register of mental health professionals, sets minimum standards and receives complaints about deficient services.

Mental health establishment

Any facility, public or private and including AYUSH facilities, offering care for mental illness; it must register with the relevant authority and conform to prescribed standards. A family home where a person lives with relatives is not an establishment.

The division of labour is the point: the review board adjudicates the rights of a named patient, functioning as an accessible tribunal; the central and state authorities license and inspect the establishments and hold the registers of professionals. Every supported admission must be reported to the board, which is the mechanism that keeps compulsory care under continuing external scrutiny rather than clinician discretion alone.

29.6 The decriminalisation of attempted suicide

The provision that changed emergency practice overnight. Section 115 delivers the **decriminalisation of attempted suicide**. Its words are the ones to keep: notwithstanding anything contained in Section 309 of the Indian Penal Code, 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 that Code. The presumption is the engine of the clause: the burden inverts, so the person who has attempted suicide is taken to have been under severe stress rather than treated as an offender. The section pairs this immunity with a positive duty on the appropriate government to provide care, treatment and rehabilitation to a person under such severe stress, to reduce the risk of a further attempt. The practical effect is that a survivor of self-harm now reaches a clinician, not a police station, and can be assessed and treated without the shadow of prosecution. The clinical assessment that follows, the suicide risk evaluation and the C-SSRS as used inside the mental state examination, is developed in the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

> **COMMON TRAP**
>
> Section 115 does not repeal Section 309 of the Penal Code; the older offence remains on the statute book. What the Act does is raise a rebuttable presumption of severe stress that *overrides* Section 309 in almost every case, so the attempt is not tried or punished. Say "presumption of severe stress, overriding Section 309", not "Section 309 has been deleted".

29.7 Prohibited and safeguarded treatments

The Act draws a hard line around the interventions most open to abuse. Section 95 flatly prohibits a short, high-yield list, and each item answers a documented historical harm: electroconvulsive therapy without the use of muscle relaxants and anaesthesia (unmodified ECT is banned outright); electroconvulsive therapy for minors, except with the prior approval of the review board and the guardian's consent; sterilisation of men or women when it is intended as a treatment for mental illness; and chaining a person in any manner or form whatsoever. Around this core the Act fences other interventions with consent and oversight rather than banning them.

PROVISION	SECTION	THE SAFEGUARD
Prohibited treatments	Section 95	**Unmodified ECT, ECT for minors, sterilisation as treatment for mental illness, and chaining are forbidden**
Psychosurgery	Section 96	Permitted only with the informed consent of the person and the prior approval of the review board
Seclusion and restraint	Section 97	**Seclusion and solitary confinement banned; physical restraint only as the least means to prevent imminent harm, psychiatrist-authorised, recorded, and never a punishment**
Emergency treatment	Section 94	Any needed treatment permitted to prevent death, serious self-harm or harm to others, capped at seventy-two hours or until assessment at an establishment

The Act's treatment safeguards. The four Section 95 prohibitions are the most examined line; emergency treatment under Section 94 has a firm seventy-two-hour ceiling.

16
CHAPTERS IN THE ACT, SPANNING 126 SECTIONS

2018
CAME INTO FORCE, ON 29 MAY, REPEALING THE 1987 ACT

30
DAYS, THE SECTION 89 SUPPORTED-ADMISSION CEILING BEFORE SECTION 90

72
HOURS, THE SECTION 94 EMERGENCY-TREATMENT CEILING

GOOD TO REMEMBER

- **The principle:** the mental healthcare act 2017 replaced the custodial 1987 Act with a rights-based, capacity-centred law that honours the UN Convention on the Rights of Persons with Disabilities; capacity is presumed and decision-specific, and it decides whether a patient is admitted independently on their own consent or supported when consent is lost.
- **The one discriminator:** independent admission (Section 86, capacitous, self-requested, self-dischargeable) versus supported admission (Section 89 up to thirty days on one psychiatrist plus one other professional; Section 90 beyond thirty days on two psychiatrists), each reported to the mental health review board.
- **The one exam fact:** Section 115 presumes severe stress, unless proved otherwise, in anyone who attempts suicide and bars trial and punishment under Section 309 of the Penal Code; the advance directive and nominated representative give a patient a binding voice in future care; and Section 95 forbids unmodified ECT, ECT for minors, sterilisation as treatment, and chaining.

HOLD THIS

The Mental Healthcare Act 2017 is a rights-based, capacity-gated statute: capacity is presumed and sorts patients into independent (Section 86) or supported (Sections 89 and 90) admission, the advance directive and nominated representative carry the patient's voice, the review board and the two authorities police the system, Section 115 presumes severe stress and decriminalises attempted suicide, and Section 95 bans unmodified ECT, ECT for minors, sterilisation and chaining.

30 · Capacity, consent and confidentiality

Three ideas govern the ethics and the law of every clinical encounter, and psychiatry tests all three harder than the rest of medicine because the illnesses it treats can themselves erode a patient's judgement. **Capacity** asks whether this patient can make this decision; **consent** is the permission a patient with capacity gives to be treated; and **confidentiality** is the duty to hold what the patient tells you in confidence. They form a chain: capacity underwrites valid consent, and consent is what makes it lawful to treat and, later, one of the things that can lift the duty of confidentiality. The examiner rewards the candidate who can define each cleanly, state its limits and its exceptions, and, in an Indian answer, tie it to the Mental Healthcare Act, 2017.

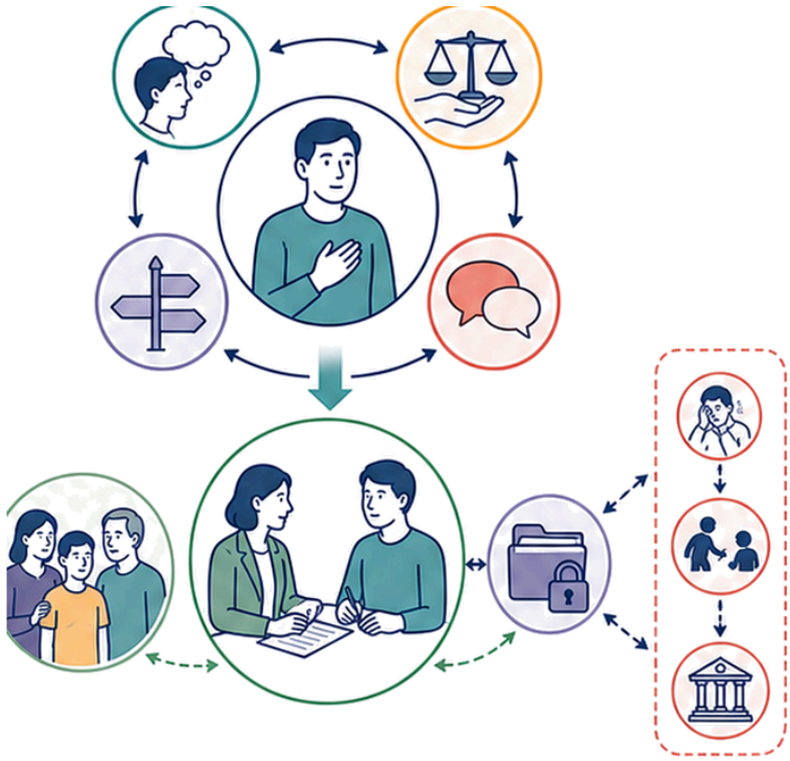


Fig 19.17 Decision-making capacity requires understanding relevant information, appreciating consequences, reasoning between options and communicating a choice. Valid consent is informed and voluntary; confidentiality is preserved except for defined safety or legal grounds.

How to use this page. Fix **decisional capacity** first, because valid consent is impossible without it, and learn the four **elements of capacity** as a functional test the clinician performs. Then take **informed consent** as three conditions (adequate disclosure, capacity and voluntariness) with a short, carefully-bounded list of exceptions. Then take confidentiality and its recognised limits, and name the Tarasoff principle. Finally read all three through the Indian statute. Throughout, hold apart the two words examiners try to conflate: *capacity* is a clinical judgement a doctor makes, *competence* is the legal status a court confers.

30.1 Decisional capacity: the four elements

Capacity is the ability to make a particular decision, tested by four abilities. Capacity is the patient's ability to understand and use information well enough to reach and express a treatment decision. It is assessed functionally, by what the patient can actually do with the relevant information, not by their diagnosis and not by whether their choice pleases the clinician. The examinable test has four **elements of capacity**, and a patient must satisfy all four to have

capacity to consent to (or refuse) the decision in front of them: they must **understand** the information relevant to the decision, **retain** it long enough to use it, **use and weigh** it as part of the process of deciding, and **communicate** their choice by any means. Fail any one element and capacity for that decision is absent.

ELEMENT	WHAT THE PATIENT MUST BE ABLE TO DO	WHERE IT TYPICALLY FAILS
Understand	Take in the nature of the condition, the proposed treatment, its risks, benefits and alternatives	**Intellectual disability, dementia, acute confusion, low attention**
Retain	Hold the information long enough to use it in the decision (not necessarily for long)	Amnestic syndromes, delirium, severe dementia
Use and weigh	Reason with the information, balancing risks against benefits in line with the patient's own values	**Psychosis, severe depression, delirium, a delusion that overrides the facts**
Communicate	Express a stable choice by speech, writing, gesture or any other means	Coma, catatonic mutism, a fixedly non-communicating patient

The four elements of decisional capacity. All four are required; the "use and weigh" element is the one most often lost in psychosis and severe depression, where the patient can repeat the facts yet cannot reason with them.

This four-element functional test (understand, retain, use and weigh, communicate) is the one adopted in modern mental-capacity law and in Indian teaching. The closely-related clinical model of Appelbaum and Grisso, widely quoted in the American literature, names four parallel abilities: to *communicate a choice*, to *understand* the relevant information, to *appreciate* the situation and its consequences (apply the facts to oneself), and to *reason* about the options. "Appreciation" and "using and weighing" cover the same clinical ground: the patient who says "the tablets treat infection but my body does not need them because I am already dead" understands the facts but cannot appreciate or weigh them, and so lacks capacity.

RULE **Capacity is clinical and functional; competence is legal.** A clinician assesses *capacity* for a specific decision at the bedside; a court determines *competence* as a legal status. Assess capacity, do not pronounce competence.

30.2 The three principles that govern any capacity assessment

Presumption, specificity and process, not outcome. Three principles frame every assessment and each is a stock exam line. First, the **presumption of capacity**: every adult is presumed to have capacity unless the opposite is shown, and the burden falls on the person who alleges incapacity. Crucially, a psychiatric diagnosis, even a severe one, does *not* by itself remove capacity. Second, capacity is **decision-specific and time-specific**: it is judged for one decision at one moment, so a patient may have capacity to consent to a blood test yet lack it for a complex operation, and capacity lost in an acute relapse may return with recovery. Third, the test is of the

process of decision-making, not its *outcome*: a capacitous patient is entitled to make what others regard as an unwise choice.

Presumption of capacity

Every adult is assumed to have capacity until incapacity is demonstrated; mental illness does not equal incapacity.

Decision-specific

Capacity is assessed for the particular decision, not globally; it can be present for one choice and absent for another.

Time-specific

Capacity can fluctuate; it is judged at the moment the decision must be made and re-assessed as the clinical state changes.

Process over outcome

Capacity turns on how the patient reaches the decision, not on whether the decision is sensible; an unwise choice is not, by itself, evidence of incapacity.

COMMON TRAP

Reading a refusal, or an unwise choice, as proof of incapacity. A patient who declines a life-saving blood transfusion on settled religious grounds understands and weighs the facts and retains capacity; a starving patient with anorexia nervosa who refuses food because they cannot accept anything is wrong may lack it, because the illness blocks the "use and weigh" element. The test is the reasoning, not the answer, and the equally common error runs the other way: assuming a patient with schizophrenia automatically cannot consent.

TRAP **Confusing capacity with the diagnosis.** Incapacity must be shown for the specific decision through the four elements; it is never inferred from the mere presence of a mental disorder. The presumption of capacity survives the diagnosis.

30.3 Informed consent: disclosure, capacity and voluntariness

Valid consent stands on three legs. Informed consent is the patient's voluntary agreement, given with capacity and adequate information, to a proposed intervention; it is a continuing process, not a signature on a form. For a **consent** to be valid, three conditions must all hold. There must be adequate **disclosure** of information; the patient must have the **capacity to consent**; and the decision must be **voluntary**, free of coercion, duress or undue influence. Remove any one and the consent is invalid, so a signed form from a patient who was not told the risks, or who lacked capacity, or who was pressured, is worthless.

Disclosure

The patient is given the information a reasonable person in their position would want: the diagnosis, the nature and purpose of the proposed treatment, its material risks and benefits, the alternatives (including no treatment), and the likely outcome of each.

Capacity

The patient meets the four-element test for this decision (the subject of the preceding sections); without capacity there can be no valid personal consent, and a substitute route is needed.

Voluntariness

The choice is the patient's own, free of coercion, threat, undue influence or manipulation, whether from clinicians, family or institution.

How much must be disclosed is set by a legal standard. The older *professional (reasonable-doctor) standard* asked what a responsible body of clinicians would disclose; the modern, patient-centred position is the *reasonable-person (materiality) standard*, which asks what a reasonable patient in this position would want to know, supplemented by the *subjective standard* of what *this* patient would want. The shift is toward the patient's informational needs, not the profession's custom.

RULE **Consent is not a form, it is three conditions.** Disclosure, capacity and voluntariness must all be present; a signature without any one of them is not informed consent.

30.4 When treatment may proceed without the patient's consent

Three carefully-bounded exceptions. The default is that no adult is touched or treated without their informed consent. The recognised exceptions are narrow and each must be documented. In an **emergency**, immediately necessary treatment may be given to save life or prevent serious harm to a patient who cannot consent, limited to what the emergency requires. For the **incapacitous patient** (one who fails the capacity test and is not in an emergency), treatment proceeds not by overriding consent but by a substitute route: a decision in the patient's best interests, a valid advance directive, or a legally-recognised substitute decision-maker. **Therapeutic privilege** is the narrowest and most easily abused: it is the clinician's right to withhold a specific piece of information from a patient who does have capacity, where full disclosure would itself cause the patient serious, foreseeable harm. It is not a licence to keep a patient in the dark for convenience, must be invoked for the individual patient and rarely, and must be recorded with reasons.

EXCEPTION	WHAT IT PERMITS, AND ITS LIMIT
Emergency	**Immediately necessary, life- or harm-preventing treatment for a patient who cannot consent; confined to what the emergency demands**
The incapacitous patient	Treatment via best interests, a valid advance directive or a substitute decision-maker, not by ignoring consent
Therapeutic privilege	**Withholding a specific disclosure that would itself gravely harm a capacitous patient; narrow, individual, documented, not routine paternalism**

The exceptions to informed consent. Emergency and incapacity dispense with personal consent by law; therapeutic privilege trims disclosure only, and is the one an examiner expects you to state with caution.

PEARL

Therapeutic privilege and the emergency exception are limits on *consent*, not on *capacity*: the therapeutic-privilege patient still has capacity, and the emergency patient is treated *because* the emergency prevents a valid consent from being obtained in time. Keep the two axes separate in the viva and you will not tangle them.

30.5 Confidentiality and its limits: patient consent, the duty to protect, statute and the court

A strong duty, but not an absolute one. The duty of confidentiality, owed since the Hippocratic oath and codified by professional bodies, holds that information a patient shares in the clinical relationship is theirs and is not disclosed without their leave. In psychiatry the duty is unusually weighty, because disclosure of a psychiatric contact still carries stigma. It is nonetheless a duty that can be outweighed, and the examinable task is to name the situations in which a **breach of confidentiality** is justified. There are four the candidate must give: the patient's own **consent** to disclosure; the **duty to warn or protect** an identifiable third party at serious risk; a **statutory reporting** obligation; and a **court order** compelling disclosure. In every case the disclosure is kept to the minimum necessary for the purpose.

JUSTIFIED DISCLOSURE	TRIGGER
Patient consent	**The patient authorises release, for example to a family member, insurer or another treating clinician**
Duty to warn or protect	A serious, credible threat of harm to an identifiable third party (the Tarasoff situation)
Statutory reporting	**A legal reporting duty, for example child or elder abuse, certain notifiable conditions, unfitness to drive**
Court order	A judge compels production of records or testimony; also risk of harm to self

The recognised limits of confidentiality. Patient consent is the routine lifting of the duty; the other three lift it against the patient's wishes, and each must be justified and minimised.

The Tarasoff principle. The duty to warn and protect was crystallised by the American case of Tarasoff v. Regents of the University of California. A student, Prosenjit Poddar, in psychotherapy at a university clinic, told his therapist he intended to kill a young woman, Tatiana Tarasoff, who had rebuffed him. The therapist alerted his supervisor and the campus police, who briefly detained and then released Poddar, but no one warned Tarasoff herself; Poddar later killed her, and her parents sued. The Supreme Court of California held (an initial 1974 ruling framed a duty to warn, and the landmark **1976** ruling a broader duty to protect) that when a therapist determines a patient poses a serious danger of violence to an identifiable other, the therapist incurs a duty to take reasonable steps to protect the foreseeable victim, and that this duty can override confidentiality. In the court's phrase, the protective privilege ends where the public peril begins. Tarasoff binds only California and is not a precedent elsewhere, but it has shaped professional and legal attitudes internationally, including in India.

WORKED EXAMPLE

A man in outpatient care names a specific former colleague he intends to kill, describes a plan and has the means. The clinician weighs the duty of confidentiality against the risk: the threat is serious, the victim is identifiable, and the danger is credible. Following the Tarasoff logic, the clinician takes reasonable protective steps (which may include warning the potential victim and informing the police), disclosing only what the risk requires and documenting the reasoning. Had the patient voiced only a vague, non-specific hostility with no identifiable target, the threshold for a protective breach of confidentiality would not be met, and the duty of confidentiality would hold.

RULE **Confidentiality is strong but not absolute.** It yields to the patient's own consent, to a duty to protect an identifiable third party at serious risk, to a statutory reporting duty and to a court order, and never more than the minimum the purpose demands.

30.6 The Indian statutory frame: the Mental Healthcare Act, 2017

In India these three principles are not only ethical, they are law. The Mental Healthcare Act, 2017 writes capacity, consent and confidentiality into statute and re-centres the Indian system on the rights and will of the person with mental illness. Its capacity test (Section 4) mirrors the elements taught above: a person has capacity to make mental-healthcare decisions if able to understand the information relevant to the decision, to appreciate the reasonably foreseeable consequences of deciding or not deciding, and to communicate the decision by speech, expression, gesture or any other means. It states the presumption of capacity, and provides (Section 4(3)) that a decision others regard as wrong does not by itself show incapacity, the process-over-outcome principle in statutory form.

INDIA

The Act supplies India's substitute-decision architecture and its confidentiality rule. Where capacity is lost, a person may plan ahead through an advance directive (Section 5), stating how they wish, and wish not, to be treated, and may appoint a nominated representative (Section 14) as substitute decision-maker; the treating clinician has a duty to check for an advance directive. The right to confidentiality is explicit in Section 23: a person with mental illness has the right to confidentiality in respect of their mental health, mental healthcare, treatment and physical healthcare, extending to records in electronic form, and Section 24 restricts release of a patient's photograph or information to the media without consent. The Act's confidentiality exceptions echo the general ones, disclosure being permitted to protect life, to prevent harm to others, on a court order or in the interests of public safety. The Act also decriminalised attempted suicide (Section 115), presuming severe stress. The full admission procedure, the Mental Health Review Board and the wider forensic machinery are developed in the Mental health legislation and forensic psychiatry notes.

Two Indian nuances are worth carrying into an answer. The reach of confidentiality is partly cultural: in the Indian family-centred setting a degree of information-sharing with a co-resident nominated representative or caregiver is often expected and, within the statute, appropriate, whereas a purely individualist reading of confidentiality would refuse it; the wider transcultural

frame is set out in the Consultation-liaison, geriatric and transcultural psychiatry notes. And the Act ties clinical practice to accepted diagnostic standards, so that capacity, consent and confidentiality operate on top of an ICD-anchored diagnostic system rather than in a vacuum.

4	3	1976	2017
ELEMENTS OF DECISIONAL CAPACITY: UNDERSTAND, RETAIN, USE AND WEIGH, COMMUNICATE	CONDITIONS FOR VALID INFORMED CONSENT: DISCLOSURE, CAPACITY, VOLUNTARINESS	TARASOFF: THE SUPREME COURT OF CALIFORNIA DUTY-TO-PROTECT RULING	MENTAL HEALTHCARE ACT, INDIA'S GOVERNING MENTAL-HEALTH STATUTE

GOOD TO REMEMBER

- **The principle:** capacity underwrites consent, and consent is one of the things that lifts confidentiality; capacity has four elements (understand, retain, use and weigh, communicate), is presumed, and is decision- and time-specific; valid consent needs disclosure, capacity and voluntariness; and confidentiality is strong but not absolute.
- **The one discriminator:** capacity is the clinician's functional bedside judgement about a specific decision, competence is the court's legal status; and confidentiality is tested on the *process* of decision-making, never on whether the patient's choice is wise.
- **The one exam fact:** the Tarasoff ruling (Supreme Court of California, 1976) established the duty to warn and protect an identifiable third party as a justified breach of confidentiality, and in India the Mental Healthcare Act, 2017 codifies the capacity test (Section 4), the presumption of capacity, the advance directive (Section 5) and the right to confidentiality (Section 23).

HOLD THIS

Capacity (four elements, presumed, decision-specific) makes consent valid; consent needs disclosure, capacity and voluntariness; confidentiality is strong but yields to the patient's consent, a Tarasoff duty to protect a named third party, statutory reporting and a court order, and in India all three are law under the Mental Healthcare Act, 2017.

Apply and consolidate

31 · Worked cases

This is the arc-closer for the whole psychotherapies, assessment and nosology chapter, and it is deliberately a set of **worked cases** rather than more theory, because the paper does not test whether you can recite a modality or list the mental-state domains; it tests whether you can *do* the five jobs the chapter teaches on a patient put in front of you. Each of the five subtopics below takes one short **vignette** and reasons it through end to end: a therapy-selection call, a mental-state write-up, a biopsychosocial formulation, a categorical-versus-dimensional argument, and a scale-selection decision. Read each as a rehearsal of the viva move it stands for.

How to use this page. For every case the discipline is the same: name the diagnosis first, then do the specific job the question asks, and justify each step out loud. Nothing here is new content; it is the chapter's machinery applied. Where a named therapy closes a case it ends with an indication-anchored recall box (the model, the lead indication, the one technique); where an assessment or nosology skill closes a case it ends with a rule-anchored recall box (the principle, the discriminator, the one exam fact).

31.1 A therapy-selection case: the ambivalent drinker

Match the disorder to its evidence base, then match the intervention to the patient's readiness. Here is the case: a 41-year-old self-employed man is referred after his wife raises concern about his drinking. He drinks daily, scores 18 out of a possible 40 on the AUDIT (the harmful range), and has no history of withdrawal seizures or features demanding urgent detoxification, and no comorbid severe depression. Crucially, he is *ambivalent*: he half-wants to cut down and half-minimises ("I can stop any time I like"). The formulation of this presentation is not a skills deficit but low readiness to change, and reading that correctly is the whole of the selection reasoning. His diagnosis is alcohol use disorder in the harmful range; the maintaining problem is that he sits in the contemplation stage of the stages of change, of which there are **five** (precontemplation, contemplation, preparation, action and maintenance; Prochaska and DiClemente).

The matched first-line therapy is motivational enhancement therapy, its brief structured four-session form, delivered in the motivational interviewing style of Miller and Rollnick; this is first-line for alcohol use disorder (IPS 2014 grade A; VA/DoD 2021). The reasoning is stage-matching: you do not hand a contemplator an abstinence contract, you evoke his own change talk and roll with his resistance, developing the discrepancy between his stated values and his drinking until he moves himself toward an action plan. Motivational interviewing as used across the addictions is developed in the Substance use disorders notes; this worked example only makes the selection call.

RULE **Read the stage before you choose the plan.** The disorder's evidence base sets the default therapy; the patient's stage of change sets how it is delivered. For an ambivalent drinker the answer is motivational enhancement therapy in a motivational-interviewing style, not action-stage abstinence work.

TRAP **Pushing an action-stage plan onto a contemplator.** Prescribing abstinence, disulfiram supervision or relapse-prevention homework to a patient who has not resolved his ambivalence is the classic mismatch; it raises resistance and predicts drop-out. Meet the stage first.

INDIA

The Indian answer adds a family limb the guideline formalises. The Indian Psychiatric Society's alcohol-use guidance endorses family-based treatment using a co-resident relative as the recovery monitor and the supervisor of supervised disulfiram (IPS 2014, grade B), a culturally specific adaptation to Indian family structures. So the fuller selection here is motivational enhancement therapy for the man, plus enlistment of a willing co-resident relative as the treatment ally once he reaches the action stage, rather than an individual-only Western template.

GOOD TO REMEMBER

- **The model:** motivational interviewing (Miller and Rollnick) is a collaborative, person-centred and directive style that resolves ambivalence and evokes change talk across the five stages of change; motivational enhancement therapy is its brief, structured four-session form.
- **The lead indication:** substance use, first-line for alcohol use disorder (IPS 2014 grade A; VA/DoD 2021), and stage-matched to the patient's readiness.
- **The one technique:** evoke change talk and roll with resistance (developing discrepancy), never an action-stage abstinence plan imposed on a contemplator.

31.2 An MSE write-up case: describing a manic presentation, domain by domain

The examined skill is to write the here-and-now in observational language, in the fixed order, without slipping into diagnosis. Here is the case: a 27-year-old man is brought by his family after three weeks of reduced sleep, overactivity, overspending and grandiose plans. The task is not to label him but to write the mental state examination, and the whole of the mark lies in running the seven domains in their order (appearance and behaviour; speech; mood and affect; thought form and content; perception; cognition; insight and judgement) and describing signs, not conclusions. The table below turns the vignette into a domain-by-domain write-up; note that every entry is an observation, that absences are recorded explicitly, and that nowhere does the word "mania" or "bipolar" appear.

MSE DOMAIN (IN ORDER)	THE WRITE-UP FROM THIS VIGNETTE
Appearance and behaviour	Flamboyantly dressed in bright, mismatched clothing; restless, pacing, intrusive and over-familiar; psychomotor activity markedly increased; fleeting, over-intense eye contact; no abnormal involuntary movements
Speech	**Rapid, pressured and loud, increased in quantity, difficult to interrupt**
Mood and affect	Subjectively "on top of the world"; objectively affect elevated and expansive, becoming irritable when thwarted, labile but reactive and congruent with the elevated mood
Thought form	**Flight of ideas, with rhyming and clang associations and marked distractibility; the links between ideas remain followable**
Thought content	Grandiose ideas of a special mission and inflated abilities; no delusions of control; no suicidal or homicidal ideation elicited
Perception	No hallucinations elicited in any modality; no illusions reported
Cognition	Alert and oriented; attention impaired by distractibility; no gross memory deficit, though formal cognitive testing is limited by his cooperation

MSE DOMAIN (IN ORDER)	THE WRITE-UP FROM THIS VIGNETTE
Insight and judgement	**Insight impaired (denies being unwell, Grade I to II); judgement impaired, evidenced by uncontrolled spending and unrealistic plans**

The manic vignette written up domain by domain in the fixed MSE order. Every line is an observed sign or a recorded absence; no diagnostic label is admitted into the examination.

WORKED EXAMPLE

Rendered as continuous notes, the same MSE reads: "A flamboyantly dressed young man, restless and over-familiar, with markedly increased psychomotor activity. Speech rapid, pressured and hard to interrupt. Subjectively elevated ('on top of the world'); objectively expansive, irritable when crossed, labile but reactive. Thought form shows flight of ideas with clang associations; content includes grandiose ideas of a special mission, with no suicidal or homicidal ideation. No hallucinations in any modality. Alert, oriented, distractible. Insight impaired; judgement impaired." Note what this worked example is not: it is not a history (no past episodes, no reported symptoms over time) and it is not a diagnosis (no "mania"). It is a cross-sectional description that, set against the history, will later support one.

RULE **The MSE is a cross-sectional snapshot of signs, not the history and not a diagnosis.** Write what you observe and what the patient says, in the seven-domain order, and record absences explicitly; the label is reasoned later from the MSE plus the history, never written into the MSE itself.

GOOD TO REMEMBER

- **The principle:** the mental state examination is a here-and-now observational survey across seven domains in fixed order (appearance and behaviour; speech; mood and affect; thought form and content; perception; cognition; insight and judgement), and the descriptive vocabulary that populates it is developed in the Psychometry, Assessment and Descriptive Psychopathology notes.
- **The one discriminator:** record observed signs and the patient's own words, not interpretations; a manic patient's overactivity, pressured speech and flight of ideas are the signs, "mania" is the later conclusion.
- **The one exam fact:** state the absence of a phenomenon (no hallucinations, no suicidal ideation) as deliberately as its presence; an unrecorded domain reads as an incomplete examination.

31.3 A formulation case: first-episode psychosis on the 4-Ps grid

Name the diagnosis, then explain the individual by crossing the three domains with the four Ps. Here is the case: a 22-year-old engineering student presents with two months of social withdrawal, suspiciousness, auditory hallucinations and a decline in academic function; he uses cannabis regularly, has a paternal uncle with schizophrenia, was premorbidly shy and solitary, moved recently to a hostel in a new city, and has a critical, high-expressed-emotion father, though the family remains engaged and brought him in early. The diagnosis is a first-episode psychotic disorder. The formulation then places every factor onto the biopsychosocial four-Ps grid, so that the plan can attack the perpetuating column and mobilise the protective one.

DOMAIN	PREDISPOSING	PRECIPITATING	PERPETUATING	PROTECTIVE
Biological	Family history of schizophrenia (paternal uncle); genetic loading	Heavy cannabis use	**Continued cannabis use; likely medication non-adherence**	Young, first episode, no physical comorbidity, prospect of good treatment response
Psychological	Premorbid shy, solitary temperament; limited stress-coping	Perceived academic failure	**Poor insight; hopelessness about studies**	Good premorbid intelligence and function
Social	Academic pressure; few close ties	Migration to a hostel; isolation in a new city	**High expressed emotion at home; stigma; academic disruption**	Engaged, financially stable family who sought help early

The filled four-Ps grid for this first-episode-psychosis case. The perpetuating column (shaded) is what treatment attacks; the protective column carries the prognosis and the plan's allies.

The plan falls straight out of the grid, read down the rows and across the columns: an antipsychotic and active work on the cannabis use (biological), psychoeducation and cognitive behaviour therapy for psychosis as an adjunct (psychological), and a family intervention to lower expressed emotion (social), all aimed squarely at the perpetuating factors while enlisting the already-engaged family as the protective one. Notice the discipline: the diagnosis named the category, the formulation explained *this* young man, and the plan mirrored the grid.

GOOD TO REMEMBER

- **The principle:** a formulation crosses the three biopsychosocial domains with the four Ps (predisposing, precipitating, perpetuating, protective) to explain why this person is ill now; the diagnosis names the category, the formulation explains the individual, and it is a revisable hypothesis.
- **The one discriminator:** perpetuating factors (continued cannabis, non-adherence, high expressed emotion) are the treatment target; protective factors (an engaged family, a first episode) carry the prognosis.
- **The one exam fact:** name the diagnosis first and formulate second; the management plan is built biopsychosocially, attacking the perpetuating column and mobilising the protective column.

31.4 A categorical-versus-dimensional case: the borderline presentation argued both ways

A boundary presentation is best answered by arguing it categorically and dimensionally, then stating the pragmatic call. Here is the case: a 23-year-old woman has a five-year history of recurrent self-harm, chronic emptiness, intense and unstable relationships, impulsive spending and bingeing, identity disturbance, affective instability and transient stress-related suspiciousness. She is a genuinely "borderline" presentation in both senses of the word, and the higher-order question is not "what is the label?" but "how do the two nosological models describe her, and which is more useful here?".

READING	HOW THIS PATIENT IS DESCRIBED	ITS STRENGTH AND ITS LIMIT
Categorical (DSM-5-TR)	She meets at least five of the nine borderline personality disorder criteria, so the categorical label is "borderline personality disorder"; the ten types sit in the main text, the five-domain alternative model in Section III	**Strength: one communicable term with an immediate treatment implication (dialectical behaviour therapy). Limit: two patients can share the label with different symptom sets, and her affective features blur the mood-personality boundary**
Dimensional (ICD-11)	A single personality disorder diagnosis, graded moderate in severity, with trait qualifiers from the five domains (prominently negative affectivity and disinhibition) and the borderline pattern qualifier	**Strength: preserves severity and the trait profile and absorbs her mixed features without a second box. Limit: a profile of scores is harder to remember and to communicate than a single name**

The same patient described categorically and dimensionally. DSM-5-TR keeps the categorical types up front; ICD-11 abolished them for one severity-graded diagnosis plus five trait domains and a borderline pattern qualifier.

The pragmatic call is that both current manuals are hybrids, so you use both: name the categorical label because it communicates instantly and matches her to a therapy, and add the dimensional severity-and-trait description because it is truer to a boundary case that straddles the mood and personality territory. The matched therapy is dialectical behaviour therapy, delivered in its **four** modes (individual therapy, group skills training, telephone coaching and the therapist consultation team; Linehan), which is the lead therapy for borderline personality disorder where recurrent self-harm dominates (IPS 2023; NICE 2009); dialectical behaviour therapy and schema therapy for the personality disorders are developed in the Personality disorders notes.

TRAP **Forcing one label onto a boundary case.** A patient who straddles two categories, or sits one symptom short of a threshold, is not diagnosis-free and is not settled by a single box; the mixed and sub-threshold presentation is exactly where a severity-and-trait description carries more truth than a category, and the strong answer argues it both ways.

GOOD TO REMEMBER

- **The principle:** no statistical test proves psychopathology is kinds rather than degrees, so categories (usability) and dimensions (accuracy) are combined; both ICD-11 and DSM-5-TR are categorical-dimensional hybrids, most fully at personality disorder.
- **The one discriminator:** DSM-5-TR keeps the ten categorical types in its main text with its five-domain alternative model in Section III; ICD-11 abolished the types for one diagnosis graded into three severity levels plus five trait domains and a borderline pattern qualifier.
- **The one exam fact:** argue the boundary case both ways, categorical for communication and treatment matching, dimensional for severity and trait profile, then state the call.

31.5 A scale-selection case: measuring depression severity in two settings

Choose the instrument to fit the construct, the setting, the rater and the purpose; a screen is not an outcome measure and neither is a diagnosis. Here is the case: a liaison colleague asks

two questions about the same construct, depressive severity, in two different settings, and each setting selects a different scale. In a busy primary-care clinic he wants to screen and then monitor treatment; in a specialist depression service he wants to measure outcome precisely. The selection reasoning weighs four things: the construct, who administers the scale (self versus clinician), the purpose (screening versus severity or outcome), and whether the instrument tracks change.

SETTING AND PURPOSE	THE SCALE TO CHOOSE	RATER	READING IT
Primary-care screening and repeat monitoring	PHQ-9 (nine self-report items, out of a possible 27)	Patient self-completed	**Brief and sensitivity-tuned; she scores 16 out of a possible 27, in the moderately severe band, but a positive screen is not a diagnosis and must be confirmed clinically**
Specialist severity rating and outcome or trial use	MADRS (ten clinician-rated items, out of a possible 60)	Clinician-administered	**Sensitive to treatment-related change and less confounded by somatic overlap; the reference-standard interviewer-rated outcome measure**

Two scales for one construct, chosen by setting and purpose. A self-report screen (PHQ-9) rules out and monitors cheaply; a clinician-administered severity scale (MADRS) is the outcome and trial standard. The HAM-D, MADRS and YMRS in clinical use are developed in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes.

The interpretive discipline is that a raw number means nothing until it is read against validated, locally-relevant norms and cut-offs. An imported cut-off is only valid in the population its norms were drawn from, which is why an instrument used in India should be translated, re-validated and re-normed rather than borrowed wholesale; the psychometric theory of standardisation and norms underneath this is developed in the Psychometry, Assessment and Descriptive Psychopathology notes.

7 MSE DOMAINS, APPEARANCE AND BEHAVIOUR TO INSIGHT AND JUDGEMENT	**4** THE FOUR PS OF THE FORMULATION GRID	**27** PHQ-9 MAXIMUM (OUT OF A POSSIBLE 27)	**40** AUDIT MAXIMUM (OUT OF A POSSIBLE 40)

GOOD TO REMEMBER

- **The principle:** a scale is chosen to fit the construct AND the setting AND the purpose; a screen (brief, self-report, high sensitivity) is not the same instrument as an outcome measure (clinician-rated, sensitive to change).
- **The one discriminator:** self-report screens (PHQ-9, out of a possible 27) rule out and monitor cheaply; clinician-administered severity scales (MADRS, out of a possible 60) are the outcome and trial standard; a screening score is never a diagnosis.
- **The one exam fact:** read a score against validated, locally-normed cut-offs, not raw; an imported cut-off is only valid in the population it was normed on.

HOLD THIS

Work every case the same way: name the diagnosis, then do the exact job asked, match the therapy to the disorder's evidence base and the patient's stage of change, write the MSE as cross-sectional signs in seven-domain order, formulate on the biopsychosocial four-Ps grid, argue a boundary case both categorically and dimensionally, and pick the scale that fits the construct, the setting and the rater.

32 · Consolidation

This is the closing topic of the chapter, and its job is not to teach anything new but to make the twenty-odd topics before it *retrievable* under examination pressure: the psychotherapies with their models, techniques and lead indications; the mental state examination and the bedside cognitive screens; the psychometric principles that decide whether a scale can be believed; and the two classifications with the debate that shapes them. The organising idea comes from the science of learning rather than from psychiatry: you keep what you have *pulled out* of memory, not what you have looked at again, so this page is built as **active recall** and **retrieval practice**, not as a summary to skim.

How to use this page. First collect the master **mnemonic** paid off from the opening classification and common factors topic, then work the answer-free prompt bank aloud, then walk the two branches of the **synthesis map**, the therapy branch and the assessment-and-nosology branch, testing each count and discriminator against what you can produce cold rather than what you can recognise on the page. Finish by covering the accompanying figure and trying to **redraw from memory**; the branch that stalls is the branch to revise tonight.

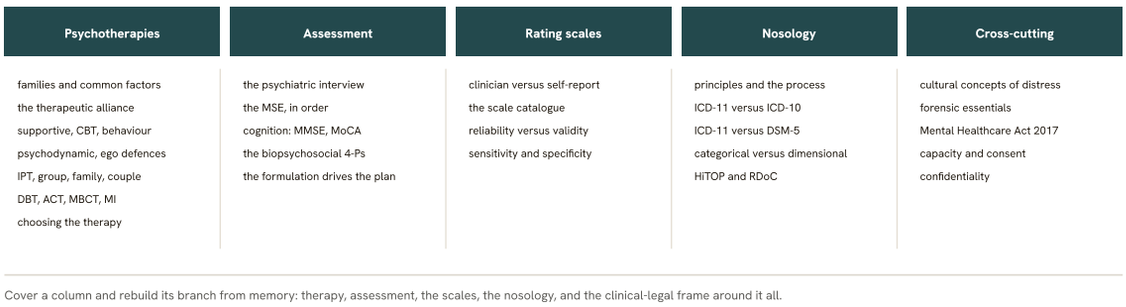


Fig 19.18 Chapter synthesis map. The chapter reduces to five branches: the psychotherapies (their families, the common factors and the alliance, the specific modalities, and how to choose one for a presentation); clinical assessment (the interview, the mental state examination in order, the cognitive screen, and the biopsychosocial formulation that drives the plan); the rating scales (clinician-rated versus self-report, the catalogue, and reliability versus validity); nosology (the principles of classification, ICD-11 against ICD-10 and against DSM-5, and the categorical-versus-dimensional debate with HiTOP and RDoC); and the cross-cutting clinical issues (the cultural concepts of distress, the forensic essentials, the Mental Healthcare Act 2017, and capacity, consent and confidentiality). Cover each column and rebuild its branch from memory.

32.1 Consolidation is retrieval practice, not re-reading

You keep what you pull out of memory, not what you look at again. The single most robust finding in the psychology of learning is the testing effect: actively retrieving a fact strengthens

the memory far more than re-reading it, and the effort of retrieval is itself the mechanism, which is why fluent, comfortable re-reading is a poor guide to what you will produce in the hall. Consolidation therefore means self-testing, not re-highlighting. The efficient way through this chapter is to turn every heading into a question, answer it aloud or on paper without looking, and only then check, spending the revision time on the branches you could not produce rather than the ones you could. The master **mnemonic** below is the trunk of the whole map: seeded deliberately at the opening classification topic and paid off here, it holds the six schools that every specific modality hangs from, and the phrase itself carries the common-factors message that most of the healing is shared, not branded.

RULE **Retrieve, do not re-read.** Recognising a familiar page feels like learning but is not; only pulling the answer from memory before you check it builds the recall the examination actually tests.

MNEMONIC

PLEASE BRING CARE, HOPE, SUPPORT, TRUST

The chapter's master mnemonic for the six **schools of psychotherapy**, seeded at the opening classification topic and paid off here as the trunk of the synthesis map: **P**sychodynamic, **B**ehavioural, **C**ognitive (and cognitive-behavioural), **H**umanistic (and experiential), **S**ystemic (and family), **T**hird-wave. Every named therapy hangs off one of these six trunks, and the phrase's meaning, care, hope, support and trust, is itself the common-factors payload, the shared ingredients that carry more of the outcome than any single technique.

32.2 The active-recall prompt bank: the therapy families and the common factors

Cover the rest of this page and answer each aloud before you read on. This list is deliberately answer-free, because supplying the answer defeats the point: the whole value is in the retrieval attempt. Work down it, and any prompt you cannot complete cleanly marks the topic to reopen. The prompts run across the psychotherapy families and the common factors first, then the assessment and nosology skills that the synthesis map below expands.

1. Name the six schools of the psychotherapy-family tree from the master mnemonic, and say why supportive belongs on the depth axis, not the school axis.
2. Give Frank's four common ingredients shared by every bona fide psychotherapy, and state which single common factor is the best-evidenced predictor of outcome.
3. Recite Bordin's three components of the therapeutic alliance, and say what you do when one of them ruptures.
4. List the five stages of change, and name the intervention error of handing an action plan to a precontemplator.
5. Draw the CBT cognitive model as a causal chain, and name the three views of Beck's cognitive triad.
6. Distinguish systematic desensitisation from flooding by whether a graded hierarchy is used, and place behavioural activation against both.

7. Rank the four levels of Vaillant's defence hierarchy, and place suppression and splitting on the correct levels.
8. List Yalom's therapeutic factors, give the exact count, and name the central one.
9. Name the four modes of standard DBT and the distinct function each delivers.
10. Recite the seven mental state examination domains in their conventional order, and say why the examination is a cross-sectional snapshot and not a diagnosis.
11. Separate reliability from validity in one line, and state which is necessary for the other.
12. Give the MMSE and the MoCA cut-offs out of a possible 30, and say which screen catches mild cognitive impairment and why.
13. State the one-line ICD-11 versus DSM-5 format discriminator, and name the official system used in India.
14. Say why no statistical test settles the categorical versus dimensional debate, and name the disorder where both manuals went most dimensional.

TRAP **Mistaking recognition for recall.** Reading the synthesis map and nodding along is recognition, which feels fluent and predicts almost nothing about performance; only covering it and producing the branch unaided is the retrieval practice that consolidates. If it felt easy, you probably read rather than retrieved.

32.3 The synthesis map, therapy branch: models, techniques and the counts to reproduce cold

Each widely-practised therapy compresses to a model, a signature technique and a lead indication. This is the therapy branch of the map, and the exam-ready form of every modality is exactly these three cells, the one-line mechanism, the one procedure that names it, and the one condition it is first choice for (the chapter's therapy topics and the guideline evidence). Cover the right-hand columns and produce them from the therapy name alone; the niche modalities (brief and crisis work, relaxation and biofeedback, and the projective tests) stay compact and are recalled by their one distinguishing feature rather than by this full grid.

THERAPY (SCHOOL)	MODEL IN ONE LINE	SIGNATURE TECHNIQUE	LEAD INDICATION
Supportive (depth axis)	Bolsters existing adaptive defences, self-esteem and coping without probing the unconscious	Reassurance, ventilation, reinforcing healthy defences	**The seriously or chronically ill and those in crisis; SSCM is first-line for anorexia nervosa**
Cognitive behaviour therapy	Interpretation, not the event, drives the emotional, physiological and behavioural response	Cognitive restructuring via the thought record, within collaborative empiricism	**Depression and the anxiety disorders; the best-evidenced therapy, first-line across the widest range**

THERAPY (SCHOOL)	MODEL IN ONE LINE	SIGNATURE TECHNIQUE	LEAD INDICATION
Behaviour therapy	Maladaptive behaviour is learned and can be unlearned by conditioning principles	Graded exposure and systematic desensitisation; behavioural activation; exposure and response prevention	Specific phobia and OCD (exposure); depression (behavioural activation)
Psychodynamic (STPP)	Unconscious conflict, transference and defence worked through to insight	Interpretation of transference and defence	A second-line or alternative option for depression and somatisation; MBT for borderline personality disorder
Interpersonal therapy	Symptoms are linked to one of four current interpersonal problem areas (grief, role transitions, role disputes, deficits)	Working the identified interpersonal problem area	**Depression, first-line, and particularly the perinatal period**
Group	The group is a social microcosm healing through Yalom's eleven therapeutic factors, cohesiveness central	Here-and-now process illumination and peer feedback	Interpersonal and relational problems; group CBT inherits CBT's evidence (first-line for gambling disorder)
Family and couple (systemic)	The family or couple, not the individual, is the unit of treatment	Restructuring communication, roles and expressed emotion	**Adolescent anorexia (FT-AN, first-line) and relapse prevention in schizophrenia**
Dialectical behaviour therapy (third wave)	Linehan's biosocial theory: emotional vulnerability meeting an invalidating environment, balancing acceptance and change	The four modes delivering the four skills modules	**Borderline personality disorder, especially where self-harm must be reduced**
Motivational interviewing / MET	Collaborative, person-centred, directive resolution of ambivalence across the stages of change	Evoking change talk; MET is its brief structured form	The substance use disorders (first-line); MET runs to four structured sessions

The therapy branch of the synthesis map: cover the last three columns and produce the model, the technique and the lead indication from the therapy name alone (the chapter's therapy topics; the guideline evidence).

The counts an examiner asks for cold, and the defence ladder underneath the dynamic therapies. Several numbers on this branch must be reproduced exactly, because a wrong count is itself a marked error. Beck's cognitive triad has exactly **3** views (self, world, future); the transtheoretical model has **5** stages of change (precontemplation, contemplation, preparation, action, maintenance); Yalom's therapeutic factors number exactly **11**, with cohesiveness the central one; and standard DBT from Linehan has exactly **4** modes (individual therapy, skills-training group, telephone coaching and the therapist consultation team) delivering the four skills

modules (mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness). Beneath the psychodynamic and supportive therapies sits Vaillant's maturity hierarchy of the ego defences, ranked into **4** levels, and it is the predominant level, not any single defence, that locates a patient's personality organisation.

Mature defences

Sublimation, altruism, humour, suppression, anticipation. The hallmark of healthy adult functioning; suppression is the only partly conscious member.

Neurotic defences

Repression, reaction formation, displacement, intellectualisation, isolation of affect, undoing, rationalisation. Repression-based; undoing underlies obsessional rituals.

Immature defences

Projection, acting out, splitting, passive aggression, somatisation, regression, idealisation and devaluation. A predominance of splitting marks borderline personality organisation.

Psychotic defences

Denial (of an obvious external reality), distortion, delusional projection. They abolish reality itself and are normal only in early childhood and in dreams.

11 YALOM'S THERAPEUTIC FACTORS (COHESIVENESS CENTRAL)	**4** MODES OF STANDARD DBT (LINEHAN)	**5** STAGES OF CHANGE (TRANSTHEORETICAL MODEL)	**3** VIEWS IN BECK'S COGNITIVE TRIAD (SELF, WORLD, FUTURE)

32.4 The synthesis map, assessment-and-nosology branch, and how to redraw it from memory

The assessment and nosology topics compress to a principle, a discriminator and a single exam fact. This is the other branch of the map, and it is examined as understanding rather than recall, so the retrieval target is the governing rule, the one contrast that separates a right answer from a wrong one, and the fact the paper reaches for. The mental state examination anchors the branch: it is a cross-sectional, here-and-now examination of the seven domains in their conventional order, *appearance and behaviour; speech; mood and affect; thought (form and content); perception; cognition; insight and judgement* (the mnemonic ALL SANE MEN THINK PRECISELY CONSIDERING INSIGHT), and it is neither the history nor a diagnosis but a snapshot that a diagnosis is later built upon.

TOPIC	THE PRINCIPLE	THE ONE DISCRIMINATOR OR EXAM FACT
Mental state examination	A cross-sectional here-and-now examination of seven domains in a fixed order	**It is not the history and not a diagnosis; a snapshot, not a summary of the illness over time**
The cognitive examination	A hierarchy tested attention first, then orientation, memory, language and praxis, then executive function	**Fluctuating inattention, not amnesia, is the hallmark of delirium and it invalidates every tier below it**

TOPIC	THE PRINCIPLE	THE ONE DISCRIMINATOR OR EXAM FACT
MMSE and MoCA	Bedside cognitive screens, each bundling the same items and scored out of a possible 30	**MMSE cut-off 24 (no executive items, misses mild impairment); MoCA cut-off 26, plus one point for twelve years or fewer of schooling, the more sensitive to mild cognitive impairment**
Reliability and validity	Reliability is consistency; validity is accuracy	**A scale can be reliable without being valid, but never valid without being reliable (reliability is necessary but not sufficient)**
ICD-11 versus DSM-5	Two harmonised classifications built by different bodies for different purposes	**ICD-11 gives prose essential features with no operationalised counts (clinical judgement); DSM-5 uses operationalised criteria with explicit counts and durations; the ICD is India's official system**
Categorical versus dimensional	Psychopathology as kinds versus degrees; no statistical test settles it, so both manuals are hybrids	**Categories win on usability, dimensions on accuracy; the manuals went most dimensional at personality disorder (ICD-11 severity plus five trait domains)**

The assessment-and-nosology branch of the synthesis map: cover the last two columns and produce the discriminator and the exam fact for each topic (the chapter's assessment and nosology topics; ICD-11 CDDR; DSM-5-TR).

Now cover the branches and redraw the chapter from memory. The accompanying figure draws the whole chapter as a single branching tree: the trunk is the master mnemonic's six schools, the leaves are the named modalities, and a second main branch carries the assessment skills (the mental state and cognitive examinations, the psychometric principles) and the nosology (the two classifications and the categorical-versus-dimensional debate). The retrieval drill is to hide it and rebuild it: speak, for each therapy leaf, its model, technique and lead indication, and for each assessment or nosology node, its principle, discriminator and one exam fact. Wherever the redraw stalls is the exact branch to reopen; wherever it flows, the consolidation has taken.

PEARL

Do the cover-the-branches redraw against the clock. In a viva you have seconds, not minutes, so practise producing a whole branch (the six schools, or the seven mental-state domains, or the four DBT modes) as a single fluent run rather than hunting item by item. Speed of retrieval, not mere possession of the fact, is what separates a confident answer from a hesitant one.

INDIA

The Indian MD and DNB psychiatry examinations are heavily viva-based and drill exactly this branch structure: the ego-defence grid, the mental state examination and the eponym counts are perennial theory-paper and viva questions taken straight from Kaplan and Sadock, so the counts are examined here, not treated as a Western aside. Two anchors are genuinely Indian and worth holding. The classification you diagnose forward in is the ICD-11, because India as a World Health Organization member state uses the ICD as its official statistical and training system and the Mental Healthcare Act 2017 ties the determination of mental illness to nationally or internationally accepted standards including the latest ICD. And the cognitive screens travel poorly across the country's languages and literacy levels, which is why the Hindi Mental State Examination and the vernacular adaptations from the NIMHANS and AIIMS assessment tradition exist, and why an imported cut-off is re-standardised rather than borrowed.

GOOD TO REMEMBER

- **The principle:** consolidation is retrieval practice, not re-reading; turn every heading into a question, answer it from memory, and spend the revision time on the branches you could not produce, because the effort of retrieval is what builds the recall the examination tests.
- **The one discriminator:** the synthesis map has two branches, the therapy branch (each modality compresses to a model, a signature technique and a lead indication) and the assessment-and-nosology branch (each topic compresses to a principle, a discriminator and one exam fact); learn each leaf as its three cells.
- **The one exam fact:** the master mnemonic (PLEASE BRING CARE, HOPE, SUPPORT, TRUST) holds the six schools; the counts to reproduce cold are Yalom's eleven factors, DBT's four modes, the five stages of change and Beck's three-view triad; and the cut-offs are the MMSE at 24 and the MoCA at 26, each out of a possible 30.

HOLD THIS

Consolidate by retrieval, not re-reading: cover the accompanying synthesis map and redraw it from memory, producing for every therapy leaf its model, technique and lead indication (the six schools of PLEASE BRING CARE, HOPE, SUPPORT, TRUST, with Yalom's eleven factors, DBT's four modes, the five stages of change and Beck's three-view triad as the counts to reproduce cold), and for every assessment-and-nosology node its principle, discriminator and one exam fact (the seven-domain MSE is a snapshot not a diagnosis; reliability is consistency and validity is accuracy; the MMSE cut-off is 24 and the MoCA 26 out of a possible 30; ICD-11 gives essential features while DSM-5 operationalises; and the categorical-versus-dimensional call is a pragmatic hybrid).

Previously asked

This chapter is examined as skills rather than syndromes, and it rewards precise, structured answers. The reliable pattern is that the specific psychotherapies recur as short notes (each wanting its model, its technique, its evidence and its one indication), that the defence mechanisms and transference come as their own essay and note, that the mental state examination, the projective tests and the rating scales are asked as assessment notes, and that the culture-bound syndromes and testamentary capacity are the recurring cross-cutting questions.

The long essays reward a named structure (a hierarchy of defences, the domains of the examination in order, an enumerated list of culture-bound syndromes), so the scheme and its exact count must be exam-ready. The genuine questions on record are grouped by band below.

HOW THIS TERRITORY IS ACTUALLY TESTED

- **The specific psychotherapies, as short notes.** Each named modality has come as a 10-mark note: "CBT (Cognitive Behaviour Therapy)" and "Cognitive Behaviour therapy", "Dialectical Behaviour Therapy (DBT)", "Interpersonal therapy", "Family therapy", "Biofeedback", "Meditation as a relaxation technique", and "Describe the principles, process and uses of Rational Emotive Behaviour Therapy (REBT)"; "Basic principles and application of behaviour therapy" has come as a full 25-mark essay. Prepare each modality to be described the same way, its model, its core technique, its evidence base and its one lead indication, and be able to place it on the psychotherapy-family tree. essay and short note, recurring

- **The defence mechanisms and the transference, the psychodynamic essay and note.** "Discuss defence mechanisms and their relevance in mental illness" has come as a 25-mark essay across more than one sitting, and "Transference and counter-transference" recurs as a 10-mark note. Prepare the defence-mechanism maturity hierarchy (mature, neurotic, immature, psychotic) with a clinical example for each, and the clinical meaning of transference, counter-transference and resistance. essay and short note, recurring

- **The projective tests, the mental state examination and the rating scales, as assessment notes.** "Rorschach's test" recurs as a 10-mark note across several sittings, with "Indications of the various psychiatric disorders on the Rorschach test" as a later note; "MMSE" and the frontal-lobe screen have come as notes; and "Rating scales in psychiatry" and the "need, clinical implications and problems of psychiatric rating scales" recur. Prepare the projective hypothesis and the main instruments, the mental state examination domain by domain, the bedside cognitive screen and the MMSE and MoCA cut-offs, and the rating scales as a catalogue with reliability versus validity. short note, recurring

- **The culture-bound syndromes, the recurring cross-cutting essay.** "Discuss the culture-bound syndromes" has come as a 25-mark essay across several sittings, and "Enumerate the culture-bound syndromes and describe Dhat syndrome in detail" as a 10-mark note. Prepare the reframing to cultural concepts of distress (syndromes, idioms, explanations), the enumerated examples, and the cultural formulation; the deep treatment of Dhat as an Indian culture-bound presentation is developed in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. essay and short note, recurring

- **Testamentary capacity and the forensic essentials, as notes.** "Testamentary capacity" and "Assessment of testamentary capacity" recur as 10 to 25-mark answers, and the medico-legal and forensic-science angle has come as an essay. Prepare the Banks versus Goodfellow criteria for a valid will, fitness to stand trial, and criminal responsibility under the McNaughten rules and the Indian frame; the fuller legislation and forensic procedure are developed in the Mental health legislation and forensic psychiatry notes. short note and essay, recurring

- **Classification and the nosological shifts, as essays.** The classification questions come attached to a disorder, for example "Discuss the nosological shift of OCD in DSM-5 and its spectrum" or "Classification of personality disorders". Prepare the principles of classification and the diagnostic process, the ICD-11 changes against ICD-10 and the ICD-11-versus-DSM-5 discriminator, and the categorical-versus-dimensional debate here; the disorder-specific nosological shifts are developed in the disorder chapters they belong to. essay, disorder-attached

Prepare this material to be applied, not just recited: each therapy ready to be chosen for a presentation, the mental state examination ready to be performed and written up, the rating scales ready to be selected and interpreted, and the nosology ready to place a case in the current classification. The disorder-specific therapy protocols (exposure and response prevention,

trauma-focused CBT, dialectical behaviour therapy for borderline personality disorder, interpersonal therapy for depression) and the disorder-specific rating scales are developed in their disorder chapters; the deep psychometric theory and the descriptive psychopathology are developed in the Psychometry, Assessment and Descriptive Psychopathology notes; and the fuller mental-health legislation is developed in the Mental health legislation and forensic psychiatry notes.

Quick review

THE PSYCHOTHERAPIES: CLASSIFICATION, THE COMMON FACTORS, AND CHOOSING	
CLASSIFICATION	By **depth** (supportive to reconstructive), by **school** (psychodynamic, behavioural, cognitive and cognitive-behavioural, humanistic, systemic and family, third-wave), by **duration** (brief to long-term) and by **format** (individual, group, family).
COMMON FACTORS	Much of the outcome is carried not by the technique but by factors common to all therapies: above all the **therapeutic alliance** (Bordin: the bond, plus agreement on goals and tasks), and alongside it expectancy and hope, the therapist's empathy and warmth, and the patient's own resources. Frank's shared credible rationale. The technique is one contributor, not the whole effect.
STAGES OF CHANGE	**Precontemplation, contemplation, preparation, action, maintenance** (five core; relapse recycles to an earlier stage). Match the intervention to the stage; this is the frame motivational interviewing works within.
CHOOSING THE THERAPY	Match the presentation and the formulation to the evidence-based modality (depression to CBT or IPT; borderline personality to DBT; substance use to MI and CBT; a family problem to family therapy; psychosis to family psychoeducation and CBTp alongside medication). The disorder-specific protocols are developed in their disorder chapters.
THE SPECIFIC THERAPIES: MODEL, TECHNIQUE AND LEAD INDICATION	
SUPPORTIVE	Ego-supportive (not exploratory); reassurance, ventilation, guidance, environmental manipulation, ego-strengthening. The most widely used therapy; for acute crisis, chronic and severe illness, and low ego-strength. Not a stand-alone guideline first-line specific treatment.
CBT (CORE)	The Beckian **cognitive model**: situation to automatic thought to emotion, body and behaviour; the levels (automatic thoughts, intermediate and core beliefs); the **cognitive triad** (self, world, future); the distortions. Cognitive restructuring plus behavioural experiments and activation. The most-evidenced therapy; first-line for depression and the anxiety disorders (ERP for OCD, cross-ref).
BEHAVIOUR THERAPY	Learning theory. **Systematic desensitisation** = a graded hierarchy plus relaxation (reciprocal inhibition, Wolpe); **flooding** = maximal exposure with NO hierarchy. Token economy (operant, Ayllon and Azrin). Trap: confusing flooding with desensitisation.

THE SPECIFIC THERAPIES: MODEL, TECHNIQUE AND LEAD INDICATION	
PSYCHODYNAMIC	Topographic and structural models; **transference**, counter-transference and resistance; free association, interpretation, working through. From classical analysis to brief dynamic therapy. The defences run **mature to neurotic to immature to psychotic**.
INTERPERSONAL (IPT)	Four problem areas: **grief, role dispute, role transition, interpersonal deficits**. Time-limited, present-focused; first-line for depression.
GROUP	**Yalom's eleven therapeutic factors** (universality, instillation of hope, imparting information, altruism, corrective recapitulation, socialising techniques, imitative behaviour, interpersonal learning, cohesiveness, catharsis, existential factors).
FAMILY AND COUPLE	Systemic (the system, not the individual, is treated); **structural** (Minuchin), **strategic** (Haley, Milan); the genogram; expressed emotion.
THIRD-WAVE	**DBT** (Linehan): biosocial theory, the **four modes** (individual, skills group, phone coaching, consultation team) and four skills modules; for borderline personality disorder. **ACT** (psychological flexibility, the hexaflex). **MBCT** for depressive relapse prevention.
MOTIVATIONAL INTERVIEWING	The spirit (partnership, acceptance, compassion, evocation); work with **ambivalence** and elicit **change talk**; OARS. For substance use and behaviour change.

CLINICAL ASSESSMENT: THE INTERVIEW, THE MSE, COGNITION AND FORMULATION	
THE HISTORY	Presenting complaint and history of the present illness, past psychiatric and medical history, drug and family history, personal and developmental history, premorbid personality, and the collateral history.
THE MSE, IN ORDER	**Appearance and behaviour; speech; mood and affect; thought (form and content); perception; cognition; insight and judgement.** A cross-sectional here-and-now examination: it is NOT the history, and it is NOT a diagnosis. Mood is subjective, affect is observed.
THE COGNITIVE EXAMINATION	Attention, orientation, memory, language and praxis, and the frontal-executive tests. **MMSE**: out of a possible 30, impairment at or below 23, read against age and education, ceilings in the educated. **MoCA**: out of a possible 30, normal at or above 26, add one point if twelve years or fewer of education; more sensitive to mild and executive impairment. India: the HMSE and the NIMHANS battery.
THE FORMULATION	The biopsychosocial model and the **4-Ps** (predisposing, precipitating, perpetuating, protective) across the biological, psychological and social levels. The formulation, not the diagnosis, drives the plan.

RELIABILITY, VALIDITY AND THE RATING SCALES	
RELIABILITY VERSUS VALIDITY	**Reliability = consistency** (test-retest, inter-rater, internal consistency and Cronbach's alpha); **validity = accuracy** (content, criterion, construct). A test can be reliable without being valid, but not valid without being reliable. Sensitivity rules a condition out (SnNout), specificity rules it in (SpPin).
THE CLINICIAN-RATED VERSUS SELF-REPORT SPLIT	Clinician-rated (HAM-D, MADRS, YMRS, PANSS, BPRS, HAM-A, Y-BOCS): captures signs, resists faking, needs training. Self-report (GAD-7, PHQ-9, the Beck inventories): fast, the patient's view, limited by insight and candour.
THE CRUNCH CUT-OFFS	**MMSE** impaired at or below 23 and **MoCA** normal at or above 26 (each out of a possible 30) are the two to hold. **MADRS** remission at or below 10 and **YMRS** at or below 12 (each out of a possible 60); **HAM-D** remission at or below 7; **GAD-7** screen-positive at or above 10 (out of a possible 21); **Y-BOCS** symptomatic at or above 16 (out of a possible 40); **PANSS** floored at 30 (up to a possible 210, never zero); **AUDIT** at or above 8 (out of a possible 40).

NOSOLOGY: THE PRINCIPLES, THE SYSTEMS AND THE DEBATE	
PRINCIPLES AND THE PROCESS	The Kraepelinian dichotomy; the reliability crisis that drove the operationalised turn (Feighner, DSM-III); the purposes of classification; the diagnostic process (prototype and criteria, the hierarchy, the formulation); the Robins and Guze validators.
ICD-11 VERSUS ICD-10	The schizophrenia **subtypes removed** (symptom and course specifiers instead); a **dimensional** personality-disorder model (severity plus trait domains); new entities (complex PTSD, prolonged grief disorder, gaming disorder, compulsive sexual behaviour disorder); **catatonia** a standalone grouping; **gender incongruence moved out** of the mental-disorders chapter; the clinical-descriptions-and-diagnostic-requirements format.
ICD-11 VERSUS DSM-5	The discriminator: ICD-11 states **essential features** with NO operationalised counts (clinical judgement against a prototype); DSM-5-TR sets **polythetic operationalised criteria** with symptom counts and durations. WHO global-health versus APA research orientation. ICD is India's official system.
CATEGORICAL VERSUS DIMENSIONAL	Categorical: discrete, familiar and actionable, but arbitrary thresholds, comorbidity and heterogeneity. Dimensional: a continuum, fits the data and captures sub-threshold states, but still needs a cut point. Hybrids: ICD-11 personality severity plus traits, the DSM-5 alternative model; the research frameworks **HiTOP** (spectra) and **RDoC** (functional domains).

THE CROSS-CUTTING CLINICAL ISSUES	
CULTURAL CONCEPTS OF DISTRESS	The reframing from culture-bound syndromes to cultural **syndromes, idioms and explanations**; the cultural formulation interview; the examples (Dhat and koro in the Indian and Asian context, amok, ataque de nervios). Deep treatment of Dhat is in the somatic and suicide notes.
FORENSIC ESSENTIALS	**Fitness to stand trial** (understand the proceedings, instruct counsel); **criminal responsibility** (the McNaughten rules; India: unsoundness of mind, IPC Section 84); **testamentary capacity** (Banks versus Goodfellow). The fuller statute and procedure are in the legislation and forensic notes.
MENTAL HEALTHCARE ACT 2017	**Independent** (capacitous, consenting) versus **supported** admission (with safeguards and time limits); the **advance directive**; the **nominated representative**; the Mental Health Review Board; the decriminalisation of attempted suicide (the presumption of severe stress, Section 115).
CAPACITY, CONSENT, CONFIDENTIALITY	**Capacity** (understand, retain, use and weigh, communicate; decision-specific and time-specific; presumed); informed consent and its exceptions; confidentiality and its limits (the duty to warn or protect, the Tarasoff principle).
THE TRAPS	Confusing flooding with systematic desensitisation; confusing reliability (consistency) with validity (accuracy); calling the MSE a history or a diagnosis; misplacing a defence on the maturity hierarchy; quoting the PANSS floor as zero; and forcing a categorical label where a dimensional formulation fits.

The rating scales in full

This appendix gathers the rating instruments used across the whole series into one place. The licence-cleared forms are reproduced as their actual instruments and the permission-required ones are typeset from their published structure; every cut-off here is verified against a primary source and stated out of its possible total. These reproductions are cleared for the free, non-commercial resident edition only, never a paid product.

Cognition

MMSE (TYPESET, NOT REPRODUCED)	VERIFIED STRUCTURE AND CUT-OFF
Instrument	Mini-Mental State Examination, the standard bedside cognitive screen (Folstein, Folstein and McHugh, 1975)
Domains	orientation to time and place (10), registration (3), attention and calculation (5), recall (3), language covering naming, repetition, a three-stage command, reading and writing (8), and construction by copying interlocking pentagons (1)
Total	sum of all items, out of a possible 30
Cut-off	**a score below 24 out of a possible 30 is the common threshold for cognitive impairment, adjusted for age and education; a rough severity reading is 24 to 30 no or questionable impairment, 18 to 23 mild and below 18 more marked (bands vary by source)**

A.1 The Mini-Mental State Examination (MMSE). The standard bedside cognitive screen across orientation, registration, attention and calculation, recall, language and construction, summing to a total out of a possible 30, with a score below 24 the common cut-off for cognitive impairment (adjusted for age and education). The instrument is copyright (PAR Inc, from 2001) and permission-required, so its structure is typeset from the published instrument rather than reproduced (Folstein MF, Folstein SE, McHugh PR. J Psychiatr Res. 1975).

MOCA (TYPESET, NOT REPRODUCED)	VERIFIED STRUCTURE AND CUT-OFF
Instrument	Montreal Cognitive Assessment, a screen more sensitive than the MMSE to mild cognitive impairment (Nasreddine et al., 2005)
Domains	visuospatial and executive (5), naming (3), attention (6), language (3), abstraction (2), delayed recall (5) and orientation (6)
Total	out of a possible 30, with one point added if the person has 12 or fewer years of formal education
Cut-off	**a score below 26 out of a possible 30 suggests cognitive impairment**

A.2 The Montreal Cognitive Assessment (MoCA). A cognitive screen more sensitive than the MMSE to mild cognitive impairment, spanning visuospatial and executive function, naming, attention, language, abstraction, delayed recall and orientation, out of a possible 30, with one point added for 12 or fewer years of education; a score below 26 suggests impairment. Copyright and permission-required (registration is needed to use it), so typeset from the published structure rather than reproduced (Nasreddine ZS, et al. J Am Geriatr Soc. 2005).

Mood

HAM-D (TYPESET)	VERIFIED STRUCTURE AND BANDS
Instrument	Hamilton Depression Rating Scale, 17-item version, the reference clinician-rated severity measure for depression (Hamilton, 1960)
Items	17 items, nine scored 0 to 4 and eight scored 0 to 2
Total	out of a possible 52
Severity bands	**0 to 7 none or remission, 8 to 16 mild, 17 to 23 moderate, 24 or more severe**

A.3 The Hamilton Depression Rating Scale (HAM-D, 17-item). The reference clinician-rated depression severity measure: 17 items, nine scored 0 to 4 and eight scored 0 to 2, summing to a total out of a possible 52, with 0 to 7 normal or remission, 8 to 16 mild, 17 to 23 moderate and 24 or more severe. The HAM-D is in the public domain; its structure is typeset here for the consolidated appendix (Hamilton M. J Neurol Neurosurg Psychiatry. 1960).

MADRS (TYPESET, NOT REPRODUCED)	VERIFIED STRUCTURE AND BANDS
Instrument	Montgomery-Asberg Depression Rating Scale, clinician-rated and designed to be sensitive to change (Montgomery and Asberg, 1979)
Items	10 anchored items, each scored 0 to 6
Total	out of a possible 60
Severity bands	**0 to 6 normal, 7 to 19 mild, 20 to 34 moderate, 35 to 60 severe**

A.4 The Montgomery-Asberg Depression Rating Scale (MADRS). A clinician-rated depression severity measure designed to be sensitive to change: ten anchored items each scored 0 to 6, out of a possible 60, with 0 to 6 normal, 7 to 19 mild, 20 to 34 moderate and 35 to 60 severe. Copyright and permission-required, so typeset from the published structure rather than reproduced (Montgomery SA, Asberg M. Br J Psychiatry. 1979).

YMRS (TYPESET, NOT REPRODUCED)	VERIFIED STRUCTURE AND THRESHOLDS
Instrument	Young Mania Rating Scale, the reference clinician-rated measure of manic severity (Young, Biggs, Ziegler and Meyer, 1978)
Items	11 items; four core items weighted 0 to 8 and seven items scored 0 to 4
Total	out of a possible 60
Interpretation	**dimensional, with no official diagnostic cut-off; a total near 12 out of a possible 60 is the most widely used remission threshold and near 20 the common acute-mania trial entry level**

A.5 The Young Mania Rating Scale (YMRS). The reference clinician-rated measure of manic severity: 11 items, four core items weighted 0 to 8 and seven scored 0 to 4, out of a possible 60. It is dimensional with no official diagnostic cut-off; a total near 12 is the common remission threshold and near 20 the usual acute-mania trial entry level. Copyright and permission-required, so typeset from the published structure rather than reproduced (Young RC, Biggs JT, Ziegler VE, Meyer DA. Br J Psychiatry. 1978).

Psychosis

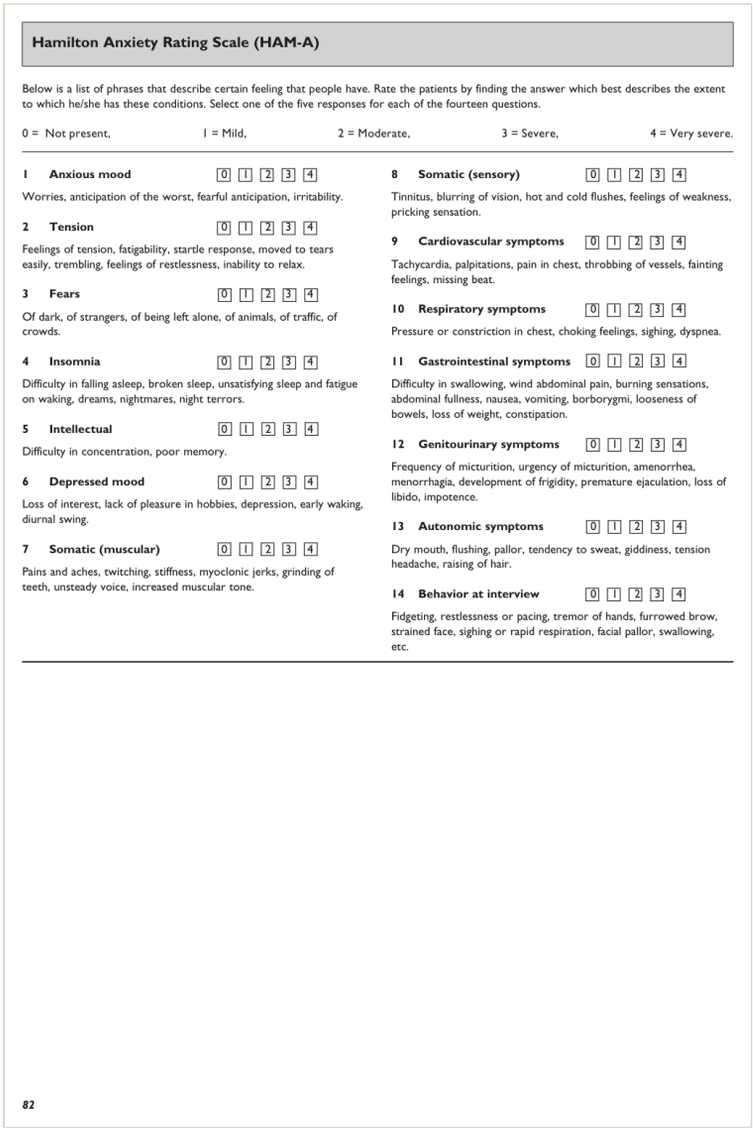
PANSS (TYPESET, NOT REPRODUCED)	VERIFIED STRUCTURE
Instrument	Positive and Negative Syndrome Scale, the interview-based severity measure for schizophrenia (Kay, Fiszbein and Opler, 1987)
Subscales	30 items each rated 1 to 7: Positive P1 to P7 (7 to 49), Negative N1 to N7 (7 to 49), General Psychopathology G1 to G16 (16 to 112)
Total	out of a possible 210; the floor is 30 because the lowest rating on each item is 1
Interpretation	**dimensional, with no official cut-off; any CGI-anchored severity mapping is approximate**

A.6 The Positive and Negative Syndrome Scale (PANSS). The interview-based severity measure for schizophrenia: 30 items each rated 1 to 7, split into Positive (seven items), Negative (seven items) and General Psychopathology (sixteen items), for a total out of a possible 210 (the floor is 30 because the lowest rating is 1). It is dimensional with no official cut-off. Copyright and permission-required, so typeset from the published structure rather than reproduced (Kay SR, Fiszbein A, Opler LA. Schizophr Bull. 1987).

BPRS (TYPESET)	VERIFIED STRUCTURE
Instrument	Brief Psychiatric Rating Scale, a broad clinician-rated symptom-severity measure (Overall and Gorham, 1962); the widely used expanded version has 18 items
Items	18 items, each rated 1 (not present) to 7 (extremely severe)
Total	range 18 to 126, out of a possible 126
Interpretation	**dimensional severity, with no official cut-off**

A.7 The Brief Psychiatric Rating Scale (BPRS). A broad clinician-rated measure of psychiatric symptom severity, most often the 18-item expanded version, each item rated 1 (not present) to 7 (extremely severe), for a total out of a possible 126 (range 18 to 126). It is dimensional with no official cut-off. Typeset here as structure only for the consolidated appendix (Overall JE, Gorham DR. Psychol Rep. 1962).

Anxiety and OCD



Hamilton Anxiety Rating Scale (HAM-A)

Below is a list of phrases that describe certain feeling that people have. Rate the patients by finding the answer which best describes the extent to which he/she has these conditions. Select one of the five responses for each of the fourteen questions.

0 = Not present, 1 = Mild, 2 = Moderate, 3 = Severe, 4 = Very severe.

1 Anxious mood [0] [1] [2] [3] [4]
Worries, anticipation of the worst, fearful anticipation, irritability.

2 Tension [0] [1] [2] [3] [4]
Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.

3 Fears [0] [1] [2] [3] [4]
Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.

4 Insomnia [0] [1] [2] [3] [4]
Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.

5 Intellectual [0] [1] [2] [3] [4]
Difficulty in concentration, poor memory.

6 Depressed mood [0] [1] [2] [3] [4]
Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.

7 Somatic (muscular) [0] [1] [2] [3] [4]
Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone.

8 Somatic (sensory) [0] [1] [2] [3] [4]
Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation.

9 Cardiovascular symptoms [0] [1] [2] [3] [4]
Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat.

10 Respiratory symptoms [0] [1] [2] [3] [4]
Pressure or constriction in chest, choking feelings, sighing, dyspnea.

11 Gastrointestinal symptoms [0] [1] [2] [3] [4]
Difficulty in swallowing, wind abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation.

12 Genitourinary symptoms [0] [1] [2] [3] [4]
Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.

13 Autonomic symptoms [0] [1] [2] [3] [4]
Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.

14 Behavior at interview [0] [1] [2] [3] [4]
Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, etc.

82

A.8 The Hamilton Anxiety Rating Scale (HAM-A). The clinician-rated severity measure for anxiety: 14 items spanning psychic and somatic anxiety, each scored 0 to 4, for a total out of a possible 56; the reproduced form's bands read below 17 mild, 18 to 24 mild to moderate and 25 to 30 moderate to severe (bands vary by source). Reproduced as its actual form; the HAM-A is in the public domain (Hamilton M. Br J Med Psychol. 1959).

GENERALIZED ANXIETY DISORDER 7-ITEM SCALE (GAD-7)

Spitzer RL, Kroenke K, Williams JBW, Lowe B, 2006

Over the **last 2 weeks**, how often have you been bothered by the following problems? *(Use the scale to the right to indicate your answer.)*

Question	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Add columns (total): Column totals summed give a total score of 0 to 21.

Score interpretation: 0-4 minimal anxiety; 5-9 mild anxiety; 10-14 moderate anxiety; 15-21 severe anxiety.

Clinical threshold: A score of 10 or greater is the common cut-off for probable generalized anxiety disorder (a cut-off of 8 or greater maximizes sensitivity and specificity).

If you checked off any problems, how **difficult** have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult □

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006;166(10):1092-1097.

Copyright / permission: Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. Copyright Pfizer Inc. No permission required to reproduce, translate, display or distribute. Reproduced here for free, non-commercial educational use.

A.9 The GAD-7 (Generalised Anxiety Disorder 7-item scale). The brief self-report screen for generalised anxiety: seven items each scored 0 to 3 over the last two weeks, for a total out of a possible 21, with 0 to 4 minimal, 5 to 9 mild, 10 to 14 moderate and 15 to 21 severe, and a score of 10 or more the common cut-off for probable generalised anxiety disorder. Reproduced as its actual open form (Spitzer, Kroenke, Williams and Lowe, 2006; developed with an educational grant from Pfizer, no permission required to reproduce).

Y-BOCS (TYPESET, NOT REPRODUCED)	VERIFIED STRUCTURE AND BANDS
Instrument	Yale-Brown Obsessive Compulsive Scale, the reference clinician-rated severity measure for OCD (Goodman, Price, Rasmussen and colleagues, 1989)
Items	10 items: 5 rate the obsessions and 5 rate the compulsions, each across time occupied, interference, distress, resistance and control; each item scored 0 to 4 (obsession subscale 0 to 20, compulsion subscale 0 to 20)
Total	out of a possible 40
Severity bands	**0 to 7 subclinical, 8 to 15 mild, 16 to 23 moderate, 24 to 31 severe, 32 to 40 extreme**

A.10 The Yale-Brown Obsessive Compulsive Scale (Y-BOCS). The reference clinician-rated severity measure for OCD: ten items, five for obsessions and five for compulsions, each rating time occupied, interference, distress, resistance and control on a 0 to 4 scale, for a total out of a possible 40, with 0 to 7 subclinical, 8 to 15 mild, 16 to 23 moderate, 24 to 31 severe and 32 to 40 extreme. Copyright and permission-required, so typeset from the published structure rather than reproduced (Goodman WK, Price LH, Rasmussen SA, et al. Arch Gen Psychiatry. 1989).

Trauma and somatic

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then select one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

Your worst event: _____

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0 ○	1 ○	2 ○	3 ○	4 ○
2. Repeated, disturbing dreams of the stressful experience?	0 ○	1 ○	2 ○	3 ○	4 ○
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0 ○	1 ○	2 ○	3 ○	4 ○
4. Feeling very upset when something reminded you of the stressful experience?	0 ○	1 ○	2 ○	3 ○	4 ○
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0 ○	1 ○	2 ○	3 ○	4 ○
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0 ○	1 ○	2 ○	3 ○	4 ○
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0 ○	1 ○	2 ○	3 ○	4 ○
8. Trouble remembering important parts of the stressful experience?	0 ○	1 ○	2 ○	3 ○	4 ○
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0 ○	1 ○	2 ○	3 ○	4 ○
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0 ○	1 ○	2 ○	3 ○	4 ○
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0 ○	1 ○	2 ○	3 ○	4 ○
12. Loss of interest in activities that you used to enjoy?	0 ○	1 ○	2 ○	3 ○	4 ○
13. Feeling distant or cut off from other people?	0 ○	1 ○	2 ○	3 ○	4 ○
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0 ○	1 ○	2 ○	3 ○	4 ○
15. Irritable behavior, angry outbursts, or acting aggressively?	0 ○	1 ○	2 ○	3 ○	4 ○
16. Taking too many risks or doing things that could cause you harm?	0 ○	1 ○	2 ○	3 ○	4 ○
17. Being "superalert" or watchful or on guard?	0 ○	1 ○	2 ○	3 ○	4 ○
18. Feeling jumpy or easily startled?	0 ○	1 ○	2 ○	3 ○	4 ○
19. Having difficulty concentrating?	0 ○	1 ○	2 ○	3 ○	4 ○
20. Trouble falling or staying asleep?	0 ○	1 ○	2 ○	3 ○	4 ○

PCL-5 (18 August 2023) National Center for PTSD Page 3 of 3

A.11 The PTSD Checklist for DSM-5 (PCL-5). The 20-item self-report measure of the DSM-5 PTSD symptoms, each scored 0 to 4 over the past month, for a total out of a possible 80; a provisional cut-off of 31 to 33 flags probable PTSD, which the National Center for PTSD frames as provisional and under review. Reproduced as its actual form; the PCL-5 is in the public domain (Weathers, Litz, Keane, Palmieri, Marx and Schnurr, 2013; National Center for PTSD, US Department of Veterans Affairs).

Patient Health Questionnaire-15: Physical Symptoms

During the last 4 weeks, how much have you have been bothered by any of the following problems? Please place a check mark in the box to indicate your answer.

		Not bothered	Bothered a little	Bothered a lot
		0	1	2
1.	Stomach pain	☐	☐	☐
2.	Back pain	☐	☐	☐
3.	Pain in your arms, legs, or joints (knees, hips, etc)	☐	☐	☐
4.	Menstrual cramps or other problems with your periods [women only]	☐	☐	☐
5.	Headaches	☐	☐	☐
6.	Chest pain	☐	☐	☐
7.	Dizziness	☐	☐	☐
8.	Fainting spells	☐	☐	☐
9.	Feeling your heart pound or race	☐	☐	☐
10.	Shortness of breath	☐	☐	☐
11.	Pain or problems during sexual intercourse	☐	☐	☐
12.	Constipation, loose bowels, or diarrhea	☐	☐	☐
13.	Nausea, gas, or indigestion	☐	☐	☐
14.	Feeling tired or having low energy	☐	☐	☐
15.	Trouble sleeping	☐	☐	☐
TOTAL SCORE =				

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Source instrument available at http://www.phqscreeners.com/
Consortium version 12May2013. Available at http://www.rdc-tmdinternational.org/

A.12 The PHQ-15 (Patient Health Questionnaire, physical symptoms). The 15-item somatic-symptom severity scale, each item scored 0 to 2, for a total out of a possible 30, with 0 to 4 minimal, 5 to 9 low, 10 to 14 medium and 15 to 30 high somatic-symptom burden. Reproduced as its actual open form (Kroenke, Spitzer and Williams; copyright Pfizer Inc, no permission required to reproduce).

Substance use and dependence

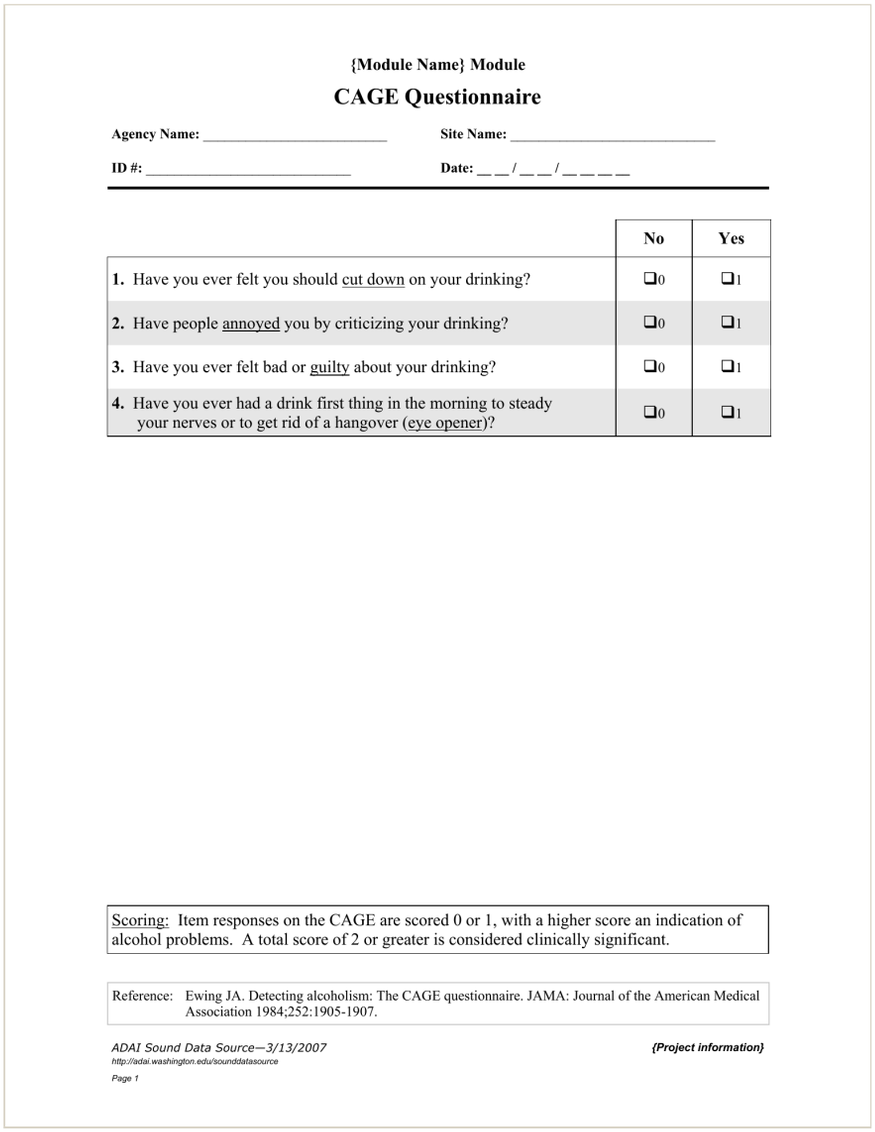
Box 10

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.
Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

A.13 The AUDIT (Alcohol Use Disorders Identification Test). The WHO 10-item screen for hazardous and harmful drinking, each item scored 0 to 4, for a total out of a possible 40, with a score of 8 or more indicating hazardous or harmful use and possible dependence (a lower cut-off of 7 is recommended for women and adults over 65). Reproduced from the WHO manual, free for non-commercial reproduction under the WHO copyright grant (Babor, Higgins-Biddle, Saunders and Monteiro, WHO, 2001).



{Module Name} Module

CAGE Questionnaire

Agency Name: _____ Site Name: _____

ID #: _____ Date: __ __ / __ __ / __ __ __ __

	No	Yes
1. Have you ever felt you should cut down on your drinking?	❑0	❑1
2. Have people annoyed you by criticizing your drinking?	❑0	❑1
3. Have you ever felt bad or guilty about your drinking?	❑0	❑1
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?	❑0	❑1

Scoring: Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

Reference: Ewing JA. Detecting alcoholism: The CAGE questionnaire. JAMA: Journal of the American Medical Association 1984;252:1905-1907.

ADAI Sound Data Source—3/13/2007
http://adai.washington.edu/sounddatasource
Page 1

{Project information}

A.14 The CAGE questionnaire. The four-item screen for alcohol misuse (Cut down, Annoyed, Guilty, Eye-opener), each item scored 0 or 1, for a total out of a possible 4, with a score of 2 or more clinically significant and warranting fuller assessment. Reproduced with acknowledgement for non-commercial use per the Bowles Center permission (Ewing JA. JAMA. 1984).

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient:_____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ Blood pressure:_____

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

PAROXYSMAL SWEATS -- Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

A.15 The CIWA-Ar (Clinical Institute Withdrawal Assessment for Alcohol, revised). The ten-item scale for alcohol-withdrawal severity: nine items scored 0 to 7 and orientation scored 0 to 4, for a total out of a possible 67; the form's own anchor is that patients scoring below 10 do not usually need additional medication, and any severity bands above that are protocol-dependent. Reproduced as its actual form; the CIWA-Ar is not copyrighted and may be reproduced freely (Sullivan et al., 1989).

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APPENDIX 1
Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date and Time ____/_____/____:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs*, 35(2), 253–9.

A.16 The COWS (Clinical Opiate Withdrawal Scale). The eleven-item clinician-rated scale for opioid-withdrawal severity, for a total out of a possible 48, with 5 to 12 mild, 13 to 24 moderate, 25 to 36 moderately severe and more than 36 severe withdrawal. Reproduced from the NIDA form, freely reproducible with acknowledgement (Wesson and Ling, 2003).

NIDA Clinical Trials Network

Fagerstrom Test for Nicotine Dependence (FND)

Segment: _ _

Visit Number: _ _

Date of Assessment: (mm/dd/yyyy) _ _/_ _/_ _ _ _

Do you currently smoke cigarettes?

☐No ☐Yes

If "yes," read each question below. For each question, enter the answer choice which best describes your response.

1. **How soon after you wake up do you smoke your first cigarette?**
   ☐Within 5 minutes ☐31 to 60 minutes
   ☐6 to 30 minutes ☐After 60 minutes
2. **Do you find it difficult to refrain from smoking in places where it is forbidden** (e.g., in church, at the library, in the cinema)**?**
   ☐No ☐Yes
3. **Which cigarette would you hate most to give up?**
   ☐The first one in the morning ☐Any other
4. **How many cigarettes per day do you smoke?**
   ☐10 or less ☐21 to 30
   ☐11 to 20 ☐31 or more
5. **Do you smoke more frequently during the first hours after waking than during the rest of the day?**
   ☐No ☐Yes
6. **Do you smoke when you are so ill that you are in bed most of the day?**
   ☐No ☐Yes

Comments:

Heatherton TF, Kozlowski LT Frecker RC (1991). The Fagerström Test for Nicotine Dependence: A revision of the Fagerström Tolerance Questionnaire. British Journal of Addiction 86:1119-27.

A.17 The Fagerstrom Test for Nicotine Dependence (FTND). The six-item measure of nicotine dependence, for a total out of a possible 10, with 0 to 2 very low, 3 to 4 low, 5 moderate, 6 to 7 high and 8 to 10 very high dependence. Reproduced from the NIDA government-hosted form, freely reproducible with acknowledgement (Heatherton, Kozlowski, Frecker and Fagerstrom, 1991).

SMART! INNOVATIONS IN DRUG SERVICES

SEVERITY OF ALCOHOL DEPENDENCE QUESTIONAIRE (SADQ-C)[1]

NAME_____AGE_____No._____

DATE:

Please recall a typical period of heavy drinking in the last 6 months.

When was this? Month:…… Year……..

Please answer all the following questions about your drinking by circling your most appropriate response.

During that period of heavy drinking

1. The day after drinking alcohol, I woke up feeling sweaty.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

2. The day after drinking alcohol, my hands shook first thing in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

3. The day after drinking alcohol, my whole body shook violently first thing in the morning if I didn't have a drink.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

4. The day after drinking alcohol, I woke up absolutely drenched in sweat.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

5. The day after drinking alcohol, I dread waking up in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

6. The day after drinking alcohol, I was frightened of meeting people first thing in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

7. The day after drinking alcohol, I felt at the edge of despair when I awoke.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

8. The day after drinking alcohol, I felt very frightened when I awoke.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

9. The day after drinking alcohol, I liked to have an alcoholic drink in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

10. The day after drinking alcohol, I always gulped my first few alcoholic drinks down as quickly as possible.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

11. The day after drinking alcohol, I drank more alcohol to get rid of the shakes.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

[1] Stockwell, T., Sitharan, T., McGrath, D.& Lang, . (1994). The measurement of alcohol dependence and impaired control in community samples. Addiction, 89, 167-174.

A.18 The SADQ (Severity of Alcohol Dependence Questionnaire). The 20-item self-report measure of alcohol-dependence severity, each item scored 0 to 3, for a total out of a possible 60, with below 16 mild, 16 to 30 moderate and 31 or more severe dependence (16 or more is the usual threshold at which an assisted detoxification regime is considered). Reproduced with acknowledgement for non-commercial use (Stockwell, Hodgson, Edwards and colleagues).

Global function and disability

GAF (TYPESET, NOT REPRODUCED)	VERIFIED STRUCTURE AND BANDS
Instrument	Global Assessment of Functioning, the DSM-IV Axis V single-number rating of overall psychological, social and occupational functioning
Scale	a single 1 to 100 scale read in ten anchored decile bands, each pairing a symptom clause with a functioning clause; higher scores mean better functioning
Anchor bands	**91 to 100 superior functioning, no symptoms; 81 to 90 absent or minimal symptoms; 71 to 80 transient, expectable reactions and slight impairment; 61 to 70 mild symptoms or some difficulty; 51 to 60 moderate symptoms or difficulty; 41 to 50 serious symptoms or serious impairment; 31 to 40 some impairment in reality testing or major impairment in several areas; 21 to 30 conduct strongly influenced by psychosis or serious impairment in judgment; 11 to 20 some danger to self or others or gross impairment; 1 to 10 persistent danger or persistent inability to maintain hygiene; 0 inadequate information**
Total	out of a possible 100 (higher is better functioning)

A.19 The Global Assessment of Functioning (GAF). The DSM-IV Axis V single-number rating of overall psychological, social and occupational functioning on a 1 to 100 scale, read in ten anchored decile bands where higher means better functioning, out of a possible 100. It derives from the Global Assessment Scale (Endicott et al., 1976); the American Psychiatric Association no longer licenses or endorses it and it was dropped from DSM-5, so its band structure is typeset here in our own words rather than lifted from the manual.

WHODAS 2.0 (TYPESET, NOT REPRODUCED)	VERIFIED STRUCTURE AND SCORING
Instrument	WHO Disability Assessment Schedule 2.0, a generic measure of functioning and disability across any health condition (WHO, 2010)
Versions	a 36-item full version and a 12-item short version; self-administered, interviewer-administered and proxy forms
Domains	six domains: cognition (understanding and communicating), mobility (getting around), self-care, getting along with people, life activities (household and work or school) and participation in society
Scoring	**each item rated none, mild, moderate, severe, or extreme or cannot do; a summary score is computed from 0 to 100, out of a possible 100, where 0 is no disability and 100 is full disability**

A.20 The WHO Disability Assessment Schedule 2.0 (WHODAS 2.0). The WHO generic measure of functioning and disability, in a 36-item full version and a 12-item short version, covering six domains (cognition, mobility, self-care, getting along, life activities and participation); items are rated from none to extreme and summarised on a 0 to 100 metric, out of a possible 100, where 0 is no disability and 100 is full disability. The WHODAS 2.0 is WHO copyright and free for clinicians to use with their own patients, but any other or electronic use requires written WHO permission, so it is typeset from the published structure rather than reproduced (WHO, 2010).

CGI (TYPESET)	VERIFIED ANCHORS
Instrument	Clinical Global Impression, a brief global clinician rating of illness severity and change (Guy, 1976)
CGI-Severity	rated 1 to 7: 1 normal, not ill; 2 borderline ill; 3 mildly ill; 4 moderately ill; 5 markedly ill; 6 severely ill; 7 among the most extremely ill
CGI-Improvement	rated 1 to 7: 1 very much improved; 2 much improved; 3 minimally improved; 4 no change; 5 minimally worse; 6 much worse; 7 very much worse
Scoring	**the two scales are rated separately, each out of a possible 7; the instrument does not yield a single summed total**

A.21 The Clinical Global Impression (CGI). The brief global clinician rating used across trials and clinics: CGI-Severity rates current illness from 1 (normal, not ill) to 7 (among the most extremely ill) and CGI-Improvement rates change from 1 (very much improved) through 4 (no change) to 7 (very much worse), each out of a possible 7 and rated separately rather than summed. The CGI is in the public domain (Guy W, ECDEU Assessment Manual for Psychopharmacology, 1976).

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The psychotherapy, assessment and nosology content is grounded in the standard psychiatry sources (the source hierarchy below), with Kaplan and Sadock and the New Oxford Textbook as the depth bar for the modality models and the classification, Fish and Sims for the mental state examination and descriptive psychopathology, Gabbard for the psychodynamic material, Beck for cognitive therapy, Linehan for dialectical behaviour therapy and Yalom for group therapy, and Clinical Methods in Psychiatry for the Indian context, the rating scales and the forensic and capacity frame. The therapy indications are guideline-first, anchored on the Indian Psychiatric Society psychotherapy and disorder guidelines, with NICE, CANMAT and WHO mhGAP. The Indian legal provisions (the Mental Healthcare Act 2017, the Indian Penal Code Section 84 and its recodification) were checked against their primary texts. Every rating-scale cut-off, eponym count and nosology fact was checked against these sources, and anything that could not be confirmed was stated conservatively or omitted rather than guessed. Each journal identifier below was verified against PubMed this build and matched on title, first author and year; books, guidelines and statutes are cited by author or body, title and year.

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Index

Every entry jumps to its page. Numbers are the page of first mention.

#

4-Ps grid 303
5-HIAA 157
5-HT2A 75

A

Aaron Beck 202
acceptance and commitment therapy 27
acquired capability 135
Addyi 75
adjunct 68
advance directive 367
aetiological formulation 304
agomelatine 99
allostatic load 107
alprostadil 60
alternative model of personality disorders 345
altruism 225
altruistic 134
ambivalence 195
American Psychiatric Association 90
amitriptyline 21
amok 358
anankastia 337
Anna Freud 225
anomic 134
Appelbaum 376
applied relaxation 256
aripiprazole 101
artefactual comorbidity 354
Arthur Kleinman 359
ASEX 61
ASPIRE 142
ataque de nervios 358
AUDIT 284
autogenic training 257
automatic thoughts 203
aversion therapy 190
Ayllon and Azrin 213
Ayurveda 94

B

Balint 222
Banks v Goodfellow 363
battery 167
BDNF 159
Beck 121
Beck's cognitive triad 202
behaviour therapy 21
behavioural activation 50
behavioural experiments 203
Bender Gestalt 324
Bharatiya Nyaya Sanhita 2023 117
biofeedback 50
biopsychosocial 68
biopsychosocial 4-Ps grid 304
biopsychosocial model 104
biosocial theory 260
bodily distress disorder 13
Body dysmorphic disorder 12
body integrity dysphoria 19
Bordin 37
boundary problem 354
BPRS 307
bremelanotide 73
Brief Psychiatric Rating Scale 309
brief psychotherapy 252
bupropion 99

C

C-SSRS 120
Campbell and Fiske 317
Capacity 55
care-avoidant type 13
care-seeking type 23
case formulation 300
catatonia 286
categorical 188
categorical approach 330
categorical versus dimensional 330
catharsis 198
CBT 23
CBT-I 208
Central Mental Health Authority 371
CGI 311
change talk 267
Charcot 29
choosing the right therapy 189
Chronic fatigue syndrome 52
cisgender 88

classical conditioning 209
Clinical Descriptions and Diagnostic Requirements 185
Clinical Descriptions and Diagnostic Requirements (CDDR) 335
Clinical Global Impression 311
clinician-rated 306
Clozapine 12
Cognitive behaviour therapy 21
cognitive behaviour therapy 21
cognitive distortions 84
cognitive model 202
cognitive restructuring 27
cognitive triad 202
cognitive-behavioural therapy 27
cohesiveness 237
collaborative empiricism 206
Columbia Suicide Severity Rating Scale 118
common factors 188
comorbidity 20
complex post-traumatic stress disorder 344
complex PTSD 332
compulsive sexual behaviour disorder 112
concurrent validity 317
confidentiality 188
construct validity 317
consultation-liaison psychiatry 104
content validity 317
contingency management 213
Convention on the Rights of Persons with Disabilities 367
core beliefs 203
corrective emotional experience 199
corrective recapitulation 238
counter-transference 216
couple therapy 73
crisis intervention 141
criterion validity 317
Cronbach and Meehl 317
Cronbach's alpha 316
cultural concepts of distress 95
cultural formulation 22
Cultural Formulation Interview 95
Culturally-adapted CBT 272
culture-bound syndromes 181
Cuthbert 352
cyproterone acetate 85

D

D'Zurilla 255
Da Costa syndrome 18
Dapoxetine 62
Davanloo 222
DBT 190
delayed ejaculation 61
Deliberate self-harm 11
delirium 109
dementia praecox 327
denial 122
desire phase 54
developing discrepancy 269
dexamethasone suppression test 159
Dhat 11
dhat 11
Dhat syndrome 22
dhatu 94
diagnostic hierarchy 330
diagnostic overlap 354
dialectical behaviour therapy 149
diaphragmatic breathing 50
diathesis 130
DiClemente 194
digit span 290
dimensional 188
dimensional personality disorder 337
directed masturbation 72
discriminant validity 317
dissociative neurological symptom disorder 29
divalproex sodium 114
dodo-bird verdict 195
dose reduction 97
DSM-5 13
DSM-5-TR 13
DSM-III 327
DSM-IV Defensive Functioning Scale 226
dual diagnosis 357
Dubois 296
duloxetine 21
Duralast 65
Durkheim 130
Dusky 363
Dusky standard 363
duty to warn 379
dyspareunia 72

E

Edmund Jacobson 257
ego-strengthening 198
ego-supportive 197
egoistic 134
Ellen Frank 236
Emil Kraepelin 327
emission 20
empirically-supported treatments 195

enactment 246
Endocrine Society 92
Engel 104
erectile dysfunction 11
esketamine 142
essential features 24
exhibitionistic disorder 81
Exner 322
explanatory model 50
exposure and response prevention 27
expressed emotion 243
expressive-supportive continuum 197

F

F68.10 33
face validity 317
factitious disorder 11
Factitious disorder imposed on another 32
family and couple therapy 244
Family or couple therapy 278
family therapy 188
fatalistic 134
Feighner 327
Feighner criteria 327
female orgasmic disorder 69
female sexual dysfunctions 11
female sexual interest/arousal disorder 69
fenfluramine challenge test 158
fetishistic disorder 81
Fibromyalgia 52
flibanserin 69
flight of ideas 286
flooding 190
fluoxetine 27
focal therapy 253
Folstein 290
formulation 22
Frank 103
Franz Alexander 107
free association 220
Frontal Assessment Battery 296
frotteuristic disorder 81
FSFI 73
functional analysis 209
functional neurological symptom disorder 11

G

GAD-7 307
GAF 311
gaming disorder 332
Ganser syndrome 32
Gatekeeper training 11
gender dysphoria 86
Gender identity 87
gender incongruence 11
gender-affirmative 86
gender-affirmative care 86
genito-pelvic pain/penetration disorder 69
genitourinary syndrome of menopause 72
genogram 244
George Engel 106
Gerald Caplan 252
Gerald Klerman 232
Global Assessment of Functioning 311
Goldberg 49
graded exposure 207
guidance 27
guru-chela 272

H

Halstead-Reitan 324
HAM-A 309
HAM-D 307
Hamilton 307
Hamilton Anxiety Rating Scale 309
Hamilton Depression Rating Scale 308
harm minimisation 149
Hayes 264
heterogeneity 348
hexaflex 264
Hindi Mental State Examination 299
HiTOP 347
HIV-associated neurocognitive disorder 111
Hoover's sign 29
HPA axis 107
hyperprolactinaemia 62
hypoactive sexual desire disorder 61
hypochondriasis 13
hypothalamic-pituitary-adrenal axis 159

I

ICD 12
ICD-10 13
ICD-11 12
ICD-11 impulse-control 112
IDEAS 145
identified patient 244
ideomotor apraxia 296
idioms of distress 108
IIEF-5 60
illness anxiety disorder 11
implosion 211

impulsive aggression 112
impulsive-aggression 158
independent admission 368
Indian context 94
Indian Penal Code Section 84 117
Indian Psychiatric Society 47
indication 27
Informed consent 87
Insel 352
insight 24
inter-rater reliability 307
intermediate beliefs 203
intermittent explosive disorder 112
internal consistency 186
Interpersonal and social rhythm therapy 236
interpersonal deficits 233
interpersonal inventory 232
interpersonal learning 237
interpersonal psychotherapy 232
interpretation 21
InterSePT 142
invalidating environment 261
IPS psychotherapy guidelines 272
IPSRT 236
IPT-A 235
ISSM 12

J

Jacobson progressive muscular relaxation 257
Jaspers 288
Jay Haley 246
Jerome Frank 193
Johannes Schultz 257
Joiner 130
Joseph Wolpe 210

K

Kendell 330
Kendell and Jablensky 348
Kernberg 224
Kessler 354
Ketamine 142
kleptomania 112
koro 93
Kotov 351
Kraepelin 326

L

La belle indifférence 31
Lambert 194
Lars-Goran Ost 257
lay counsellor 274
learning theory 190
legal insanity 364
leuprolide 85
Lindemann 252
Linehan 261
Lipowski 110
Lithium 12
longitudinal formulation 304
loosening of associations 284
Luria 296
Luria three-step 296
Luria-Nebraska 324

M

M-FAST 41
MADRS 307
Maj 23
Malan 222
male hypoactive sexual desire disorder 61
Malingering 11
Manforce 60
manic-depressive insanity 327
Mann 88
Mara Selvini Palazzoli 246
Masters and Johnson 54
matching 141
Maxwell Jones 240
McMaster 249
McNaughten 363
McNaughten rules 363
Meadow 34
meditation-based 189
meditation-based interventions 189
medroxyprogesterone acetate 85
Melanie Klein 231
Menninger Psychotherapy Research Project 198
Mental Health Act 1987 367
Mental Health Review Board 371
Mental Healthcare Act 129
Mental Healthcare Act 2017 129
Mental Healthcare Act, 2017 133
mental state examination 188
mhGAP 21
MI 11
Milan 243
mindfulness 27
mindfulness-based cognitive therapy 27
Mini-Mental State Examination 293
mirtazapine 99
MMSE 188
mnemonic 13

MoCA 188
Montgomery 308
Montgomery Asberg Depression Rating Scale 308
Montreal Cognitive Assessment 290
moral treatment 197
motivational enhancement therapy 271
motivational interviewing 188
Munchausen by proxy 32
Munchausen syndrome 32
Murray Bowen 246
muscle dysmorphia 45
myotonia 55
Myrna Weissman 232

N

Naeem 208
NALSA judgment 87
naltrexone 115
Nasreddine 290
National Crime Records Bureau 132
National Mental Health Programme 111
National Mental Health Survey 274
National Suicide Prevention Strategy 151
negative predictive value 319
Neki 275
neuroinflammation 159
NICE ESNM40 76
NICE NG225 124
NIMHANS 111
NIMHANS fitness-to-stand-trial proforma 366
NIMHANS Neuropsychological Battery 325
nitric oxide 57
nominated representative 367
Non-suicidal self-injury 122
normative 81
norms 241

O

OARS 267
obsessive-compulsive and related disorders 19
olanzapine 101
operant conditioning 209
orientation 84

P

p factor 68
paedophilic disorder 81
PANSS 307
Papageno effect 155
paraphilia 11
paraphilic disorder 11
parasympathetic 57
Pavlov 209
PDE5 inhibitor 59
penile prosthesis 60
perceived burdensomeness 135
peregrination 34
perpetuating 58
personality disorder 36
Phantom limb pain 52
phosphodiesterase-5 57
PHQ-15 14
PHQ-9 118
physician-centred care 21
POCSO Act 86
polyamine system 159
polythetic criteria set 326
Positive and Negative Syndrome Scale 308
positive predictive value 319
post-SSRI sexual dysfunction 98
precipitating 105
predictive validity 317
predisposing 300
premature ejaculation 54
Priligy 76
principles of consultation-liaison 110
Pritchard 363
Pritchard criteria 363
problem-solving therapy 252
Prochaska 194
Prochaska and DiClemente 194
progressive muscle relaxation 257
projection 223
prolonged grief disorder 332
Prosenjit Poddar 379
protective 11
prototype 27
pseudologia fantastica 34
psychiatric history-taking 284
psycho-oncology 104
psychoanalysis 188
psychodynamic psychotherapy 190
psychoeducational 93
Psychological factors affecting other medical conditions 104
psychological flexibility 261
psychological mindedness 200
psychometric properties 314
psychoneuroimmunology 107
psychophysiological disorders 104
psychosocial assessment 69
Psychosomatic medicine 11
pudendal nerve 57

pyromania 112

R

rating scales 12
Rattan Lal 364
Rattan Lal versus State of Madhya Pradesh 364
Raven's Progressive Matrices 325
Raymond Prince 360
RDoC 347
re-educative 191
re-educative therapy 191
Reasons for Living Inventory 125
reassurance 13
Reattribution 21
reciprocal inhibition 210
reconstructive 192
reconstructive therapy 192
refractory period 54
relaxation training 256
reliability 186
reliability of diagnosis 326
resistance 30
Resnick 41
Responsible media reporting 151
responsive desire 56
retrograde ejaculation 57
righting reflex 269
risperidone 101
Robins and Guze 333
Robins and Guze validators 333
role dispute 233
role transition 233
rolling with resistance 269
Rorschach 232
Rosemary Basson 54
Rosenzweig 195

S

SAD PERSONS 118
SAD PERSONS scale 127
SAFE-T 138
safety plan 11
Safety Planning Intervention 128
Salvador Minuchin 246
Sangath 274
scale catalogue 311
scale selection 311
schema 54
schizoaffective 142
schizoaffective disorder 142
schizophrenia 12
Section 115 129
Section 115 of the Mental Healthcare Act 2017 129
Section 115 of the Mental Healthcare Act, 2017 133
Section 309 of the Indian Penal Code 129
Section 84 of the Indian Penal Code 364
Segal, Williams and Teasdale 265
self-harm 11
self-help 237
self-help group 239
self-report 35
sensate focus 73
sensitivity 234
serial sevens 290
serotonergic system 158
sex assigned at birth 87
sexual masochism disorder 81
sexual response cycle 11
sexual sadism disorder 81
shen-k'uei 96
sick role 32
Sifneos 222
Sigmund Freud 225
sildenafil 60
SIMS 41
SIRS 41
Skinner 209
Socratic questioning 206
Somatic symptom disorder 11
Somatisation disorder 13
sound disposing mind 365
Specialist supportive clinical management 201
specialist supportive clinical management (SSCM) 201
specificity 107
specificity hypothesis 107
spirit of motivational interviewing 267
split-half 316
splitting 22
splitting versus lumping 354
SSD-12 14
SSRI 27
SSS-8 21
stages of change 190
standardisation 290
Stanford-Binet 325
Stanley-Brown 128
Stanley-Brown Safety Planning Intervention 128
State Mental Health Authority 371
Static-99R 83
Stephen Rollnick 267

stepped care 278
Steven Hayes 264
strategic 243
stress-diathesis model 130
structural family therapy 243
structural model 217
sublimation 223
supported admission 368
supportive 36
supportive psychotherapy 188
supportive therapy 191
Susan Johnson 246
susto 359
sympathetic 57
symptom-domain specifiers 336
systematic desensitisation 190
systemic therapy 75

T

tadalafil 60
taijin kyofusho 359
Tarasoff 375
task sharing 274
test-retest 316
Thematic Apperception Test 232
therapeutic alliance 21
therapeutic community 240
therapeutic factors 194
therapeutic privilege 378
therapy selection 277
third-wave therapies 188
thought record 204
thwarted belongingness 135
time-limited psychotherapy 222
token economy 190
TOMM 41
topographic model 217
trait domains 331
transference 37
transgender 86
Transgender Persons (Protection of Rights) Act, 2019 92
transtheoretical model 190
transvestic disorder 81
trauma-focused CBT 208
tremor entrainment test 29
triptorelin 85
true comorbidity 354
Tuckman 241
two-factor theory 210

U

universal, selective and indicated prevention 152
universality 238

V

vaginismus 70
Vaillant 223
validity 186
vasocongestion 55
ventilation 198
vorbeireden 36
vortioxetine 99
voyeuristic disorder 81

W

Wampold 193
Wechsler 324
Werman 202
Werther effect 153
which therapy 244
WHODAS 2.0 311
William Miller 267
Williams and Teasdale 265
Wolberg 191
working through 190
World Health Organization 132
WPATH SOC-8 12

Y

Y-BOCS 307
Yale-Brown Obsessive Compulsive Scale 309
Yalom 196
YMRS 307
yoga 189
Young Mania Rating Scale 308

Z

Z76.5 39
zone of rarity 348
zones of rarity 330

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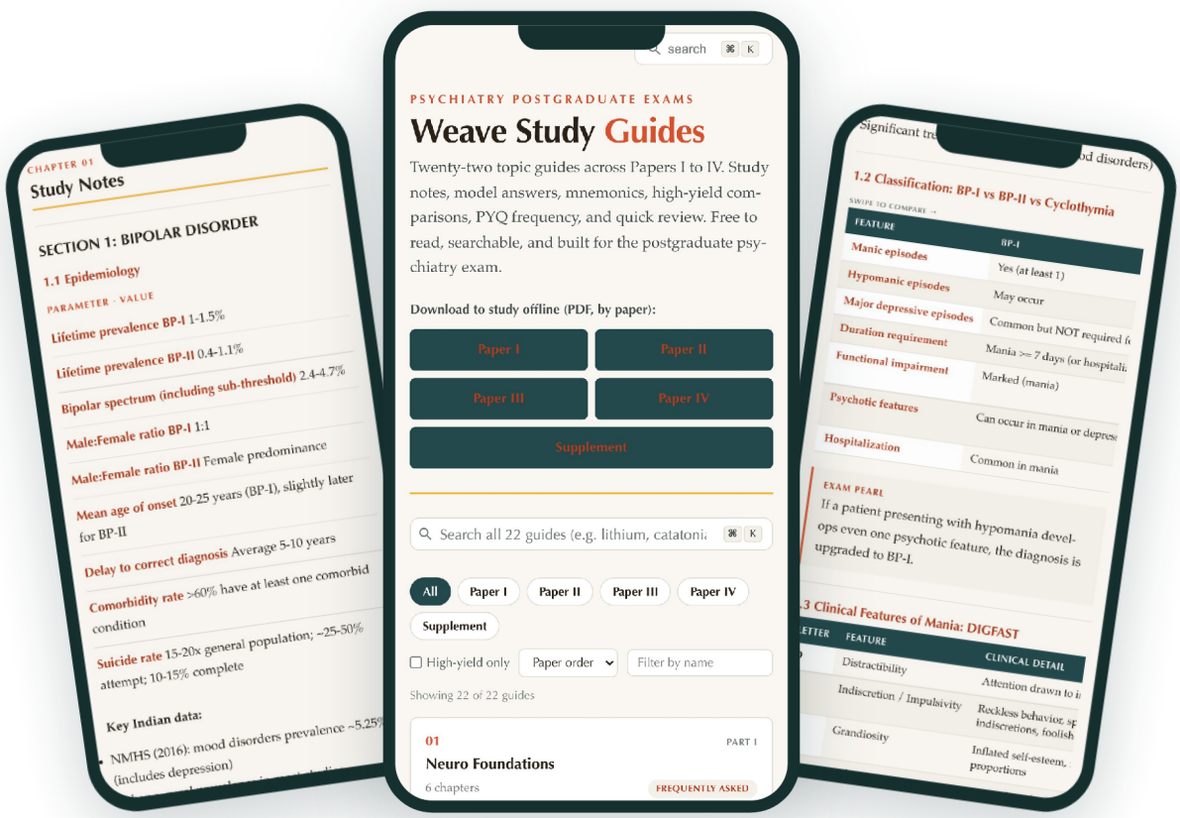
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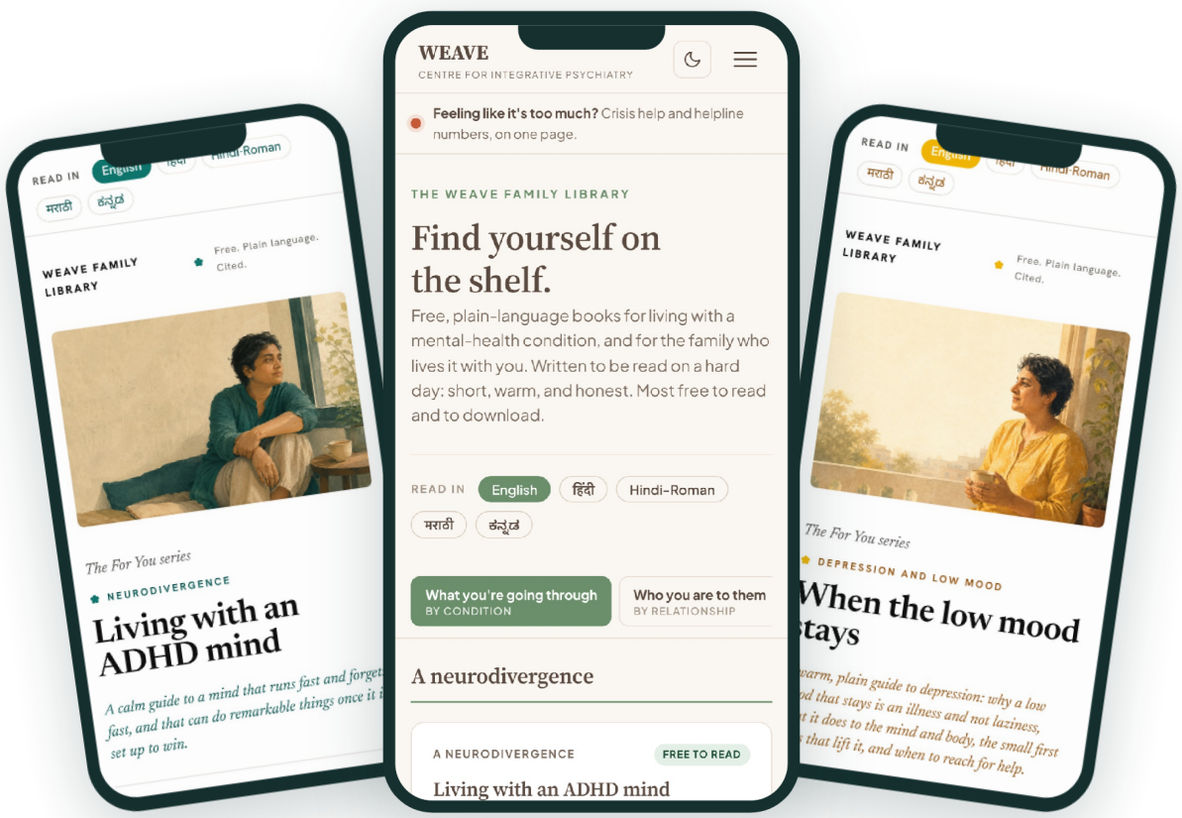
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Volume Six of the second paper closes it: the somatic-symptom, sexual and impulse-control disorders, with the assessment and prevention of suicide; then the psychotherapies, the clinical interview, the mental state examination and nosology, the craft that holds the clinical work together. Two complete sets of notes, written to be understood the first time and recalled every time after, with a colour memory code, a clickable contents and a full index.

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